TOWN OF ARLINGTON
MASSACHUSETTS

REPORT OF THE

BOARD OF SELECTMEN

TO THE

SPECIAL TOWN MEETING
MONDAY, NOVEMBER 15, 2010

8:00 P.M.

ARTICLE 3 CONTINGENT TRANSFER OF REAL ESTATE/ THOMPSON SCHOOL AND NORTH UNION STREET PLAYGROUND

VOTED: The three members of the Board present voted their preliminary, contingent support for the land swap proposed under Article 3 of the Special Town Meeting Warrant, but wish to wait until full Board is present on November 8 to formalize vote. (3-0)
Mrs. Mahon and Ms. Rowe absent

ARTICLE 5 HOME RULE LEGISLATION/ GROUP INSURANCE COMMISSION

VOTED: That no action be taken under Article 5. (3-0)
Mrs. Mahon and Ms. Rowe absent

COMMENT: As you are aware, last spring at the Annual Town Meeting, the attached resolution was approved by a vote of 126 in favor and 37 opposed.

Along with the resolution, we have attached a copy of the Town Manager's report on this issue from last spring which provides useful background information on this subject as well as the original proposed home rule petition.

Since then, the Town Manager has met with the Public Employee Committee (PEC) throughout the summer. A number of productive sessions were held culminating in a recent tentative agreement. The agreement is subject to ratification votes of the employee unions. A 70% weighted vote is needed to approve the agreement to move employees into the State's health care program (GIC). Information and education sessions are scheduled for all the various employee groups over the next several weeks with the actual union votes taking place shortly after Town Meeting.

Given the good faith bargaining that has taken place and given the tentative agreement reached, the Town Manager and the Board concur that a vote of NO ACTION would be appropriate at this time. If anything should change prior to Town Meeting to indicate that the PEC would likely not follow through with a positive vote, the Board will reconsider its recommendation on the previously proposed home rule petition.

Town of Arlington
Office of the Town Manager

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Town Manager

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MEMORANDUM

DATE: May 21, 2010

TO: Board of Selectmen

SUBJECT: Healthcare Resolution Article 27

Attached is a copy of the proposed resolution along with the original home rule petition.

As you know, the Board of Selectmen asked for postponement of this article in the hopes that we could get further clarification from the employee unions as to their willingness to move forward in negotiations and agree to meaningful health care cost reductions and containment measures.

I indicated to the unions that if they all agreed to engage in earnest and expeditious negotiations, that I would recommend to Town Meeting to hold off action on the proposed home rule petition and instead I would recommend the adoption of the resolution that you have before you.

I am pleased to report that the unions have stepped up and agreed to resume discussions. It has always been my preference to negotiate the changes to health care. I want to state that our goal has been, and will continue to be, to provide quality healthcare to our employees at an affordable price – a price that is fair to both our employees and taxpayers.

Our employees do a great job under difficult circumstances. Neither my original proposal, nor this one, is intended to be anti-employee. Nothing could be further from the truth. The actions proposed would actually protect the jobs of many employees while also preserving quality healthcare at no additional cost to the employees.

We spent over a year negotiating with the unions. With the help of consultants to verify numbers, we evaluated the GIC option as well as every other option that anyone suggested. In the end what it came down to was that the GIC option, because of the economy of scale of such a large health insurance pool, was the only option that met our goals of maintaining quality health care coverage while also providing savings to the employees and the Town.

Because of the importance of this issue, it makes sense to make one more attempt to negotiate changes that are fair to both the employees and the taxpayers. Fortunately we know there is an option available that can accomplish this. While I believe that the GIC is the best option, I am willing to discuss any and all options that can provide savings comparable to the GIC.

The status quo, however, is simply unacceptable. The current situation puts an unfair burden on the taxpayers who have had their own health care plans changed and have taken pay cuts if not lost their jobs. Left unchanged, our "Cadillac" health care plans will be taxed millions of dollars by the federal government and will eventually bankrupt this community.

While I remain hopeful that negotiations will be successful, for the sake of our residents, particularly our school children, we have to be prepared to take action on the home rule petition, which would be the only responsible option available to us if we are to properly execute our fiduciary responsibility to the Town.

I urge your favorable action on this resolution.

_____
Town Manager

TM VOTED ON 5/24/10: **(STANDING VOTE-126 IN THE AFFIRMATIVE AND 37 IN THE NEGATIVE) (QUORUM PRESENT)**

R E S O L U T I O N

Whereas, the Town of Arlington's operating budget is under great pressure from declining revenues and increases in fixed costs resulting in reductions to important services; and

Whereas, one of the major fixed cost increases that the Town of Arlington faces on an annual basis is the employee group health insurance account which for the past ten years has increased an average of 9.2% a year; and

Whereas, employee group insurance represented 9.6% of the fiscal year 2001 budget, and has risen to represent 16.8% of the proposed fiscal year 2011 budget; and

Whereas, the Federal Government plans to implement a luxury tax in 2018 on "Cadillac" health care plans that Arlington's current plans would be subject to, potentially costing the Town millions of dollars unless the plan costs are reduced; and

Whereas, the Town desires to provide quality health care plans to its employees at a cost that is fair and reasonable to both the employees and taxpayers; and

Whereas, there are options, such as the GIC, that will maintain the same quality health care coverage for town employees that, in the aggregate, will reduce costs for both the employees and the Town;

Now, therefore, be it resolved that:

Town Meeting urges in the strongest terms that the employee unions and Town Manager negotiate an agreement as expeditiously as possible that results in the Town opting into the State's Group Insurance Commission or agreeing to plan design changes to the Town's current menu of health insurance options that achieves cost savings similar to that of the Group Insurance Commission; and

Be it further resolved that:

If such agreement is not reached by Friday, September 24th, 2010, Town Meeting requests that the Board of Selectmen call a Special Town Meeting for the purpose of acting upon and approving the Home Rule Petition proposed in Article 27 of the 2010 Annual Town Meeting Warrant.

