

Everybody's Doing It:

Health Insurance Premium-Sharing
by Employees and Retirees in the
Public and Private Sectors

January 2013



FOREWORD

Founded in 1932, the Citizens Budget Commission (CBC) is a nonprofit, nonpartisan civic organization devoted to influencing constructive change in the finances and services of New York State and New York City governments. A major activity of the Commission is conducting research on the financial and management practices of the State and City.

All research by the CBC is overseen by a committee of its Trustees. This report was prepared under the auspices of the Budget Policy Committee, which we chair. The other members of the Committee are: Lawrence D. Ackman, Stephen Berger, Seth P. Bernstein, Les Bluestone, Lawrence B. Buttenwieser, Vishaan Chakrabarti, Eileen Cifone, Karen Lynne Daly, Eric R. Dinallo, Bud H. Gibbs, William J. Gilbane III, Martin Grant, Peter C. Hein, H. Dale Hemmerdinger, Brian T. Horey, William N. Hubbard III, David A. Javdan, Steven J. Kantor, Eugene J. Keilin, Robert Kurtter, Richard A. Levine, James L. Lipscomb, Randolph Mayer, Richard J. Raphael, Carol Raphael, John Rhodes, Denise Richardson, Carol E. Rosenthal, Heather L. Ruth, Michael L. Ryan, Edward L. Sadowsky, Teddy Selinger, Timothy Sheehan, Meryll H. Tisch, Sonia Toledo, Cynthia King Vance, Mark L. Wagar, Claudia Wagner, Kevin Willens, Michael A. Zarcone, and Kenneth D. Gibbs, *ex-officio*.

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INTRODUCTION AND SUMMARY

The cost of health insurance for New York City public employees and retirees has more than doubled in the last ten years, and its continued growth will be a major driver of projected budget gaps. While the total city budget is projected to grow 11 percent from fiscal years 2012 to 2016, health insurance costs will grow by almost 40 percent and comprise 70 percent of the projected budget gap in 2016.

Currently, more than 90 percent of the municipal workforce is enrolled in health insurance plans that require no employee contribution toward the cost of the premium for basic individual and family coverage. The City continues to pay the full cost for employees and their families if they retire before the age of 65. When they enroll in Medicare at age 65, retirees are reimbursed by the City for the full cost of the Part B premiums.

Employees and retirees should share the premium cost of their health insurance. Reducing the taxpayer burden for premiums will not reduce the City's attractiveness as an employer and is essential to balance the budget and reduce the City's long-term financial obligations. Sharing premium costs also gives employees and retirees a vested interest in controlling future premium increases by selecting cost-effective features in plan design.

To determine a reasonable level of contribution, the Citizens Budget Commission (CBC) undertook a comparative analysis of prevailing premium-sharing arrangements for employees and retirees in the public and private sectors in the U.S. This report reviews the health insurance premium sharing policies for employees and retirees of the federal government, the State of New York and six large U.S. municipalities: Los Angeles, Chicago, Boston, Houston, Phoenix and San Francisco. It also presents data on health insurance offered by large corporations in New York State and nationwide.

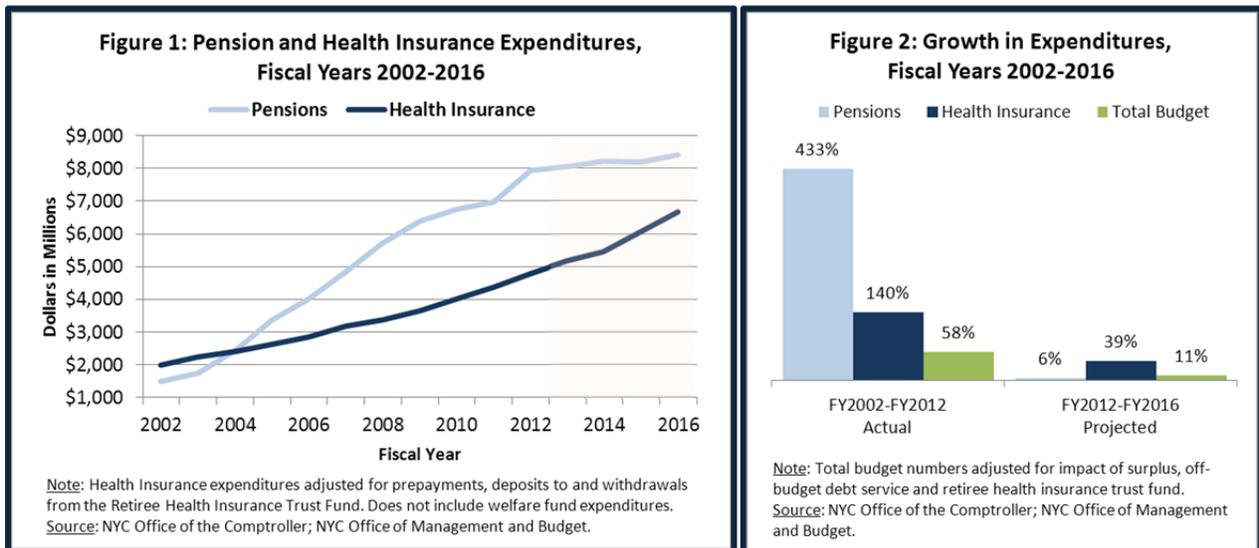
The analysis has a clear finding: **New York City's health premium policies for employees *and* retirees are more generous than those of comparable employers in the public and private sectors.** The City is especially generous with respect to retiree health benefits – particularly its reimbursement of Medicare Part B premiums for retirees and their spouses. Savings can and should come from an agreement between labor and lawmakers to implement premium-sharing in the largest plans. If CBC's recommendations are adopted, the savings would total \$1.8 billion in fiscal year 2014 and rise to \$2.2 billion in fiscal year 2016.

THE GROWING FISCAL IMPACT OF HEALTH INSURANCE

Since local governments are primarily service providers, it is not surprising that more than half of all spending by the City of New York— \$38.3 billion— is devoted to compensating the employees that provide these services. Traditionally, public employee compensation consisted mostly of a salary or wage; today, providing fringe benefits has become increasingly expensive. For every dollar the City pays directly to employees in wages, it spends an additional 71 cents on fringe benefits.

The most costly fringe benefits are pensions and health insurance. New York City public employees are enrolled in defined benefit pension plans that guarantee a certain payout upon retirement, and the City bears the risk of ensuring the funds are there to make the payments. Driven by benefit enhancements and severe investment losses, the City’s required pension contributions grew five times over during the last decade to reach a peak of \$8 billion in fiscal year 2012. In March 2012, state leaders enacted a new “tier” of less costly benefits for new State, City and local employees that is expected to restrain the growth in required pension fund contributions over the next three decades. In addition, actuarial changes implemented by the City Actuary are projected to keep pension costs high, but fairly level, for the remainder of the City’s four-year financial plan.

While the skyrocketing growth in pension contributions has been a focus of reform efforts, the significant growth in the cost of health insurance has attracted less attention. Health insurance costs for New York City municipal employees and retirees more than doubled from \$2.0 billion in fiscal year 2002 to \$4.8 billion in fiscal year 2012. In contrast to pension contributions, health insurance costs are projected to continue growing rapidly, reaching almost \$7 billion by fiscal year 2016. This growth is directly related to growth in the cost of health insurance premiums.



