REVIEW OF PROVISIONS OF 2012 BUDGET BILL

AND RELATED LEGISLATION

DEALING WITH MUNICIPAL HEALTH INSURANCE

From the Law Office of PAUL MULKERN July, 2011

This advisory provides a review of the provisions dealing with municipal health insurance that are included in outside sections of the 2012 budget bill and related legislation (Chapter 69 of the Acts of 2011).

Different sections of that legislation contain a number of changes to Chapter 32B of the General Laws. Among those changes are the following:

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 will be effective July 1, 2011.

3.) Changes to Section 19(a) that (1) effect 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.

The centerpiece of the legislation is a series of amendments to Chapter 32B that will allow governmental units (1) to change plan design without engaging in the traditional bargaining process or (2) to transfer subscribers to the Group Insurance Commission (GIC) without following the requirements of Section 19(e). Those changes are addressed in three new sections (Sections 21, 22 and 23) that are added to Chapter 32B.

Plan Design Changes

Section 22 permits a governmental unit, that has followed the procedures outlined in Section 21, to include in its non-Medicare health plans: "co-payments, 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 payments and other cost-sharing plan design features" offered by the GIC in the non-Medicare plan with the largest subscriber enrollment (hereafter referred to as the GIC non-Medicare "benchmark" plan).

Similarly, those sections allow the governmental unit to include in its Medicare plans, copayments, etc. that are no greater in dollar amount than the plan design features offered by the GIC in the Medicare plan with the largest subscriber enrollment (hereafter referred to as the Medicare "benchmark" plan).

The new Section 29 of Chapter 32B requires the GIC, each fiscal year, to place on its website a report delineating the dollar amount of the co-payments, deductibles, tiered provider network co-payments and other design features offered by the GIC in its benchmark non-Medicare and Medicare health plans.

Provided that the procedures outlined in Section 21 are followed, the decision to accept and implement changes will not be subject to bargaining pursuant to Chapter 150E or (for communities that have accepted it) Section 19.

Section 21 is a local option statute that must be accepted by the governmental unit. An 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. Among other things, this will require that new "savings" be shared with employees and retirees each time a governmental unit subsequently elects to use Sections 21 and 22 to change plan design.

Section 22 allows a governmental unit to offer plan design features that exceed the GIC benchmark, but only after the governmental unit has satisfied any bargaining obligations pursuant to chapter 150E and/or, with regard to a governmental unit that has previously accepted it, Section 19.

Section 22 further provides that if an APA includes a plan design feature:

> "which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network or (sic) providers,"

it must also offer a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

Finally, 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.

Transfer to the GIC

Section 23 permits a governmental unit that has followed the procedures outlined in Section 21 to transfer its subscribers to the GIC. Most notably, a governmental unit must be able to demonstrate that the anticipated savings that it would realize by transferring its subscribers to the GIC would be at least 5% greater than the maximum possible savings that it could realize by changes to plan design authorized by Section 22. While Section 23 will generally require notice to the GIC by December 1 of a governmental unit's intention to transfer its subscribers with an effective date (for the transfer) of the following July 1, Section 6 of Chapter 69 of the Acts of 2011 provides for "rolling " notice and effective dates during fiscal year 2012. More particularly, a governmental unit that provides notice to the GIC by September 1, 2011 will be permitted to transfer its subscribers to the GIC by January 1, 2012. Notice to the GIC by December 1, 2011 will allow transfer by April 1, 2012, while notice to the GIC by March 1, 2012 will allow transfer by July 1, 2012.

Section 23 essentially tracks the language of the existing Section 19(e). A notable exception involves contribution ratios. As with Section 19(e), Section 23 leaves the negotiation of contribution ratios to the collective bargaining process. Unlike Section 19(e), Section 23 does not empower the PEC to negotiate contribution ratios. Instead, Section 23 would seem to envision contribution ratios negotiated on a unit-by-unit basis. Also, unlike Section 19(e), Section 23 does not require that contribution ratios be the same for each bargaining unit. Section 19(e) intended that contribution ratios, prior to subscribers' transfer to the GIC, would be negotiated as part of the agreement between the APA and the PEC. As Section 23 does not require negotiation over the decision to transfer subscribers to the GIC, the Legislature needed to address what the initial contribution ratios would be upon the transfer of subscribers to the GIC. The Legislature addressed that issue in Section 7 of Chapter 69 of the Acts of 2011. That section provides that a governmental unit transferring its subscribers to the GIC "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, on the date of transfer to the GIC, the governmental unit is not offering both a PPO and an indemnity plan, the contribution ratio toward both the PPOs and the indemnity plans offered by the GIC shall be the ratio that the governmental unit was contributing toward its PPO or indemnity plan for each collective bargaining unit on that date.

Procedures Mandated by Section 21

Before instituting changes to plan design or transferring subscribers to the GIC, the APA must satisfy the requirements outlined at Section 21.

The APA must first evaluate its health insurance coverage and determine the estimated savings that it will realize during the first 12 months after the changes are implemented or after its subscribers are transferred to the GIC.

Next, the appropriate public authority must notify its insurance advisory committee (IAC) of the estimated savings and provide the IAC with any documentation that supports the estimate.

After discussion of the estimated savings with the IAC, the APA must provide notice to each of its bargaining units and to a retiree representative (designated by the Retired State, County and Municipal Association) of its intention to enter into negotiations to implement changes to health insurance benefits. The representative(s) of each bargaining unit and the retiree representative shall constitute the public employee committee (PEC).