A true copy of the vote under
Article 27 of the Warrant for the
Annual Town Meeting of the
Town of Arlington at the session held May 24, 2010.
ATTEST:

Town Clerk

Home Rule Petition as Presented to Town Meeting in the Spring of 2010

VOTED: That the Town hereby authorizes and empowers the Board of Selectmen to cause the filing of a petition in substantially the following form with the General Court:
AN ACT relative to health insurance coverage for employees of the Town of Arlington.
Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:
SECTION 1. Notwithstanding any general or special laws to the contrary, and notwithstanding in particular, but not limited to, any contrary provisions of Section nineteen (a), (b), (d), or (e) of Chapter thirty-two B, the Town of Arlington, through action of its Board of Selectmen as the appropriate public authority, may transfer its subscribers to the Group Insurance Commission pursuant to said Section nineteen (e) without the requirement of an agreement between the appropriate public authority and a public employee committee.
SECTION 2. Notwithstanding any general or special laws to the contrary, and notwithstanding in particular, but not limited to, any contrary provisions of Section nineteen of Chapter thirty-two B, upon the effective date of any transfer of the Town's subscribers to the Group Insurance Commission pursuant to Section one of this act, the total cost (premiums, co-pays, and deductibles) to the aggregate of such transferred subscribers shall be no greater for the insurance plan provided to such subscribers by the Group Insurance Commission than the total cost (premiums, co-pays, and deductibles) to the aggregate of such subscribers for the actuarially equivalent plans provided by the Town at the time of transfer. The cost to the aggregate of transferred subscribers at the time of transfer shall be determined based on the most recent and available 18 months of claims experience and pursuant to generally accepted actuarial standards by an actuary qualified to perform such calculations who shall be mutually selected by the Town and Employee Committee and who shall certify such cost determination in a report detailing the methodology and assumptions used and the maximum percentage of premium contributions by employees for each GIC plan so as to comply with the provisions of this section. Said Employee Committee shall be comprised of a representative of each collective bargaining unit and a retiree representative designated by the Retired State, County and Municipal Employees Association. If the Town and Employee Committee cannot agree on an actuary, the Arlington Retirement Board shall select one. The determination of the actuary shall be final and binding.
Section 3. This Act shall take effect upon its passage.

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MEMORANDUM

DATE: April 28, 2010

TO: Town Meeting Members

SUBJECT: Home Rule Petition - GIC

Under this article, I am proposing home rule legislation to allow the Town to move our employees into the GIC (the State's healthcare plan) without having to reach an agreement through the coalition bargaining process. I am adding protections for the employees by requiring that the costs to the employees (premiums, co-pays, and deductibles) can be no greater than what they are under the Town's plans, and that the benefits and coverage have to be comparable. This all has to be certified by mutually selected actuary with expertise in healthcare.

I have attached a copy of my November 16, 2009 letter to Town Meeting explaining the lengthy GIC bargaining process that we went through previously. I also attached a letter from the teachers' union stating flatly that they will not bargain over or consider the GIC. They did say that they are willing to talk about other areas of healthcare. This is a positive statement but the problem is we have already investigated other areas and they all just meant cost shifting to the employees and the amount of savings compared to the GIC were negligible.

As you may be aware, last year the GIC had a funding shortfall which required some extraordinary co-pay and deductible changes this year and premium increases for next year. In the attached spreadsheet, our healthcare consultant calculated the Town and employee savings using the new co-pays, deductibles, and premiums. Whereas before the total savings was estimated at $ 5.1 million ($4.65 million net of Medicare Part B 50% subsidy agreed to in negotiations), with the new structure and rates the total savings is estimated at $3.35 million net of the Medicare Part B. The breakdown is $2.65 million for the Town and $700,000 for the employees. So contrary to what you may hear from some union members, there are still huge savings to be obtained for both the Town and employees by going to the GIC, and many, many jobs could be saved.

I want to note that just because I have proposed filing this legislation does not mean that I am unwilling to try to negotiate an agreement to join the GIC or to negotiate other changes that would provide comparable savings. Despite that fact that we spent a year trying to negotiate the GIC and other changes to no avail, I have asked the unions to come back to the table and try to work out an agreement. If we do come to an agreement within the next several months, I would be more than willing to drop the pursuit of the legislation. Because the legislative process takes several months to complete, there is adequate time as Chairman Mahon said to "roll up our sleeves" and work out a negotiated agreement.

We are committed to start these negotiations in earnest right away. We have proposed to the unions, engaging a facilitator to assist in this process. Our stated goal has been and is to retain quality health care coverage for our employees while reducing costs for both the Town and employees.

As I mentioned, for the last year, we explored every option that the employees, consultants and we suggested. In the end, the unions rejected all the options. While most of the unions supported the GIC option as the only option that supported all of our goals of maintaining quality health care coverage while also providing savings to the employees and Town, unfortunately one union was able to block the deal. Clearly the process to address the municipal health care issues is broken and needs to be fixed.

Over the last several months there has been a dramatic increased recognition that something has to be done to provide increased control to municipalities over healthcare plan designs and healthcare in general. I have attached several news articles and editorials on this issue including one concerning a group of Mayor's proposing a ballot initiative to bypass the Legislature. My preference is to go into the GIC through a bargaining process or in the alternative, implement plan and design changes that would give us savings comparable to the GIC. Our experience to-date has shown, however, that the process has not worked. The letter from the teachers' union also makes it clear that they refuse to bargain about the GIC. Accordingly, I have been left with no choice but to pursue the dual route of negotiations and the home rule petition. If at any time during the process, the employees want to bargain about the GIC or propose changes that would provide comparable savings as the GIC ($2.65 million), I would be happy to drop the pursuit of this legislation.

_____

Town Manager

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November 16, 2009

Report on GIC Status

Given the number of inquiries that I have received from Town Meeting Members, the amount of misinformation that has been passed around, and the relative importance of this issue, I felt that it was important that I provide this update to you on the issue of health insurance and the Town's attempt to better control this major cost.

Two years ago the State passed legislation that allows municipalities to join the State's health insurance plan, GIC, after negotiations with the unions through coalition bargaining. The first opportunity to join GIC in October 2007 was too soon to investigate the cost savings to the Town and employees. Further, the GIC was in the process of bidding all of its health insurance plans for July 1, 2008, making a comprehensive evaluation impossible.

We began meeting in earnest with the unions and retirees in June of 2008 to educate them on health insurance issues and the options available. At that time, we were working with facilitator Bob McKersie, an Arlington resident, and the Massachusetts Teachers Association (MTA) health insurance consultant, Carol Chandor of Boston Benefits Partners, LLC. Additionally, we met with the main architect of the recent legislation which allows municipalities to join the GIC. He explained the process and provided some basic information about the GIC. We then met with officials from the GIC who explained in detail the plans and benefits offered under the GIC.

At that point, I felt it appropriate that we commence the formal coalition bargaining process for the purpose of negotiating an agreement to join the GIC. Accordingly, on October 20, 2008, I recommended to the Board of Selectmen, and the Board unanimously passed, the following vote:

> *The Board of Selectmen accept M.G.L. c. 32B, section 19 (as amended) for the purpose of transferring all subscribers for whom the Town provides health insurance to the Group Insurance Commission pursuant to M.G.L. c. 32B, section 19 (e).*
>
> *And further, to authorize the Town Manager to: notice forthwith the initial meeting of a Public Employee Committee for the purposes of M.G.L. c. 32, section 19 (e); bargain with such Public Employee Committee for the purposes of M.G.L. c. 32B, section 19 (e); enter*

into an agreement with such Public Employee Committee for the purposes of M.G.L. c. 32B, section 19 (e); and take all such other steps as are reasonably related to the transfer of all subscribers into the Group Insurance Commission.

