



Group  Benefits Strategies

MUNICIPAL HEALTH INSURANCE REFORM OVERVIEW
For the
MAYFLOWER MUNICIPAL HEALTH GROUP

*Steering Committee Meeting and Board Meeting - September 14, 2011
Packet Contents*

- Overview of Municipal Health Insurance Reform Sections 21-23 as they pertain to MMHG
 - ✓ Role of the MMHG as Authorized by MGL 69
 - ✓ Role of MMHG Member Units
- Important Information
- MGL Ch 69
- Outside Sections of MGL Ch 69
- New Regulations
- MGL Ch 32B Section 3 - IAC

Important Information

1. MMHG Steering Committee will recommend certain plan design changes to those of the GIC's benchmark plan(s) and a date for implementation of change. See article 4A MMHG Agreement (GBS will provide assistance)
2. Need to form Insurance Advisory Committee IAC if you have not done so.
3. Need to provide all notices by certified mail delivery, confirmation and return receipt requested. Either post office evidence of attempted delivery or return receipts shall be prima facie evidence of time of receipt. Notices to Secretary of Administration and Finance (Secretary) shall be sent electronically to municipalhealth@state.ma.us.
4. Need to determine the number of employees eligible for health insurance under MGL 32B, employed in each collective bargaining unit.
5. Need to determine description of the current health plan with the enrollment broken out by individual, individual plus one if applicable and family for each plan offered. (GBS will provide assistance)
6. Subscribers covered under a collective bargaining agreement where the specific dollar amounts for plan design features are included shall not be subject to changes that are inconsistent with the specific plan design features that are included in the body of the collective bargaining agreement until the initial term stated in that CAB has ended.
7. Any fee or compensation provided to the impartial Panel member shall be shared equally by the APA and the PEC. The impartial member will be reimbursed for reasonable travel expenses.
8. Meeting of the Panel shall be conducted under the Open Meeting Law.

9. The percent contribution by retirees, surviving spouses and dependents cannot increase before 7/1/2014 unless the employer can prove that the contribution change was approved prior to 7/1/2011.
10. Provisions of former Section 18 are mandatory for all governmental units. (GBS will provide assistance)
11. APA must provide 60 day notice to subscribers before implementing changes to plan design after agreement is signed. (GBS will provide assistance)
12. A governmental unit that does not make changes is required to annually file a report with A&F that documents savings that it could have realized if it had made changes pursuant to Sections 21-23. (GBS will provide assistance)
13. Allows APA to provide flexible spending , HRA's. (GBS will provide assistance)
14. Requires APA to conduct enrollment audit not less than once every 2 years. (GBS will provide assistance)

Role of Mayflower Municipal Health Group as Authorized by MGL 69

1. The MMHG governing board may vote to implement changes to health plan co-payments, deductibles, tiered provider network co-payments and other design features to the level offered by the current GIC non-Medicare and Medicare “benchmark” plans. See Ch 69 Section 2, Pg 3 (GBS will provide assistance)

Role of MMHG member units

- ✓ 1. Evaluate proposed changes to determine anticipated savings after first 12 months of implementation of plan design changes, or transfer of subscribers to GIC only if the savings is at least 5 % greater than the maximum possible savings realized by plan design changes. See NR 52.01 Pg 2, 52.02 (2) Pg 4 (GBS will provide assistance)
- ✓ 2. Provide at least a 2 calendar day written Notice to Collective Bargaining Units (CBU) and Retired State, County and Municipal Employees Association (RSCME) of Appropriate Public Authority’s (APA) intent to vote. MGL 32 B section 21-23 See NB 52.02 (1) Pg 4 (GBS will provide assistance)
- * 3. Notice to Insurance Advisory Committee (IAC) to meet within 10 days after receipt of Notice to discuss estimated savings and any other reports or documents requested by IAC before meeting. See 52.02 (2) Pg 4 and 52.03 (a)(b)(c)(d) Pgs 5,6,7,8 (GBS will provide assistance)
- ✓ 4. Not later than 2 business days after IAC meeting APA will send IAC Notice as required. See NR 52.02 (b)(c)(d) Pg 5 (GBS will provide assistance)
- ✓ 5. Not later than 2 business days following receipt of requested information, the APA will send the newly formed Public Employee Committee (PEC) a 7 day meeting Notice which says that the APA wants to implement changes to health insurance benefits. The 30 day negotiation period begins when each member of PEC is in receipt of Notice. See 52.03 (a)(b)(c)(d) 52.04 (1) Pgs 5,6,7,8 (GBS will provide assistance)
6. Negotiations between APA and PEC are encouraged to be in good faith. Any agreement between the 2 parties must be reduced to writing. The PEC vote is a weighted majority vote. See MGL 32 B Section 19 A (GBS will provide assistance)
7. Within 3 business days after 30 day Notice to negotiate, Notices are required between Secretary of A&F (Secretary), APA and the PEC. See NR 52.05 (a)(b)(c)(d) (GBS will provide assistance)
8. If 30 day negotiation period ends with no agreement between APA and PEC a 3 member Review Panel (Panel) receives APA original proposal within 3 days after 30 day period ends. See NR 52.05 (1)(2) (GBS will provide assistance)
9. The impartial Panel member convenes first meeting, the Panel has 10 days to review APA plan design changes, savings estimates and mitigation proposals. Panel may request a new proposal if necessary and may allow PEC to respond to mitigation and savings proposals. Panel decision will be binding on all parties. NR 56.06 4 (a)(b)(c) Pgs 11,12,13 (GBS will provide assistance)

Chapter 69

THE COMMONWEALTH OF MASSACHUSETTS

In the Year Two Thousand and Eleven

AN ACT RELATIVE TO MUNICIPAL HEALTH INSURANCE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is immediately to authorize municipalities to implement local health insurance changes, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience. _____

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. Chapter 32B of the General Laws is hereby amended by striking out section 2, as appearing in the 2008 Official Edition, and inserting in place thereof the following section:-

Section 2. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Appropriate public authority", as to a county, except Worcester county, the county commissioners; as to a city, the mayor; as to a town, the selectmen; as to a district, the governing board of the district and for the purposes of this chapter if a collective bargaining agreement is in place, as to a commonwealth charter school as defined by section 89 of chapter 71, the board of trustees; and as to an education collaborative, as defined by section 4B of chapter 40, the board of directors.

"Commission", the group insurance commission established by section 3 of chapter 32A.

"Dependent", an employee's spouse, an employee's unmarried children under 19 years of age and any child 19 years of age or over who is mentally or physically incapable of earning the child's own living; provided, however, that any additional premium which may be required shall be paid for the coverage of such child 19 years of age or over; provided further, that "dependent" shall also include an unmarried child 19 years of age or over who is a full-time student in an educational or vocational institution and whose program of education has not been substantially interrupted by full-time gainful employment, excluding service in the armed forces; provided further, that any additional premium which may be required for the coverage of such student shall be paid in full by the employee. The standards for such full-time instruction and the time required to complete such a program of education shall be determined by the appropriate public authority.

"District", any water, sewer, light, fire, veterans' services or other improvement district or public unit created within 1 or more political subdivisions of the commonwealth to provide public services or conveniences.

"Employee", any person in the service of a governmental unit or whose services are divided between 2 or more governmental units or between a governmental unit and the commonwealth, and who receives compensation for any such service, whether such person is employed, appointed or elected by popular vote, and any employee of a free public library maintained in a city or town to the support of which that city or town annually contributes not less than one-half of the cost; provided, however, that the duties of such person require not less than 20 hours, regularly, in the service of the governmental unit during the regular work week of permanent or temporary employment; provided further, that no seasonal employee or emergency employees shall be included, except that persons elected by popular vote may be considered eligible employees during the entire term for which they are elected regardless of the number of hours devoted to the service of the governmental unit. A member of a call fire department or other volunteer emergency service agency serving a municipality shall be considered an employee, if approved by vote of the municipal legislative body, and the municipality shall charge such individual 100 per cent of the premium. If an employee's services are divided between governmental units, the employee shall, for the purposes of this chapter, be considered an employee of the governmental unit which pays more than 50 per cent of the employee's salary. But, if no one governmental unit pays more than 50 per cent of that employee's salary, the governmental unit paying the largest share of the salary shall consider the employee as its own for membership purposes, and that governmental unit shall contribute 50 per cent of the cost of the premium. If the payment of an employee's salary is equally divided between governmental units, the governmental unit having the largest population shall contribute 50 per cent of the cost of the premium. If an employee's salary is divided in any manner between a governmental unit and the commonwealth, the governmental unit shall contribute 50 per cent of the cost of the premium. An employee eligible for coverage under this chapter shall not be eligible for coverage as an employee under chapter 32A. Teachers and all other public school employees shall be deemed to be employees during the months of July and August under this chapter; provided, however, that employee contributions for such health insurance for those 2 months are deducted from the compensation paid for services rendered during the previous school year. A determination by the appropriate public authority that a person is eligible for participation in the plan of insurance shall be final. Nothing in this paragraph shall apply to Worcester county or its employees.