The appropriate public authority (or the PEC) may convene the initial meeting of the committee upon 7 days' notice. Either the PEC or the APA may convene any subsequent meeting with notice of not less than 3 business days. The notice shall detail (1) the proposed changes, (2) the APA's analysis and estimate of anticipated savings from those changes, and (3) a proposal to mitigate, moderate or cap the impact of those changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected ("highly impacted subscribers").

The APA and the PEC shall have not more than 30 days from the PEC's receipt of notice to negotiate all aspects of the proposal.

An agreement between the APA and the PEC requires a majority vote of the PEC, except that the retiree representative shall have a 10% vote. (There is no indication in Section 21 that the vote is a weighted vote, as would be the case under Section 19. Perhaps the remaining 90% of the vote is split evenly between the bargaining units and a total affirmative vote of greater than 50% is required for approval of the agreement with the APA.)

If an agreement is not reached within 30 days, the matter is submitted to arbitration before a tri-partite panel, known as the Municipal Health Insurance Review Panel ("Panel"), that is comprised of one member appointed by the APA, one member appointed by the PEC, and one selected from a list of three candidates that is proposed by the Secretary of Administration and Finance ("the Secretary"). If the APA and the PEC cannot agree upon one of those three candidates within 3 days, the Secretary selects the final member.

The Panel is required to approve the "immediate implementation" of the plan design changes proposed by the APA, provided that those changes do not exceed the GIC benchmarks. If the Panel concludes that the proposed changes exceed the benchmarks, the APA may submit a new proposal to the PEC (presumably with the same 30 day period for negotiation.)

If the APA's proposal is to transfer subscribers to the GIC, the Panel must also approve the "immediate implementation" of that change provided that the Panel confirms that the

anticipated savings by that transfer would be at least 5% greater than the maximum possible savings that the governmental unit could realize by plan design changes authorized by Section 21. If the Panel does not approve the implementation of the transfer to the GIC (presumably because the APA could not demonstrate the required savings) the APA may submit a new proposal to the PEC for consideration.

With regard to mitigation, the Panel must, within 10 days of receiving the proposed changes (for plan design or for transfer to the GIC), take the following action.

1.) It must confirm the APA's estimated monetary savings provided that those savings are substantiated by the documentation that was provided to the IAC. If the Panel determines that the estimated savings are unsubstantiated the Panel may require the APA to submit a new estimate or provide additional information to substantiate the original estimate.

2.) It must review the proposal submitted by the APA to mitigate the impact of the changes on subscribers, including "highly impacted subscribers".

3.) It must concur with the APA's proposal or revise the proposal. If the Panel determines that the APA's proposal is insufficient and should be revised, the Panel may require that additional savings be shared with subscribers, particularly "highly impacted subscribers."

In reaching its decision, the Panel may consider an alternative proposal advanced by the PEC. In evaluating the distribution of savings to retirees, the Panel may consider any discrepancy between the governmental unit's contribution ratios for retirees as opposed to contributions for active employees. The Panel may require that the savings be distributed to subscribers in the form of:

- 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 others qualified medical expenses.

The statute states, unequivocally: "The Panel shall not impose any change to contribution ratios."

In no case may the Panel designate more than 25% of the initial 12 months' savings to subscribers. For purposes of these sections, "savings" is defined as the difference between the total projected premium costs for health insurance after the plan design changes or GIC transfer and the total projected premium costs without such changes for the same 12 month period. Thus, in determining "savings," both the Employer's and the

Employees' reductions in premium expenses are considered. The statute provides further that the Panel "shall not require a municipality to implement a proposal to mitigate … changes … which has a total multi-year cost that exceeds 25% of the estimated savings. All obligations on behalf of the 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 Secretary is directed to promulgate regulations "establishing administrative procedures" for the negotiations with the PEC and the Panel, and to issue guidelines to be utilized by the APA and the Panel in evaluating (1) which subscribers are disproportionately affected, (2) subscribers income and (3) subscribers out-of-pocket costs associated with health insurance benefits.

Limitations For CBAs that Include Dollar Amounts for Specific Plan Design Features

Section 4 of Chapter 69 of the Acts of 2011 requires that a governmental unit delay implementation, for any subscribers covered by a collective bargaining agreement (or Section 19 agreement) that is in effect on the date of implementation, of any changes to the dollar amounts of plan design features that are inconsistent with any dollar limits on such plan design features that are specifically included in the body of that collective bargaining agreement (or Section 19 agreement). The delay in implementation will last until the initial term stated in that collective bargaining agreement (or Section 19 agreement) has ended.

Joint Purchase Arrangements

The legislation contains three (3) references to joint purchase arrangements. Section 2 of Chapter 69 of the Acts of 2011 amends Section 12 of Chapter 32B by adding a new paragraph that provides as follows:

> "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 co-payments 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 co-payments, deductibles, tiered provide network co-payments 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."

The new Section 22 of Chapter 32B contains the following sentence at sub-section (c):

> "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."

Finally, the new Section 28 of Chapter 32B provides:

> "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."

Additional Health Insurance Provisions

The new Section 24 of Chapter 32B allows the APA to provide health care flexible spending accounts.

The new Section 25 of Chapter 32B allows the APA to provide health reimbursement arrangements.

The new Section 26 of Chapter 32B requires the APA to conduct an enrollment audit not less than once every 2 years.

The new Section 27 of Chapter 32B 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, subject to the redaction of personally identifying information.

Further Analysis

The above reflects a fairly straightforward review of the new legislation. As with any complex legislation, we can expect that a number of issues will develop dealing with its interpretation and application. These issues will be reviewed in future updates.