The only avenue available to join the GIC is through the formation of a PEC (Public Employees Committee) with a 70% weighted vote requirement through a coalition bargaining process. The weighted vote for each union is listed in the following table. Each union and the retirees have one voting representative on the PEC who is authorized to make binding agreements subject to a ratification vote of their respective union memberships.

Union	Weighted Vote
AEA - Arl. Ededucation Assoc.	44.04%
AFSCME - Local 680	25.50%
Firefighters	7.56%
Patrolmen	4.43%
SEIU	3.23%
AAA - Arl. Administrators Assoc.	2.22%
Ranking Officers	1.81%
Librarians	1.21%
Retirees	10.00%
	100%

While we began meeting immediately, it was difficult keeping the unions (PEC) engaged in the process. Nonetheless, ten separate meetings were held. This was in addition to the several informational sessions held earlier. From November 18, 2008 to June 3, 2009 six negotiating sessions were held. We requested to meet through the summer, but the PEC declined. It was difficult to get the PEC re-engaged in the fall. It was not until it was clear that we were facing major layoffs that the PEC agreed to meet on October 13, 2009. Subsequently, negotiating sessions were held on October 19, 20, and 29th. Throughout the ten formal negotiating sessions, the PEC was encouraged and sought the expertise of its own health insurance consultant Carol Chandor. Ms. Chandor and the Town's health insurance consultant, Group Benefits Strategies, worked together to compile factual information for the Committee's consideration. At the Committee's request, we looked at other options such as a sole provider and keeping the current providers but changing the co-pays to levels similar to the GIC. None of the options provided any significant savings and only shifted costs to the employees. The GIC, because of its size and bargaining power, was the only option that provided true and significant savings for the Town and employees.

My goal was to provide quality health care coverage for all employees without a cost increase to them while maximizing the Town savings that would go towards preserving the jobs of as many employees as possible. I reminded the PEC that the smaller the savings to the Town means more employees would lose their jobs and the health insurance that goes along with it.

On Thursday October 29th, the union representatives and I agreed to a deal that the PEC members said they could bring back to their memberships for a vote. While it put less of the savings towards minimizing layoffs than I wanted, it was better than no deal and still represented a win-win situation for the Town and employees.

The total first-year net savings were estimated at $5.1 million. The employees would have received $2.6 million through reduced health care costs and a 2% wage increase. The balance, $2.5 million, would go to the Town to reduce the number of employee layoffs and minimize service reductions. A summary of the terms of the agreement and the resulting savings is included in the following table.

Agreement:
Three year agreement to join the GIC effective July 1, 2011. Employees and retirees share of substantially reduced premiums would also be further reduced as follows:

	Employee/Retiree Contribution		
	Current	Proposed	Conditional*
Active and Retired Employees			
HMOs	15%	13%	10%
PPOs	25%	13%	10%
Surviving Spouses			
HMOs & PPOs	50%	13%	10%
Indemnity	50%	25%	
Medicare Part B	100%	50%	

** Conditional -Applicable if the deductible instituted by GIC increased above a specific amount.*

Wage Increases: FY2010: 0% FY2011: 2% FY2012: 2%
Binding offer by Town – each union free to accept or reject

TOTAL REPLACEMENT GIC		Town	Employee/ Retiree
FY2011			
	Premium Savings	(3,948,504)	(1,657,033)
	Out-of Pocket costs		520,645
	Medicare Part B	457,514	(457,514)
	Salary Increase	1,000,000	(1,000,000)
	Net Cost/(Savings):	(2,490,990)	(2,593,902)
FY2012			
	Premium Savings	(4,623,689)	(1,867,523)
	Out-of Pocket costs		557,090
	Medicare Part B	497,501	(497,501)
	Salary Increase	2,000,000	(2,000,000)
	Net Cost/(Savings):	(2,126,188)	(3,807,934)
FY2013			
	Premium Savings	(5,382,826)	(2,101,441)
	Out-of Pocket costs		596,086
	Medicare Part B	540,982	(540,982)
	Salary Increase	2,000,000	(2,000,000)
	Net Cost/(Savings):	(2,841,844)	(4,046,337)
SUMMARY			
	Premium Savings	(13,955,019)	(5,625,997)
	Out-of Pocket costs	-	1,673,821
	Medicare Part B	1,495,997	(1,495,997)
	Salary Increase	5,000,000	(5,000,000)
	Net Cost/(Savings):	(7,459,022)	(10,448,173)

On Tuesday, November 3rd the Teachers union leadership called the other members of the PEC and the Town to inform us that they had changed their minds and further that they would not even bring it to their membership for a vote.

I recognize that agreeing to join the GIC is not an easy decision for the unions. It means giving up their bargaining rights over health care plan design. I also recognize that the GIC is experiencing some budgetary problems that may result in its rates or co-pays increasing and that it may institute some level of deductibles. Any such increased costs, however, would be dwarfed by the $2.6 million in savings. There is no conceivable scenario in which the increased costs would exceed the savings for employees. To keep the deal together and to allay some of these concerns, I even offered to further increase the Town's contribution from 87% to 90% should the GIC implement a deductible greater than a percentage of the premiums which would equate to approximately $250 for an individual and $750 for a family. Some concerns were expressed that while in the aggregate the unions would save, some individuals who experienced a number of health issues during the year could end up paying out of pocket more than what they saved. To address that scenario, I suggested during negotiations that the unions could take a small portion of their $2.6 million in savings to establish a fund administered by a third party to assist those few employees. The Town is prohibited by GIC rules from contributing to, or administering, such a fund.

By its actions, not only did the AEA leadership fail to bargain in good faith, it turned a win-win situation into a lose-lose. Employees could have reduced their health care costs, received a 2% salary increase, saved the jobs of a large number of their colleagues, and retirees would have had their health care premiums reduced along with the Town paying 50% of their Medicare Part B premium for both the retiree and spouse. In addition, many valuable services would have been preserved for residents. Instead health care costs will remain high for the employees and Town, there will be no funds for raises, retirees will continue to pay high costs with no contribution from the Town towards Medicare premiums, many employees will lose their jobs, and residents will lose many services. I appreciate the union leaders who bargained in good faith and understood what was at stake and the unique opportunity for a positive outcome for all parties at the negotiating table.