"Employer", the governmental unit.

"Governmental unit", any political subdivision of the commonwealth.

"Health care flexible spending account", a federally-recognized tax-exempt health benefit program that allows an employee to set aside a portion

of earnings to pay for qualified expenses as established in an employer's benefit plan.

"Health care organization", an organization for the group practice of medicine, with or without hospital or other medical institutional affiliations, which furnishes to the patient a specified or unlimited range of medical, surgical, dental, hospital and other types of health care services.

"Health reimbursement arrangement", a federally-recognized tax-exempt health benefit program funded solely by an employer to reimburse subscribers for qualified medical expenses.

"Optional Medicare extension", a program of hospital, surgical, medical, dental and other health insurance for such active employees and their dependents and such retired employees and their dependents, except elderly governmental retirees insured under section 11B, as are eligible or insured under the federal health insurance for the aged act, as may be amended from time to time.

"Political subdivision", any county, except Worcester county, city, town or district.

"Savings", for the purposes of sections 21, 22 and 23, shall mean the difference between the total projected premium costs for health insurance benefits provided by a political subdivision with changes made to health insurance benefits under section 22 or 23 for the first 12 months after the implementation of such changes and the total projected premium costs for health insurance benefits provided by that subdivision without such changes for the same 12 month period.

"Subscribers", employees, retirees, surviving spouses and dependents of the political subdivision and may include employees, retirees, surviving spouses and dependents of a district who previously received health insurance benefits through the political subdivision.

SECTION 2. Section 12 of said chapter 32B is hereby amended by adding the following paragraph:-

The board of a trust or joint purchase group established by 2 or more governmental units may vote to implement changes to co-payments, deductibles, tiered provider network copayments and other cost-sharing plan design features which do not exceed those which an appropriate public authority may offer under section 22; provided, however, that each governmental unit that is a member of a trust or group shall comply with the requirements set forth in section 21 before any such changes may be applied to the health insurance coverage of such governmental unit's subscribers. If such changes to the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features do not exceed those permitted under section 22, such changes shall be approved in accordance with the provisions of section 21.

SECTION 3. Said chapter 32B is hereby further amended by adding the following 9 sections:-

Section 21. (a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

(b) Prior to implementing any changes authorized under sections 22 or 23, the appropriate public authority shall evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of plan design changes or upon transfer of its subscribers to the commission. The appropriate public authority shall then notify its insurance advisory committee, or such committee's regional or district equivalent, of the estimated savings and provide any reports or other documentation with respect to the determination of estimated savings as requested by the insurance advisory committee. After discussion with the insurance advisory committee as to the estimated savings, the appropriate public authority shall give notice to each of its collective bargaining units to which the authority provides health insurance benefits and a retiree representative, hereafter called the public employee committee, of its intention to enter into negotiations to implement changes to health insurance benefits provided by the appropriate public authority. The retiree representative shall be designated by the Retired State, County and Municipal Employees Association. A political subdivision which has previously established a public employee committee under section 19 may implement changes to its health insurance benefits pursuant to this section and sections 22 and 23.

Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all

aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be comprised of 3 members, 1 of whom shall be appointed by the public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

(d) The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 22; provided, however, that any increases to plan design features have been made in accordance with the provisions of section 22. The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 23; provided, that the panel confirms that the anticipated savings under those changes would be at least 5 per cent greater than the maximum possible savings under section 22. If the panel does not approve implementation of changes made pursuant to section 22 or section 23, the public authority may submit a new proposal to the public employee committee for consideration and confirmation under this section.

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income

subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

(g) The decision of the municipal health insurance review panel shall be binding upon all parties.

(h) The secretary of administration and finance shall promulgate regulations establishing administrative procedures for the negotiations with the public employee committee and the municipal health insurance review panel, and issue guidelines to be utilized by the appropriate public authority and the municipal health insurance review panel in evaluating which subscribers are disproportionately affected, subscriber income and subscriber out-of-pocket costs associated with health insurance benefits.

Section 22. (a) Upon meeting the requirements of section 21, an appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers by acceptance of any other section of this chapter may include, as part of the health plans that it offers to its subscribers not enrolled in a Medicare plan under section 18A, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment; provided, however, that for subscribers enrolled in a Medicare plan pursuant to section 18A the appropriate public authority may include, as part of the health plans that it offers to its subscribers, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment. The appropriate public authority shall not include a plan design feature which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network or providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

(b) An appropriate public authority may increase the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; provided that, for subscribers enrolled in a non-Medicare plan, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment and, for subscribers enrolled in a Medicare plan under section 18A, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment; provided, however, that the public authority need only satisfy the requirements of subsection (a) of section 21 the first time changes are implemented pursuant to this section; and provided, further that the public authority meet its obligations under subsections (b) to (h), inclusive, of section 21 each time an increase to a plan design feature is proposed.

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features

may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

(c) The decision to accept and implement this section shall not be subject to bargaining pursuant to chapter 150E or section 19. Nothing in this section shall preclude the implementation of plan design changes pursuant to this section in communities that have adopted section 19 of this chapter or by the governing board of a joint purchasing group established pursuant to section 12.

(d) Nothing in this section shall relieve an appropriate public authority from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter.

(e) The first time a public authority implements plan design changes under this section or section 23, the public authority shall not increase before July 1, 2014, the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums from the percentage that was approved by the public authority prior to and in effect on July 1, 2011; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before July 1, 2011, but to take effect on a date after July 1, 2011, said percentage increase may take effect upon the approval of the secretary of administration and finance based on documented evidence satisfactory to the secretary that the public authority approved the increase prior to July 1, 2011.

Section 23. (a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year and the transfer of subscribers to the commission shall take effect on the following July 1. On the effective date of the transfer, the health insurance of all subscribers, including elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the

political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150B and this chapter; provided, however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered

dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150B, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

(d) The commission shall negotiate and purchase health insurance coverage for subscribers transferred under this section and shall promulgate regulations, policies and procedures for coverage of the transferred subscribers. The schedule of benefits available to transferred subscribers shall be determined by the commission pursuant to chapter 32A. The commission shall offer those subscribers the same choice as to health insurance carriers and benefits as those provided to state employees and retirees. The political subdivision's contribution to the cost of health insurance coverage for transferred subscribers shall be as determined under this section, and shall not be subject to the provisions on contributions in said chapter 32A. Any change to the premium contribution ratios shall become effective on July 1 of each year, with notice to the commission of such change not later than January 15 of the same year.

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may

inform the state treasurer who shall issue a warrant in the manner provided by section 20 of chapter 59 requiring the respective political subdivision to pay into the treasury of the commonwealth as prescribed by the commission the amount of the premium and administrative expenses attributable to the political subdivision. The state treasurer shall recoup any past due costs from the political subdivision's cherry sheet under section 20A of chapter 58 and transfer that money to the commission. If a governmental unit fails to pay to the commission the costs of coverage for more than 90 days and the cherry sheet provides an inadequate source of payment, the commission may, at its discretion, cancel the coverage of subscribers of the political subdivision. If the cancellation of coverage is for nonpayment, the political subdivision shall provide all subscribers health insurance coverage under plans which are the actuarial equivalent of plans offered by the commission in the preceding year until there is an agreement with the public employee committee providing for replacement coverage.

The commission may charge the political subdivision an administrative fee, which shall not be more than 1 per cent of the cost of total premiums for the political subdivision, to be determined by the commission which shall be considered as part of the cost of coverage to determine the contributions of the political subdivision and its employees to the cost of health insurance coverage by the commission.

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare part A at no cost to the retiree, spouse or dependents, shall be required to be insured by a Medicare extension plan offered by the political subdivision under section 11C or section 16. A retiree shall provide the political subdivision, in such form as the political subdivision shall prescribe, such information as is necessary to transfer to a Medicare extension plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health insurance coverage. The political subdivision may from time to time request from a retiree, a retiree's spouse and dependents, proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare part A and part B coverage. The political subdivision shall pay the Medicare part B premium penalty assessed by the federal government on those retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan.

(g) The decision to implement this section shall not be subject to collective bargaining pursuant to chapter 150E or section 19.

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or

change eligibility standards for health insurance under the definition of "employee" in section 2.

Section 24. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter may provide health care flexible spending accounts to allow certain subscribers, as determined by the appropriate public authority, to set aside a portion of earnings to pay for qualified expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 25. Notwithstanding any general or special law or regulation to the contrary, the appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter or transfer its subscribers to the commission under this chapter may provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 26. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter shall conduct an enrollment audit not less than once every 2 years. The audit shall be completed in order to ensure that members are appropriately eligible for coverage.

Section 27. An insurance carrier, third party purchasing group or administrator or the commission in the case of a governmental unit, which has undertaken to provide health insurance coverage to its subscribers by acceptance of sections 19 or 23, shall, upon written request, provide the governmental unit or public employee committee with its historical claims data within 45 days of such request; provided, that all personally identifying information within such claims shall be redacted and released in a form and manner compliant with all applicable state and federal privacy statutes and regulations including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996.