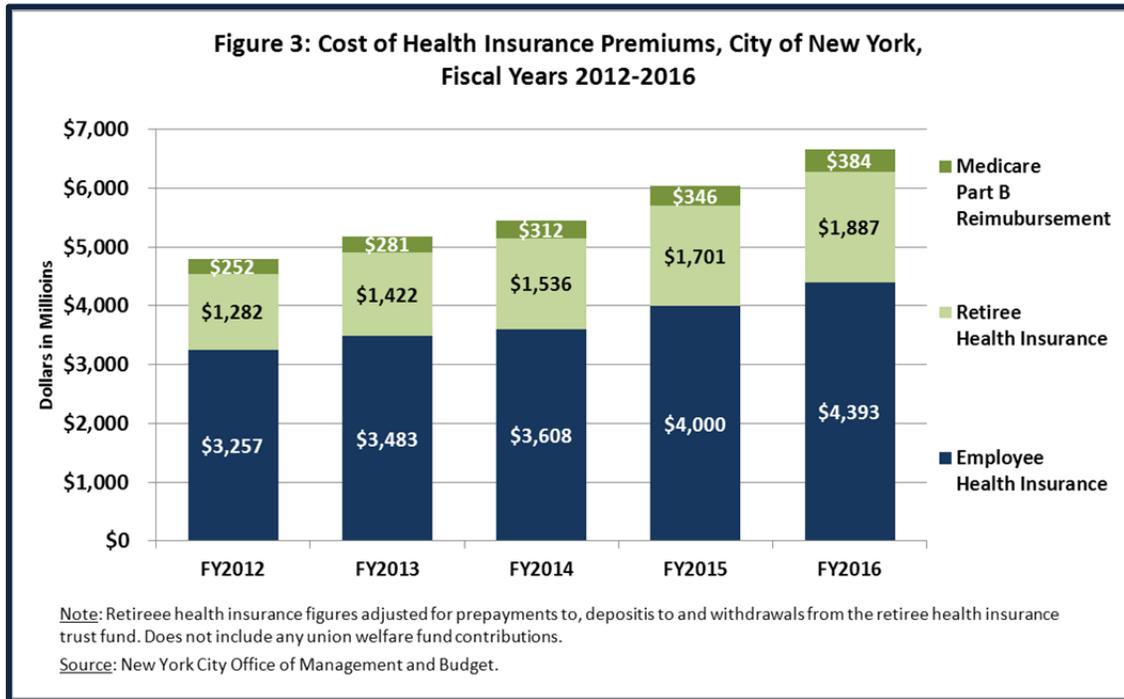
The City offers 12 comprehensive health insurance plans to employees working at least 20 hours a week.¹ While some of these plans require employees to pay part of the premium cost for coverage, more than 90 percent of the City’s workforce is enrolled in one of two plans – the GHI Comprehensive

Benefit Plan (GHI-CBP) and the HIP Prime Health Maintenance Organization (HIP-HMO) – for which the City pays the full premium for employees, their spouses and their dependents.² In fiscal year 2013, the annual HIP-HMO premium is \$6,600 for single coverage and \$16,185 for family coverage;³ this adds about one-third to the average pay of a civilian employee.⁴ In total, employee health insurance premiums will cost the City \$3.5 billion in fiscal year 2013. (See Figure 3.)

The cost of providing health insurance to New York City employees and retirees more than doubled between fiscal years 2002 and 2012, growing from \$2.0 to \$4.8 billion. This is more than the City spends to provide parks, transportation, housing, fire and homeless services combined.

Retirees who worked at least ten years receive health insurance on the same basis as employees: if they enroll in the GHI or HIP plans, they bear no responsibility for the cost of their health insurance premiums in retirement. Coverage begins upon retirement from city service without regard to other employment or age. This is an important benefit; in 2011, two-thirds of retired police officers and 45 percent of retired firefighters were not yet age 65. In total, more than one-third of all City retirees, or 97,000 people, are early retirees.⁵ Retiree premiums cost the City \$1.4 billion in fiscal year 2013.

At age 65, Medicare becomes the primary health insurance provider, with City plans available as secondary coverage. Medicare Part B, which covers common medical services, requires retirees to pay a monthly premium that is adjusted according to income; in 2013, the standard annual premium is \$1,260 and rises to \$4,030 for high-income individuals earning more than \$214,000.⁶ The City reimburses retirees and their spouses for the full out-of-pocket cost of the Medicare Part B premium—not just the standard premium. This will cost \$280 million in fiscal year 2013.



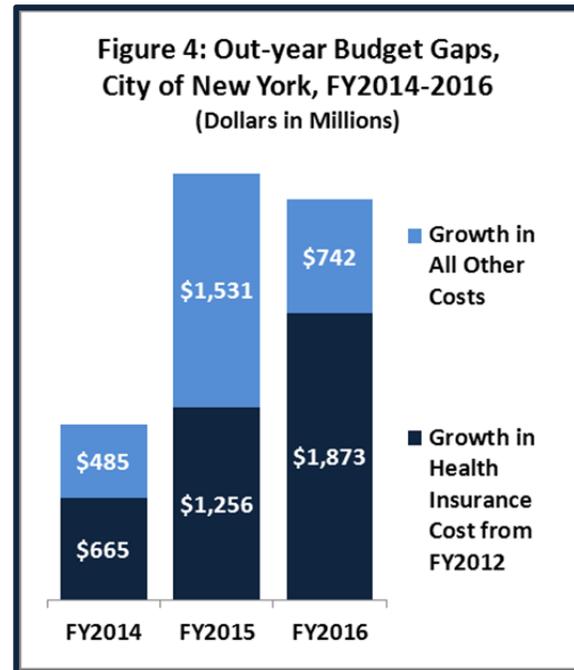
The Short- and Long-Term Challenges

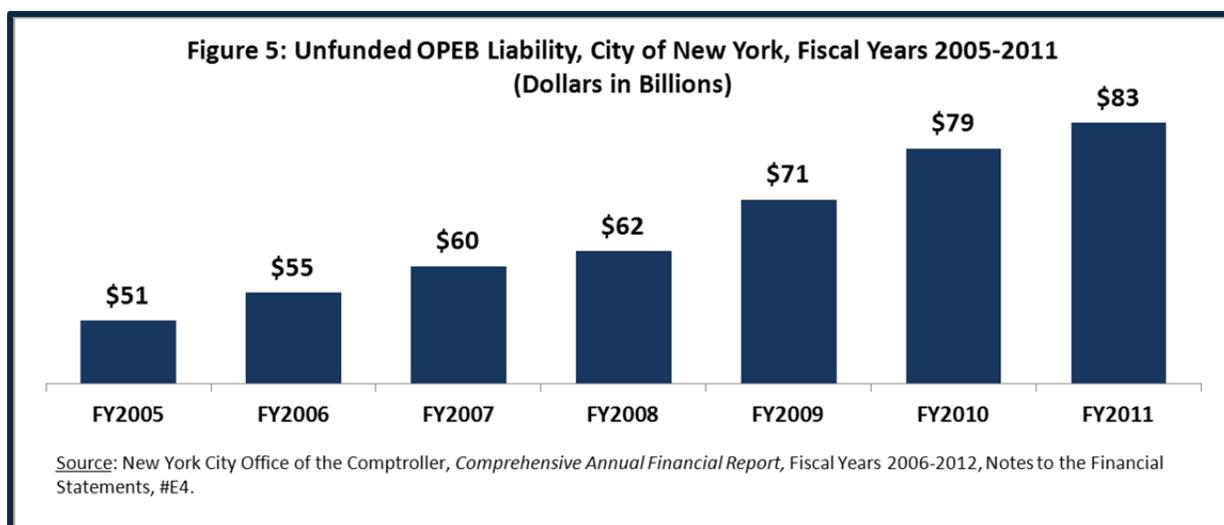
The growing cost of health insurance benefits has a short-term and a long-term fiscal impact. In coming years, balancing the budget will become increasingly difficult, as deficits are projected and few reserves are available to close the gaps. Health insurance costs will be a large driver of out-year gaps: these costs are expected to grow 39 percent to \$6.6 billion in fiscal year 2016, an increase of \$1.8 billion that accounts for 72 percent of the \$2.6 billion projected gap.

The City is also accruing a growing unfunded liability for retiree health insurance and other post-employment benefits (OPEB). City employees receive a pension and health care coverage when they retire, and each creates a financial liability for the City. But the City pays for the liabilities differently. Funding for pensions is actuarially-determined; the City actuary annually reassesses the size of the future liability and calculates the amount the City must pay each year to ensure the pension funds will be able pay out benefits. In contrast, retiree health benefits are funded on a “pay-as-you-go” basis. This means current taxpayers are paying for the retiree health benefits

promised to employees when they were hired decades ago; the challenge is the City has accumulated a debt, or unfunded liability, for the future benefit payments of current employees when they retire.

This unfunded liability is estimated to be \$83 billion, up from \$55 billion just five years ago. There is no legal requirement to fund OPEB obligations, but credit rating agencies are beginning to take the magnitude of unfunded liabilities and strategies to address them into account in their fiscal evaluations.⁷ Other cities, such as Los Angeles, Washington DC and Denver, have funded half of their total OPEB liabilities.⁸ In New York City, the Mayor and City Council created a trust to begin to fund the OPEB liability in 2006, and \$2.5 billion was deposited in the trust fund in fiscal years 2006 and 2007; however, the fund is now on the verge of being completely depleted. Withdrawals were made for general budget relief in the last few years, and the current financial plan will eliminate the balance in fiscal years 2013 and 2014 to help close budget gaps.