It's important to note that the GIC offers quality health care in a cost effective manner. Ask a State employee about the quality of their health care options and I'm sure the overwhelming response would be that they are very satisfied. We have Town employees who, through their spouses, have the option of joining the GIC and have opted for the GIC over the Town's health insurance.

Arlington health care costs have increased close to 10% on average annually for the last decade. While we have been able to negotiate some changes, the fact that it took us five years and two expensive arbitrations to make minimal co-pay changes such as going from $5 to $10 for a doctor's visit is clear evidence that the current process does not work.

It is time to change the law. The Legislature must remove the handcuffs it has placed on cities and towns preventing them from exercising effective control over their largest cost. To put it simply, Massachusetts cities and towns are being crushed under a two-tiered system. The State implements plan design changes and contribution changes as it deems appropriate. However, the State does not grant that option to municipalities, forcing them to obtain union approval before any changes can be made.

A law that allows one union to block the other unions and Town from taking this important step is unacceptable. There is absolutely no justification for the double standard whereby the State retains authority over its employee health care program but denies that same authority to cities and towns. Cities and towns should have the option of managing their healthcare plan designs in the same fashion as the State. At the barest minimum cities and towns should be able to join the GIC without having to obtain union approval.

Unfortunately this will not happen until our legislators hear from you and other residents demanding that they file and push for legislation that allows the Town to join the GIC without first having to obtain union approval. Please call and write to our legislators, the legislative leadership, and the Governor now. Their contact information is a follows:

Representative Jay R. Kaufman
The State House, Room 156
Boston, MA 02133
617-722-2320
Rep.JayKaufman@hou.state.ma.us

Representative Sean Garballey
The State House, Room 134
Boston, MA 02133
617-722-2400
Rep.SeanGarballey@Hou.State.MA.US

Rep. William Brownsberger
The State House, Room 437
Boston, MA 02133
617-722-2676
WilliamBrownsberger@Hou.State.MA.US

State Senator Kenneth J. Donnelly
The State House, Room 416-A
Boston, MA 02133
617-722-1432
Kenneth.Donnelly@State.ma.us

Governor Deval Patrick
The State House, Room 208
Boston, MA 02133
617-725-4005

Senate President Theresa Murray
The State House, Room 330
Boston, MA 02133
617-722-1500
Theresa.Murray@State.ma.us

Speaker of the House Robert A. DeLeo
The State House, Room 356
Boston, MA 02133
617-722-2500
Robert.DeLeo@State.ma.us

Town Manager

The Boston Globe GLOBE EDITORIAL

Soaring municipal health costs cry out for a state overhaul

March 2, 2010

MUNICIPAL HEALTH care costs in Massachusetts are unjustified and unsustainable. Curbing their excesses is an essential mission for the governor and Legislature.

From 1999 to 2009, the cost of insuring municipal employees and retirees surged from 8 percent of the budgets of Massachusetts cities and towns to 14 percent, according to a Globe survey of 25 communities. That's hundreds of millions of dollars that are not going to property-tax relief, schools, parks, law enforcement, or any other legitimate government purpose. These costs are a yoke around Massachusetts, hurting the state's economic prospects.

Cities and towns have been happy to take state aid but have proven incapable of using it wisely by cracking down on abuses in their own payrolls. Lawmakers must enact a thorough overhaul of the system. Their guiding principles should be to sharply reduce costs to taxpayers while providing reasonable health-care coverage to all municipal employees and retirees. People who worked for the government and expected to be covered for life should remain covered. But no one should be exempt from reasonable changes in coverage to bring municipal health costs more in line with the private sector.

The problem to be overcome is twofold: Lifetime benefits promised to workers for too-few years of public service, and a stubborn resistance by the state's Balkanized municipalities to seek savings in larger group plans or by shifting eligible seniors onto Medicare.

Three reforms that should be enacted as soon as possible are:

■Cities and towns should be compelled to reassess such totally unjustified practices as granting lifelong health benefits to people who serve on local boards for as few as 10 years. In exchange for attending as little as two meetings a month for that period, the officials get lifetime coverage costing taxpayers as much as $30,000 per year. While no current beneficiaries should lose coverage, such boondoggles must end now.

■All beneficiaries over age 65 should be compelled to join Medicare. The shift to the federally subsidized program would reap major savings - $5 million per year in Boston alone. Under current law, cities and towns have the option of moving eligible recipients to Medicare, but local opposition has proved to be insurmountable in some places. The Legislature should require all communities to make the switch.

■Cities and towns should be given the same ability to design their health plans, without municipal worker union approvals, as the state now employs for its own workers. The inefficiency is costing taxpayers as much as $100 million a year, according to the Massachusetts Municipal Association. A bill in the House offers a solution that is fair to both employees and the people who pay their salaries. It would give municipalities the authority to design their own health plans, including raising copays and deductibles, provided that recipients get coverage on par with state workers. Another good reform would be to allow city and town officials to enroll their workers in the state Group Insurance Commission plan without first getting union approval.

There are reasons why such sensible reforms have failed in the past. Workers and retirees

represent a disproportionate political constituency in places where other citizens participate only sporadically in local politics, and they refuse to give up such overly generous benefits as doctor visits with copayments of $5 or less. The rest of the taxpayers who are footing the bill should demand changes.

Rather than legislate for the greater good, the forces on Beacon Hill tend to defer to local control. While the system of micromanagement, in which each town operates its own services, has its appeals, it also has weaknesses. And it is incumbent on the state to recognize those weaknesses rather than submit to them.

More than money is at stake. Public confidence is eroded when taxpayers feel that the government is being run primarily for the benefit of its workers. Massachusetts lacks crucial infrastructure, and budget cuts are eating away at such important civic services as libraries and summer jobs for teenagers. The state's ability to answer these challenges is directly related to its ability to quell the perception that its workers and officials are gaming the system.

Generations of reformers of both parties have failed to curb these and similar excesses, or backed away in favor of more glamorous pursuits. Now the perception that nothing can be done carries the day on Beacon Hill. And yet those same representatives profess to be shocked when voter anger surges against the system, as if they were victims of a natural disaster rather than their own failure to grapple with the state's problems.

The deficiencies in the municipal health system are real. The solutions are clear enough. Now something must be done. ■

Runaway health costs are rocking municipal budgets But there's no will or willingness to roll back benefits granted in palmier times

By Sean P. Murphy, Globe Staff | February 28, 2010

First of two parts.

Elizabeth Debski spent eight years as Everett's city planner, before losing her job in 2006 when a newly elected mayor installed his own team.

