The New Municipal Health Insurance Law

1. What is the new municipal health insurance law?

The new municipal health insurance law was enacted on July 11, 2011. For the last seven years, municipalities have pushed the Legislature for more authority to make unilateral changes in health insurance offered to employees and retirees to reduce premium costs. This effort continued to build over the last three years during the fiscal crisis. The MTA had successfully opposed any change to the bargaining rights of unions in this area, but it became clear this year that changes were inevitable, and the MTA and other public-sector unions developed a coalition to shape the legislation. The new law delivers savings while protecting the very sick and retirees through a streamlined bargaining process wherein municipalities are allowed to make limited plan design changes or to transfer subscribers to the Group Insurance Commission (GIC) for coverage. The details of the new legislation are described in this Q&A.

2. Does the law apply to every municipality?

Yes, but not every municipality will seek to make changes envisioned by the new law. Any municipality seeking to make changes under the new law must take a vote to do so. The decision to accept the new law and implementation of the allowed changes are not subject to bargaining pursuant to Chapter 150E or Section 19.

3. What changes are allowed under the new law?

a. Plan design. The new law allows *limited* changes in the various existing group health insurance plans. The plan design changes allowed are:

- Increases in co-payments, deductibles and increases in any tiered networks that currently exist in plans.
- Introduction of tiered networks within existing plans.

Additional Information:

- No increase can be more than the dollar amount of the co-payments, deductibles or tiered-network co-payments or deductibles that are in place in the GIC plan with the largest subscriber enrollment. The cap on co-payments and deductibles is determined by the dollar amounts paid by subscribers in the GIC non-Medicare plan with the largest subscriber enrollment (currently Tufts Navigator). The cap on increases in Medicare plans is linked to the dollar amount paid by subscribers in the GIC Medicare plan with the largest subscriber enrollment.

- Information about the current out-of-pocket costs in the GIC plans is available on the GIC website.

- Municipalities may bargain other plan design changes, change in carriers, change in plan administrators, introduction of limited networks, etc., through traditional collective bargaining under G.L. c. 150E, but may *not* implement those types of plan design changes under the new law *absent agreement of the municipal unions.* Those types of changes remain subject to G.L. c. 150E bargaining. In addition, should a municipality seek to implement changes that exceed the dollar amounts of the GIC plan with the largest enrollment, it must do so through Chapter 150E.

b. Transfer to the GIC. The new law also allows a municipality to transfer subscribers to the GIC for coverage if the municipality can establish that the savings to be achieved would be more than 5 percent higher than the savings that would be achieved through the plan design changes allowed under the law. If subscribers are transferred to the GIC, the municipality must provide notice to the GIC by the following dates to effectuate the transfer:

- Notice to the GIC by September 1, 2011, for transfer effective January 1, 2012.
- Notice to the GIC by December 1, 2011, for transfer effective April 1, 2012.
- Notice to the GIC by March 1, 2012, for transfer effective July 1, 2012.

4. What is the process that a municipality must follow to implement changes under the new law?

a. A vote must be taken. Any municipality seeking to make changes under this law has to take a vote to do so. Only one vote is required, so a municipality could elect to make some changes this fiscal year and then implement the process again in two or three years without a second vote.

b. The estimate of savings must be determined. The municipality must evaluate its existing health insurance plans and determine the savings to be realized after the first 12 months of implementation of the desired changes (either through plan design changes or transfer to the GIC). Because the municipality does not have unilateral authority to transfer subscribers to the GIC unless the savings to be achieved by the transfer are 5 percent higher than the amount that could be achieved by plan design changes, both amounts must be calculated and documented by the municipality.

c. Notice to IAC provided. The appropriate public authority next provides notice to its Insurance Advisory Committee (IAC). The notice must include the estimated savings amount and underlying reports and documentation of estimated savings as requested by the IAC.

d. Discussion with IAC required. The municipality then must discuss the estimated savings with the Insurance Advisory Committee.

e. **Notice to PEC provided.** The municipality must then provide notice to each of its collective bargaining units and a retiree representative (the Public Employee Committee, or PEC) of its intention to negotiate implementation of changes to health insurance. The notice shall detail:

- The proposed changes.
- The appropriate public authority's analysis and estimate of its anticipated savings from the changes.
- 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).

f. The PEC and municipality have 30 days from receipt of notice to negotiate. The PEC and municipality negotiate over the changes and the mitigation proposal. If no written agreement is reached to implement the changes, the matter is submitted to a municipal health insurance review panel (the panel).

g. The panel's authority and process. The panel shall, within 10 days of receipt of the proposed changes:

- **Approve implementation of changes that are allowed under the law.** The panel shall approve the immediate implementation of the changes in plan design provided that the changes are limited to those allowed under the new law. If the proposed changes involve the transfer of subscribers to the GIC, the panel shall approve the transfer if the savings to be achieved exceed 5 percent of what would have been achieved through plan design. If the panel does not approve implementation of the changes, the public authority may submit a new proposal to the PEC.
- **Confirm estimated savings substantiated by documentation.** If the municipality is not able to substantiate its estimate of the savings amount, the panel may require a new estimate or additional substantiating information.
- **Review the proposal to mitigate, moderate or cap the impact of changes on subscribers to determine if it is sufficient.** The panel may consider an alternative mitigation proposal from the PEC. The panel may require that additional funds from the savings be used as mitigation, but the municipality cannot be required to devote more than 25 percent of the savings to fund the mitigation plan.

