

ROBERT C. POZEN

## Paying for public retiree healthcare

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WHILE THE BURDENS of retiree healthcare benefits on General Motors are well known, Massachusetts residents will be surprised by the large unfunded obligations of the public sector to pay similar benefits. Starting this year, state and local governments will be required by new accounting rules to disclose estimates of their unfunded obligations for retiree healthcare benefits. This estimate for the Commonwealth of Massachusetts will exceed \$13 billion -- which does not include any estimates for cities, towns, and other public entities. Although most of these estimates have not yet been published, they are likely to be startling -- for example, the unfunded obligations for retiree healthcare will be as high as \$650 million for the city of Newton.

Healthcare costs are higher in the public sector than the private sector in Massachusetts. In 2003, the total healthcare costs in the government sector were \$3,844 for a single person and \$8,755 for a family, as compared to \$3,529 and \$8,429 respectively in the private sector. Moreover, employees of state government typically pay 15 percent of their healthcare costs, in contrast to an average of 20 to 30 percent in the private sector. In the past, this differential has been justified by lower salaries in the public sector. Unlike pension payouts, retiree healthcare benefits are almost always paid out of current tax revenues by state and local governmental units. These units have not provided advance funding for such benefits by making regular contributions to separate trusts, which would generate investment returns to help pay for future benefits. Nor will these units be required to establish such trusts under the new accounting rules. However, these rules do allow more favorable assumptions in estimating unfunded obligations for retiree healthcare if a state or city provides some advance funding for this purpose.

In other parts of the country, a few governmental units have issued bonds to finance their pension or healthcare benefits. The bonds do allow these government units to spread the costs of these benefits over the life of the bonds. However, the bonds do not reduce these costs at all, and they create an additional risk -- that the investment returns on the bond proceeds will be less than the interest and principal payments on the bonds.

So what can fruitfully be done? First, Massachusetts residents should press all cities, towns, and other governmental units to publish estimates of their retiree healthcare obligations as soon as practical -- and not wait until the end of 2007 as allowed by the new accounting rules. We cannot develop strategies to cope with these obligations unless we have a much more precise understanding of the amounts involved. For some governmental units, these amounts may be small enough to be easily financed out of current tax revenues. For other cities and towns, these amounts may be large enough to jeopardize their bond ratings and provoke a debate on raising local taxes above the Proposition 2 1/2 limit.

Second, we should explicitly integrate retirement healthcare benefits into the new state plan for universal access. For example, after retirement but before Medicare, some former employees of governmental units may be eligible for premium subsidies from the state -- which extend to families of four with annual incomes up to \$60,000. These premium subsidies should be credited against any retiree healthcare benefits to avoid double dipping.

Third, we should encourage all governmental units in Massachusetts to establish and fund separate trusts for retiree healthcare obligations, as they have done for pension benefits. The state already provides a good investment vehicle for pension plans of many governmental units, so it could create a common trust fund to provide these units with an option for financing their retiree healthcare obligations. Such advance funding would not only lower the accounting entries for their unfunded obligations, but also would help defray the cost of such obligations through investment returns.

Finally, and most important, we should have a public dialogue about possible constraints on future growth of retiree healthcare benefits in the public sector.

While it would not be politically feasible to change already accrued benefits, we could substantially reduce such benefits for new public employees and set a ceiling on future accruals

by current employees below a certain age. Moreover, we should analyze whether 15 percent continues to be the appropriate level for sharing retiree healthcare costs by former public employees in light of their total compensation and the overall budget picture.

*Robert C. Pozen is chairman of MFS Investment Management.* ■

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