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CADILLAC COVERAGE: The High Cost of Public Employee Health Benefits

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Executive Summary

In light of budget deficits and the need to identify ways to reduce spending in states across the U.S., increasing public discussion has focused on health-care costs for public employees. Much of that discussion has focused on the relatively low share of insurance premiums paid by government workers, when compared with their private-sector counterparts. Although this is a real phenomenon, it is not the only, or even the most important, reason for high health-insurance costs.

This report explores the reasons that government-employee benefits cost more, and it makes concrete recommendations for how costs can be brought into line with those of the private sector.

Among the reasons identified for the cost differences are:

- Public employees contribute less to their premiums—an average of about 15 percent of the overall premium, compared with about 25 percent in the private sector.
- Public-employee plans offer more generous benefits, including lower deductibles and lower co-payments.
- Governments require shorter enrollment waiting periods for new employees than in the private sector.
- Public employees have higher opt-in rates for employer-provided coverage: 26 percent of private-sector workers choose not to participate in available employer health plans, while just 16 percent of government workers chose not to.

Realigning government-employee contributions to match those of the private sector could save taxpayers millions of dollars a year. However, this simple approach does not bend the cost curve over time—benefits will still continue to grow astronomically—and further, it will understandably upset workers by reducing their take-home pay.

We recommend instead that governments work more broadly to reduce their spending on health benefits—including by reducing the overall cost of plans offered to employees. We detail, in particular, how Indiana has achieved significant savings since shifting to consumer-directed health plans in 2006. Consumer-directed plans are designed so that, except for catastrophic expenses, employees bear the responsibility of paying their own health-care costs. This sharply reduces the cost of insurance because a smaller percentage of an employee's medical bills are paid by the insurer and because employees have a strong incentive to consume care more judiciously.

Characteristics of successful consumer-directed health plans include:

- A generous Health Savings Account (HSA), funded by the employer and employee, which is used to pay day-to-day medical expenses and which can be rolled over into future years and even drawn on for other expenses after retirement.
- A high-deductible, low-premium catastrophic insurance policy to cover large expenses.

In Indiana, this reform is saving the state $17–$23 million each year, while employees are saving $7–$8 million because of lower utilization. When designed properly, consumer-directed health care benefits employers and employees alike and can result in significant savings for taxpayers if implemented at the state and local level nationwide.

About the Author

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THE CHALLENGE OF PUBLIC-EMPLOYEE HEALTH BENEFITS

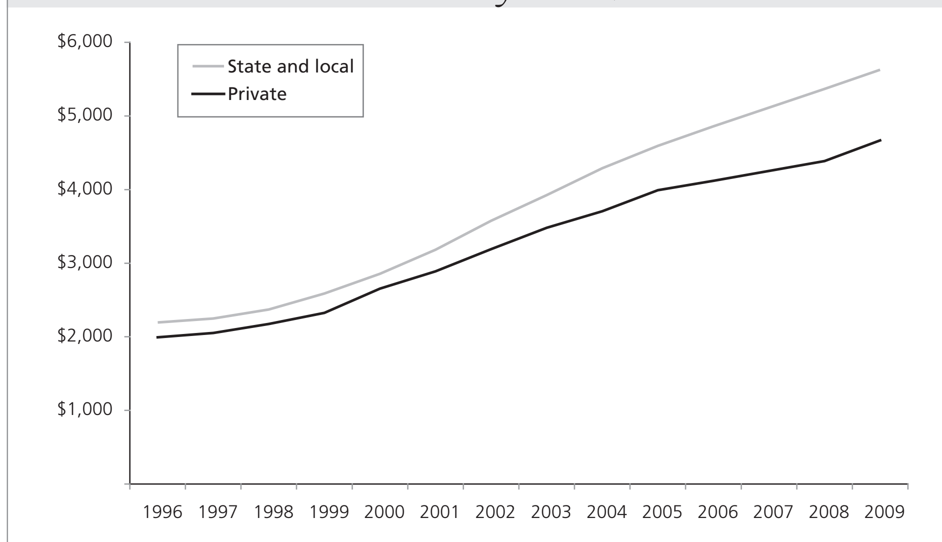
As state and local governments suffer under crushing budget imbalances, policymakers are examining areas where spending can be reduced without cutting public services. One area that they can examine is government-employee health benefits.