Addressing the Challenges

What can the City do to limit the adverse impact of health insurance costs on its budget and balance sheet? Options range from transformational—reconfiguring the City’s health insurance arrangements and putting the City’s business out for bid—to austere—limiting coverage and/or cutting benefits.

A more modest approach is to require employees and retirees to pay part of their insurance premiums and to eliminate the reimbursement for Medicare Part B. Implementing these changes would be within local authority (through local legislation and collective bargaining) and would significantly decrease the level of annual health insurance expenditures and projected budget deficits. Altering retiree benefits would have the added benefit of dramatically reducing the magnitude of the OPEB liability.

These changes are preferable for other reasons as well. Sharing responsibility for health insurance premiums with employees and retirees would give them a vested interest in limiting future cost increases and enhance incentives to control cost drivers. Previous savings efforts, which increased deductibles and co-pays, only shifted costs to those with medical needs rather than evenly distributing the burden among all employees and retirees.⁹

Requiring premium-sharing would not detract from the attractiveness of the City as an employer. Generous fringe benefits in the public sector were once justified as a “compensating differential” to attract talent to the public sector because the wages offered for similarly-skilled positions were lower than those provided by private employers. As CBC demonstrated in its report, *The Case for Redesigning Retirement Benefits for New York’s Public Employees*, this rationale is now questionable: for most occupations in the New York region, wages in the public sector are higher than the private sector.¹⁰ For New York City public employees in particular, wages have increased significantly over the past decade (between 25 and 40 percent for most unionized personnel)¹¹ and pension benefits remain generous even by public sector standards.¹² Even with some sharing of health insurance premium costs, the City of New York would continue to offer a competitive compensation package.

COMPARATIVE ANALYSIS: PREMIUM-SHARING IN THE PUBLIC AND PRIVATE SECTORS

To determine a reasonable contribution share for New York City municipal employees, CBC examined health insurance arrangements for employees and retirees in the public and private sectors.

There are two reliable sources of data on health insurance premiums nationwide. The first is the Medical Expenditure Panel Survey (MEPS), a survey of more than 38,000 private sector establishments and 3,000 state and local governments providing health insurance, conducted by the Agency for Healthcare Research and Quality of the U.S. Department of Health & Human Services. The most recent MEPS data is for 2011. The second is a national survey of over 2,000 employers, including state and local governments, published annually by the Kaiser Family Foundation, most recently in 2012.

The private sector analysis focuses on large corporations, both nationwide and in New York State, as they are more comparable employers to the City of New York than small businesses. For a public sector comparison, this report describes premium sharing by employees and retirees of the federal government, the State of New York and six large municipal governments: Boston, Chicago, Houston, Los Angeles, Phoenix and San Francisco. CBC reviewed a variety of sources, including city websites, employee benefit guides, retirement system publications and financial statements, to obtain the relevant information for these public employers. Where the information was not publicly available, additional efforts were made to contact human resource personnel and benefit administrators.

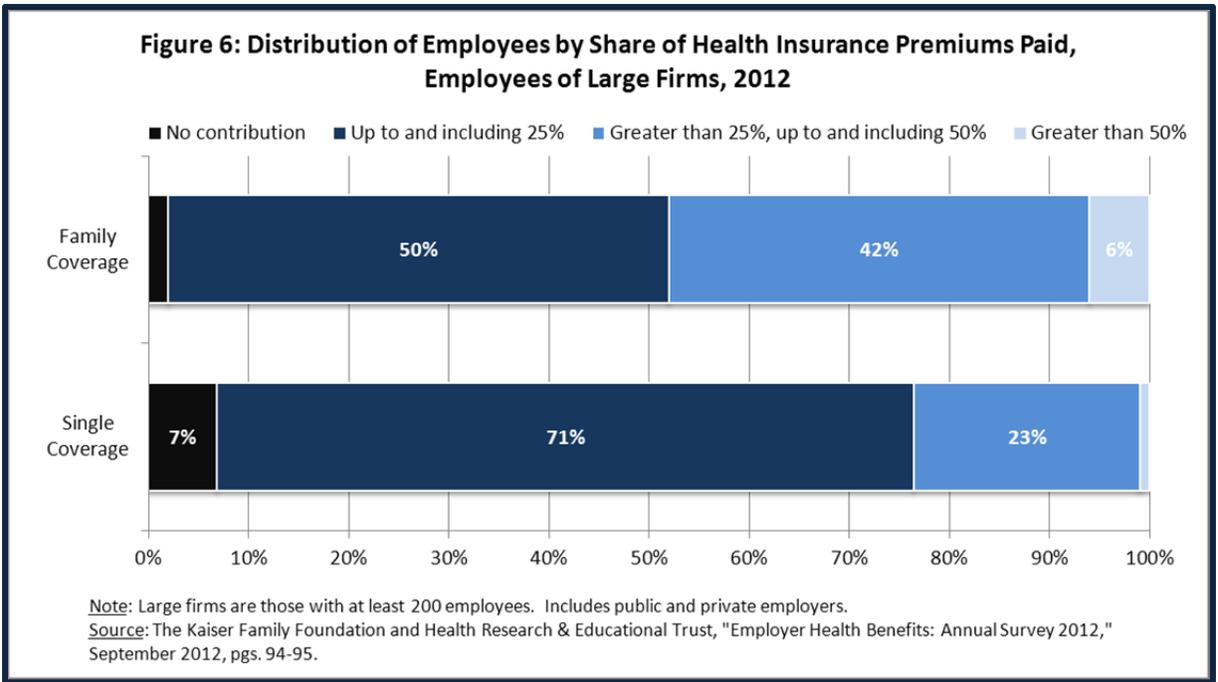
The findings are presented in three sections. The first focuses on average health insurance premiums paid by active employees and their families. The second describes benefits for “early retirees” and their families, specifically whether coverage is offered and what level of responsibility for the premium is assumed by the retiree. The third describes coverage for retirees over the age of 65 and their spouses, concentrating on whether employers reimburse any part of the premium paid by retirees for Medicare Part B.

Employee Premium-Sharing

Almost 90 percent of civilian employees in the U.S. work in establishments offering health insurance.¹³ Virtually all large employers – in both public and private sectors – offer health insurance to full-time employees;¹⁴ in contrast, coverage for part-time workers is less common. Only 45 percent of employers with at least 200 employees offer health insurance to part-time employees.¹⁵

Five important observations are:

- 1. Employee contributions toward the cost of their health insurance premiums are the norm across the country.** A small share of employees of large public and private organizations – 7 percent – do not contribute for single coverage, and only 2 percent do not contribute for family coverage.¹⁶ The most common premium-sharing arrangements are for employees to contribute up to 25 percent of the premiums for single coverage and family coverage.¹⁷



2. Nationwide, the share contributed by the employee typically is greater for family coverage than for single coverage. On average, employees contribute 18.8 percent for single coverage and 24.4 percent for family coverage.¹⁸

Table 1: Required Employee Premium Contributions by Type of Coverage and Employer, 2011

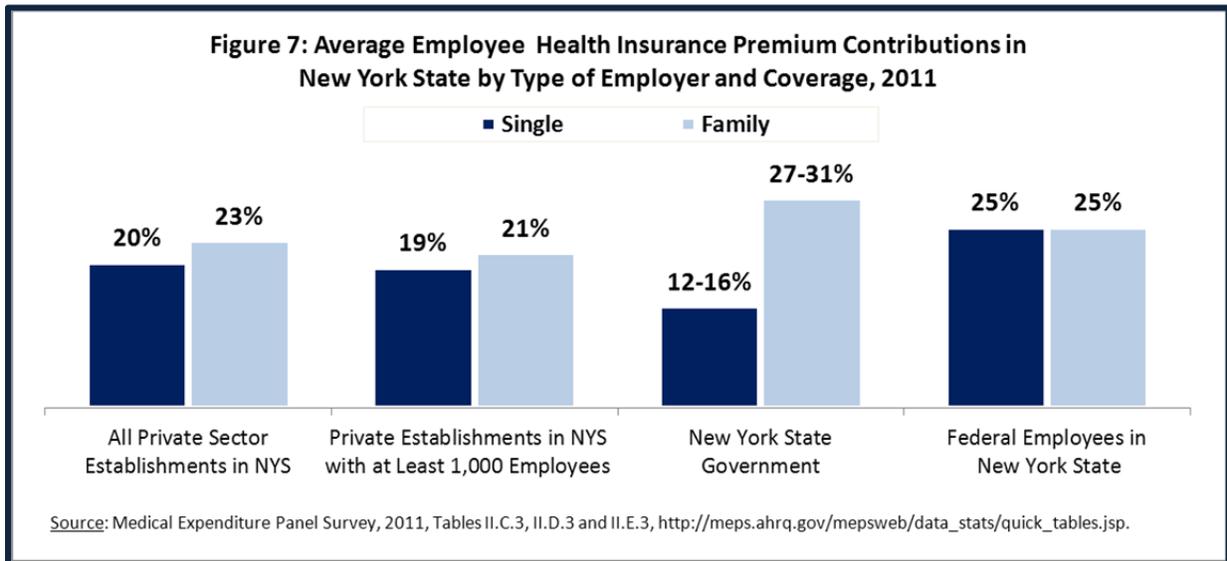
	Percent of premium contributed by employee in:	
	Single Coverage	Family Coverage
Total U.S. Civilian	18.8%	24.4%
State and Local Governments	10.2%	17.7%
Local Governments With At Least 10,000 Employees	8.7%	14.0%
Private Sector	20.9%	26.4%
Private Establishments With At Least 1,000 Employees	21.9%	24.5%

Source: Medical Expenditure Panel Survey, Tables II.C.3, II.D.3, III.C.3, III.D.3, XI.C.3, and XI.D.3, 2011. Complete tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables.jsp.