But Debski did not leave City Hall empty-handed. In addition to her pension, Debski, at 42, walked away with city-subsidized health care insurance for life. If she lives into her 80s, as actuarial charts predict, taxpayers could pay more than $1 million in all for her family's health care benefits.

That's not to say Debski manipulated the system. She simply took what she was owed under a municipal health care system whose generous benefits and colossal inefficiencies are crippling cities and towns across Massachusetts.

A six-month review by the Globe found that municipal health plans, which cover employees, retirees, and elected officials, provide benefit levels largely unheard of in the private sector. Copays are much lower. Some communities do not force retirees onto Medicare at age 65. Many citizens on elected boards - some after serving as few as six years - receive coverage for life, too.

As medical costs across the board rose over the past decade, municipal health care expenses exploded, draining local budgets and forcing major cuts in services, higher property tax bills, and billions in new debt.

“It has got to be dealt with,’’ said Richard Fortucci , the chief financial officer in Lynn. “Or we will all go bankrupt.’’

The cost of municipal health care more than doubled from fiscal 2001 to 2008, adding more than $1 billion in all to city and town budgets, according to state Department of Revenue data. A Globe survey of 25 communities found that they now devote, on average, 14 percent of their budgets to health care, up from 8 percent a decade ago. Somerville, for one, spends $20 million more annually than it did 10 years ago, now devoting almost 20 percent of its budget to health care.

So far, with powerful labor unions resistant to giving away hard-won benefits and a lack of political will in the state Legislature to force changes, efforts to overhaul the system have fallen short.

To be sure, many municipal employees, elected officials, and retirees are paying a greater percentage of their health premiums than ever. Still, almost all of the increase in municipal health care costs in the past 10 years has been shouldered by taxpayers, who are subsidizing plans that are often superior to their own.

“It’s a nice deal,’’ said Debski, now a part-time planner in Malden.

She could get insurance through her husband’s employer but doesn’t, for a simple reason: The municipal plan is far more generous and costs less.

“The system was there,’’ she said. “I find it hard to believe that anyone wouldn’t take what the system offered.’’

A crippling cost

The consequences of failing to face this crisis are on display in many cities and towns, nowhere more vividly than in Lawrence.

In that city, on Feb. 1, children were momentarily trapped in a burning apartment building, down the street from a fire station. But the city had recently shuttered the station, to help close a $24 million budget gap, and firefighters had to race from another location. The children escaped, but the fire chief warned the city it may not be so lucky next time.

Meanwhile, Lawrence, one of the poorest municipalities in Massachusetts, continues to pay among the highest rates in the state for health care benefits. The city’s health care kitty, which it uses to pay for coverage, is currently $4 million in the red.

Health care costs are not the only budget-buster for cities and towns, of course, but their rise has led not just to fewer firefighters in Lawrence but diminished services across the state.

Library hours have been cut in Wayland and Hull. Wakefield has deferred road and sidewalk repairs. Malden has introduced fees for trash pickup. Class sizes have increased in Chelsea. Major layoffs have hit, among others, Boston, New Bedford, Worcester, and Brockton - with officials in all those communities citing rising health care costs as a major factor. Revere last year closed City Hall on Fridays, to save cash.

“What am I going to do next, put a padlock on the police station and tell people to call the State Police instead?’’ asked Mayor Thomas G. Ambrosino of Revere, who, like other mayors, is covered by municipal insurance.

Communities, under a 30-year-old initiative known as Proposition 2 1/2, can raise their tax levy each year by no more than 2.5 percent. In Revere, health care costs are rising at close to 10 percent a year. This fiscal year, the rise in health care expenses alone is projected to consume all of Revere’s $1.5 million allowable tax increase - and then some.

With health costs soaring year after year, communities must ask taxpayers for more money even while providing fewer services. Indeed, local officials say, Proposition 2 1/2 overrides - loathed at kitchen tables - are often attributable, at least in part, to skyrocketing health expenses.

Voters in Weston passed a $1.1 million override in 2006, primarily because of health care costs, which had risen by more than 80 percent in four years.

It proved to be a temporary fix. By 2009 Weston needed more money to cover health care increases, said Donna S. VanderClock, town manager. The town avoided another override after unionized employees agreed to join the state’s health care system, saving about $1.7 million in the first year, VanderClock said.

Beyond the immediate costs, huge liabilities loom. Communities have promised current and future retirees billions in health care subsidies, a burden taxpayers will bear long into the future.

Lynn owes current and future retirees an estimated $450 million in benefits over the course of their lives - five times as much as it takes in annually in taxes, according to estimates by city actuaries. Brookline’s unfunded liability for health care is $320 million; Boston’s is $5.7 billion.

Though some communities, such as Wellesley, Needham, and Boston, have begun putting aside interest-earning money every year to help meet those obligations, the vast majority of municipalities have not. Local officials say they can barely afford to pay today’s health care bills, let alone tomorrow’s.

“We have an unfunded liability of more than $600 million and with no plan to address it,’’ said John Condon, Brockton’s chief financial officer. “Even if we wanted to address it, we don’t have the money for it.’’

‘Very, very rich plans’

Jane Teal said she only wanted to help her hometown when she ran successfully for Lynn City Council in 1995. She served for six years, then stepped down, eventually moving to Florida with her husband. Today, Lynn taxpayers are paying $22,600 a year for the couple’s health care.

“It never crossed my mind that I would get insurance when I ran for office,’’ she said. “But I am glad to have it.’’

Six former city councilors are insured by Everett, plus 12 current ones. In Kingston, 10 part-time elected officials receive town-subsidized health coverage, including four Planning Board members, three Health Board members, and a sewer commissioner, all of whom typically attend two meetings a month.

“That’s the way it’s been done for a long time in Kingston,’’ said Dennis Randall, vice chairman of the Board of Selectmen. “But in tough times, everything should be under review.’’

The extension of benefits to local elected officials is one vivid example of how generous many municipal health care plans are. In fact, national data show that state and local government pay significantly more for health benefits than private employers.

Municipal health care plans were once deemed affordable and have helped cities and towns attract workers to the public sector, where salaries have often been lower. Today, however, they stand out for their comparatively low cost to subscribers and favorable terms.

Taxpayers now underwrite as much as 89 percent of active employees' premiums in some of the state's largest cities, while private-sector employers often cover less than 70 percent, local and state data show. As health care expenses have climbed for everyone, taxpayers - already paying a generous share of municipal benefits - have been hit especially hard as those benefits have grown more costly.

The insurance plans many cities and towns offer to employees, retirees, and elected officials also require minimal out-of-pocket expenses, with copayments for office appointments as low as $5. Most have copays for emergency room visits of $25 or less.

