

Highlights Of The 2011 Municipal Health Insurance Reform Legislation

PRESENTED BY:

Attorney Paul Mulkern
Milton, MA
(617) 696-7070

Provisions of 2012 Budget Bill and Chapter 69 of the Acts of 2011

Together these statutes substantially change
Chapter 32B:

- Repeal 1 section
- Strike-out and replace 1 section
- Amend 3 sections
- Add 9 new sections



Centerpiece Of The Law

New Sections 21, 22 and 23

Section 21

Sets out the procedures that a governmental unit must follow in order to make the changes allowed by Sections 22 and 23.

Section 22

Allows a governmental unit to include as part of its non-Medicare health plans:

- ▶ Co-payments, deductibles, tiered provider network co-payments, and other cost-sharing plan design features up to the dollar amounts of those same or similar features in the GIC's most-subscribed non-Medicare plan.

Section 22

- ▶ **Allows** a governmental unit to include in its Medicare plans:

Features comparable to those in the GIC Medicare benchmark plan



Section 22(b)

Allows: a governmental unit to include in its health plans cost-sharing features with

- ▶ higher dollar amounts than the GIC benchmark plan
- ▶ but only after satisfying any bargaining obligations

Section 22(c) states:

“The decision to accept and implement this section shall not be subject to bargaining pursuant to Chapter 150E or Section 19.”

Section 23

Allows a governmental unit to transfer its subscribers to the **GIC** provided:

- anticipated savings for the first 12 months of at least 5% more than maximum possible savings achievable through Section 22



Maximum Possible Savings

Regulations promulgated under Section 21 define “maximum possible savings” as the savings that would be realized for the first 12 months if the governmental unit implemented changes to its plan designs that equal the dollar amounts of the benchmark non-Medicare and Medicare plans.



REQUIRED NOTIFICATION

For years after Fiscal '12

- ▶ Notification to GLC by: December 1
- ▶ Transfer Effective Date: July 1

REQUIRED NOTIFICATION

For Fiscal '12

Notification to GLC by:

October 1, 2011

December 1, 2011

March 1, 2012

Transfer Effective Date:

On or before January 1, 2012

On or before April 1, 2012

On or before July 1, 2012

CONTRIBUTION RATIOS UPON **TRANSFER TO GIC**

- ▶ “unless otherwise agreed”
- ▶ “shall use current contribution ratios for each class of plan for each collective bargaining unit”
- ▶ If not offering both PPO and Indemnity ratio for whichever type plan it was offering
- ▶ Contribution ratios remain subject to bargaining pursuant to Chapters 32B and 150E



Delayed Implementation

- ▶ APA must delay implementation, for subscribers covered by provisions of a CBA, of any changes to cost-sharing features that are inconsistent with
- ▶ Dollar amounts of cost-sharing features
“Specifically included in the body of CBA”
 - Until initial term of CBA has ended.

Additional Notes on Delayed Implementation

- ▶ Delay in implementation until initial term of CBA ends applies to changes to plan design (Section 22) and to transfer to GIC (Section 23)
- ▶ But new GIC regulations
- ▶ Subscribers without CBA provisions may be transferred
- ▶ Delayed implementation for other subscribers at end of contract

Section 21

- ▶ Section 21 describes the procedures that governmental unit must follow to implement the changes provided at Sections 22 and 23.
- ▶ Technically, 1st step is to accept Section 21.

Acceptance is:

- ▶ Town – Board of Selectmen
- ▶ City with Plan D or E charter – majority vote of the city council and approval by manager
- ▶ In any other City – majority vote of the city council and approval by mayor
- ▶ County – County Commissioner
- ▶ Regional School District – Regional District School Committee
- ▶ In all other districts – vote of the registered voters of the district at a district meeting

Form of Vote:

“The [name of political subdivision] elects to engage in the process to change health insurance benefits under M.G.L. c. 32B, Sections 21 – 23.”

NOTICE of vote to bargaining units and RSCME:

- ▶ at least 2 calendar days prior to meeting

That notice must be sent by **certified mail, delivery confirmation and return receipt requested, or may be delivered by hand with certification of delivery** and a copy must be sent to the Secretary of A & F by e-mail. Either post office evidence of attempted delivery or return receipt shall be prima face evidence of time of receipt for certified mail.