3. **Employee contributions required by state and local governments, on average, are lower than those required by private sector establishments.** This is particularly true for single coverage: the average private sector contribution, about 21 percent, is double what is typically required by state and local governments. Public sector employers require employee contributions of 14 to 18 percent for family coverage— less than the 25 to 26 percent required in the private sector.¹⁹

4. **In New York, the prevailing practice among public and private employers is to require employee contributions toward the cost of health insurance premiums.**

Only 54.4 percent of private sector establishments in New York State offer health insurance, but almost all businesses with at least 1,000 employees offer coverage.²⁰ Average premium contributions for private employees in New York approach national averages: 20 percent for single coverage and 23 percent for family coverage. Employers of large private establishments average slightly smaller contributions: 19 percent and 21 percent, respectively.²¹



The State of New York has required employee premium-sharing since 1983.²² For many years, employees paid 10 percent for single coverage and 25 percent for coverage of dependents. In 2011, Governor Andrew Cuomo and two of the State’s largest unions agreed to increase the contributions, and the increases were also extended to non-unionized personnel. Employees in Grade 9 or below, earning up to \$47,000, now contribute 12 percent for single coverage and 27 percent for dependent coverage. Grade 10 and above employees contribute 16 percent for single coverage and 31 percent for family coverage. Relative to the private sector, contributions for single coverage are low, but are higher than the average for family plans. Contributions are also higher than the national average for large state and local governments.

Federal employees working in New York also contribute to the cost of their health insurance premiums. The U.S. government's policy is to pay the lesser of (1) 75 percent of the premium of the employee's chosen plan; or (2) 72 percent of the average premium of all plans weighted by enrollment.²³ In New York, most employees are enrolled in the Blue Cross and Blue Shield Service Benefit Plan. For this plan, employees pay 25 percent for both single and family coverage.²⁴

It is also common for school districts in New York State (outside New York City) to require teachers to share the cost of health insurance premiums. A 2011 CBC analysis found the most common premium sharing arrangements to be a 10 percent employee contribution for single coverage and 11 to 15 percent for family coverage.²⁵ These contribution rates are in line with nationwide trends for local governments for single coverage, but low with respect to family coverage.

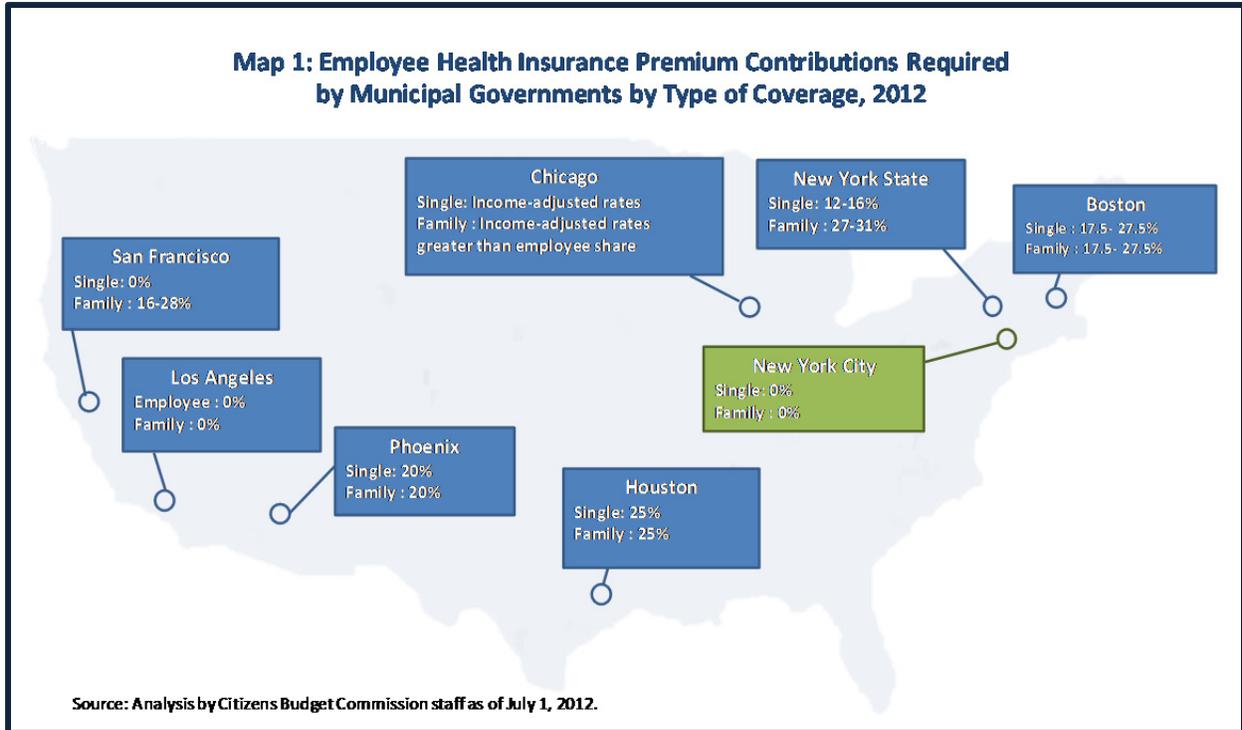
5. Premium-sharing is prevalent among large municipal governments: only one other city pays the full cost of health insurance premiums for single and family coverage.

All the cities surveyed offer health insurance to full-time employees and their dependents, and most also offer health insurance to part-time employees. Employees enrolled in New York City's two major plans bear no responsibility for the premium cost of coverage for themselves, their spouses and their families. Only two cities – Los Angeles and San Francisco – come close to matching that arrangement.

Los Angeles offers three medical plans, and employees (who are not engineers or architects) do not pay a premium for single coverage in any of the plans. Only one plan offers "free" family coverage.²⁶ In San Francisco, 98 percent of public employees are enrolled in two plans.²⁷ Most employees do not contribute toward the cost of single coverage. For family coverage, most employees are required to pay 16 percent of the premium in one plan and 28 percent of the premium in the other.²⁸ On a weighted basis, employees pay 17 percent of combined premium costs for single and family coverage.²⁹

All other cities studied require employees to pay up to 27.5 percent of the premium cost. Some cities pay the same share for employee and dependent coverage. Employees of the City of Phoenix pay 20 percent³⁰ and employees of the City of Houston pay 25 percent of the premium costs.³¹ In April 2011, the City of Boston and its unions agreed to increase the share of the premium paid by employees and retirees in all plans. Employees now pay 17.5 percent for the dominant HMO plan and up 27.5 percent for other plans.³²