Section 28. Nothing in section 21, 22 or 23 shall be construed to prevent 2 or more governmental units under a joint purchase or trust agreement from jointly negotiating and purchasing coverage as authorized in section 12.

Section 29. Each fiscal year, the commission shall prepare and place on its website a report delineating the dollar amount of the copayments, deductibles, tiered provider network co-payments and other design features offered by the commission in the non-Medicare plan with the largest subscriber enrollment and the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the commission in the Medicare extension plan with the largest subscriber

enrollment. The commission shall also provide information on its plans with the largest subscriber enrollment upon request of any appropriate public authority or political subdivision.

SECTION 4. Notwithstanding any general or special law to the contrary, an appropriate public authority that implements changes to health insurance benefits pursuant to sections 22 and 23 of chapter 32B of the General Laws shall delay implementation of such changes, as to those subscribers covered by a collective bargaining agreement or section 19 agreement that is in effect on the date of implementation of such changes, of any changes to the dollar amounts of copayments, deductibles or other cost-sharing plan design features that are inconsistent with any dollar limits on copayments, deductibles or other cost-sharing plan design features that are specifically included in the body of that collective bargaining agreement or section 19 agreement, until the initial term stated in that collective bargaining agreement or section 19 agreement has ended.

SECTION 5. Nothing in this act shall be construed to alter, amend or affect chapter 36 of the acts of 1998, chapter 423 of the acts of 2002, chapter 27 of the acts of 2003 or chapter 247 of the acts of 2004.

SECTION 6. Notwithstanding any general or special law to the contrary, the group insurance commission shall prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before January 1, 2012, if such political subdivision provides notice to the group insurance commission on or before September 1, 2011, that it is transferring its subscribers to the group insurance commission under sections 19 or 23 of chapter 32B of the General Laws; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before April 1, 2012, if such political subdivision provides notice to the group insurance commission on or before December 1, 2011, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before July 1, 2012, if such political subdivision provides notice to the group insurance commission on or before March 1, 2012, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B.

SECTION 7. Notwithstanding any general or special law to the contrary, unless otherwise agreed, a governmental unit transferring its subscribers to the group insurance commission under section 23 of chapter 32B of the General Laws shall use current contribution ratios in existence for each class of plan for each collective bargaining unit in order to transfer to the commission.

If a governmental unit was not offering both a preferred provider organization plan or an indemnity plan on the date of transfer to the commission, the governmental unit's initial contribution ratio toward the commission's preferred provider organization plans and indemnity plans shall be the ratio that the governmental unit was contributing toward its preferred provider organization plan or indemnity plan for each collective bargaining unit on that date. Except as specifically provided in this section, all contribution ratios shall remain subject to bargaining pursuant to chapter 32B of the General Laws and chapter 150E of the General Laws.

House of Representatives, July 11, 2011.

Preamble adopted,

Paul Donato, Speaker.

In Senate, July 11, 2011.

Preamble adopted,

Kenneth J. Dannelly, President.

House of Representatives, July 11, 2011.

Bill passed to be re-enacted,

Paul Donato, Speaker.

In Senate, July 11, 2011.

Bill passed to be re-enacted,

Kenneth J. Dannelly, President.

12 July, 2011.

Approved,
at 11 o'clock and 36 minutes, A. M.

Edward J. Starnick
Governor

2011 JUL 12 PM 12:47
REGULATORY DIVISION
SECRETARY OF STATE



Municipal Health Insurance Initiative

SECTION 52. Section 12 of said chapter 32B is hereby amended by inserting, at the end thereof, the following paragraph:-

The board of a trust or joint purchase group established by 2 or more governmental units may vote to implement changes to co-payments, deductibles, tiered provider network copayments and other plan design features which do not exceed those which an appropriate public authority may offer under section 22; provided, however, that each governmental unit that is a member of a trust or group shall comply with the requirements set forth in section 21 before any such changes may be applied to the health insurance coverage of such governmental unit's subscribers. If such changes to the dollar amounts for copayments, deductibles, tiered provider network copayments and other plan design features do not exceed those permitted under section 22, such changes shall be approved in accordance with the provisions of section 21.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



Municipal Health Reform

SECTION 53. Section 18 of said chapter 32B of the General Laws is hereby repealed.

- [Previous Outside Section](#)
- [Next Outside Section](#)



Municipal Health Reform

SECTION 54. Said chapter 32B is hereby further amended by striking out section 18A, as appearing in the 2008 Official Edition, and inserting in place thereof the following section:-

Section 18A. (a) A retiree, spouse or dependent insured or eligible to be insured under this chapter, if enrolled in Medicare Part A at no cost to the retiree, spouse or dependent or eligible for coverage under Medicare Part A at no cost to the retiree, spouse or dependent, shall be required to transfer to a Medicare health plan offered by the governmental unit under section 11C or section 16, if the benefits under the plan and Medicare Part A and Part B together shall be of comparable actuarial value to those under the retiree's existing coverage, but a retiree or spouse who has a dependent who is not enrolled or eligible to be enrolled in Medicare Part A at no cost shall not be required to transfer to a Medicare health plan if a transfer requires the retiree or spouse to continue the existing family coverage for the dependent in a plan other than a Medicare health plan offered by the governmental unit.

(b) Each retiree shall provide the governmental unit, in such form as the governmental unit shall prescribe, such information as is necessary to transfer to a Medicare health plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health coverage. The governmental unit may, from time to time, request from a retiree, a retiree's spouse or a retiree's dependent, proof certified by the federal government, of eligibility or ineligibility for Medicare Part A and Part B coverage.

(c) The governmental unit shall pay any Medicare Part B premium penalty assessed by the federal government on the retiree, spouse or dependent as a result of enrollment in Medicare Part B at the time of transfer.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



Municipal Health Reform

SECTION 55. The fifth paragraph of subsection (a) of section 19 of said chapter 32B, as so appearing, is hereby amended by striking out the fourth sentence and inserting in place thereof the following 2 sentences:- Either the public employee committee or the appropriate public authority may convene the initial meeting of the committee at any time upon 7 days notice. Either the public employee committee or the appropriate public authority may convene any subsequent meeting with notice of not less than 3 business days.

- [Previous Outside Section](#)
- [Next Outside Section](#)



Municipal Health Reform

SECTION 56. Said section 19 of said chapter 32B, as so appearing, is hereby amended by striking out, in line 58, the words "70 per cent" and inserting in place thereof the following words:- a majority.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



OPEB Funds

SECTION 57. Said chapter 32B is hereby further amended by striking out section 20, as so appearing, and inserting in place thereof the following section:-

Section 20. (a) A city, town, district, county or municipal lighting plant that accepts this section may establish an Other Post-Employment Benefits Liability Trust Fund, and may appropriate amounts to be credited to the fund. Any interest or other income generated by the fund shall be added to and become part of the fund. Amounts that a governmental unit receives as a sponsor of a qualified retiree prescription drug plan under 42 U.S.C. section 1395w-132 may be added to and become part of the fund. All monies held in the fund shall be segregated from other funds and shall not be subject to the claims of any general creditor of the city, town, district, county or municipal lighting plant.

(b) The custodian of the fund shall be (i) a designee appointed by the board of a municipal lighting plant; (ii) the treasurer of any other governmental unit; or (iii) if designated by the city, town, district, county or municipal lighting plant in the same manner as acceptance prescribed in this section, the Health Care Security Trust board of trustees established in section 4 of chapter 29D, provided that the board of trustees accepts the designation. The custodian may employ an outside custodial service to hold the monies in the fund. Monies in the fund shall be invested and reinvested by the custodian consistent with the prudent investor rule established in chapter 203C and may, with the approval of the Health Care Security Trust board of trustees, be invested in the State Retiree Benefits Trust Fund established in section 24 of chapter 32A.

(c) This section may be accepted in a city having a Plan D or Plan E charter, by vote of the city council; in any other city, by vote of the city council and approval of the mayor; in a town, by vote of the town at a town meeting; in a district, by vote of the governing board; in a municipal lighting plant, by vote of the board; and in a county, by vote of the county commissioners.