Subsequent notices may be sent by certified mail if first notice reserves that right. However, if recipient does not provide e-mail address, must be sent

- a.) certified mail, or
- b.) delivery by hand

For recipients who provide e-mail address, delivery may be by

- a.) certified mail
- b.) delivery by hand
- c.) e-mail

- ▶ Leverage to negotiate changes in lieu of accepting Sections 21 - 23
- ▶ Traditional Chapter 150E bargaining would apply
- ▶ Changes negotiated pursuant to c.150E likely not feasible unless accepted by all collective bargaining units.
- ▶ Perhaps consider acceptance of Section 19
 - Changes could be accepted by majority weighted vote of PEC
 - No longer 70%



Steps UNDER Section 21

- ▶ Evaluate coverage and determine savings that changes would generate for first 12 months
- ▶ Notify Insurance Advisory Committee (IAC) of estimated savings. For detailed information required in NOTICE, see 801 CMR 52.03.
- ▶ If no IAC in existence, notify president of each collective bargaining unit (CBU) and designate retiree representative.
- ▶ Within 2 days of meeting with IAC, or 10 days after notice to IAC, whichever is sooner, provide 52.03 NOTICE to president of each CBU and to RSCME.
- ▶ Activate or establish Public Employee Committee (PEC) and provide with 52.03 information.

▶ **52.03 NOTICE:**

- ▶ Indicates type of CHANGE - whether (1) making changes to Plan Design or (2) Transferring Subscribers to GIC

1) If making changes to plan design, include the specific changes APA intends to make

2) If transferring to GIC, provide the expected migration of subscribers within the GIC plans

- ▶ Includes estimated savings to be generated. If transfer to GIC, savings must be based upon “maximum possible savings.”
- ▶ Includes APA’s proposal to mitigate impact of proposed changes

NOTE: 52.03 NOTICE
must include proposed allocation of
subscribers' share of savings

Statute directed A&F to “issue guidelines” to be
used by the APA and the PEC in evaluating
allocation of “savings” among subscribers



A few points to emphasize:

- ▶ If the APA intends to transfer subscribers to GIC, it shall include in its analysis its projection of migration within GIC plans
- ▶ Savings estimate shall not include:
 - savings resulting from transfer of Medicare-eligible retirees to Medicare under new Section 18A
- ▶ Savings estimate shall include savings due to changes to plan design of Medicare plans (or transfer to GIC Medicare plans)

Savings estimate where CBA sets specific dollars amounts for plan design features

- ▶ Calculation of estimated savings must include subscribers for whom implementation delayed
- ▶ However, eligibility of those subscribers for mitigation funds delayed until changes implemented for them
- ▶ Proportionate amount of mitigation funds reserved until changes implemented for those subscribers



The 30 - Day Negotiation Period

- ▶ Section 21(c) - The APA and the PEC “shall have not more than 30 days” from PEC’s receipt of NOTICE to negotiate all aspects of proposal
- ▶ 52.04(1) – period commences when each member of the PEC has received NOTICE
- ▶ 52.04(2) – negotiations may include all aspects of the APA’s proposal.
- ▶ “Parties are encouraged to negotiate in good faith”
- ▶ The APA may not implement changes during negotiations without the PEC agreement

The Agreement

- ▶ An AGREEMENT with the APA must be approved by a majority weighted vote of the PEC.
- ▶ (Retiree representative has 10% vote.)

Any Agreement between the APA and the PEC must be reduced to writing and include:

- ▶ The plan design changes agreed-to (or agreed-upon transfer to GIC)
- ▶ Process to notify subscribers of changes
- ▶ Timeframe for implementation of changes and mitigation plan
- ▶ Same information included in 52.03 NOTICE



- ▶ All subscribers shall be provided with at least 60 days' advance notice of changes prior to implementation
- ▶ **“Notice” is not effective until written agreement is executed or panel issues written decision**
- ▶ Agreement binding upon all subscribers and their representatives



Health Insurance Review Panel Formation

- ▶ The APA must notify Secretary within 3 business days after start of 30-day period
- ▶ Secretary provides the APA, the PEC and 2 Panel members with a list of 3 candidates for the PANEL Chair
- ▶ Secretary also provides parties with name of an Actuary to assist the PANEL in verifying savings calculations
- ▶ If no agreement, the APA notifies Secretary, who appoints one of the 3 candidates

EMPANELMENT OF PANEL

If the APA and the PEC are unable to reach agreement within 30 days:

- APA must submit to the Panel the “original proposal” that it made to the PEC.
- If proposal included introduction of limited network plan, must provide information listed at 52.05(2)
- The PEC shall submit to the PANEL alternate mitigation proposal and other information it wants the PANEL to consider

Panel Process:

At any time before the PANEL issues a decision, parties may agree in writing to terminate, or suspend the Panel process because they have

- reached an agreement,
- would like additional time to negotiate an agreement, or
- have mutually decided to return to collective bargaining under c. 150E or to resume negotiations under c. 32B, § 19

Panel's Responsibilities (Section 22)

