NEW REGULATIONS –
801 CMR 52.00 MUNICIPAL HEALTH INSURANCE

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52.01 General provisions

(1) Authority

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

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

(2) Definitions

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

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

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

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

"Insurance advisory committee" means an advisory committee established by a public authority as specified in M.G.L. c. 32B, §3.

"Limited provider network" means a reduced or selective provider network which is smaller than a carrier's general provider network and from which the carrier may choose to exclude from participation other providers who participate in the carrier's regional provider network or general provider network for the purpose of reducing premium costs but which offers the same benefits to those provided by the carrier's general provider network .

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

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

"Mitigation proposal" means 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.

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

"RSCME" means the Retired State, County and Municipal Employees Association, located at 11 Beacon Street, Suite 321, Boston, MA 02108.

"Review panel" means the municipal health insurance review panel 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 under the process set forth in 801 CMR 52.05(1).

"Secretary" means the Secretary of Administration and Finance.

"Tiered provider network" means a provider network in which a carrier assigns providers to different benefit tiers based on the carrier's assessment of a provider's cost efficiency and quality, and in which insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a provider's assigned benefit tiers.

(3) Notices.

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

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

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

(1) Advance notice of intent to vote.

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

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

(a) A political subdivision which has elected under M.G.L. c. 32B, §21(a) to change health insurance benefits under M.G.L. c. 32B, §§ 22-23, shall, before implementing any changes, evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of cost-sharing 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 its estimated savings. The notice shall include all the information required in section 52.03. In any political subdivision in which an insurance advisory committee has not already been established under M.G.L. c. 32B, §3, the appropriate public authority shall notify the president of each organization of employees affected and shall designate and notify a retiree of a governmental unit as a member of the committee. The insurance advisory committee, within 10 days after receiving this notice, shall meet with the appropriate public authority to discuss its estimated savings and any reports or other documentation requested by the insurance advisory committee before that meeting. If the committee does not meet within 10 days after receiving proper notice, it shall be considered to have discussed the matter with the appropriate public authority.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the appropriate public authority has indicated that it is considering transferring to the commission, it shall include in its analysis the estimates regarding plan choice that subscribers will make if transferred to the commission.

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

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

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

(d) the mitigation proposal, including:
(i) the estimate of the cost to fund the proposal and what percentage that cost is of the savings;
(ii) an explanation and rationale for the proposal;
(iii) the manner in which it affects various subscribers, including those disproportionately affected;
(iv) the manner of distribution or allocation of estimated savings from the proposal.

52.04 The 30-day negotiation period

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

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

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

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

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

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

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

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

52.05 Health insurance review panel

(1) Creation of the panel

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

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

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

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

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

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

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

52.06 The health insurance review panel review process

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

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

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

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

(a) Review the public authority's proposed changes

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

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

(2) Determine within 10 days whether the proposed increased dollar amounts for co-payments and deductibles proposed for a Medicare-extension plan under M.G.L. c. 32B, §22 exceed the dollar amounts of the plan design features for the same or most similar benefits offered by the commission for the Medicare-extension plan under section 10C and section 14 of M.G.L. c.32A with the largest subscriber enrollment. If such increased amounts do not exceed the dollar amounts of the plan design features for the same or most similar benefits offered by the commission for the Medicare-extension plan under section 4 of chapter 32A with the largest subscriber enrollment, the panel shall approve the appropriate public authority's immediate implementation of the proposed changes under M.G.L. c. 32B, § 22, subject to Section 52.07. Where the political subdivision is not proposing a tiered provider network, the determination shall be made by comparing the savings that would result if the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features in the political subdivision's plan equaled the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features under tier 2 of the commission's most-subscribed plan. Where the political subdivision currently is proposing a tiered provider network that is tiered differently from the tiering in the commission's most-subscribed plan, the determination shall be made by assuming the co-pays, deductibles and cost-sharing plan design features in each tier of the political subdivision's plan are equal to those in the same tier of the commission's most-subscribed plan, beginning with a comparison of the highest tier. If the political subdivision's plan has fewer tiers than the commission's plan, the political subdivision's highest tier shall be compared to the commission's tier 3, and the second highest tier to the commission's tier 2.

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

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

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

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

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

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

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

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

(1) Within 10 calendar days of receiving proposed changes under M.G.L. c. 32B, § 22 or § 23, the panel shall review the 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.

(2) The municipal health insurance review panel may approve the mitigation proposal, or it may determine the proposal to be insufficient and may require additional savings to be shared with 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, as determined by the panel. Premium reductions for subscribers that result from the plan design changes shall not be credited against the total amount determined to be required to fund the mitigation proposal. Any health reimbursement arrangements created under a mitigation proposal shall be administered by the appropriate public authority and shall not be the responsibility of the Commission.

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

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

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

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

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

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

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

(2) Any political subdivision which does not seek to make changes under M.G.L. c. 32B, §§ 21-23, including any political subdivision which votes against adopting G.L. c. 32B, §§ 21-23, shall file with the Executive Office for Administration and Finance a report by June 30, 2012 comparing existing plan design to the maximum possible savings available if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23. To maintain comprehensive records of political subdivisions that make use of this process, savings in health insurance costs that resulted, and potential savings not achieved, and to measure the extent to which political subdivisions took advantage of this process, each political subdivision shall file an annual report by June 30 of each year with the Secretary showing:
(i) the health insurance plans that it offers and the number of subscribers in each;
(ii) whether it made use of M.G.L. c. 32B, § 19 or §§ 21-23;
(iii) if it did not make use of these processes, the maximum possible savings available if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23.

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

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

of M.G.L. c. 32B, §§21-23. An appropriate public authority shall seek such waiver from the Secretary in writing, with a copy to the public employee committee. Any member of the public employee committee may present the Secretary with its position on the waiver request within 3 business days of receipt of the request.