(d) Every city, town, district, county and municipal lighting plant shall annually submit to the public employee retirement administration commission, on or before December 31, a summary of its other post-employment benefits cost and obligations and all related information required under Government Accounting Standards Board standard 45, in this subsection called "GASB 45", covering the last fiscal or calendar year for which this information is available. On or before June 30 of the following year, the public employee retirement administration commission shall notify any entity submitting this summary of any concerns that the commission may have or any areas in which the summary does not conform to the requirements of GASB 45 or other standards that the commission may establish. The public employee retirement administration commission shall file a summary report of the information received under this subsection with the chairs of the house and senate committees on ways and means, the secretary of administration and finance and the board of trustees of the Health Care Security Trust.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



Municipal Health Reform

SECTION 58. Said chapter 32B is hereby further amended by adding the following 9 sections:-

Section 21. (a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

(b) Prior to implementing any changes authorized under sections 22 or 23, the appropriate public authority shall evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of plan design changes or upon transfer of its subscribers to the commission. The appropriate public authority shall then notify its insurance advisory committee, or such committee's regional or district equivalent, of the estimated savings and provide any reports or other documentation with respect to the determination of estimated savings as requested by the insurance advisory committee. After discussion with the insurance advisory committee as to the estimated savings, the appropriate public authority shall give notice to each of its collective bargaining units to which the authority provides health insurance benefits and a retiree representative, hereafter called the public employee committee, of its intention to enter into negotiations to implement changes to health insurance benefits provided by the appropriate public authority. The retiree representative shall be designated by the Retired State, County and Municipal Employees Association. A political subdivision which has previously established a public employee committee under section 19 may implement changes to its health insurance benefits pursuant to this section and sections 22 and 23.

Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be comprised of 3 members, 1 of whom shall be appointed by the public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected

through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

(d) The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 22 or section 23; provided, however, that any increases to plan design features have been made in accordance with the provisions of section 22. If the panel does not approve implementation of changes made pursuant to section 22, the public authority may submit a new proposal to the public employee committee for consideration and confirmation under this section.

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to

contribution ratios.

(g) The decision of the municipal health insurance review panel shall be binding upon all parties.

(h) The secretary of administration and finance shall promulgate regulations establishing administrative procedures for the negotiations with the public employee committee and the municipal health insurance review panel, and issue guidelines to be utilized by the appropriate public authority and the municipal health insurance review panel in evaluating which subscribers are disproportionately affected, subscriber income and subscriber out-of-pocket costs associated with health insurance benefits.

Section 22. (a) Upon meeting the requirements of section 21, an appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers by acceptance of any other section of this chapter may include, as part of the health plans that it offers to its subscribers not enrolled in a Medicare plan under section 18A, copayments, deductibles, tiered provider network copayments and other plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment; provided, however, that for subscribers enrolled in a Medicare plan pursuant to section 18A the appropriate public authority may include, as part of the health plans that it offers to its subscribers, copayments, deductibles, tiered provider network copayments and other plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment. The appropriate public authority shall not include a plan design feature which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network or providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

(b) An appropriate public authority may increase the dollar amounts for copayments, deductibles, tiered provider network copayments and other plan design features; provided that, for subscribers enrolled in a non-Medicare plan, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment and, for subscribers enrolled in a Medicare plan under section 18A, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment; provided, however, that the public authority need only satisfy the requirements of subsection (a) of section 21 the first time changes are implemented pursuant to this section; and provided, further that the public authority meet its obligations under subsections (b) to (h), inclusive, of section 21 each time an increase to a plan design feature is proposed.

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

(c) The decision to accept and implement this section shall not be subject to bargaining pursuant to chapter 150E or section 19. Nothing in this section shall preclude the implementation of plan design changes pursuant to this section in communities that have adopted section 19 of this chapter or by the governing board of a joint purchasing group

established pursuant to section 12.

(d) Nothing in this section shall relieve an appropriate public authority from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter.

(e) The first time a public authority implements plan design changes under this section, the public authority shall not increase the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums for a period of ~~2~~³ years once such changes are in effect.

Section 23. (a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year and the transfer of subscribers to the commission shall take effect on the following July 1. On the effective date of the transfer, the health insurance of all subscribers, including elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150E and this chapter; provided,

however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150E, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

(d) The commission shall negotiate and purchase health insurance coverage for subscribers transferred under this section and shall promulgate regulations, policies and procedures for coverage of the transferred subscribers. The schedule of benefits available to transferred subscribers shall be determined by the commission pursuant to chapter 32A. The commission shall offer those subscribers the same choice as to health insurance carriers and benefits as those provided to state employees and retirees. The political subdivision's contribution to the cost of health insurance coverage for transferred subscribers shall be as determined under this section, and shall not be subject to the provisions on contributions in said chapter 32A. Any change to the premium contribution ratios shall become effective on July 1 of each year, with notice to the commission of such change not later than January 15 of the same year.

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may inform the state treasurer who shall issue a warrant in the manner provided by section 20 of chapter 59 requiring the respective political subdivision to pay into the treasury of the commonwealth as prescribed by the commission the amount of the premium and administrative expenses attributable to the political subdivision. The state treasurer shall recoup any past due costs from the political subdivision's cherry sheet under section 20A of chapter 58 and transfer that money to the commission. If a governmental unit fails to pay to

the commission the costs of coverage for more than 90 days and the cherry sheet provides an inadequate source of payment, the commission may, at its discretion, cancel the coverage of subscribers of the political subdivision. If the cancellation of coverage is for nonpayment, the political subdivision shall provide all subscribers health insurance coverage under plans which are the actuarial equivalent of plans offered by the commission in the preceding year until there is an agreement with the public employee committee providing for replacement coverage.

The commission may charge the political subdivision an administrative fee, which shall not be more than 1 per cent of the cost of total premiums for the political subdivision, to be determined by the commission which shall be considered as part of the cost of coverage to determine the contributions of the political subdivision and its employees to the cost of health insurance coverage by the commission.

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare part A at no cost to the retiree, spouse or dependents, shall be required to be insured by a Medicare extension plan offered by the political subdivision under section 11C or section 16. A retiree shall provide the political subdivision, in such form as the political subdivision shall prescribe, such information as is necessary to transfer to a Medicare extension plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health insurance coverage. The political subdivision may from time to time request from a retiree, a retiree's spouse and dependents, proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare part A and part B coverage. The political subdivision shall pay the Medicare part B premium penalty assessed by the federal government on those retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan.

(g) The decision to implement this section shall not be subject to collective bargaining pursuant to chapter 150E or section 19.

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or change eligibility standards for health insurance under the definition of "employee" in section 2.

Section 24. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter may provide health care flexible spending accounts to allow certain subscribers, as determined by the appropriate public authority, to set aside a portion of earnings to pay for qualified expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 25. Notwithstanding any general or special law or regulation to the contrary, the appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter or transfer its subscribers to the commission under this chapter may provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 26. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter shall conduct an enrollment audit not less than once every 2 years. The audit shall be completed in order to

ensure that members are appropriately eligible for coverage.

Section 27. An insurance carrier, third party purchasing group or administrator or the commission in the case of a governmental unit, which has undertaken to provide health insurance coverage to its subscribers by acceptance of sections 19 or 23, shall, upon written request, provide the governmental unit or public employee committee with its historical claims data within 45 days of such request; provided, that all personally identifying information within such claims shall be redacted and released in a form and manner compliant with all applicable state and federal privacy statutes and regulations including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996.

Section 28. Nothing in section 21, 22 or 23 shall be construed to prevent 2 or more governmental units under a joint purchase or trust agreement from jointly negotiating and purchasing coverage as authorized in section 12.

Section 29. Each fiscal year, the commission shall prepare and place on its website a report delineating the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the commission in the non-Medicare plan with the largest subscriber enrollment and the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the commission in the Medicare extension plan with the largest subscriber enrollment. The commission shall also provide information on its plans with the largest subscriber enrollment upon request of any appropriate public authority or political subdivision.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



Access to Personal Information

SECTION 59. Section 32 of chapter 59 of the General Laws, as amended by section 46 of chapter 188 of the acts of 2010, is hereby further amended by adding the following sentence:- Nothing in this section shall prevent a person who submitted that information, or his designated representative, from inspecting or being provided a copy of the submission upon request.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)



Muni health insurance transfer to GIC

SECTION 201. Notwithstanding any general or special law to the contrary, the group insurance commission shall prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before January 1, 2012, if such political subdivision provides notice to the group insurance commission on or before September 1, 2011, that it is transferring its subscribers to the group insurance commission under sections 19 or 23 of chapter 32B of the General Laws; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before April 1, 2012, if such political subdivision provides notice to the group insurance commission on or before December 1, 2011, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before July 1, 2012, if such political subdivision provides notice to the group insurance commission on or before March 1, 2012, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B.

