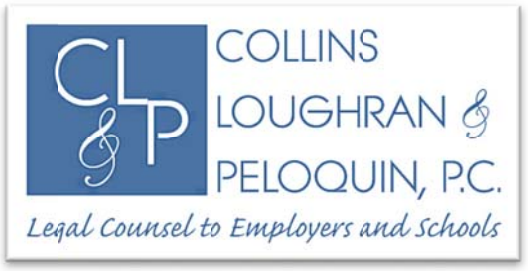
Municipal Health Reform in the FY 2012 Massachusetts Budget



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Introduction

Municipal health insurance reform in Massachusetts has been a hot topic in recent months, both within the Commonwealth and across the nation. But after a series of legislative amendments and months of heated debate, the Governor recently signed a compromise bill that ushers in a new era of municipal health insurance reform aimed at significantly reducing costs for cities and towns. To briefly summarize, once the executive votes to accept this statute, it provides communities with two ways to save money on health insurance costs: The community may (1) implement health insurance plan design changes at the local level, or (2) transfer its subscribers into the Group Insurance Commission ("GIC" or "Commission"). Section 21 lays out both the procedure for accepting the statute and the procedure that communities must follow each time it proposes plan design changes. Section 22 discusses the substantive rules for a community that wishes to implement its own design plan changes, while Section 23 concerns the transfer of subscribers into the Commission.

This review of the law does not simply provide a summary of the key changes, as there will be no shortage of such articles elsewhere. Rather, the goal here is to condense the convoluted language of the legislation into a concise, section-by-section description of the new law in user-friendly terms. If you wish to view the law in its entirety, it is available at St. 2011, c. 69, and will be codified in Chapter 32B. If you have any further questions about the new health insurance law and its potential effect on your community, please feel free to contact any of our attorneys.

SECTION 1, to be inserted at G.L. c. 32B, § 2

"Appropriate Public Authority" (APA) – in a city, the mayor; in a town, the selectmen; in a district, the governing board of the district.

"Commission" – the Group Insurance Commission, established under section 3 of chapter 32A.

"Savings" – the difference between (a) the town/city/district's total projected premium costs for health insurance benefits with changes made under the new sections of this chapter for the first 12 months after implementation and (b) the town/city/district's total projected premium costs without such changes for the same 12 month period.

SECTION 2, amending c. 32B, § 12 by inserting this paragraph at the end of the section:

If two or more governmental units have established a trust or joint purchase group, the Board may vote to implement changes to copayments, deductibles, tiered provider network copayments, and other cost-sharing plan design features that do not exceed those which an appropriate public authority ("APA") may offer under section 22; provide, however, that each governmental unit in the trust or group shall comply with the requirements set forth in section 21 before the changes can be made. Such changes shall be approved in accordance with section 21, as long as the changes to dollar amounts for copayments, deductibles, tiered provider network copayments, and other cost-sharing plan design features, do not exceed those permitted under section 22.

SECTION 3, to be inserted as new sections, at G.L. c. 32B, §§ 21-29

Section 21 – <u>Procedures for Implementing Insurance Plan Design Changes</u>

(a) Describes the method of electing to change health insurance benefits under sections 22 through 23. In a town, by vote of the board of selectmen; in a city with Plan D or E charter, by majority vote of city council and approval by the manager; in any other city, by majority vote of city council and approval by the mayor; in a regional school district by vote of district school committee.

(b) Prior to implementing changes, the APA must evaluate the savings that may be realized in the 12 months following implementation of the plan. The APA must then notify its Insurance Advisory Committee of the estimated savings. After that, the APA must give notice to each of its collective bargaining units and a retiree representative (the Public Employee Committee), of its intention to enter into negotiations to implement changes to health insurance benefits. Changes under sections 22 through 23 may also be implemented if the APA had previously established a Public Employee Committee. Notice to collective bargaining units shall be provided in the same manner as in section 19. It should detail the proposed changes, the APA's analysis and estimate of savings,

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) After the notice is given, the APA and the Public Employee Committee have 30 days to negotiate all aspects of the proposal. An agreement shall be approved by vote of the Public Employee Committee, with the retiree representative having 10% of the vote. If no agreement is reached, the matter shall be submitted to the Municipal Health Insurance Review Panel, which is comprised of three members (1 appointed by Public Employee Committee, 1 by the APA, and 1 by the Secretary of Administration and Finance).