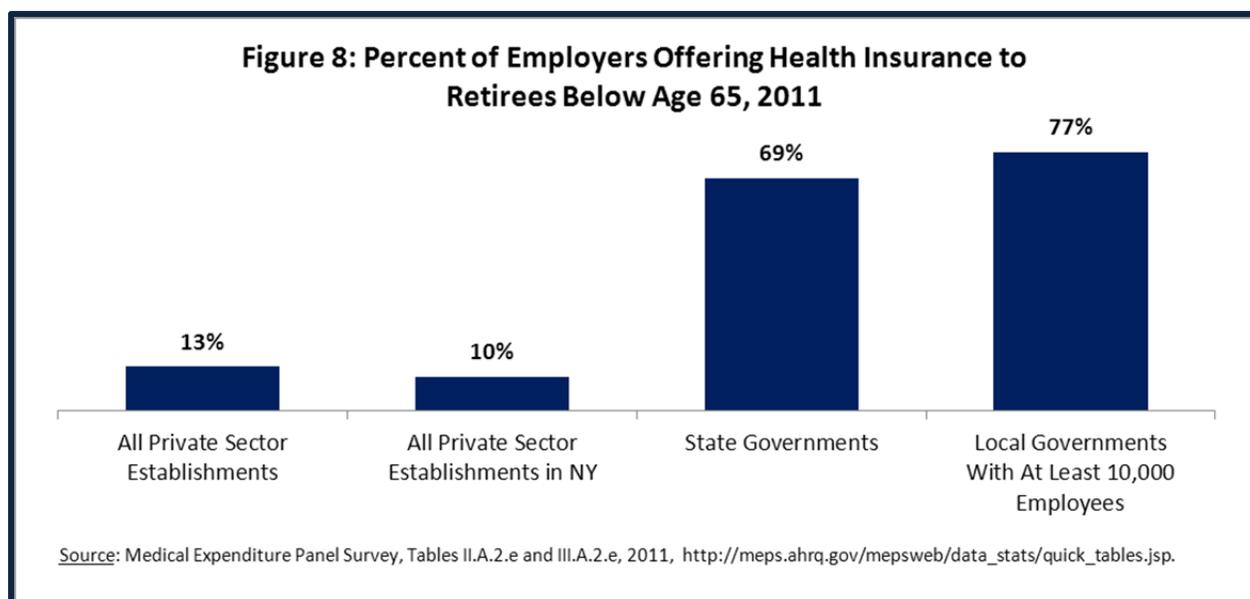
The City of Chicago has established income- and plan-adjusted rates. Employees earning up to \$30,000 and those earning more than \$90,000 pay a flat dollar rate, with the rate for highly-paid employees more than three times that of lower earners. Mid-salary employees pay a percentage of their salary. All employees pay a greater amount for spousal coverage than for single coverage, and the greatest amount for family coverage.³³



Retirees Under Age 65

Four observations can be made about the availability of health insurance to early retirees and premium-sharing requirements when this insurance is available:

- 1. Health insurance is not offered to early retirees as commonly as insurance to employees.** Employer-based retiree health insurance is extremely rare among small employers,³⁴ and is on the decline for large firms. Only a quarter of large public and private employers surveyed offered health benefits to retirees— a significant decrease from 46 percent in 1991 and 37 percent in 2001.³⁵
- 2. Early retiree health benefits are more common among municipal employers than private ones.** Only one-eighth of private sector establishments offer health insurance to early retirees.³⁶ In New York State, only 10 percent of private sector establishments offer health insurance to retirees under age 65. In contrast, nationwide 77 percent of local governments with at least 10,000 employees and 69 percent of state governments offer this insurance.³⁷



3. Public employers offering retiree health insurance typically require significant premium-sharing, often at rates greater than those paid by employees.

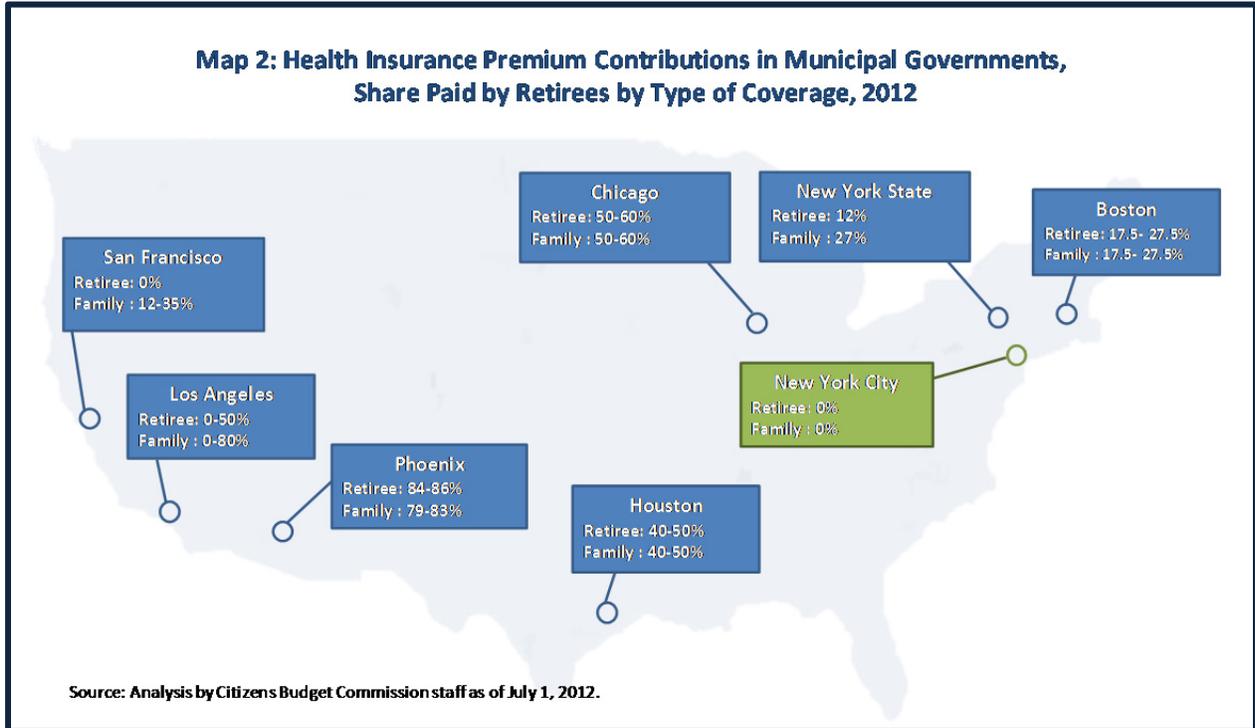
Early retirees of the City of Boston, the State of New York and the federal government make contributions that mirror those for employees. Boston retirees are responsible for 17.5 percent of premiums in the dominant plan, and New York State retirees pay 12 percent of the cost of single coverage and 27 percent of the cost of family coverage.³⁸ Federal retirees continue to be covered and make the same contributions they did as employees; in New York, this is approximately 25 percent of the premium cost for single coverage and family coverage.³⁹

Large cities have varied arrangements for retiree health insurance, but typically require retirees to pick up a greater share of the premium than they did as employees. For example, retirees under the age of 65 of the City of Houston pay between 40 to 50 percent of the premium cost in the dominant plan compared to 25 percent for employees.⁴⁰

Chicago and Los Angeles vary premium contributions according to years of service. Retirees of the City of Chicago are responsible for 50 to 60 percent of the cost of their premiums. The City of Chicago reimburses 40 percent of the premium for retirees with 10 to 14 years of service, 45 percent for 15 to 19 years of service, and 50 percent for 20 or more years of service.⁴¹

The City of Los Angeles subsidizes retiree health benefits through its pension funds. Early retirees with ten years of service receive a 40 percent subsidy; for each additional year of service, the subsidy is increased by 4 percent, so that retirees with 25 years of service receive the maximum subsidy. The subsidy is not directly tied to the premium cost; however, retirees with the maximum subsidy pay nothing for the cost of single coverage and up to 50 percent of the cost for family coverage.⁴² Those with ten years of service, who receive the lowest subsidy, pay 20 to 50 percent of the cost of single coverage and 60 to 80 percent of family coverage.⁴³

The City of Phoenix provides fixed dollar contributions that vary by type of coverage. Required retiree contributions amount to 84 to 86 percent of the 2012 premium cost for single coverage and 80 to 83 percent for family coverage, depending on the type of plan.⁴⁴



4. Fully subsidizing the premium for retiree family coverage is extremely rare. In its dominant plan, the City of San Francisco pays the entire premium for retiree-only coverage, with retirees responsible for 12 to 35 percent of the premium costs for dependent coverage.⁴⁵ In Los Angeles, only retirees with more than 25 years of service receive fully subsidized coverage, which does not fully cover the costs of dependent coverage in two of three plans.⁴⁶