As of 2008, state and local governments were spending about $132 billion annually on employee health benefits, or more than 5 percent of overall expenditures.[1] This cost has risen rapidly: in 1996, the average single coverage premium was $2,194. By 2008, that figure had risen by 156 percent, to $5,627. For family coverage, premiums also rose quickly: from $5,627 to $14,024, or a 169 percent increase.

Of course, rising employee health-care costs are not just a problem for governments; large corporations and small businesses are also struggling (see Chart 1 on next page), though the rate of increase is lower for private-sector employers. And certainly Medicaid and Medicare are the number-one drivers of long-term fiscal imbalances at the state and federal levels, respectively.

States and especially localities are not in a strong position to slow overall health-care inflation. There are a handful of steps they should take to combat it, such as easing medical-licensing rules, legalizing retail health clinics, and increasing reliance on nurse practitioners

Chart 1. Average Total Single Coverage Employer-Provided Health Plan Premium by Sector, 1996-2009



for simple care. But in general, major steps to slow the growth in health-care costs are the province of the federal government.

However, with public-employee health benefits, states and localities do control their own destiny. One thing is clear: government jobs offer richer health benefits than those typically offered in the private sector. On average, government-employee health plans cost between 8 percent (families) and 20 percent (singles) more than private-sector plans. Public employees also contribute less to their premiums, making the overall value of the benefit even greater. As health-care costs continue to rise, policymakers are finding these generous benefits difficult to ignore.

Many governments have been responding to recent budget crises by increasing the share of health-insurance premiums paid by their employees—controversial public-employee reforms in New Jersey, Ohio, and Wisconsin included mandated increases in employee contributions toward health benefits, and similar changes are being debated elsewhere.

In general, such moves make sense. However, it is important that governments not limit their approach to increasing employee contributions. Public-sector health plans tend to be more costly overall, before you even get into the division of costs. States should therefore look at plan changes that reduce the total cost of health insurance.

HOW MUCH RICHER ARE HEALTH BENEFITS IN THE PUBLIC SECTOR?

Looking at the numbers on a gross basis, it's easy to see the huge differences between public- and private-employee health costs. As of the fourth quarter of 2010, public workers were earning an average of $4.66 per hour in health benefits, compared with $2.08 in the private sector, a difference of 124 percent. Over the last several years, overall health-benefit costs have been growing rapidly, but the gap has been widening somewhat: in the first quarter of 2004, the difference was 119 percent. Over the intervening seven years, government workers gained $1.31 in hourly health-benefit earnings, compared with just $0.55 in the private sector.[2]

Differences in plan benefits account for only some of the higher gross expenditure, however. One key driver is that state and local government employees are much more likely to participate in employer-provided health plans: 71 percent versus 55 percent.[3] Additionally,

public employees tend to have more education, which drives their overall compensation higher.

But even after adjusting for these factors, a large cost difference persists. For example, let's compare public-sector workers with private-sector counterparts with similar job classifications. Some 66 percent of management, professional, and related workers collect health benefits in the private sector, compared with 73 percent in the public sector.[4] Yet the average public employee in this classification is collecting $5.03 per hour in health benefits, a 62 percent advantage over the $3.11 average in the private sector. Adjusting to exclude workers not receiving health benefits, the number is still 46 percent.[5] Clearly, a significant part of the excess cost of public-employee health plans is driven by plan design, not workforce demographics or a higher participation rate.