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- [Previous Outside Section](#)
 - [Next Outside Section](#)

July - March
January - September?
April December

1
2
3 **NEW REGULATIONS –**
4 **801 CMR 52.00 MUNICIPAL HEALTH INSURANCE**
5

6 52.01 General provisions

- 7 (1) Authority
8 (2) Definitions
9 (3) Notices

10
11 52.02 The vote by a political subdivision to implement changes in group health insurance
12 benefits pursuant to M.G.L. c. 32B, §§ 21-23

- 13 (1) Advance notice of intent to vote.
14 (2) Notice of vote, request for name and contact information for the public employee
15 committee representatives, and number of eligible unit members

16
17 52.03 The Implementation Notice

18
19 52.04 The thirty-day negotiation period

20
21 52.05 Health insurance review panel

22
23 52.06 Health insurance review panel process

24
25 52.07 Implementation of agreements reached under M.G.L. c. 32B, §§ 21 to 23

26
27
28
29 *52.01 General provisions*

30 *(1) Authority*

31
32 (a) 801 CMR 51.00 is adopted by the Secretary of Administration and Finance,
33 under the authority of M.G.L. c. 32B, §21 to carry out the process by which
34 political subdivisions elect to change health insurance benefits under M.G.L. c.
35 32B, §§ 21-23.
36

37 (b) The process set forth in 801 CMR 52.00 shall be followed each time a political
38 subdivision elects to change health insurance benefits under the process
39 authorized by M.G.L. c. 32B, §§21- 23 (the implementation process), except that
40 acceptance under M.G.L. c. 32B, § 21(a) need only occur once.
41

42
43 *(2) Definitions*

44
45 Unless otherwise provided, terms shall have the meanings assigned to them in
46 M.G.L. c. 32B. The following terms shall have the following meanings:

47
48 “Collective bargaining unit” means an employee organization as defined in
49 M.G.L. c. 150E, §1 that is acting as the exclusive bargaining representation of the
50 bargaining unit. Notice to a collective bargaining unit under 801 CMR 52.02 shall
51 be made to the principal officer of each bargaining unit.
52

53
54 “Impartial member” means the member of the review panel selected from a list of
55 3 potential members provided by the Secretary of Administration and Finance
56 under the process set forth in 801 CMR 52.05(1).
57

58 “Implementation notice” means the notice required under M.G.L. c. 32B, §21(b)
59 of the intent to enter into negotiations to implement proposed changes to health
60 insurance benefits.
61

62 “Insurance advisory committee” means an advisory committee established by a
63 public authority as specified in M.G.L. c. 32B, §3.
64

65 “Limited provider network” means a reduced or selective provider network which
66 is smaller than a carrier’s general provider network and from which the carrier
67 may choose to exclude from participation other providers who participate in the
68 carrier’s regional provider network or general provider network for the purpose of
69 reducing premium costs but which offers the same benefits to those provided by
70 the carrier’s general provider network .
71

72 “Maximum possible savings” is used to determine whether a proposal to transfer
73 subscribers to the Commission would achieve at least five percent greater savings
74 than the maximum possible savings that would be attained by plan design changes
75 authorized under M.G.L. c. 32B, § 22 and means the savings that would be
76 realized for the first 12 months if a political subdivision were to provide health
77 insurance coverage to its subscribers by implementing changes to health insurance
78 benefits that equal the dollar amounts of the most-subscribed plan’s design
79 features for the same or most similar benefits offered by the commission for a
80 non-Medicare plan under section 4 of M.G.L. c. 32A and for a Medicare-
81 extension plan under section 10C and section 14 of M.G.L. c. 32A. Where the
82 political subdivision currently does not offer a tiered provider network, the
83 maximum possible savings shall be calculated by comparing the savings that
84 would result if the dollar amounts of the co-pays, deductibles and other cost-
85 sharing plan design features in the political subdivision’s plan equaled the dollar
86 amounts of the co-pays, deductibles and other cost-sharing plan design features
87 under tier 2 of the commission’s most-subscribed plan. Where the political
88 subdivision currently offers a tiered provider network that is tiered differently
89 from the tiering in the commission’s most-subscribed plan, the maximum possible
90 savings shall be calculated by assuming the co-pays, deductibles and cost-sharing
91 plan design features in each tier of the political subdivision’s plan are equal to
92 those in the same tier of the commission’s most-subscribed plan, beginning with a

93 comparison of the highest tier. If the political subdivision’s plan has fewer tiers
94 than the commission’s plan, the political subdivision’s highest tier shall be
95 compared to the commission’s tier 3, and the second highest tier to the
96 commission’s tier 2.

97
98
99 “Mitigation proposal” means a proposal to mitigate, moderate or cap the impact
100 of these changes for subscribers, including retirees, low income subscribers and
101 subscribers with high out-of-pocket health care costs, who would otherwise be
102 disproportionately affected.

103
104
105 “Public Employee Committee” means the committee established under M.G.L. c.
106 32B, §19 or § 21. If a public employee committee has not been established under
107 Section 19, a public employee committee shall be established exclusively to
108 negotiate changes under Sections 21 to 23, and shall be established in the same
109 form and with the same percent votes as prescribed in the fifth paragraph of
110 subsection (a) of Section 19. A public employee committee established under
111 Section 21 exclusively to negotiate changes under M.G.L. c. 32B, §§ 21 to 23
112 shall be considered dissolved upon completion of the process described in those
113 sections.

114
115 “RSCME” means the Retired State, County and Municipal Employees
116 Association, located at 11 Beacon Street, Suite 321, Boston, MA 02108.

117
118 “Review panel” means the municipal health insurance review panel comprised of
119 3 members, 1 of whom shall be appointed by the public employee committee, 1 of
120 whom shall be appointed by the public authority and 1 of whom shall be selected
121 under the process set forth in 801 CMR 52.05(1).

122
123
124 “Secretary” means the Secretary of Administration and Finance.

125
126 “Tiered provider network” means a provider network in which a carrier assigns
127 providers to different benefit tiers based on the carrier’s assessment of a
128 provider’s cost efficiency and quality, and in which insureds pay the cost-sharing
129 (copayment, coinsurance or deductible) associated with a provider’s assigned
130 benefit tiers.

131
132
133 *(3) Notices.*

134
135 (a) All notices provided under 801 CMR 52.00 shall be sent by certified mail,
136 delivery confirmation and return receipt requested, and a copy shall be sent to the
137 Secretary. Either post office evidence of attempted delivery or return receipts shall be
138 prima facie evidence of the time of receipt.

139
140 (b) All notices to the Secretary shall be sent electronically to:
141 MunicipalHealth@state.ma.us.
142

143
144
145
146
147 *52.02 The vote by a political subdivision to implement changes in group health insurance*
148 *benefits under M.G.L. c. 32B, §§ 21-23*
149

150
151 *(1) Advance notice of intent to vote.*
152

153 At least two calendar days in advance of any vote electing to change group health
154 insurance under the process authorized by M.G.L. c. 32B, §§ 21-23, the
155 appropriate public authority shall send a notice to each collective bargaining unit
156 to which the authority provides health insurance benefits and to the Retired State,
157 County Municipal Employees Association (RSCME) that the political subdivision
158 intends to vote on whether to implement the process. The vote of the political
159 subdivision under M.G.L. c. 32B, § 21(a) may be in the following form: "The
160 [name of political subdivision] elects to engage in the process to change health
161 insurance benefits under M.G.L. c. 32B, §§ 21-23."
162

163 *(2) Notice of vote, request for name and contact information for public employee*
164 *committee representatives, and number of eligible unit members.*
165

166 (a) A political subdivision which has elected under M.G.L. c. 32B, §21(a) to
167 change health insurance benefits under M.G.L. c. 32B, §§ 22-23, shall, before
168 implementing any changes, evaluate its health insurance coverage and determine
169 the savings that may be realized after the first 12 months of implementation of
170 cost-sharing plan design changes or upon transfer of its subscribers to the
171 commission. The appropriate public authority shall then notify its insurance
172 advisory committee, or such committee's regional or district equivalent, of its
173 estimated savings. The notice shall include all the information required in
174 section 52.03. In any political subdivision in which an insurance advisory
175 committee has not already been established under M.G.L. c. 32B, §3, the
176 appropriate public authority shall notify the president of each organization of
177 employees affected and shall designate and notify a retiree of a governmental unit
178 as a member of the committee. The insurance advisory committee, within 10 days
179 after receiving this notice, shall meet with the appropriate public authority to
180 discuss its estimated savings and any reports or other documentation requested by
181 the insurance advisory committee before that meeting. If the committee does not
182 meet within 10 days after receiving proper notice, it shall be considered to have
183 discussed the matter with the appropriate public authority.
184

185
186 (b) Not later than 2 business days after the insurance advisory committee meets
187 with the appropriate public authority or 10 days after the insurance advisory
188 committee receives notice from the appropriate public authority, whichever
189 occurs first, a political subdivision which has elected under M.G.L. c. 32B, §
190 21(a) to make changes under M.G.L. c. 32B, §§ 22 or 23 shall, provide a notice of
191 its decision, in writing, to the president or designee of each collective bargaining
192 unit and to the RSCME and shall include the number of employees eligible for
193 health insurance under M.G.L. c. 32B employed in each bargaining unit of the
194 political subdivision.

195
196 (c) In any political subdivision which has not previously formed a public
197 employee committee under M.G.L. c. 32B, §19 of this chapter, the notice shall
198 request that each of the collective bargaining units and the RSCME provide the
199 name, address, phone number, and email address of its designated public
200 employee committee representative.