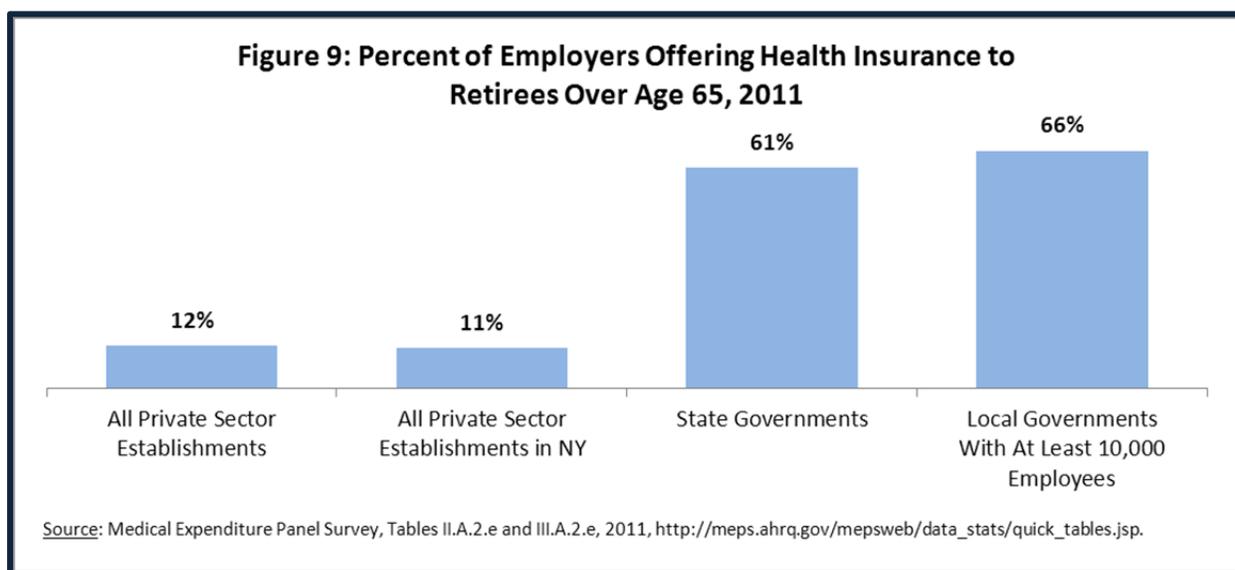
Retirees Over Age 65

Eligibility for Medicare starts at age 65. Medicare Part A covers inpatient services and hospital care. Part B covers medically necessary and preventative services, including doctors visits, as well as other services not covered by Part A. Medicare Part A is available without charge for those who have paid payroll taxes for at least ten years, but Part B requires payment of a premium that is adjusted according to income. In 2013, the standard annual premium is \$1,260 and rises to \$4,030 for high-income retirees.⁴⁷

Medicare A and B do not cover all possible medical expenses, so supplemental health insurance is sometimes provided by employers. Typically, retirees are required to subscribe to both Medicare A and B before they can enroll in supplemental retiree health plans.

Three observations can be made about employer responsibilities for health insurance for retirees over age 65:

1. Fewer state and local governments offer health insurance plans to retirees over 65 than to early retirees and employees. Sixty-one percent of state governments and 66 percent of large local governments offer health insurance to Medicare-eligible retirees compared to 69 and 77 percent, respectively, for early retirees.⁴⁸ Only 12 percent of private establishments nationally and 11 percent in New York offer plans, approximately the same shares as for early retirees.



2. Among public employers, retirees over age 65 are required to share premium costs to the same extent as or more than early retirees.

All the public employers in this analysis offered supplemental health insurance to retirees over age 65, with Medicare serving as the primary insurer. Typically, retirees who are enrolled in Medicare Part A and B pay a lower share of the premium or are eligible for a greater employer subsidy than those who are not subscribed to both parts or those with dependents who are not subscribed. The premium share for Part A and B subscribers is typically equivalent to that paid by early retirees, though the premiums are usually lower.

3. It is uncommon for public employers to reimburse the premium cost of Medicare Part B. New York City reimburses the full out-of-pocket cost of the Medicare Part B premium for retirees and their spouses. Only two other cities, Los Angeles and Boston, offer any reimbursement. The City of Los Angeles reimburses the cost of the standard premium for retirees only – nothing above the standard premium and no spousal premiums are reimbursed.⁴⁹ Boston reimburses 50 percent of the premium paid by retirees.⁵⁰

Federal employees do not receive a Medicare reimbursement. Until 2010, New York State offered full reimbursements; since then, the cost of the premium has been built into the insurance premiums of employees and retirees and is offset by employee and retiree contributions. In his Executive Budget for Fiscal Year 2013-14, Governor Andrew Cuomo has proposed eliminating additional reimbursement beyond the standard premium for high-income retirees.

Table 2: Public Employers and Medicare Part B Reimbursement

Full Reimbursement for Retirees & Spouses	Partial Reimbursement	No Reimbursement
New York City	Boston Los Angeles New York State	Federal Government Chicago Houston Phoenix San Francisco

Source: Analysis by Citizens Budget Commission staff.

A BETTER PREMIUM-SHARING ARRANGEMENT IN NEW YORK CITY

Even among public employers, New York City is a clear outlier in the generosity of its health insurance arrangements, particularly with respect to retirees:

- Only one other public employer pays the full premium cost of coverage for single and family coverage;
- No other public employer pays the full premium costs for health insurance for all retirees and their families;
- No other public employer reimburses the full premium cost of Medicare Part B for retirees and spouses.

The City must take steps to more equitably share the cost of health insurance premiums with employees and retirees. Three changes would bring New York City closer to the standards set by the private sector and municipal governments and would establish an employee interest in future cost containment.

1. **Implement Premium-Sharing by Employees** – Employee contributions toward the cost of health insurance are the norm in the private sector and in state and local governments. Table 3 shows the potential savings to the City from a range of employee premium-sharing requirements. For example, requiring a contribution of 5 percent for single and family coverage would provide \$180 million in savings.

Table 3: Potential Savings to the City of New York From Employee Premium-Sharing, Fiscal Year 2014
(dollars in millions)

Employee Contribution Share For Single Coverage	Employee Contribution Share for Family Coverage						
	5%	10%	15%	20%	25%	30%	35%
5%	\$180	\$299	\$417	\$535	\$653	\$771	\$889
10%	\$243	\$361	\$479	\$597	\$715	\$833	\$952
15%	\$305	\$423	\$541	\$659	\$778	\$896	\$1,014
20%	\$367	\$485	\$603	\$722	\$840	\$958	\$1,076
25%	\$429	\$548	\$666	\$784	\$902	\$1,020	\$1,138

Notes: CBC recommendation is shaded. Savings calculated by CBC staff based on 35 percent enrollment in single coverage and 65 percent enrollment in family coverage, using figures provided by the New York City Office of Management and Budget.

Moving the City closer to the national average for state and local governments – 10 percent for single coverage and 20 percent for family coverage – would generate close to \$600 million in annual savings. Contributions of 10 percent and 25 percent would generate \$715 million in fiscal year 2014.

2. **Require Premium-Sharing by**

Retirees – Few private sector employers offer retiree health insurance. In the public sector, state and local governments typically require retirees to contribute more toward the cost of health insurance premiums than they did as employees. A required contribution of 20 percent would save the City more than \$300 million annually. A 50 percent contribution by retirees, which is higher than that of State retirees but not as high as other cities, would save \$768 million in fiscal year 2014.

Table 4: Potential Savings to the City of New York From Retiree Premium-Sharing, Fiscal Year 2014
(dollars in millions)

Retiree Contribution Share For Single Coverage	Retiree Contribution Share for Family Coverage			
	20%	25%	50%	75%
10%	\$235	\$276	\$479	\$683
20%	\$307	\$348	\$551	\$755
25%	\$343	\$384	\$588	\$791
50%	\$524	\$564	\$768	\$972
75%	\$704	\$745	\$948	\$1,152