Indiana's Experience: How One State Holds Down Health-Benefit Expenditures

In 2006, under Governor Mitch Daniels, Indiana undertook a major reform of employee health benefits. Previously, Indiana state workers had a choice of four managed-care plans, all with rapidly escalating costs. In an attempt to contain expenses, the state introduced a high-deductible plan option linked to an HSA (Health Savings Account), followed by a similarly consumer-directed option in 2007 with a lower deductible and a higher employee contribution to premium. Employees choosing these plans would pay little toward premiums and would receive an annual state contribution to the HSA. Meanwhile, the managed-care plans were consolidated into a single PPO (Preferred Provider Organization, the most common form of managed-care plan) with a significant employee contribution.

The key idea behind consumer-directed plans is that the employee pays more out-of-pocket for each doctor visit, as a way to encourage frugality and to help reduce overall health-care spending.

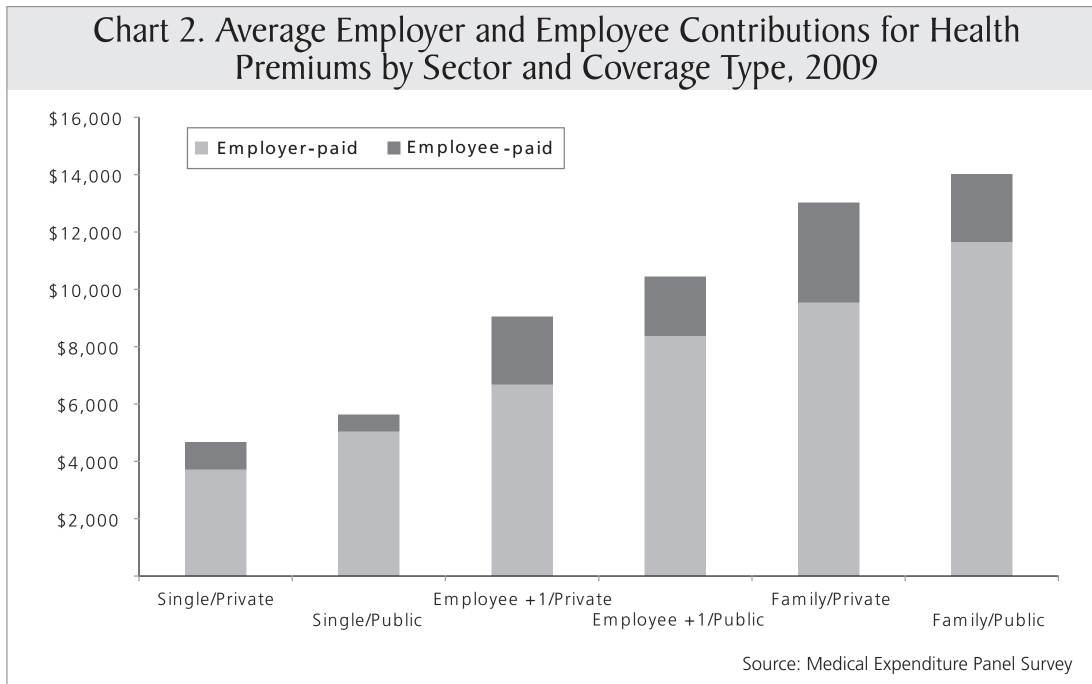
By 2010, 70 percent of state employees had chosen to enroll in one of the two consumer-directed plans. The three plans were designed to have similar actuarial values: the PPO requires a much higher employee contribution to premium in exchange for greater benefits. Yet employees have shown a strong preference for the less expensive, less generous plans.

It's important to note that Indiana required employees to pay if they wanted richer plans. For the comprehensive PPO plan, employee contributions are indeed high—about $6,000 per year for family coverage, more than twice the national average for state and local health plans. But employee contributions for the consumer-driven plans are quite low, at $260 per year for the higher-deductible option and $1,551 for the lower-deductible option (less than $1,000 for single coverage).

For the consumer-driven plans, the employee contribution to the premium is more than offset by state-paid HSA contributions, meaning that most Indiana state workers make a net-negative contribution toward their health-plan premiums. Yet because the premiums themselves are very low, Indiana taxpayers have realized significant savings.