Additional Information:

- **The panel cannot change contribution ratios.**
- **The decision of the panel is final and binding.**

5. How is the amount of "savings" available for a mitigation plan calculated?

The law defines "savings" as the difference between the total projected premium costs for health insurance with the changes (either plan design or transfer to the GIC) for the first
12 months after implementation and the projected premium costs for health insurance without such changes for the same 12-month-period.

6. What will the mitigation plans look like, and how long are they in place?

The mitigation plan will be determined by agreement between the PEC and the municipality. It may include options such as Health Reimbursement Accounts (HRAs), flexible savings accounts, caps on out-of-pocket costs, health care trust funds for emergency medical care or inpatient hospital care or wellness programs. The municipality's obligations under the mitigation plan end once the funds are exhausted. The new law does not preclude traditional bargaining under G.L. c. 150E to maintain an HRA, so even when the funds negotiated for an HRA under this process are exhausted, unions could seek to maintain HRAs through bargaining.

7. What about HRAs at the GIC for municipal employees?

The law specifically states that HRAs can be negotiated by municipalities for employees, retirees and other subscribers covered by plans through the GIC.

8. How does the PEC vote, and how is the retiree representative for the PEC chosen?

The majority rules on the PEC. Each union designates the individual to serve as its representative. Each representative's vote on the PEC is weighted based on the number of members in the representative's bargaining unit eligible for health insurance coverage as compared to the total number of eligible members of all of the bargaining units. There is also a retiree representative who has a 10 percent vote; this representative is designated by the Retired State, County and Municipal Employees Association.

9. How are members of the Municipal Health Insurance Review Panel determined, and how are they compensated?

The panel is made up of three members: one appointed by the PEC, one appointed by the public authority and one selected by the parties from a list of three names provided by the secretary of administration and finance. If there is no agreement from the names on the list within three business days, the secretary of administration and finance selects the final member. The fees are shared equally between the PEC and the public authority.

10. Is the new law applicable to a joint purchasing group?

Third-party purchasing groups are allowed to implement changes under the new law, but changes may not be applied to a governmental unit's subscribers, *unless and until* that governmental unit has complied with the process and procedure mandated by the new law.

11. What if the collective bargaining agreement addresses group health insurance benefits? Can these changes be implemented while a collective bargaining agreement is in effect? What about Section 19 agreements?

The law specifically prevents implementation of any changes (both plan design and transfer to the GIC) that are inconsistent with dollar limits on co-payments, deductibles or other plan design features *specifically included in the body of that collective bargaining agreement* until the initial term has ended. The collective bargaining agreement must be in effect on the date the changes are implemented. The same protection is in place for a Section 19 agreement.

12. Does the new law change the manner in which premium contributions are determined?

For unionized employees, the percentage of employees' premium contribution continues to be determined by bargaining pursuant to G.L. c. 150E. The new law does not change c. 150E in that regard.

And, retirees' premium rates are still determined in the same manner under G.L. c. 32B. MTA maintains that a municipality must bargain with the union before altering the future benefits of current bargaining unit members (including premium percentage to be paid upon retirement). However, any municipality that elects to make changes under the new law may *not* increase the percentage being paid by retirees from what was in effect on July 1, 2011, *until on or after July 1, 2014*.

13. When will the regulations be enacted by Administration and Finance to provide administrative procedures for negotiations and guidelines?

We expect that Administration and Finance will issue emergency regulations within two or three weeks. Emergency regulations are only in effect for 90 days, so during that time period, A&F will conduct the required public hearing, receive comment and adopt final regulations.

14. What is an enrollment audit?

The new law requires every political subdivision to conduct an enrollment audit not less than once every two years. The audit is mandated to ensure that subscribers participating in the municipal health insurance plans are in fact eligible for coverage. Therefore, the eligibility audit may focus on verification of employment, retirement, Medicare eligibility, dependent status (age. college enrollment, disabled, etc.) and marriage or remarriage, among other things.

15. Can a municipality force Medicare-eligible retirees into coverage under Medicare and a supplemental plan?

Yes. Coverage under Medicare plans saves municipalities money, and all Medicare-eligible retirees are now required to be covered by Medicare and a Medicare supplemental plan. That combination of coverage must be comparable to what is provided in the non-Medicare plans. In addition, the municipality must pay any premium penalty assessed by the federal government for Part B coverage at the time of transfer into the Medicare supplemental plans.

There is an important exception to Medicare being mandatory. If a retiree or spouse has a dependent who is not eligible to enroll in Medicare Part A at no cost and therefore *must continue to be covered under the existing family plan,* the retiree or spouse is not required to participate in Medicare.

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