By comparison, private-sector copays for office visits are typically at least $20, sometimes more, with $75 copays standard for emergency room visits, according to a survey of Massachusetts employers by the state Division of Health Care Finance and Policy. Unlike most municipal plans, private-sector plans also often force subscribers to pay thousands annually in deductibles before insurers pay anything.

In addition, cities and towns are among the last employers to offer costly indemnity plans, which provide virtually unrestricted medical care. Though phased out in much of the private sector, indemnity plans live on in about a third of Bay State municipalities, according to a 2008 survey by the Massachusetts Municipal Association.

Even with family HMO plans, which typically limit access within a defined network of providers, municipal premiums are, in some cases, 30 percent higher than in the private sector, according to a Globe survey of communities and state data.

Though cities and towns have some control over what benefits they provide, they are limited by state law: Not only does the law subject health benefits to local collective bargaining, the state also imposes certain mandates on municipalities. Communities that offer health care to active workers, for example, must also offer coverage to retirees.

The generous terms of municipal plans compound the problem, because they create incentives for higher use: Low out-of-pocket costs - particularly the minimal copays - encourage subscribers to use more medical services, thus driving up the overall expense to communities.

"When a group uses a high number of services, high premiums result,'' said Brian Pagliaro, senior vice president of Tufts Health Plan.

Among the communities that pay the highest family premiums are Framingham, which spends $34,075 per family; Waltham, at $30,100; and Everett, at $26,000.

"The municipal plans are rich plans,'' said Mayor Joseph A. Curtatone of Somerville. "They are very, very rich plans.''

A boon for retirees

For taxpayers, there is no relief in sight, and for one simple reason: Municipal health benefits are especially good in retirement, and the number of retirees has grown by a steady 2.5 percent per year since 2001, in part because of longer life expectancies.

Under state law, any municipal employee with 10 years service is eligible, in retirement, to get health care benefits for life from age 55, a benefit typically worth hundreds of thousands of dollars per person. (People such as Debski, who have 20 years public service - she worked 12 years in Salem before going to Everett - can immediately qualify if they are terminated, regardless of their age.)

Most municipalities also grant spouses generous health care benefits.

In some cases, retirees and spouses live decades beyond the date of retirement, the Globe found in a review of thousands of pages of municipal retirement records. The widow of a Lynn police officer who retired on disability in his 30s in 1953 is still receiving city-subsidized insurance - 57 years later.

Less than one-quarter of private-sector retirees nationally receive any health care benefits from their former employers, said Roland McDevitt, director of health care research for the consulting firm Towers Watson.

Some cities and towns do not even compel retirees to use Medicare for nonemergency care once they reach 65, in effect leaving millions of dollars in federal subsidies on the table. Instead, retirees choose to stick with the more generous, and more costly, municipal plans.

Communities, under a state law passed in 1991, can force employees to enroll with Medicare, but only if the change is approved by the city council or town meeting. In some places, that has proven politically difficult, given the clout of active and retired municipal workers.

Boston, Lowell, and Lawrence are among those that have yet to adopt the provision. In Boston alone, there are more than 1,500 retirees who are eligible for Medicare but do not take it, costing the city almost $5 million, according to city estimates.

“Getting into Medicare is a tough vote,’’ said Condon, of Brockton. “People don’t like change. And in Brockton, we have more than 700 retirees on the voting rolls.’’

Other municipal retirees don’t sign up for Medicare simply because they are not eligible. Most police, firefighters, and teachers retire before age 65, and are thus too young to be covered by the federal system. That means cities and towns pay as much to insure them - at least until they reach 65 - as they do to insure active employees.

Even when retirees are on Medicare, it is still expensive for municipalities, because state mandates require communities to help cover drug costs and other expenses not paid by the program. By contrast, private-sector retirees are typically on their own.

“In the private sector, when you turn 65, most employers say, ‘Good luck on Medicare,’ ’’ said McDevitt, the national health care consultant. “And that’s it.’’

Tomorrow: How cities, towns, and the state have tried and often failed to solve the problem.

Unions safeguard health benefits
Strapped towns seek law change

By Sean P. Murphy, Globe Staff | March 1, 2010

Second of two parts

It was the spring of 2009, and Salem Mayor Kim Driscoll, staring at a $1 million shortfall for her city, had an idea: What if she could get employees to pay more for their health care?

Salem had already trimmed 18 positions since 2008, partly to help offset rising municipal health care costs, and Driscoll offered the city's eight unions a deal: No further layoffs if they agreed to raise, from $5 to $15, certain copayments. She even pledged to pay the first five higher copayments for every worker.

"To my mind, it was a no-brainer,'' Driscoll said. "But we got turned down by all eight unions. One of them, the police, wouldn't even discuss it.''

It is a familiar lament. Mayors, city and town leaders, and state officials, including Governor Deval Patrick, have launched repeated efforts to rein in the expense of providing health care to municipal workers, retirees, and elected officials.

But organized labor, fiercely protective of its members, has largely refused to budge, resisting local efforts to transfer more health care costs to workers and move communities onto the state's health care plan. State lawmakers have shown little appetite for forcing an overhaul of the system.

The state forbids cities and towns from shifting health care costs to employees without bargaining with unions. It is this aspect of state law that municipal officials say the Legislature must rewrite to address the crisis.

Municipal unions and retiree groups, however, have for decades cultivated close ties on Beacon Hill - spending generously in campaign contributions - and have so far successfully fought major changes.

Nancy O'Donnell, president of the Salem Police Patrolmen's Association, which represents about 50 patrol officers, said police rejected Driscoll's proposal for higher copayments because just a year earlier they had reluctantly agreed to her demand that officers pay an additional 5 percent in premiums.

"We didn't feel it was right to come back for more,'' she said. "Basically, we had to stand our ground.''

O'Donnell bristled at the suggestion that employees should bear a greater burden of health care costs. She said it was up to the mayor and other City Hall officials to come up with "creative solutions'' to the budget crisis, including possible tax increases and better management.

Still, she said, "I really don't know what the answer is.''

In recent months, cities and towns from Braintree to North Reading have tried to win similar health care concessions from unions. In Arlington, town officials spent a year at the bargaining table before all unions finally agreed in November to join the state's health care plan, a move the

town said would save as much as $2.5 million annually. But at the last moment, the teachers union backed out, killing the deal.

“It was terribly disappointing and discouraging,’’ said Brian F. Sullivan, town manager. “Without the deal, we’re back to facing a substantial budget deficit.’’

Robert McCarthy, president of the Professional Fire Fighters of Massachusetts, an umbrella group for municipal firefighters, said unions are not about to just give away health care benefits won in tough negotiations over many years.