A Mercer Consulting study examined Indiana's reforms. Net payouts under the two consumer-directed plans are far lower than under the PPO, largely because of adverse selection: young and healthy employees are more likely to choose the consumer-directed plans, especially the most bare-bones option. However, even after adjusting for health status and demographic factors, Mercer found large savings due to what it calls "consumerism"—the tendency of consumer-directed health-plan members to spend health dollars more judiciously. Consumerism reduced claims by 10.7 percent, saving Indiana taxpayers $17–$23 million per year. Meanwhile, employees themselves saved $7–$8 million per year because of their own lower utilization.[6]

Total savings of about 15 percent of health-benefit costs, divided among taxpayers and public employees, is significant; similar savings for public employees across the entire country would amount to nearly $20 billion per year, or nearly 1 percent of state and local spending. As such, Indiana's effort demonstrates a promising option for reform.



There are other sizable gaps between public- and private-employee benefits. According to the Medical Expenditure Panel Survey (MEPS) conducted by the Department of Health and Human Services, state and local employees receive more expensive health plans than their private-sector counterparts, and they pay a smaller percentage of premiums. Public-employer contributions average 36 percent larger for single beneficiaries and 22 percent larger for families. Chart 2 shows distributions of total premiums in the public and private sectors, broken down by employee and employer contribution.[7]

WHAT MAKES PUBLIC-EMPLOYEE HEALTH BENEFITS SO COSTLY?

As Chart 2 shows, public-employee health benefits are more expensive than those in the private sector. Several factors are driving the costs, including lower co-payments and deductibles, more plans with no deductible at all, and shorter waiting periods required before receiving benefits.

Taxpayers also face excess costs for public-worker health benefits because of unusually high "take-up" rates: the percentage of workers who accept the health benefits offered to them. Many people have access to health insurance through more than one avenue, generally through a spouse. For couples or families where there is a choice between private and public plans, people will respond rationally and opt for the more generous public package.

A. Lower employee contributions to premiums

As shown in Table 1, public employees do pay a significantly lower percentage of their health-insurance premiums than their counterparts in the private sector, by about 10 percentage points for both single and family coverage. The gap for employee plus one coverage is smaller—about six percentage points.

Table I. Average Employee Shares of Premium and Average Potential Savings per Employee

Plan type	Private sector	State and local government	Savings by realigning
Single	20.5%	10.3%	$ 574
Employee +1	26.1%	19.7%	$ 664
Family	26.7%	16.9%	$ 1,376

Source: Medical Expenditure Panel Survey, 2009

The table also shows the average dollar savings per employee that state and local governments would realize by increasing employee contributions. On average, governments could save over $500 per employee taking single coverage and nearly $1,400 per employee taking family coverage simply by matching employee contributions with those in the private sector.

However, even if public employees' health-premium contribution percentages were adjusted to match the private sector, health benefits in the public sector would still significantly exceed those in the private sector because of differences in total plan premiums, as shown in Chart 1 (page 2).

B. Differences in cost sharing

State and local government health plans tend to require fewer and smaller co-payments and deductibles. That makes health benefits more expensive for two reasons: first, the insurance plan must pay a greater percentage of bills; second, the insured has less of an incentive to be judicious about the consumption of health care.

Public employees are more likely to be enrolled in plans that do not have any deductible, and when their plans do have deductibles, they tend to be lower.

Table 2. Average Deductible among Plans Requiring a Deductible

Plan type	Private sector	Large private (1,000+ employees)	State and local government
Single	$ 917	$ 678	$ 636
Family	$ 1,761	$ 1,477	$ 1,285

Source: Medical Expenditure Panel Survey, 2009

The difference in deductibles is, in significant part, a factor of small private employers, which tend to favor plans with higher deductibles. However, even plans offered by private companies with 1,000 or more employees generally require larger deductibles than public employee plans do. Additionally, 70 to 75 percent of private employees receiving health insurance from firms of all sizes must pay a deductible, compared with just under half of state and local workers.

