Beacon Hill

State workers get the shift

But move may not control health costs

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State employees have been feeling like Gov. William Weld's personal punching bag for some time now, with the administration reneging on salary increases negotiated by the previous regime at the same time it proposes privatizing everything from skating rinks to mental health care.

A new study by Boston University's School of Public Health shows how much the past four years has taken out of state workers' pocketbooks—and how much more will be taken out if Weld's proposal to make employees pay 35 percent of health insurance costs gets legislative approval.

State workers got their last pay raises early in 1988, state managers in 1985 or 1986. Since 1988, the public employees have lost nearly 20 percent of their real income to inflation and rising health-care costs, according to the study.

But increasing the employee share of health insurance from 10 percent to 35 percent would be the real kicker. The one-year premium jump of $1,400 for family coverage would bring the income drop to 28 percent—the equivalent of more than three months' pay. The state worker who earned a salary of $25,000 in 1988 would be left with $18,000 in purchasing power at the end of the fifth year of income and benefit erosion.

"This cost-shifting is unfair to state workers," the report concludes.

But it is not so much the economic fate of state workers that interests the BU researchers; it is what they call the state's abdication of health-care cost control as represented by simply sticking employees with more of the tab.

"Since 1988, state government has failed to diagnose and treat the underlying sources of high health costs," said Alan Sager, associate professor of public health. "Shifting a greater share of health costs to workers . . . does little or nothing to reduce the costs themselves. If anything, such cost-shifting weakens the drive to attack high costs, because it reduces state government's own stake in finding honest solutions that get to the roots of the cost problem."

Sager and his colleagues—Deborah Socolar and former state Insurance Commissioner Peter Hiam—have weighed in on this issue before. And their conclusions remain the same: The most popular cost-control measures—"competition, most payment reforms, and the like"—have proved fruitless.

"In the first half of the 1970s, when these techniques were little used, health costs per person expressed in constant dollars rose by 3.8 percent annually in the U.S.," according to the report. "By the second half of the 1980s, they were widely used and the annual increase had risen to 5.4 percent."

"Shifting health costs to workers by increasing their share of insurance premiums and by increasing out-of-pocket costs . . . are gimmicks," Sager and company believe. "They camouflage state government's abandonment of responsibility for attacking the sources of high health costs head-on."

Cost shifts, according to the report, "are narrow and misguided because they pursue an objective of reducing the visible cost of health insurance premiums to state government without recognizing that these health insurance premiums are part of a compensation package whose salary component has been fixed since 1988."

State government, of course, is not alone in pushing more health costs onto employees. But Sager's perspective finds its echoes in the private sector. Note this passage from a survey of New England employers by the Benefits Resource Group of Framingham:

> ***"It reduces state government's own stake in finding honest solutions . . . [to] the cost problem."***

"Shifting costs to employees was favored among surveyed employers, but it may not offer an effective long-term solution. Employer costs have increased from about 7.5 percent in 1986 to nearly 20 percent in 1991. At the same time, employee salary increases are down from 6 percent in 1986 to just under 5 percent in 1991. Expecting employees to pay a share of health care cost increases is part of a sound strategy. More far-reaching solutions must come from other areas as well. These must address the underlying causes of health care costs."