(d) The Municipal Health Insurance Review Panel shall approve the APA's immediate implementation of proposed changes under section 22; provided, however, that any increases to plan design features have been made in accordance with section 22. The panel shall approve the APA's immediate implementation of proposed changes under section 23; provided, however, that the panel confirms that the anticipated savings would be at least 5% greater than the maximum possible savings under section 22. If the panel does not approve, the APA may submit a new proposal to Public Employee Committee for consideration and confirmation.

(e) Within 10 days, the Municipal Health Insurance Review Panel shall:

  (i.) confirm the APA's estimated savings through substantiating documentation (if the savings are deemed unsubstantiated, the panel may require new documents be submitted);

  (ii.) review the proposal submitted by the APA 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 APA that the proposal is sufficient to mitigate, moderate, or cap the impact of these changes for subscribers.

(f) The Municipal Health Insurance Review Panel may determine the proposal to be insufficient and may require additional savings be shared with subscribers (but not more than 25% of the estimated savings). The Panel may consider an alternative proposal submitted by the Public Employee Committee to mitigate, moderate, or cap the impact of these changes for subscribers. The Panel shall not impose any change to contribution ratios.

(g) The Panel's decision shall be binding on all parties.

(h) The Secretary of Administration and Finance shall promulgate regulations for the administrative procedures for negotiations with the Public Employee Committee and for the Municipal Health Insurance Review Panel. The Secretary of Administration and Finance shall also create guidelines for evaluating which subscribers meet the standard of being disproportionately affected.

Section 22 – <u>Insurance Plan Design Changes</u>

(a) The APA may include "copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than [those] offered by the Commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment." The APA may not include a plan design which seeks to achieve premium savings by offering a plan with reduced or selective network providers, unless the APA also offers a plan to all subscribers that does not contain a reduced or selective network or providers.

(b) The APA may increase dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features, but no greater than those offered by the Commission with the largest subscriber enrollment. Under section 21 (a), a community votes only once to opt in to this section. But every time a plan increase is proposed, the APA must go through the process under section 21 (b)-(h). Nothing in this section prohibits the APA from including even higher copayments, deductibles, etc. than those allowed by this section, but only after satisfying bargaining obligations under 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."

(d) "Nothing in this section shall relieve an APA 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 the APA implements plan design changes, it shall not increase the percentage contributed to health insurance premiums by retirees, surviving spouses, and their dependents until July 1, 2014. The percentages that were approved by the APA prior to and in effect on July 1, 2011 must remain in effect until July 1, 2014. If an APA had already approved a percentage increase before July 1, 2011, but it will not take effect until after July 1, 2011, such a rate may take effect upon approval of the Secretary of Administration and Finance after reviewing evidence that the APA actually approved the rate prior to July 1, 2011.

Section 23 – <u>GIC Transfer</u>

(a) The APA may elect to provide health coverage by transferring its subscribers to the Commission. Notice to the Commission must be provided by December 1, to take effect the following July 1. Once the transfer date becomes effective, the health insurance benefits are determined exclusively by the Commission and are not subject to collective bargaining--however, contribution ratios will still be subject to collective bargaining. The APA may withdraw from the Commission at 3 year intervals from the date of transfer. To withdraw, the APA shall provide notice by October 1, with the withdrawal to take effect the next July 1. Upon withdrawal, the town/city/district and the public employee unions shall return to governance of negotiations under chapter 150E. But the

town/city/district can later return coverage to the Commission after following the procedures of section 21 (b)-(h) for negotiating/arbitrating a mitigation agreement.