201
202 (d) Where a public employee committee already exists under M.G.L. c. 32B, §
203 19, each collective bargaining unit and RSCME shall, within 2 business days of
204 receipt of notice under this section, provide the appropriate public authority with
205 the name, address, phone number and email address of its designated public
206 employee committee representative. If no public employee committee exists at
207 the time of receipt of the notice, each collective bargaining unit and RSCME shall
208 designate a representative to a public employee committee exclusively to
209 negotiate changes under M.G.L. c. 32B, §§21-23 and provide the appropriate
210 public authority with the name, address, phone number and email address of its
211 designated public employee committee representative within 5 business days after
212 receipt of notice under 801 CMR 52.02(3). If no public employee committee
213 exists at the time of receipt of notice from the political subdivision and the
214 appropriate public authority has not received this information from a collective
215 bargaining unit or RSCME within 5 business days, the collective bargaining unit's
216 principal officer shall be the unit's representative on the public employee
217 committee, the president of the RSCME shall be its representative on the public
218 employee committee, and the appropriate public authority shall send the notice
219 specified under 801 CMR 52.03 to the collective bargaining unit's principal
220 officer and to RSCME's president.

221
222 *52.03 The Implementation Notice/(Notification by public authority to its public employee*
223 *committee of its intention to enter into negotiations to implement changes to its health insurance*
224 *benefits under M.G.L. c. 32B, §21)*

225
226 The appropriate public authority shall give the written notice required in M.G.L. c. 32B,
227 § 21(b) to the insurance advisory committee in accordance with Section 52.02(2)(a) and,
228 not later than 2 business days following the appropriate public authority's receipt of
229 notice of the representatives of the public employee committee under Section
230 52.02(2)(d), to each public employee committee representative identified by the

231 collective bargaining units and the RSCME. The notice shall include the following
232 information:

233
234
235 (a) the proposed changes to the political subdivision's health insurance benefits,
236 including:

237 (i) a description of the political subdivision's current health
238 insurance plans and each plan's co-pays, deductibles and other
239 cost-sharing plan design features, enrollment (broken out by
240 enrollment in individual, individual plus one, and family plans),
241 annual premium total cost, and percentage of premium total cost
242 paid by political subdivision;

243 (ii) a description of the proposed changes, including:(a) the
244 earliest practical date for implementing the changes under law;(b)
245 each plan to be offered, and the projected enrollment under each
246 plan, including continued projected enrollment for subscribers
247 covered by existing collective bargaining agreements that specify
248 plan design features; retirees enrolled and being transferred for the
249 first time to Medicare under M.G. L. c. 32B, § 18A and Medicare
250 supplemental health insurance plans; and subscribers moved to the
251 new, proposed insurance plans; and (c) the proposed dollar
252 amounts for each plan's co-pays, deductibles and other cost-
253 sharing plan design features. A proposal shall not include a health
254 benefit plan design feature which seeks to achieve premium
255 savings by offering a limited network of providers unless the
256 appropriate public authority also offers a health benefit plan to all
257 subscribers that does not contain a limited network of providers.
258

259
260 (b). the co-payments, deductibles, tiered provider network co-payments and other
261 cost-sharing plan design features for the same or most similar benefits of the non-
262 Medicare plan and the co-payments, deductibles, and other cost-sharing plan
263 design features for the same or most similar benefits of the Medicare-extension
264 plan with the largest subscriber enrollment offered by the Commission, as
265 provided by the Commission under M.G.L. c. 32B, §28;
266

267 (c). the appropriate public authority's estimate of anticipated savings of such
268 changes and the supporting information and analysis, including but not limited to:

269
270 i. the total projected premium costs and enrollment of plans under
271 the existing coverage for the first 12-month period in which the
272 appropriate public authority seeks to make changes as if no such
273 changes were made,
274

275 ii. the anticipated total projected premium costs of plans, including
276 plans with the proposed changes, and anticipated enrollment for
277 the same 12-month period,
278

279 iii. the analysis that the appropriate public authority has to support
280 its estimate of savings and the projected premium costs which may
281 include quotes or bids from any insurance plan, third party
282 administrator or insurance broker regarding the total premium cost
283 of such plans with and without the proposed changes; demographic
284 data regarding the number of employees, the number of
285 subscribers, the number of subscribers enrolled in non-Medicare
286 plans (by coverage -family or individual) and Medicare-extension
287 plans; any data regarding out-of-pocket costs paid by subscribers;
288 and any other factors relied upon by the appropriate public
289 authority, including any information provided by an actuary or
290 other consultant in developing the savings estimate.
291

292 If the appropriate public authority has indicated that it is
293 considering transferring to the commission, it shall include in its
294 analysis the estimates regarding plan choice that subscribers will
295 make if transferred to the commission.
296
297
298
299
300

301 The savings estimate shall not take into account: savings resulting
302 from transferring eligible retirees to Medicare under M.G.L. c.
303 32B, § 18A, but the savings estimate shall include savings due to
304 proposed increases in dollar amounts for co-pays and deductibles
305 for Medicare-extension plans under M.G.L. c. 32B, § 22 or the
306 savings resulting from the transfer to Commission's medicare
307 extension plans under M.G.L. c. 32B, §23.
308

309 The savings estimate shall be calculated based on the number of
310 subscribers who will be covered under the proposed plans,
311 including subscribers covered by existing collective bargaining
312 agreements for whom implementation of the proposed changes
313 would be delayed under St. 2011, c. 69, § 4. The appropriate public
314 authority shall allocate funds to the mitigation plan in proportion to
315 the number of total subscribers who will be covered under the
316 proposed plan, with additional funds allocated when the plan
317 changes are implemented for additional subscribers. Subscribers
318 will not be eligible for mitigation funds before they are transferred
319 to the new plans.
320

321 If the proposed change involves a transfer of health insurance
322 coverage of subscribers to the commission, the savings estimate
323 shall be based on a determination of maximum possible savings.
324

- 325 (d) the mitigation proposal, including:
- 326 (i) the estimate of the cost to fund the proposal and what
327 percentage that cost is of the savings;
 - 328 (ii) an explanation and rationale for the proposal;
 - 329 (iii) the manner in which it affects various subscribers, including
330 those disproportionately affected;
 - 331 (iv) the manner of distribution or allocation of estimated savings
332 from the proposal.
333
334
335
336
337

338 *52.04 The 30-day negotiation period*
339

340 (1) The 30 (calendar) day negotiation period shall commence when each member of the
341 public employee committee has received the implementation notice, with the information
342 required under Section 52.03, in the manner specified under 801 CMR 52.01(3).
343

344 (2) The negotiations between the public employee committee and the appropriate public
345 authority may include all aspects of the public authority's proposal. The parties are
346 encouraged to negotiate in good faith.
347

348 (3) The public authority shall not implement any changes in health insurance benefits
349 during negotiations absent mutual agreement of the public employee committee and the
350 appropriate public authority.
351

352 (4) Any agreements reached between the public employee committee and the appropriate
353 public authority shall be reduced to writing, and executed by the parties within the 30-day
354 period.
355

356 (a) A written agreement shall include the plan design changes or transfer to the
357 Commission, the process to notify subscribers of the changes, the timeframe to
358 implement the changes and the mitigation plan. The same information required
359 for the appropriate public authority's proposal under Section 52.03 shall be
360 included in the agreement or in a separate document accompanying it. The
361 appropriate public authority shall send a copy of the agreement and other
362 documents accompanying it to the Secretary within 3 business days after
363 execution of the agreement, and shall send notice to the health insurance review
364 panel created under 801 CMR 52.05 that there is no need for its services.
365

366 (5) All subscribers shall be provided with at least 60 days advance notice in accordance
367 with M.G.L. c. 175, §24B, of any changes in plan design, including an agreement to
368 transfer to the Commission. Notice shall not be effective until the changes are included
369 in a written agreement between the appropriate public authority and the public employee
370 committee under this section or a written decision of the review panel under Section
371 52.06.

372
373 (6) If the appropriate public authority and the public employee committee are able to
374 reach a written agreement within 30 calendar days, the agreement shall be binding on all
375 subscribers and their representatives, and the public authority shall implement the
376 changes agreed to in the written agreement as quickly as practicable and in observance of
377 the 60-day notice requirement identified above in 801 CMR 52.04(4)(b).

378
379 (7) If the change is to transfer subscribers to the Commission, the notice shall include
380 information about the Commission plans, the enrollment process, and any other
381 information specified by the Commission in its rules and regulations issued under M.G.L.
382 c. 32B, §23 relating to the process by which subscribers shall be transferred to the
383 Commission.

384
385 *52.05 Health insurance review panel*

386
387 *(1) Creation of the panel*

388
389 (a) The appropriate public authority shall notify the Secretary in writing within 3
390 business days after the beginning of the 30-day negotiation period under 801
391 CMR 52.04. The notice shall include the start and end dates of the 30-day
392 negotiation period, and the name and contact information of the public authority's
393 representative for the health insurance review panel. The appropriate public
394 authority shall provide each member of the public employee committee with a
395 copy of the notice to the Secretary.