“It’s not like we’re just sucking this thing dry,’’ he said. “We go by the law. We go by collective bargaining. That’s the system. What are we supposed to do? Give them everything? They have to negotiate. That’s the system.’’

BENCHMARKS SET EARLY

So how did we get to this impasse?

The Legislature first gave cities and towns the authority to provide coverage in the 1950s, but only if approved by the local city council or by town voters.

Many communities initially decided against providing benefits. Those that did give them were limited by law to paying no more than 50 percent of premiums. Across the state, about 10 percent of municipalities - mostly towns - still adhere to that original 50 percent rate, including Hingham, Barnstable, and Hudson, according to a 2008 Massachusetts Municipal Association survey.

Lawmakers gradually gave cities and towns wider discretion in setting the proportion of premiums they could pay. With health insurance historically not a huge budget driver, some municipalities offered, during contract negotiations, to pay a higher percentage in exchange for lesser pay raises.

In 1989, the Legislature established a cap of 90 percent on municipal contributions to HMO premiums. But that cap became a benchmark as many unions fought to increase their benefits.

“Since that time, municipal unions have been aggressively resisting municipal efforts to increase employees’ share of premium cost,’’ said Paul Mulkern, an attorney who specializes in municipal health care law.

The Legislature decades ago also linked health care and pension benefits. Anyone who qualifies for a pension qualifies for health care coverage. But there is one key difference: With pensions, employees have to work decades to earn full retirement benefits; with health care, municipal employees, the moment they reach 10 years of service, are entitled under state law to full benefits when they retire, from age 55.

This has made even relatively low-paying jobs, such as teachers’ aides and school cafeteria workers, highly coveted.

“People understand the value of health care benefits, and there’s great competition to get any job because of the benefits,’’ said Frank J. Zecha, director of the Brookline retirement system.

PUSH FOR CHANGES FALLING SHORT

With great fanfare, Patrick in his 2007 inaugural address invited municipalities into “a new partnership with state government,’’ one that promised to bring long-sought relief from persistent increases in local property taxes.

The Legislature responded by crafting a bill to allow cities and towns to shift their employees and retirees from locally managed health care plans to the state’s much larger, more flexible one, called the Group Insurance Commission. Consolidating all municipal plans into the state GIC would save more than $1 billion a year by 2018, according to estimates by the Massachusetts Taxpayers Foundation and the Boston Municipal Research Bureau, two nonpartisan business-backed watchdog groups.

The GIC saves taxpayers money in two ways, including by requiring employees, retirees, and elected officials to pay more out of pocket.

In contrast to cities and towns, the GIC is free by law to make changes in the health care plans for its 265,000 subscribers without union bargaining. As recently as Feb. 1, the GIC imposed higher copayments to meet a funding shortfall. The GIC, in some cases, requires a $250 copay for hospitalizations; in Boston, subscribers pay nothing.

The GIC also uses its market clout, as the state’s largest purchaser of health care insurance, to get better rates, said Dolores L. Mitchell, the GIC executive director. “We get better service because we are a bigger customer,’’ she said.

But the bill allowing local communities into the state plan contained a major catch. It required a 70 percent vote of a committee of local union representatives before a municipality could join, effectively giving teachers unions, typically the largest, a veto.

After some early interest, unions have shut the door, and the initiative has fallen far short of expectations. In the first year the GIC was offered, 10 municipalities, school districts, and charter schools joined; the second year, there were 15. But then the exodus from local plans ground almost to a halt; only Brookline and Hopedale have signed up to join, as of July 1 of this year.

“The City of Boston would save more than $18 million a year if its employees paid the same copays and deductibles as the state GIC,’’ said Lisa Calise Signori, director of administration and budget for the city. “That’s the entire budget for the Parks Department.’’

Leaders of communities that have joined the GIC say it has made a huge difference. Springfield officials credit the GIC as a major factor in the city’s recent financial turnaround. With Springfield’s finances still shaky, the city’s unions agreed in 2007 to become the first municipality in the GIC. The move lowered annual health care costs by about $7 million.

“The city has definitely saved money,’’ said Linda Parent, Springfield’s city insurance director. “Every study that’s been done shows it.’’

One study, conducted in 2009 by the University of Massachusetts-Boston and Harvard University’s Kennedy School of Government, confirmed Springfield’s savings.

There are two bills pending on Beacon Hill that would give cities and towns the authority to reduce health care benefits without union approval. One was filed by Boston Mayor Thomas M. Menino, the other by the municipal association.

“It’s simple: Health insurance costs are unsustainable over the long term,’’ Menino said. “The more we pay for health insurance, the less we have for city programs.’’

Both bills remain in committee, and proponents are not optimistic they will move forward. A separate measure on Beacon Hill originally included a provision to give communities greater flexibility in setting health care benefits, but it was deemed “too controversial’’ and removed, said state Representative Paul J. Donato, Democrat of Medford, the bill’s lead sponsor.

Meanwhile, even with greater attention in Massachusetts and nationally toward reining in the expense of medical care, no one expects health care costs to stop their rapid rise anytime soon.

“It’s a cataclysmic situation,’’ said Marc Waldman, Wellesley’s treasurer. “Something has to happen.’’

Coverage switch urged for localities
Study finds savings in state health plan; Law change sought to empower towns

By Sean P. Murphy, Globe Staff | March 3, 2010

Cities and towns would save tens of millions of dollars in health care costs for employees, retirees, and elected officials by joining the state’s much larger, more flexible health care system, according to a new report by the Boston Foundation.

The foundation’s detailed study of four municipalities - Boston, Cambridge, Melrose, and Marshfield - illustrates how health care expenses are severely hampering communities across Massachusetts.

Boston, for example, could reduce its health insurance premiums this fiscal year by up to 17 percent, or $45 million, by joining the state’s Group Insurance Commission, the report finds. Melrose, which joined the GIC in July, will likely save $1.6 to $1.8 million annually, says the report, which the foundation will release today.

“The irrefutable point,’’ the report concludes, “is that there could be significant savings for cities and towns - in a time of severe fiscal challenges - if they were allowed to join the GIC apart from collective bargaining.’’

Currently, communities can join the GIC only with the approval of local unions. But with some exceptions, unions across the state have rejected such a move because it would end up costing their members more money, particularly in the form of higher copayments.

Cities and towns are pushing the Legislature to change the law so communities can join the state system without union approval.

“It’s the single most important step the Legislature can take to address the budget crisis of the cities and towns,’’ Paul S. Grogan, president of the Boston Foundation, said in an interview yesterday.