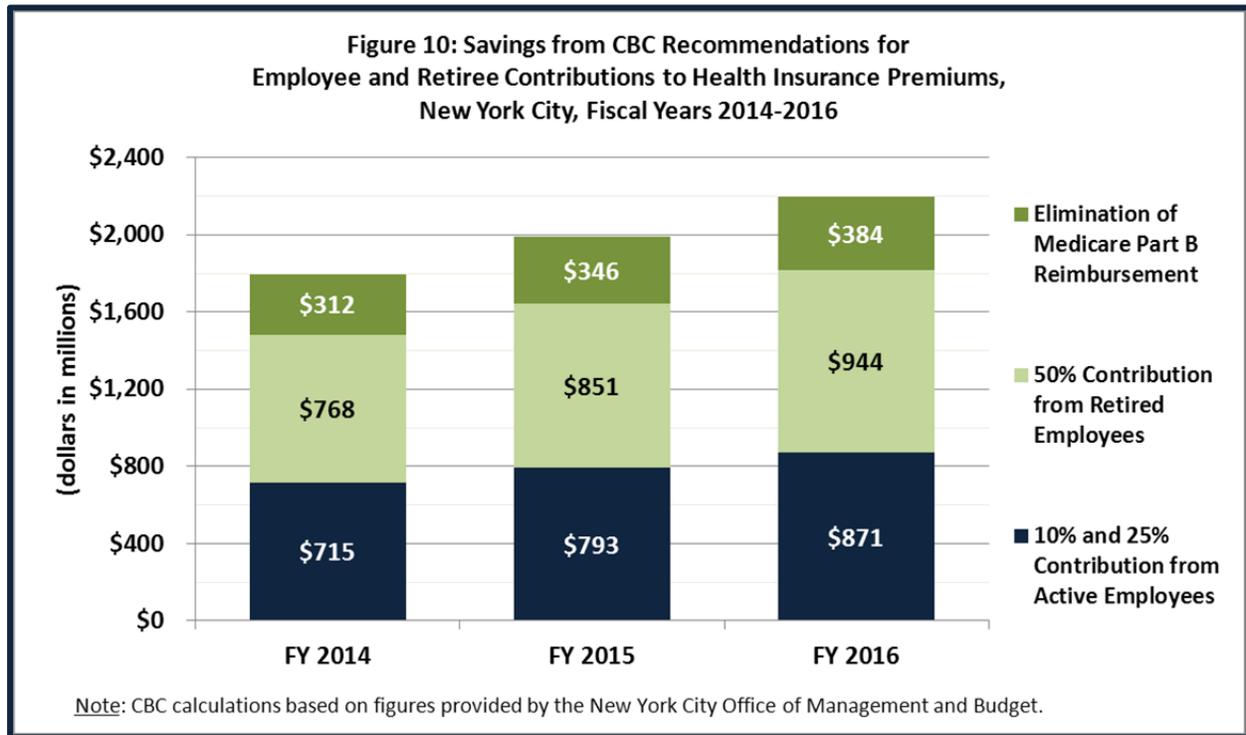
Notes: CBC recommendation is shaded. Savings calculated by CBC staff based on 47 percent enrollment in single coverage and 53 percent enrollment in family coverage, using figures provided by the New York City Office of Management and Budget.

3. **Eliminate Medicare Part B Reimbursement** – Reimbursement of Medicare Part B premiums is rare, even among state and local governments. Eliminating spousal reimbursement would save approximately \$45 million. Halving the reimbursement would save \$140 million a year, and eliminating it entirely would save \$280 million.

How meaningful would these savings be? Employee contributions of 10 percent for single coverage and 25 percent for family coverage, 50 percent contributions by early retirees, and the full elimination of Medicare Part B reimbursement would save \$1.8 billion in fiscal year 2014. The savings would grow to \$2.2 billion by fiscal year 2016.

Enacting these changes will require the cooperation of the Mayor, City Council and labor leaders. The amount the City contributes to employee and retiree health insurance, as well as the Medicare Part B reimbursement, is set in the New York City Administrative Code, which is adopted by the City Council.⁵¹ The changes also need the approval of the Municipal Labor Committee (MLC), a coalition of representatives of the city’s public employee unions. While individual unions negotiate directly with the City regarding terms of employment and wages, health insurance arrangements are negotiated

through the MLC. The last agreement between the City and MLC on health benefits was in 2009, and, like most collective bargaining agreements, its terms continue until a new agreement is negotiated.



The City’s leaders should work together to make these changes. Health insurance reforms will generate recurring savings to help bring the City’s finances into long-term structural balance, while expecting of employees and retirees the same participation in paying for their own health care that is experienced by most New Yorkers and other public employees across the country.

ENDNOTES

- ¹ New York City Office of Labor Relations, "Summary Program Description: Health Benefits Program," accessed October 2, 2012, http://www.nyc.gov/html/olr/downloads/pdf/healthb/full_spd.pdf.
- ² The plans do not include prescription drug coverage. For most workers, these benefits are provided through city-funded union welfare funds. For more information, see Citizens Budget Commission, "Better Benefits for Our Billion Bucks: The Case for Reforming Municipal Union Welfare Funds," August 2010, http://www.cbcny.org/sites/default/files/REPORT_UWF_08032010.pdf.
- ³ Rates provided by the New York City Office of Management and Budget. In 1983, the City and the Municipal Labor Committee agreed that the City's cost for health insurance would be the HIP premium rate approved by the State Insurance Department. This was subsequently codified in the New York City Administrative Code.
- ⁴ Estimate based on fiscal year 2008 figures. See Citizens Budget Commission, "Six-Figure Civil Servants: Average Compensation Cost of New York City Public Employees," January 2009, http://www.cbcny.org/sites/default/files/report_sixfigure_01082011.pdf.
- ⁵ Includes retirees and beneficiaries. Figures estimated by the Citizens Budget Commission using data reported in the 2011 Comprehensive Annual Financial Reports of the New York City Police Pension Fund, New York City Fire Pension Fund, New York City Employees' Retirement System, Teachers' Retirement System of the City of New York and New York City Board of Education Retirement System.
- ⁶ Medicare.gov, "2012 Medicare costs at a glance," accessed January 3, 2013, <http://www.medicare.gov/cost/>.
- ⁷ Standard & Poors, "U.S. Local Governments Proposed GO Criteria," March 12, 2012, http://www.standardandpoors.com/spf/upload/Ratings_US/Proposed_GO_Criteria_SanFrancisco.pdf.
- ⁸ The Pew Charitable Trusts, "A Widening Gap in Cities: Shortfalls in Funding for Pensions and Retiree Health Care," January 2013, http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_city_pensions_report.pdf.
- ⁹ Some of these prior efforts are described in Carol Kellermann and Maria Doulis, "The Case Against Tapping the Health Insurance Premium Stabilization Fund," Citizens Budget Commission Blog, June 15, 2011, <http://www.cbcny.org/cbc-blogs/blogs/case-against-tapping-health-insurance-premium-stabilization-fund>.
- ¹⁰ See also Charles Brecher, "The Public and Private Sector Wage Disparity: An Update," May 25, 2010, Citizens Budget Commission Blog, <http://www.cbcny.org/cbc-blogs/blogs/public-and-private-sector-wage-disparity-update>.
- ¹¹ CBC analysis of negotiated wage increases for the City's major unions since 2002.
- ¹² Citizens Budget Commission, "The First Priority in the New Year – Pension Reform," January 2012, http://www.cbcny.org/sites/default/files/BRIEF_Pension_01112012.pdf.
- ¹³ Excludes federal employees and self-employed. Agency for Healthcare Research and Quality, Center for Financing, "Table XI.B.2: Percent of civilian employees in establishments that offer health insurance by private and State/local government sectors and census division: United States, 2011," *Medical Expenditure Panel Survey – Insurance Component*.
- ¹⁴ Smaller companies are much less likely to offer health insurance. See Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pgs. 30, 34; and Agency for Healthcare Research and Quality, Center for Financing, "Table II.A.2: Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2011," *Medical Expenditure Panel Survey – Insurance Component*, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiia2.pdf.
- ¹⁵ Among firms offering health insurance. Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pg. 37.
- ¹⁶ Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pgs. 94-95.
- ¹⁷ Unionization does not make a large difference in the results, although large firms without unionized workers tend to require slightly greater contributions than those with some union workers: the average premium was 17 percent for single and 22 percent for family coverage for large firms with at least some union workers versus 19 percent and 28

percent, respectively, for nonunionized firms. See Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pgs. 97-98.

¹⁸ Agency for Healthcare Research and Quality, Center for Financing, Tables II.C.3, II.D.3, III.C.3, III.D.3, XI.C.3 and XI.D.3, 2011, *Medical Expenditure Panel Survey – Insurance Component*, available at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1 and http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

The Kaiser Report has similar, though not identical, findings: the average premium contribution for all covered employees (in large and small firms) is 18 percent for single coverage and 28 percent for family coverage. See, Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pg. 99.

¹⁹ Agency for Healthcare Research and Quality, Center for Financing, Tables II.C.3, II.D.3, III.C.3, III.D.3, XI.C.3, and XI.D.3, *Medical Expenditure Panel Survey – Insurance Component 2011*, available at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1 and http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2.

²⁰ Agency for Healthcare Research and Quality, Center for Financing, 2011, Table II.A.2, *Medical Expenditure Panel Survey – Insurance Component*, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/ic11_iaa_f.pdf.

²¹ Agency for Healthcare Research and Quality, Center for Financing, 2011, Tables II.C.3 and II.D.3, *Medical Expenditure Panel Survey – Insurance Component*, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/ic11_iaa_f.pdf.