396
397 (b) Within 3 business days after receiving copies of notice to the Secretary under
398 (a), the public employee committee shall select one representative for the panel
399 and give notice to the appropriate public authority and the Secretary. Within 10
400 days after receiving this notice, the Secretary shall provide the appropriate public
401 authority, the public employee committee, and the public authority and public
402 employee committee representatives ("the parties") with a list ("the list") of 3
403 qualified, impartial potential members available to serve on the review panel.
404 Impartial members shall have professional experience in dispute mediation and
405 professional experience in municipal finance or municipal health benefits. The
406 Secretary shall also provide the parties with the name of an actuary selected by
407 the Commission to assist the panel in verifying the savings calculations if no
408 agreement is reached within the 30-day period and a panel is convened.
409

410 (c) Within 3 business days after receiving the list, the appropriate public authority
411 and the public employee committee shall jointly select the third member for the
412 panel from the list and shall notify the Secretary of their joint selection.
413

414 (d) If the appropriate public authority and the public employee committee cannot
415 agree within 3 business days on which person from the list to select as the third
416 member of the review panel, the notice by the public authority to the Secretary
417 shall include notification that the parties have been unable to reach agreement of
418 the selection of a name from the list of potential impartial panel members. If the
419 public authority and the public employee committee cannot agree, the Secretary
420 shall appoint the impartial member from the list and notify the parties not later
421 than the end of the 30-day negotiation period.
422

423
424
425 (2) If the appropriate public authority and the public employee committee are
426 unable to reach a written agreement on the public authority's proposal within 30
427 calendar days, the matter shall be submitted to the municipal health insurance
428 review panel. The appropriate public authority shall submit its original proposal to
429 the panel within 3 business days after the end of the 30-day negotiation period,
430 with a copy sent to the Secretary and each member of the public employee
431 committee. The appropriate public authority shall submit to the panel the same
432 proposal that it made to the public employee committee. If the proposal includes
433 the introduction of a limited network plan, the appropriate public authority shall
434 provide an enrollment survey, a determination of which subscribers would enroll
435 in a broad plan and which subscribers would enroll in a limited network plan, and
436 the effect that the addition of a limited network plan would have on total premium
437 costs and on disproportionately affected subscribers. The results of the
438 enrollment survey shall be considered in the savings analysis.
439

440 (3) The public employee committee shall also submit any alternate mitigation
441 proposal to the panel and any other information the public employee committee
442 wants the panel to consider with respect to any other matters before them within 3
443 business days after the end of the 30-day negotiation period, with a copy sent to
444 the Secretary and the other parties.
445

446
447 (4) Any fee or compensation provided to the impartial panel member for service
448 on the panel shall be shared equally between the public employee committee and
449 the appropriate public authority. The impartial members selected from the lists
450 provided by the Secretary will be reimbursed only for reasonable travel expenses.
451

452 *52.06 The health insurance review panel review process*
453
454

455 (1) At any time before the panel has made decisions in accordance with this
456 section, the parties may agree in writing, with copies to the panel and the
457 Secretary, to terminate or suspend the review process for a stated period of time
458 because they have reached an agreement, would like additional time to negotiate
459 an agreement under Section 52.04, have mutually decided to return to collective
460 bargaining pursuant to M.G.L. c. 150E or have mutually decided to resume
461 negotiations under M.G.L. c. 32B, § 19.
462

463 (2) If both parties have not mutually agreed to terminate the review process,
464 within 2 business days after receipt of notice of submission to the panel, the
465 impartial member of the review panel shall fix a time, date, and place for the
466 panel to convene and shall give notice to the parties.
467

468 (3) Meetings of the panel shall be conducted under the Open Meeting Law. The
469 impartial member shall chair the panel's meetings and shall arrange for suitable
470 records to be kept. The impartial member shall ensure that each member receives
471 advance notice of the time, place and agenda for each meeting. All decisions
472 shall be by recorded vote.
473

474
475 (4) When the panel convenes on the date and time set by the impartial panel
476 member, the panel shall do the following:
477

478 *(a) Review the public authority's proposed changes*
479

480 (1) Determine within 10 days whether the proposed increased
481 dollar amounts for co-payments, deductibles, and other cost-
482 sharing plan design features for the non-Medicare plan under
483 M.G.L. c. 32B, § 22 exceed the dollar amounts of the plan design
484 features for the same or most similar benefits offered by the
485 commission for the non-Medicare plan under section 4 of M.G.L.
486 c.32A with the largest subscriber enrollment,. If such increased
487 amounts do not exceed the dollar amounts of the plan design
488 features for the same or most similar benefits offered by the
489 commission for the non-Medicare plan under section 4 of chapter
490 32A with the largest subscriber enrollment, the panel shall approve
491 the appropriate public authority's immediate implementation of the
492 proposed changes under M.G.L. c. 32b, § 22, subject to Section
493 52.07. Where the political subdivision is not proposing a tiered
494 provider network, the determination shall be made by comparing
495 the savings that would result if the dollar amounts of the co-pays,
496 deductibles and other cost-sharing plan design features in the
497 political subdivision's plan equaled the dollar amounts of the co-
498 pays, deductibles and other cost-sharing plan design features under
499 tier 2 of the commission's most-subscribed plan. Where the
500 political subdivision currently is proposing a tiered provider

501 network that is tiered differently from the tiering in the
502 commission's most-subscribed plan, the determination shall be
503 made by assuming the co-pays, deductibles and cost-sharing plan
504 design features in each tier of the political subdivision's plan are
505 equal to those in the same tier of the commission's most-
506 subscribed plan, beginning with a comparison of the highest tier.
507 If the political subdivision's plan has fewer tiers than the
508 commission's plan, the political subdivision's highest tier shall be
509 compared to the commission's tier 3, and the second highest tier to
510 the commission's tier 2.

511
512
513 (2) Determine within 10 days whether the proposed increased
514 dollar amounts for co-payments and deductibles proposed for a
515 Medicare-extension plan under M.G.L. c. 32B, §22 exceed the
516 dollar amounts of the plan design features for the same or most
517 similar benefits offered by the commission for the Medicare-
518 extension plan under section 10C and section 14 of M.G.L. c.32A
519 with the largest subscriber enrollment. If such increased amounts
520 do not exceed the dollar amounts of the plan design features for the
521 same or most similar benefits offered by the commission for the
522 Medicare-extension plan under section 4 of chapter 32A with the
523 largest subscriber enrollment, the panel shall approve the
524 appropriate public authority's immediate implementation of the
525 proposed changes under M.G.L. c. 32B, § 22, subject to Section
526 52.07. Where the political subdivision is not proposing a tiered
527 provider network, the determination shall be made by comparing
528 the savings that would result if the dollar amounts of the co-pays,
529 deductibles and other cost-sharing plan design features in the
530 political subdivision's plan equaled the dollar amounts of the co-
531 pays, deductibles and other cost-sharing plan design features under
532 tier 2 of the commission's most-subscribed plan. Where the
533 political subdivision currently is proposing a tiered provider
534 network that is tiered differently from the tiering in the
535 commission's most-subscribed plan, the determination shall be
536 made by assuming the co-pays, deductibles and cost-sharing plan
537 design features in each tier of the political subdivision's plan are
538 equal to those in the same tier of the commission's most-
539 subscribed plan, beginning with a comparison of the highest tier.
540 If the political subdivision's plan has fewer tiers than the
541 commission's plan, the political subdivision's highest tier shall be
542 compared to the commission's tier 3, and the second highest tier to
543 the commission's tier 2.

546 (3) If the panel does not approve implementation because the
547 appropriate public authority's proposal fails to meet the criteria
548 detailed in Section 52.06(4)(a)(1) and (2), above , the appropriate
549 public authority may submit a new proposal to the public employee
550 committee and restart the process from that point pursuant to
551 Section 52.03.

552
553 (b) Review the public authority's estimated monetary savings due to
554 proposed changes, after consulting the Commission's actuary:

555
556 (1) Within 10 calendar days of receiving proposed changes under
557 M.G.L. c. 32B, §§ 22 or 23, the panel shall confirm, the
558 appropriate public authority's estimated monetary savings due to
559 proposed changes under M.G.L. c. 32B, § 22 or § 23.

560
561 (2) If the proposal is to transfer subscribers to the Commission, the
562 panel shall determine if the anticipated savings by doing so would
563 be at least five percent greater than the maximum possible savings
564 amount that would be attained by plan design changes authorized
565 under M.G.L. c.32B, § 22. If the panel confirms these savings, the
566 panel shall approve the appropriate public authority's immediate
567 implementation of the proposed changes under M.G.L. c. 32B, §
568 23, subject to procedures adopted by the commission for transfer
569 of subscribers.

570
571 (3) The appropriate public authority's estimate of savings due to
572 the proposed changes shall be confirmed by the panel after
573 consultation with the actuary selected by the Commission.

574
575 (4) If the panel finds that the savings estimate is unsubstantiated, it
576 may require the public authority to provide additional information
577 or submit a new savings estimate for the panel's review and
578 confirmation. It may also require the public employee committee
579 to submit a response to the new estimate.