The Globe reported earlier this week on how exploding municipal health care costs are wrecking local budgets, forcing cities and towns to cut services and ask more of taxpayers.

Grogan said that municipal plans stand out by being far more generous to subscribers than almost all other plans in the public or private sectors.

“The current plans in the municipalities are just way out of whack compared to what everyone else pays,’’ he said. “All we are asking is to bring the municipalities into line with others.’’

The Globe reported that municipal plans pay as much as 89 percent of premiums, while typically requiring $5 copayments for office visits and $25 for emergency room treatments.

Plans in the private sector typically pay less than 70 percent of premiums, and require $20 copayments or more for office visits and $100 for emergency room treatments.

The GIC’s copayments are on par with the private sector’s.

The Boston Foundation report also recommends that the Legislature give municipalities who do not join the GIC the power to increase premiums and copayments of the plans they offer without collective bargaining. In addition, the report says, cities and towns would save millions by forcing retirees onto Medicare at age 65, a politically difficult decision some communities have refused to make.

Since 2007, when the state Legislature changed the law to allow cities and towns into the GIC, 19 municipalities have joined the system, including Springfield, Quincy, Weston, and Norwood.

But unions in only two municipalities agreed to join the plan as of July 1 of this year: Brookline and Hopedale. Unions in other cities and towns, meanwhile, rejected such a move.

Public employee unions are leery of changes to municipal health care plans.

Brad Tenney, secretary-treasurer of the Professional Fire Fighters of Massachusetts, an umbrella group of local unions, said his members are willing to “sit down with leaders on Beacon Hill and in the municipalities to reach a meeting of the minds.’’

“We recognize the significant cost of health care,’’ he said. “But we feel it is unfair to look at health insurance in a vacuum. Members gave up pay raises or accepted smaller pay raises through the years for the health care benefits they have.’’

Public employee unions and retiree groups, which make generous donations to the treasuries of many state officer-holders, are well-connected on Beacon Hill.

In brief interviews on Monday, House Speaker Robert DeLeo and Senate President Therese Murray expressed little desire to strip union employees of long-held collective bargaining rights. Murray also said she did not believe the GIC was capable of accepting cities and towns without increasing its staff.

The GIC provides health insurance for about 300,000 state employees, retirees, and elected officials, including employees and retirees of numerous independent authorities. State law allows the GIC to adjust the amounts subscribers pay in premiums and copayments without union negotiations.

The report found that Cambridge, by moving into the GIC, would save up to 10 percent, or $4.4 million, while Marshfield would save up to 11 percent, or $530,000.

Robert Carey, a consultant and former GIC official who wrote the Boston Foundation report, said in an interview that the GIC would save municipalities not only by shifting more costs to subscribers, but also by lowering overall costs.

He said the GIC saves money in part by steering subscribers to those medical providers whom the plan rates as most cost-efficient. It does so by providing a financial incentive. Subscribers who go to doctors rated the least cost-efficient pay a $45 copayment, while they pay $20 copayments for doctors rated the most cost-efficient.

The GIC also rewards subscribers for using lower-cost hospitals.

Mayors want health costs on ballot
Legislators say cities to blame for benefits

By Sean P. Murphy, Globe Staff | March 10, 2010

A group of Massachusetts mayors, fed up with what they say is legislative inaction on skyrocketing municipal health care costs, has launched a ballot initiative for 2012 aimed at giving cities and towns more flexibility in reducing expensive benefits for employees, retirees, and elected officials.

Mayor Thomas M. Menino of Boston hosted a strategy session of about 20 mayors in City Hall Friday. The group emerged with a proposal to allow communities to reduce benefits without union negotiations. Under current state law, cities and towns are limited in what changes they can impose outside collective bargaining.

“The status quo is unacceptable,’’ said Mayor Thomas Ambrosino of Revere, one of the group’s leaders. “Without change, most communities will have to do more of the same, more reductions in services, more layoffs.’’

“There are a lot of frustrated mayors out there,’’ he said.

But yesterday, state Senate President Therese Murray blasted the mayors’ plan to circumvent the Legislature and go directly to voters, saying the problem was largely of the mayors’ making. City leaders handed out generous pay raises for years and tolerated exploitation of pension loopholes, Murray said.

“It’s time for the mayors to step up to the plate,’’ she said. “They have to look in the mirror on this. For years, they have been putting together their budgets, and now it is reaching a peak.

“It’s about time they managed their own funds better . . . instead of coming in here and saying, ‘You got to do A, B, C, and D.’ ’’

With health care costs straining cities and towns, political pressure is building on lawmakers to give municipalities more control over what benefits they provide and to whom. But there are divisions on Beacon Hill about what to do and how much to challenge the bargaining rights of labor unions.

Murray said she expected the Legislature to address the municipal health care crisis in the current session.

“Something has to be done on health care spending,’’ she said, adding that the Legislature is “spending a lot of time on this.’’

But House Speaker Robert A. DeLeo said in an interview that he was not so sure that a measure would pass, and he seemed cool to the idea of stripping long-held collective bargaining rights from the municipal unions representing police, firefighters, teachers, and other employees.

“I appreciate both sides in this, and unless there’s compromise or consensus, I don’t know if it gets done,’’ he said.

DeLeo met behind closed doors yesterday with House members, in part to discuss municipal health care costs.

“There was absolutely no consensus,’’ he said. “The opinions of members were all over the place. Everyone seemed to be making a good point.

“We have the health care costs versus collective bargaining rights of workers. There’s a concern about further diluting collective bargaining rights. This is not an easy issue.’’

Governor Deval Patrick’s administration, which in the past has pushed for communities to join the state’s health insurance plan, was noncommittal yesterday on efforts to change the system.

“The governor believes that we need to continue to work with cities and towns to find additional ways to help them get their fiscal houses in order, but their employees should not be completely shut out of those conversations,’’ Juan Martinez, a Patrick spokesman, said in a statement.

The Globe reported last week that health care costs added more than $1 billion to municipal budgets from 2001 to 2008, with many communities providing unusually generous benefits for employees, retirees, and elected officials.

Some cities now devote close to 20 percent of their budgets to health care costs.

Municipal unions have largely succeeded in fighting off benefit reductions. Many municipal workers and retirees in the state’s larger cities enjoy plans in which the city pays 80 percent or more of the premium, and copayments for office visits are as low as $5.

To get a question on the 2012 ballot, the mayors would have to collect the signatures of tens of thousands of voters who are in favor of the measure.

An initiative petition requires 3 percent of the number of voters in the most recent gubernatorial election, or 66,539, based on the 2006 election. That number will change, but probably not by much, after this year’s gubernatorial election.

The signatures would be due in August of 2011.

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