- ▶ The Panel has 10 days to complete its required task once Panel members receive APA's proposal
- ▶ Determine within 10 days whether the increased dollar amounts for plan design features exceed the dollar amounts "for the same or most similar benefits" in the GIC benchmark plans
- ▶ If the increased amounts do not exceed the dollar amounts of the benchmark plan, the Panel "shall approve the APA's immediate implementation of the proposed changes" (but subject to the 60 days' notice to subscribers)

- ▶ Separate comparison done between (1) proposed increases to non-Medicare plans with the GIC non-Medicare benchmark and (2) proposed increases to Medicare plans and the GIC Medicare plan benchmark
- ▶ If the Panel does not approve implementation of the proposed changes (due to the conclusion that the APA's proposal exceeds allowed changes), the APA may submit new proposal to the PEC and restart the process



**Allowable Changes to Dollar
Amounts Where GIC
Benchmark Plan Tiers
Providers**

1) Many municipal plans **will not have** the same **tiering** of providers offered in the **GIC benchmark plans**.

The regulations appear to envision that if a governmental unit's plan has **no** tiering for a particular provider service and the GIC benchmark plan has a **3 tier co-pay** for that service, the governmental unit's plan will be permitted to include a co-pay for that service up to the dollar amount of the **2nd tier co-pay** in the of GIC plan.



For example, Tufts Navigator has 3 tiers for specialists, while Blue Cross does not tier those services.

**TUFTS
NAVIGATOR:**

TIER 1 - \$25

TIER 2 - \$35

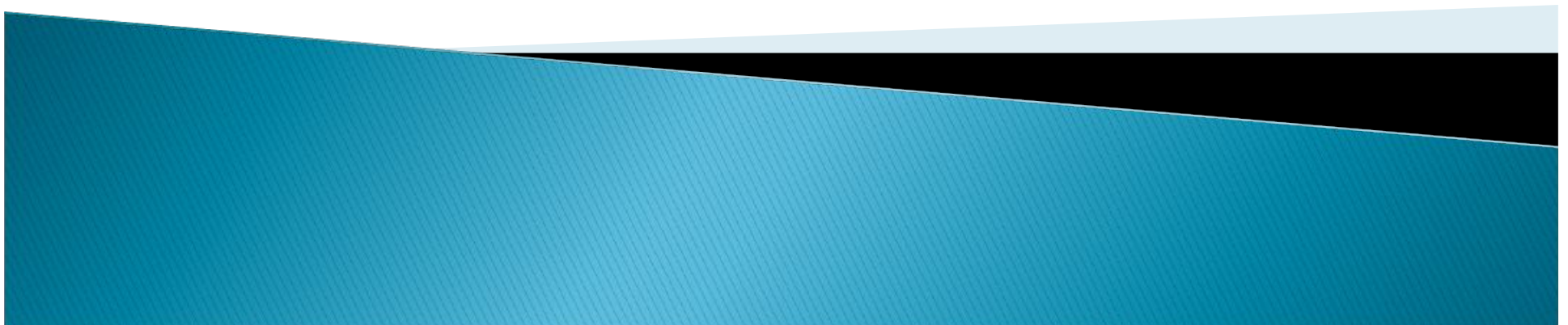
TIER 3 - \$45

A governmental unit that offers a Blue Cross plan could include up to a \$35 (Tier 2) co-pay for all specialists' services.

2) If the governmental unit's plan is tiered differently for a particular service than the GIC benchmark plan, the co-pays at each tier of the unit's plan may be set up to the same dollar amount as provided at that tier of the GIC benchmark plan.



3) If the governmental unit's plan has fewer tiers for a particular provider service than the GIC benchmark plan, the governmental unit's co-pay for its highest tier may be set up to the dollar amount of the GIC benchmark plan's Tier 3 co-pay and the unit's second-highest Tier may be set up to the dollar amount for the GIC benchmark's Tier 2 co-pay.



Estimated Savings

- ▶ Panel reviews APA's "estimated monetary savings" and consults with the GIC's actuary
- ▶ Within 10 days the panel determines whether it will confirm the APA's estimate
- ▶ If the **proposal** is to transfer subscribers to **GIC**, the panel will determine whether savings are **5% greater** than "maximum possible savings"



- ▶ If the Panel confirms 5% greater, the Panel shall approve transfer to GIC
- ▶ Alternatively, if the Panel finds savings unsubstantiated, it will require the APA to provide additional information or new savings estimate
- ▶ Presumably, the Panel will refuse to confirm a savings estimate until a proposal is submitted that can be substantiated.



MITIGATION

PROPOSAL

- The Panel must review the APA's original proposal to mitigate, moderate or cap the impact of the changes
- The Proposal should provide special consideration to retirees, low-income subscribers, and subscribers with high out-of-pocket health care costs who would otherwise be disproportionately affected
- The Panel may approve the mitigation proposal or the Panel may determine proposal insufficient

- If the Panel determines the proposal insufficient, it may require additional savings be shared with subscribers but in no event more than 25% of the savings.