Table 3. Percentage of Plans Including a Deductible and Requiring a Co-payment for a Physician Office Visit

Characteristic	Private sector	Large private	State and local government
Plan includes deductible	73.8%	74.7%	48.8%
Plan requires co-payment for office visit	72.6%	69.9%	75.7%

Source: Medical Expenditure Panel Survey, 2009

Public-employee health plans are actually slightly more likely to require co-payments for office visits than private-sector plans are. But co-payments, when required, tend to be lower in the public sector:

Table 4. Average Office Visit Co-payment among Plans Requiring a Co-payment

Office visit	Private sector	Large private	State and local government
Co-payment	$21.53	$20.53	$17.72

Source: Medical Expenditure Panel Survey, 2009

C. Waiting periods

Often, a waiting period is required before an employee may begin coverage under an employer's health plan. This reduces the cost of coverage because fewer employees are eligible for benefits at any given time and because it reduces the problem of adverse selection: people taking jobs with health benefits because they expect that they will soon need to file a claim. Public employers are less likely to impose a waiting period: 2009 MEPS data show that 74 percent of private-employer plans required a waiting period, compared with 58 percent in state and local government. Meanwhile, the Kaiser Family Foundation 2010 Employer Health Benefits Survey, which has a smaller sample size, did not find a statistically significant difference between the likelihood that public and private plans would require a waiting period. The study did find with significance that waiting periods, when required, tend to be shorter in the public sector: an average of 1.7 months, compared with 2.2 months in the private sector.[8]

The Prevalence of Retiree Health Benefits

Separately from the higher cost of current-employee health benefits in the public sector, public employers are far more likely than private ones to offer health benefits to retirees. Providing such benefits is a significant and growing cost for state and local governments. In most cases, promises to provide benefits to retirees are not pre-funded, and state and local governments have an unfunded liability for retiree health care that is estimated at $1–$1.5 trillion.[9]

While 36.4 percent of state and local governments offer health benefits to retirees under 65, only 11.2 percent of private establishments do so. However, those figures actually understate the gap because smaller units of government are overwhelmingly less likely to offer retiree health benefits than the large ones that employ most public workers.

Table A. Retiree Health-Benefit Coverage by Type of Public Employer

		Percent offering benefits to:	
Class	Share of total employees	Retirees < 65	Retirees 65+
States	27.2%	71.7%	64.6%
Locals < 250	11.5%	28.5%	19.4%
Locals 250–999	16.9%	56.5%	39.0%
Locals 1,000–4,999	21.6%	65.1%	48.5%
Locals 5,000–9,999	7.5%	70.2%	53.8%
Locals > 10,000	15.2%	82.7%	75.7%

Local governments with fewer than 250 employees, which employ less than 12 percent of public workers, are unlikely to provide retiree health coverage. But large majorities of state governments and larger local governments do provide such coverage.

The picture looks very different in the private sector. Retiree health benefits are extremely rare at private firms with fewer than 1,000 employees. Some 48 percent of private-sector workers work for firms with at least 1,000 employees, and 34.5 percent of such firms do offer health benefits to retirees under 65. However, comparable-size governments (which employ 72 percent of state and local workers) offer such coverage at rates of 65 to 83 percent, depending on their size cohort.

Table B. Retiree Health-Benefit Coverage by Type of Public Employer

		Percent of establishments offering benefits to:	
Firm size	Share of total employees	Retirees < 65	Retirees 65+
< 10	11.5%	1.2%	2.6%
10–24	8.9%	1.6%	2.7%
25–99	13.9%	2.4%	3.4%
100–999	17.4%	7.5%	8.6%
1,000+	48.3%	34.5%	31.8%
< 50	27.0%	1.5%	2.7%
50+	73.0%	23.4%	22.1%

Because of overweighting small establishments, the 11 percent and 36 percent figures above understate the prevalence of retiree health benefits in both the private and public sectors. The true percentage of workers at employers that offer pre-Medicare retiree health benefits is likely closer to 20 percent in the private sector[10] and 66 percent in state and local government.