(b) Following transfer, the Commission shall provide group coverage, and the claim experience of those subscribers shall be maintained by the Commission in a single pool with state employee and retiree claim experiences.

(c) If, at the time of transfer to the Commission, the town/city/district (1) self-insures its group health plan under section 3A, and (2) has a deficit in the claims trust fund, and (3) the deficit is the attributable to a failure to accrue incurred, but not paid, claims, then the city/town/district may capitalize the deficit and amortize it over 10 years in 10 equal amounts.

The Commission shall, exclusively and not subject to collective bargaining, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments, and obligations (excluding contribution ratios). This includes: the manner and method of payment, schedule of benefits, eligibility requirements, and choice of health insurance carriers.

(d) The Commission shall negotiate and purchase health insurance for subscribers transferred under this section. The Commission must offer the same choice to those transferred as it does to state employees and retirees. The city's/town's/district's contributions are determined by this section and not by chapter 32A.

(e) A city/town/district that transfers its subscribers shall pay for all costs of its subscribers' coverage. The Commission shall determine the amount of premium which the city/town/district shall pay. If the city/town/district does not pay through any of the manners listed in this section, then the Commission may cancel coverage to the subscribers. If such cancellation occurs, the city/town/district must provide a plan that is the actuarial equivalent of the Commission plan until it can agree with the unions on replacement coverage.

(f) If there is a withdrawal, a retiree, spouse, or dependent enrolled in Medicare Part A shall be required to be insured by a Medicare extension plan. A retiree shall provide the city/town/district such information as is necessary to transfer to a Medicare extension plan. The city/town/district may also request proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare Part A and Part B coverage.

(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 relieves a city/town/district from providing health insurance to a subscriber to whom it has an obligation to provide coverage.

Section 24

The APA may provide health care flexible spending accounts to allow certain subscribers to set aside a portion of earnings to pay for qualified expenses.

Section 25
The APA may provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses.

Section 26
The APA shall conduct an enrollment audit not less than once every 2 years, in order to ensure that members are appropriately eligible for coverage.

Section 27
An insurance carrier, third party purchasing group, or administrator shall provide the governmental unit or public employee committee with its historical claims data within 45 days of such request, with all private information redacted.

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 a report delineating the dollar amount of copayments, deductibles, tiered provider network copayments and other design features in the non-Medicare plan with the largest subscriber enrollment, and the same in the Medicare extension plan. The Commission shall also provide information on its plans with the largest subscriber enrollment upon request of any APA or city/town/district.

SECTION 4

If subscribers are currently covered by a collective bargaining agreement or a section 19 agreement, an APA that implements changes pursuant to sections 22 and 23 shall delay any such changes to the dollar amounts of copayments, deductibles, or other cost-saving plan design features that are inconsistent with the collective bargaining agreement or the section 19 agreement. In that case, the implementations under sections 22 and 23 shall take effect when the term stated in the collective bargaining agreement or the section 19 agreement has ended.

SECTION 6

The Commission shall prescribe procedures to permit a city/town/district to transfer all subscribers for whom it provides health insurance to the Commission on or before *Date A* if it provides notice to the Commission that it is transferring subscribers under sections 19 or 23 on or before *Date B*.

DATE A (transfer date)	DATE B (notice provided by)
January 1, 2012	September 1, 2011
April 1, 2012	December 1, 2011
July 1, 2012	March 1, 2012

SECTION 7

A governmental unit transferring its subscribers to the Commission under section 23 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 PPO or an indemnity plan on the date of transfer to the Commission, then the governmental unit's initial contribution ratio shall be the ratio shall be the ration that it was contributing toward its PPO or indemnity plan for each collective bargaining unit on that date. Except as otherwise provided, contribution ratios shall remain subject to bargaining pursuant to chapters 32B and 150E.