“Savings” means the total premium savings that will be realized from the changes over 12 months. The premium reductions that subscribers realize as a result of changes cannot be credited against the 25% of savings.



For example, in a community that is estimated to realize \$1 million of savings over the first 12 months and that has an average contribution ratio of 75 - 25

Employer will realize \$750,000 in premium savings

Subscribers will realize \$250,000 in premium savings

Nevertheless, the maximum amount that the PANEL could allocate for mitigation would be 25% of \$1million or \$250,000

Moreover, that \$250,000 would be in addition to the \$250,000 that subscribers saved in reduced premiums

In determining the allocation of the savings the Panel may consider as vehicles:

- ▶ Health reimbursement arrangements,
- ▶ Wellness programs,
- ▶ Health care trust funds for emergency medical care or inpatient medical care,
- ▶ Out-of-pocket caps,
- ▶ Medicare Part B reimbursements, or
- ▶ Reimbursements for other qualified medical expenses

The statute is clear that the Panel “shall not impose any change to contribution ratios...”

The Panel's decision shall be binding upon all subscribers and their representatives and shall be considered the "written agreement" between the APA and the PEC.

All obligations of the APA relating to the mitigation proposal shall expire after the amount of savings designated by the Panel has been expended.



IMPLEMENTATION

Subject to the required 60 days' notice to subscribers, the APA must implement plan design changes not later than 90 days after a written agreement is signed or the Panel decision is issued unless the PEC agrees to deferral.

Governmental Units That Do Not Make Changes

A governmental unit that does not make changes is required to annually file a report with A&F that documents the savings that it could have realized if it had made changes pursuant to Sections 21 – 23



Withdrawal from GIC

A governmental unit whose subscribers are covered by the GIC may not utilize Sections 21 – 23 to make changes until it has followed the procedures for withdrawal provided in the GIC's regulations.

Joint Purchase Groups

The legislation contains 3 provisions dealing with joint purchase groups. Together, those provisions reflect that:

- ▶ The board of a joint purchase group may vote to implement changes to plan design features of the plans that it offers to its member governmental units in the same way that the APA of an individual governmental unit may implement changes to the plan design of its plans.
- ▶ Each member unit of the joint purchase group will be required to comply with the requirements of sub-sections (b) through (g) of Section 21 (dealing with mitigation) before the changes may be applied to its subscribers.
- ▶ However, as long as the requirements of Section 21 are satisfied by the member governmental unit, and the plan design changes implemented by the board do not exceed the GIC benchmarks, those changes shall be approved.

Miscellaneous

- ▶ The APA that wishes to utilize the process of Sections 21 and 22 for the second or subsequent time need not formally “accept” Section 21 but must follow the procedures outlined at Section 21 each time an increase to a plan design feature is proposed.
- ▶ New “savings” must be shared with employees and retirees each time a governmental unit subsequently elects to use Sections 21 and 22 to change plan design.
- ▶ If a governmental unit adopts plan design changes pursuant to Section 22 or transfers its subscribers to the GIC under Section 23, it may not increase the contribution rates for retirees, surviving spouses and their dependents from the percentage that was approved by the APA prior to and in effect on July 1, 2011, until July 1, 2014.
- ▶ However, a governmental unit that approved an increase in those percentages before July 1, 2011, that was effective on a date after July 1, 2011, will be permitted to apply those increases if it can provide the Secretary of Administration & Finance with documented evidence that the APA approved the increases prior to July 1, 2011.

Additional Provisions

Different sections of the two bills contain a number of changes to Chapter 32B, including:

1. Changes to the definitions found at Section 2.
2. The repeal of Section 18, the striking out of Section 18A (each of which had been local option sections) and the introduction of a new Section 18A, which makes the provisions of the former Section 18 mandatory for all governmental units. Governmental units that have not previously accepted Section 18 will now be required to transfer their Medicare-eligible retirees and their dependents out of “active” plans and into Medicare Supplement plans. It would appear from the legislation that this requirement is effective on July 1, 2011.

3. Changes to Section 19(a) that (1) affect the notice requirements for convening initial and subsequent meetings between the Appropriate Public Authority (APA) and the Public Employee Committee (PEC), and (2) remove the requirement for a 70% weighted vote for action by the PEC and allow the PEC to act on a “majority” weighted vote.
4. Allows the APA to provide health care flexible spending accounts.
5. Allows the APA to provide health reimbursement arrangements.
6. Requires the APA to conduct an enrollment audit not less than once every 2 years.
7. Requires an insurance carrier, third party purchasing group or administrator or the GIC to provide the governmental unit or its PEC, upon request, with the governmental unit’s historical claims data.