D. Voluntary waiver of benefits

The vast majority of full-time employees have access to health benefits, but many opt not to enroll. While only 12 percent of full-time civilian workers lack access to health benefits through work, 21 percent have access to benefits but don't take them.[11] In some cases, that is because the employee decides that it is not worth paying his or her share of the premium. In other cases, it is because the employee has access to insurance through another avenue, such as coverage under a spouse's plan.

Government workers are significantly more likely than private-sector workers to have access to benefits: 99 percent of full-time state and local workers, compared with 86 percent in the private sector. But they are also far more likely to accept the benefits offered to them: 84 percent, compared with 74 percent in the private sector, accept them.[12] This is, at least in part, a reflection of the fact that public-employee health benefits are more generous. With lower premium contributions and greater coverage, it makes more sense for people with options to choose a public-employee plan—especially when it comes to very expensive family coverage.

The result is that offering generous health benefits is doubly costly for state and local governments: first, the plan costs more per employee; second, employees are more likely to opt in to high-cost family plans.

E. Other factors

Other factors may make public-employee health plans more expensive. In many cases, they offer superior physician networks and (relatedly) higher provider-reimbursement rates. On the other hand, one would expect government plans to have cost advantages due to their large size (much as large companies pay less than small ones for similar benefit plans).

Unfortunately, it is not possible to measure these effects with the MEPS data; but we can be certain that state and local governments are paying too much for employee health plans and that there are specific things that policymakers can do to bring the costs in line with those of the private sector.

REINING IN THE COST OF PUBLIC-EMPLOYEE HEALTH BENEFITS

What can governments do to reduce the cost of employee health benefits? Broadly, they should look at how the benefit packages that they offer differ from those that are typical for private firms in their states, and make changes to eliminate the excesses. Lawmakers have tended to focus on employee contributions where savings of several hundred dollars per employee are easily within reach.

Reforms should also aim to reduce the cost of the benefit package overall. There are essentially two directions that governments can take on this. The first is to operate within the framework of standard managed-care plans (in both the public and private sectors, about 75 percent of employees receive their health coverage through managed care).[13] Governments can make these plans less costly by conforming to typical private-sector standards on deductibles, co-payments, provider networks, and the like.

The second option is to make a more radical shift in the structure of public-employee health benefits. Over the last several years, the state of Indiana has moved about 70 percent of its workforce over to consumer-directed high-deductible health plans, which are linked to Health Savings Accounts. (See more about Indiana on page 3). Consumer-directed plans are designed so that, except for catastrophic expenses, employees bear the responsibility of paying their own health-care costs. This sharply reduces the cost of insurance because a smaller percentage of an employee's medical bills is paid by the insurer and because employees have a strong incentive to consume care more judiciously.

In a typical consumer-directed plan, the employer will pay most of the high-deductible insurance premium and will also make a contribution into the employee's Health Savings Account, from which the employee pays routine medical bills. The employee can also contribute to the HSA, and both employer and employee contributions are nontaxable. HSA balances do not have to be spent in the year that they are contributed; employees can roll the funds

PPACA Implications for Public-Employee Health Benefits

Under the Patient Protection and Affordable Care Act (PPACA), Medicaid eligibility will be significantly expanded in most states. While the federal government will pick up the lion's share of the cost of this expansion, state lawmakers are concerned about the effects that it will have on state budgets. Less discussed are two important PPACA effects on health benefits for state and local workers—one a risk and the other an opportunity.

The risk comes from the "Cadillac Tax" component of PPACA, a 40 percent excise tax on the portion of employer-provided health plans that exceeds a cost cap. The tax comes into effect in 2018 and, because the cap will rise more slowly than medical inflation, will affect more health plans over time.

