



Massachusetts Taxpayers Foundation

December 10, 2008

Hon. Stanley Rosenberg, Senate Chair
Hon. Paul Donato, House Chair
Special Municipal Relief Commission
State House
Boston, MA 02133

Dear Senator Rosenberg, Representative Donato, and Members of the Commission:

This letter follows up on my recent testimony to the Special Municipal Relief Commission.

The cities and towns of Massachusetts are facing a relentless fiscal squeeze in which year after year costs are growing faster than revenues for almost all communities. Despite the generous increases in local aid over the past several years, state aid in fiscal 2009 is still below the 2002 level after adjusting for inflation. With a new fiscal crisis upon us, aid to cities and towns will almost certainly be cut significantly in fiscal 2010.

This crisis presents an opportunity for the Legislature to adopt a series of important reforms which address the structural fiscal problems confronting municipalities and place the finances of cities and towns on stronger footing for years to come.

The problem needs to be addressed on both the revenue and cost fronts. For example, cities and towns should certainly be given the option of voting a 2% meals tax as well as an increase of 2 % in the so-called hotel-motel tax.

But revenues alone won't suffice. A wide range of steps must be taken to hold down the growth in costs.

The one absolutely critical area of cost control is employee benefits – health care and pensions. The present level of benefits, in particular, health care, is unsustainable. For example, there is simply no way that the vast majority of cities and towns can pay for their retiree medical obligations under GASB 45.

As a starting point, the Foundation recommends that three actions be taken to help municipalities address the escalating costs of health care which are consuming an ever larger share of municipal budgets and forcing cuts in schools, police, fire, public works and other areas.

1. **Give local officials the power to design their health insurance plans outside of collective bargaining.** This would extend to cities and towns the same authority that the state now enjoys. Unlike municipalities, which are required to negotiate and receive union approval to implement changes in their health insurance plans, the state has no



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such requirement and makes decisions on health insurance outside of collective bargaining.

The Group Insurance Commission, which handles health insurance for state employees and retirees, has incorporated realistic co-pays, deductibles and tiered networks into their still generous health plans as a way of holding down the growth in costs.

Recent legislation allowing municipalities to join the GIC through coalition bargaining was a small step in the right direction, but more dramatic action is clearly required. The process of joining the GIC is too slow and difficult, and we recommend that communities have the authority to make that decision without going through collective bargaining.

However, not every community would reap savings by joining the GIC. Giving communities the power over plan design promises quicker and larger savings for many, if not most, cities and towns. It also preserves the flexibility to design plans that meet the needs of that particular community.

- 2. Require by statute that all local retirees who are eligible for Medicare actually enroll in Medicare as their primary source of health insurance coverage.** Unlike the state which imposes such a requirement, there is no similar mandate for cities and towns. Municipalities currently have the option of adopting Section 18 of Chapter 32B to implement this requirement, but a significant fraction of cities and towns have not done so. As a result, their retirees remain in the community's health plan rather than enroll in Medicare at considerable and unnecessary expense to local taxpayers.
- 3. Adjust the municipality's contribution for retiree health care to reflect the employee's years of service.** Unlike the pension benefit, which is tied to years of service, local employees earn full retiree health benefits after only 10 years of service, with no increased benefit for working 20, 30 or 40 years. Specifically, we recommend that the percentage premium contribution paid by the employer for a retiree be tied to his or her years of service, from a minimal share at 10 years to the maximum at the point that the retiree earns the maximum pension benefit (80%).

There are many other opportunities for health care savings at the local level, but these three steps alone would achieve large savings for cities and towns while still preserving generous health benefits for employees and retirees.

Thank you for the opportunity to testify before the Commission.

Sincerely,

Michael J. Widmer

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