²² The State of New York offers 20 different HMO plans, but over 80 percent of employees and retirees are enrolled in the Empire Plan.

²³ U.S. Office of Personnel Management, "Federal Employees Health Benefits Program Handbook: Cost of Insurance," accessed October 4, 2012, <http://www.opm.gov/insure/health/reference/handbook/fehbo3.asp>

²⁴ For non-postal employees on the Blue Cross and Blue Shield Service Benefit Plan Basic Plan. Data from the U.S. Office of Personnel Management and calculated by CBC staff using U.S. Office of Personnel Management, "Non-Postal Premium Rates for the Federal Employees Health Benefits Program," accessed December 12, 2012, <http://www.opm.gov/insure/health/rates/nonpostalffs2013.pdf>.

²⁵ Elizabeth Lynam and Selma Mustovic, "School Districts Should Achieve Substantial Savings by Following State Practices for Employee Health Insurance Premiums," Citizens Budget Commission Blog, February 2, 2011, <http://www.cbcny.org/cbc-blogs/blogs/school-districts-should-achieve-substantial-savings-following-state-practices-employ>.

²⁶ City pays full cost of all coverage for the Kaiser HMO plan; single and spousal coverage in the Anthem Blue Cross HMO plan; and single coverage in the Anthem Blue Cross PPO. See City of Los Angeles, "Flex Enrollment: 2012," <http://per.lacity.org/bens/2012OEFlexGuide.pdf>, pg.9.

²⁷ Health Service System of the City & County of San Francisco, "Membership Demographics Report As of July 1, 2012," <http://www.myhss.org/downloads/finance/demographics2012.pdf>.

²⁸ Almost all public employees are enrolled in the Blue Shield HMO and the Kaiser HMO plans. See Health Service System of the City and County of San Francisco, "Active City & County of San Francisco Employees, Bi-Weekly Premium Contribution Rates: July-December 2012," http://www.myhss.org/downloads/forms_guides/2012_6MO_ActiveRates.pdf, and "SFUSD 2012 Premium Rates," http://www.myhss.org/downloads/forms_guides/2012_6MO_SFUSDRates.pdf.

²⁹ Total monthly weighted average medical premium cost per member. See Health Service System of the City & County of San Francisco, *2010-2011 Annual Report*, http://www.myhss.org/downloads/finance/HSS_AR_2010_2011.pdf, pg. 14.

³⁰ City of Phoenix, "Human Resources Extranet – Medical Premiums," accessed May 18, 2012, <http://employee.phoenix.gov/hr/benefits/citybenefits/medical/customerservice/index.html>.

³¹ Information obtained through CBC staff conversation with City of Houston Benefits Division Staff on October 9, 2012.

³² *Agreement between the City of Boston and the Boston Public Employee Committee Pursuant to M.G.L. c 32B, §19*, http://www.cityofboston.gov/Images_Documents/Coalition%20Agreement%20Update%20%20-%20Executed%20Agreement%20April%20202011_tcm3-27595.pdf, Appendix A.

³³ City of Chicago, Benefits Management Division, "Healthcare Contribution Rates For All Eligible Employees Effective 7/1/2006," accessed May 22, 2012, http://www.cityofchicago.org/dam/city/depts/fin/supp_info/Benefits/Rates/2010_Contribution_Rates.pdf.

³⁴ Only 4 percent of firms with fewer than 200 employees provide retiree health benefits. See Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pg. 202.

³⁵ Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: Annual Survey 2012," September 2012, pgs. 183-187.

³⁶ Agency for Healthcare Research and Quality, Center for Financing, 2011, Tables II.A.2.e, *Medical Expenditure Panel Survey – Insurance Component*, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/ic11_iaa_f.pdf.

³⁷ Agency for Healthcare Research and Quality, Center for Financing, 2011, Tables III.A.2.e, *Medical Expenditure Panel Survey – Insurance Component*, available at http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_3/2011/ic11_iiia_g.pdf.

³⁸ Retirees who have accrued unused sick leave can credit up to 200 days toward the out-of-pocket cost of their premiums.

³⁹ For non-postal employees on the Blue Cross and Blue Shield Service Benefit Plan Basic Plan. Data from the U.S. Office of Personnel Management and calculated by CBC staff. See U.S. Office of Personnel Management, "The 2013 Guide to Federal Benefits For Federal Retirees and Their Survivors," accessed December 12, 2012, <http://www.opm.gov/insure/health/planinfo/2013/guides/70-9.pdf>.

⁴⁰ Dominant plan is Cigna Limited Network. Information obtained through CBC staff conversation with City of Houston Benefits Division Staff on October 9, 2012.

⁴¹ For employees retiring on or after July 1, 2005 according a settlement valid through June 30, 2013. Those with less than ten years of service do not receive a City subsidy. See City of Chicago, "Annuitant Settlement Healthcare Plans," http://www.cityofchicago.org/dam/city/depts/fin/supp_info/Benefits/Handbooks/AnnuitantSettlementPlans.pdf, pgs. 87, 100.

⁴² For full details on premiums and subsidies, see premiums in Los Angeles City Employees' Retirement System, "2012 Retired Member – Health Benefits Guide Supplement," <http://www.lacERS.org/aboutlacERS/publications-forms/publications/retired/open-enrollment-guides-brochures/2012-LACERS-BG-FINAL.pdf>, pg.9, 29-33.

⁴³ CBC calculations based on premiums reported by Los Angeles City Employee Retirement System, "2012 Retired Member Health Benefits Guide," accessed May 23, 2012, <http://www.lacERS.org/aboutlacERS/publications-forms/publications/retired/open-enrollment-guides-brochures/2012-LACERS-BG-FINAL.pdf>.

⁴⁴ City of Phoenix, "2011-2012 Retiree Medical Premiums," accessed May 23, 2012, http://employee.phoenix.gov/webcms/groups/extranet/@extra/@hr/@benefits/documents/web_content/hr_17.pdf. The City of Phoenix also offers a Medical Expense Reimbursement Plan (MERP) that offsets out-of-pocket medical expenses for retirees. The amount of MERP available generally increases with years of service, but firefighters, police officers, and professional personnel also qualify for the highest reimbursement. A supplemental MERP is also available to retirees with pensions up to \$25,000. For more information, see City of Phoenix, "MERP," accessed February 27, 2012, <http://employee.phoenix.gov/hr/retirees/retireebenefits/retireemedical/merp/index.html>.

⁴⁵ Forty-five percent of all retiree enrollment is in the Kaiser Permanent HMO. Premium contributions vary according to the number of dependents and whether the dependents are Medicare-eligible. See rates in Health Service System of the City & County of San Francisco, "Retirees: 2012 Premium Rates," http://www.myhss.org/downloads/forms_guides/2012_6MO_RetireeRates.pdf.

⁴⁶ For a retiree and a dependent without Medicare, maximum subsidy only covers the cost of the Kaiser Permanente HMO, not Anthem Blue Cross HMO or PPO. See Los Angeles City Employees' Retirement System, "2012 Retired Member – Health Benefits Guide Supplement," <http://www.lacers.org/aboutlacers/publications-forms/publications/retired/open-enrollment-guides-brochures/2012%20Health%20Benefits%20Guide%20Supplement%20FINAL.pdf>

⁴⁷ Medicare.gov, "2012 Medicare costs at a glance," accessed January 3, 2013, <http://www.medicare.gov/cost/>.

⁴⁸ Agency for Healthcare Research and Quality, Center for Financing, "Table II.A.2: Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2010," *Medical Expenditure Panel Survey – Insurance Component*, http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/ic10_ii_a_f.pdf.

⁴⁹ Reimbursement occurs through the pension funds, which operate other postemployment benefit trust funds for subsidies of retiree medical expenses. The City of Los Angeles contributes to the funds. See City of Los Angeles, *Comprehensive Annual Financial Report for Fiscal Year 2011*, pgs. 66, 161-163, 202; Los Angeles Fire and Police Pensions, accessed May 23, 2012, <http://www.lafpp.com/LAFPP/2010MedicarePartBPremiumIncrease.html>; and

⁵⁰ *Agreement between the City of Boston and the Boston Public Employee Committee Pursuant to M.G.L. c 32B, §19*, http://www.cityofboston.gov/Images_Documents/Coalition%20Agreement%20Update%20%20-%20Executed%20Agreement%20April%202011_tcm3-27595.pdf, Appendix A.

⁵¹ See New York City Administrative Code § 12-126.