AFSCME, the leading union for state and local government workers, was a leading opponent of the Cadillac Tax for a reason: government workers are disproportionately likely to receive plans that would be hit by the tax. Governments that do not rein in health benefits will be hit by even-faster rising costs once the tax becomes effective. So PPACA provides extra reason to reform health benefits.

The opportunity relates to health benefits for retired workers. The traditional justification for retiree health benefits in the public sector is that public employees often retire before age 65, and it is extremely expensive or sometimes impossible for older adults to buy health insurance in the individual market. The regulations, exchanges, and subsidies included in PPACA will make it significantly cheaper and easier to do so. Governments wishing to support their retirees' health-care costs could instead offer cash payments that the retirees would put toward federally subsidized health premiums. Essentially, PPACA will offer a way for state and local governments to shift retiree health-care costs upward to the feds.

over from year to year and, after reaching retirement age, withdraw funds on a tax-deferred basis for nonmedical purposes.

Because consumer-directed health plans are often significantly cheaper than managed-care plans, governments can even save money while requiring little or no employee contribution toward premium and while still making a generous contribution into the employee HSA.

If offering a choice of health plans, public employers should require employees who choose more generous options to shoulder a higher share of their premiums. They should not set employee contributions at a fixed percentage, as this will encourage employees to take the most generous plan option and could cost taxpayers more.

Finally, beyond the design of their own employees' health plans, states should take broader steps to bend the health-care cost curve down. Rapidly rising public-employee health-benefit costs are a symptom of high overall health-care inflation. States should liberalize regulations on health-care delivery to increase supply and bring down costs, which will generate savings not just for public-employee benefits but also in Medicaid and for private employers. They should also encourage federal lawmakers to take stronger steps to control health inflation, including reform of tax subsidies that encourage overconsumption of health care.

Endnotes

1. Author’s calculations based on data from U.S. Census of State and Local Governments; and Bureau of Labor Statistics, Employer Costs for Employee Compensation.

2. Bureau of Labor Statistics, Employer Costs for Employee Compensation.

3. Bureau of Labor Statistics, Employee Benefits in the United States, 2010, http://www.bls.gov/news.release/pdf/ebs2.pdf.

4. Ibid.

5. Bureau of Labor Statistics, Employer Costs for Employee Compensation. http://www.bls.gov/data/.

6. Cory Gusland et al.,”Consumer-Driven Health Plan Effectiveness: Case Study: State of Indiana,” Mercer Global, May 20, 2010.

7. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey 2009. The MEPS Insurance Component is an annual survey of more than 30,000 employers, collecting detailed information on the health-insurance benefits that they offer to employees.

8. Kaiser Family Foundation, Employer Health Benefits Survey, 2010. http://ehbs.kff.org/.

9. Estimates of total state and local unfunded OPEB liabilities have ranged from $1 trillion to $1.5 trillion. The $1 trillion estimate was first reported in a 2005 New York Times article (“The Next Retirement Time Bomb, “Dec. 11, 2005). In 2006, a Cato Institute analysis put the figure at $1.4 trillion (Chris Edwards and Jagadeesh Gokhale, “Unfunded State and Local Health Costs: $1.4 Trillion,” Cato Tax and Budget Bulletin, No. 40.) In a 2007 research note, Credit Suisse estimated the total at $1.5 trillion (“You Dropped a Bomb on Me, GASB,” Equity Research, Accounting & Tax Note, March 22, 2007).

10. This estimate closely aligns with an Employee Benefit Research Institute (EBRI) estimate of 22 percent as of 2008; see EBRI, “Trends in Retiree Health Benefits Offered by Employers,” February 24, 2010, http://www.ebri.org/pdf/FFE156.24Feb10.Final.pdf.

11. U.S. Department of Health and Human Services, Medical Expenditure Panel Survey: http://www.meps.ahrq.gov/mepsweb/.

12. Employee Benefits in the United States, 2010.

13. Kaiser Family Foundation, Employer Health Benefits Survey, 2010. http://ehbs.kff.org/.

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