580
581 (5) A certified copy of the vote confirming the savings estimate
582 and, if the proposal is to transfer subscribers to the Commission,
583 approval or rejection of the proposal, and explanation of the basis
584 for any such change or disapproval shall be sent to the parties and
585 the Secretary.

586
587 (c) Review the public authority's mitigation proposal:

588
589 (1) Within 10 calendar days of receiving proposed changes under
590 M.G.L. c. 32B, § 22 or § 23, the panel shall review the proposal to
591 mitigate, moderate or cap the impact of these changes for

592 subscribers, including retirees, low-income subscribers and
593 subscribers with high out-of-pocket health care costs, who would
594 otherwise be disproportionately affected.
595

596 (2) The municipal health insurance review panel may approve the
597 mitigation proposal, or it may determine the proposal to be
598 insufficient and may require additional savings to be shared with
599 subscribers in the form of health reimbursement arrangements,
600 wellness programs, health care trust funds for emergency medical
601 care or inpatient hospital care, out-of-pocket caps, Medicare Part B
602 reimbursements or reimbursements for other qualified medical
603 expenses, as determined by the panel. Premium reductions for
604 subscribers that result from the plan design changes shall not be
605 credited against the total amount determined to be required to fund
606 the mitigation proposal. Any health reimbursement arrangements
607 created under a mitigation proposal shall be administered by the
608 appropriate public authority and shall not be the responsibility of
609 the Commission.
610

611 (3) In no case shall the municipal health insurance review panel
612 designate more than 25 percent of the estimated savings to
613 subscribers.
614

615 (4) All obligations on behalf of the appropriate public authority
616 related to the mitigation proposal shall expire after the initial
617 amount of estimated savings designated by the panel to be
618 distributed to subscribers has been expended.
619

620 (5) In reaching a decision on the proposal under this subsection,
621 the municipal health insurance review panel may consider: (a) any
622 alternative proposal from the public employee committee to
623 mitigate, moderate or cap the impact of these changes for
624 subscribers, (b) discrepancies between the percentage contributed
625 by retirees, surviving spouses and their dependent and the
626 percentage contributed by other subscribers, and (c) the impact of
627 the changes on subscribers, including in particular the impact on
628 retirees, low-income subscribers and subscribers with high out-of-
629 pocket costs.
630

631 (6) The panel's decision shall incorporate any agreements made
632 by the parties, and shall constitute the written agreement between
633 the public employee committee and the appropriate public
634 authority. The agreement shall be binding on all subscribers and
635 their representatives.
636
637

638 (d) Once the panel has taken the actions required above, the panel shall be
639 considered dissolved.

640
641 *52.07 Implementation of agreements reached pursuant to M.G.L. c. 32B, §§ 21- 23*
642

643
644 (1) Subject to St. 2011, c. 69, § 4, a political subdivision shall implement changes to benefits
645 for all subscribers as soon as practicable upon completing the process provided in M.G.L.
646 c. 32B, § 21 and these regulations, but the public authority shall give subscribers at least
647 60 days notice before implementing any changes in health insurance benefits under these
648 regulations. Implementation of changes under M.G.L. c. 32B, §22 shall occur not later
649 than 90 days after a written agreement has been signed under 801 CMR 52.04 or 52.06
650 or, if the appropriate public authority and the public employee committee mutually
651 determine that a mid-year change time would produce an undue burden, at the end of the
652 current health insurance policy year. Implementation of transfer of subscribers to the
653 commission shall be in accordance with the Commission's procedures. If a political
654 subdivision provides notice to the commission by October 1, 2011 that it is transferring
655 its subscribers to the commission and complies with the notice requirements provided by
656 the Commission, the Commission shall allow the political subdivision to transfer its
657 subscribers to the commission on or before January 1, 2012.

658
659 (2) Any political subdivision which does not seek to make changes under M.G.L. c. 32B,
660 §§ 21-23, including any political subdivision which votes against adopting G.L. c. 32B,
661 §§ 21-23, shall file with the Executive Office for Administration and Finance a report by
662 June 30, 2012 comparing existing plan design to the maximum possible savings available
663 if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23. To maintain
664 comprehensive records of political subdivisions that make use of this process, savings in
665 health insurance costs that resulted, and potential savings not achieved, and to measure
666 the extent to which political subdivisions took advantage of this process, each political
667 subdivision shall file an annual report by June 30 of each year with the Secretary
668 showing:

- 669 (i) the health insurance plans that it offers and the number of subscribers in each;
- 670 (ii) whether it made use of M.G.L. c. 32B, § 19 or §§ 21-23;
- 671 (iii) if it did not make use of these processes, the maximum possible savings available if
- 672 health benefit changes were made pursuant to M.G.L. c. 32B, §21-23.

673
674 (3) A political subdivision whose subscribers are currently covered by the commission shall
675 not implement changes under this procedure until it has followed the procedure for
676 withdrawal from coverage by the commission under the process set forth in the
677 commission's regulations.

678
679 (4) If a political subdivision initiated the process for implementing changes in its group
680 health insurance benefits under M.G.L. c. 32B, §§21 -23 before the effective date of these
681 regulations and has proceeded in a manner inconsistent with any provision of these
682 regulations, the Secretary may waive or modify those inconsistent provisions for that
683 political subdivision provided that the political subdivision comply with all requirements

684 of M.G.L. c. 32B, §§21-23. An appropriate public authority shall seek such waiver from
685 the Secretary in writing, with a copy to the public employee committee. Any member of
686 the public employee committee may present the Secretary with its position on the waiver
687 request within 3 business days of receipt of the request.
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PART I ADMINISTRATION OF THE GOVERNMENT
(Chapters 1 through 182)

TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS

CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 3 Purchase of group life, accidental death, etc., insurance policies; reinsurance agreements

Section 3. Upon acceptance of this chapter as hereinafter provided, the appropriate public authority of the governmental unit shall negotiate with and purchase, on such terms as it deems to be in the best interest of the governmental unit and its employees, from one or more insurance companies, savings banks or non-profit hospital, medical, dental or other, service corporations, a policy or policies of group life and accidental death and dismemberment insurance covering employees, and group general or blanket insurance providing hospital, surgical, medical and dental benefits covering employees and their dependents as provided under section eleven and section eleven A if applicable and shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf and in the name of such governmental unit. Said policy, or policies, including policies purchased under authority of sections three A and sixteen, shall contain a requirement that the insurance company, savings bank, nonprofit hospital, medical, dental or other service corporations, other intermediary or health care organizations, shall furnish the governmental unit, or its designee, all nonconfidential claims without diagnosis on a form satisfactory to the governmental unit including, but not limited to, computer tape, disc or unlined paper reports. Said insurer may, pursuant to a contract between said insurer and said governmental unit, charge the governmental unit a reasonable fee to cover the costs of providing the nonconfidential claims in the form requested by the governmental unit. Prior to the purchase of said insurance, and execution of all such agreements or contracts within the limits established by said sections, the appropriate public authority shall consult with an advisory committee for the purpose of securing the written recommendations of a majority of the membership of said committee. Said committee shall consist of eight members as follows: seven persons to be duly elected or appointed to membership on such committee by organizations of the employees affected, and one person who shall be a retiree of a governmental unit who shall be duly appointed to membership on said committee by the appropriate public authority. If the appropriate public authority finds that the committee's recommendations in whole or in part cannot be included within the aforementioned agreements or contracts, at the written request of any member of said committee within thirty days from the effective date of the agreements or contracts, the appropriate public authority shall submit to said member, in writing, the reasons for the rejection of any or all of the recommendations and a copy shall be filed with the commission. The appropriate public authority may execute said agreements or contracts for a period not exceeding five years; provided, however, that the portion of the cost of the premium per month to be borne by the governmental unit shall not exceed the estimated monthly cost for which funds have been appropriated for the then current fiscal year. If a town or district having accepted the provisions of section ten accepts any other section of this chapter but fails to appropriate the funds necessary to implement said provisions, the selectmen, in the case of a town, or the prudential committee or district commissioner, in the case of a district, shall certify the cost to the town or district, as the case may be, in carrying out the provisions of this chapter to the board of assessors who shall include the amount so certified in the determination of the tax rate of that year. If a city accepts the provisions of this chapter as provided under section ten and as further provided under sections seven A and nine E, the annual budget shall include sums necessary to implement said provisions. Arrangements may be made with the carrier or carriers issuing such policy or policies purchased under this chapter to reinsure, by reinsurance agreement, under conditions approved by the appropriate public authority, portions of the total amount of such insurance with such other carriers as may elect to participate in such insurance.

For the purposes of this chapter, any non-profit hospital service corporation or non-profit medical corporation organized under chapter one hundred and seventy-six A or one hundred and seventy-six B and any dental service corporation organized under chapter one hundred and seventy-six E shall be and is hereby authorized to enter into a reinsurance agreement as herein provided in the same manner as any other insurance company.