

PUBLIC SECTOR CLIENT ALERT: A Summary of the New Massachusetts Municipal Health Care Law

On July 12, 2011, Governor Patrick signed “An Act Relative To Municipal Health Insurance” (Chapter 69 of the Acts of 2011), which is designed to ease health insurance plan design changes and the transfer of municipal health insurance subscribers to the state’s Group Insurance Commission (GIC). Following intense pressure from labor unions, there were some late amendments to the statute that resulted in more union participation in any proposed changes to existing municipal health insurance plans or transfer to the GIC. These amendments also resulted in a more extensive and complicated process for municipalities seeking relief from increasingly onerous health insurance costs.

The new law is a local-option statute that a municipality can choose to accept. In a town, a majority vote is required by the board of selectmen; in a city, by the city council and approval by the mayor or city manager; and in a regional school district, by a regional district school committee. After voting to accept the new health care law, the municipality must take the following steps to transfer insurance subscribers to the GIC or implement certain plan design changes.

1. Calculate the Estimated Savings for Both Plan Design and Move to GIC

Prior to implementing any changes, the municipality must evaluate its health insurance coverage and determine the saving that may be realized after the first 12 months of implementation of plan design changes or upon transfer of its subscribers to the GIC.

Even if the municipality is only interested in transferring subscribers to the GIC, the law requires municipalities to at least calculate the savings of possible plan design changes (e.g. increase copayments, deductibles, tiered provider network copayments, and other cost-sharing plan design features) that are no greater in dollar amount than those features in the most-subscribed GIC plan first because the anticipated savings of any proposed transfer to the GIC must be at least 5% greater than the maximum possible savings under a plan design change. (Currently, the most-subscribed GIC plan (non-Medicare) is Tufts Health Plan Navigator.)

2. Notify the Insurance Advisory Committee

The municipality must then notify its insurance advisory committee (IAC) of the estimated savings (for plan design and/or GIC) and provide any reports or other documentation of the estimated savings as requested by the IAC.

3. Negotiate with the Public Employee Committee for Up to 30 Days

The municipality then provides notice to the Public Employee Committee (PEC), consisting of a representative from each bargaining unit and one retiree representative designated by the Retired State, County, and Municipal Employees Association, of its intent to enter into negotiations to implement the proposed changes or transfer to the GIC. The retiree representative shall have 10% of

the vote with the remaining 90% divided among a weighted vote of the bargaining unit representatives.

The municipality must give notice to the PEC with details of the proposed changes and the municipality's analysis and estimate of its anticipated savings. The municipality must also prepare and provide to the PEC a proposal to mitigate, moderate, or cap the impact of the proposed changes (plan design or GIC) for subscribers, particularly retirees, low-income subscribers and subscribers with high out-of-pocket health care costs. This mitigation proposal can include providing a portion of the estimated first year cost savings (no more than 25%) to subscribers by, for example, establishing a health reimbursement account for qualified medical expenses, health care trust funds for emergency or in-patient medical care, or wellness programs. The municipality's obligation to mitigate ends once the funds are exhausted.

After proper notice has been provided to the PEC (with all requisite information), the municipality and the PEC have no more than 30 days to negotiate all aspects of the proposal. If there is a written agreement by the end of the 30-day period, the municipality would proceed to implement the plan as agreed.

4. If No Agreement, Proceed to Municipal Health Insurance Review Panel

If there is no agreement between the municipality and the PEC after 30 days, the matter shall be submitted to a Municipal Health Insurance Review Panel ("Panel"). The Panel has three (3) members – one member is appointed by the public authority, one appointed by the PEC, and one impartial member is selected from a list provided by the Secretary of Administration and Finance. If the parties cannot mutually select the third member after three business days, the Administration and Finance secretary will choose the third member. Any fee for the impartial member must be shared between the municipality and the PEC. The Panel's decision shall be binding upon the parties.

Within 10 days of receiving any proposed design changes or transfer to the GIC, the Panel shall confirm the municipality's estimated monetary savings due to the proposed design changes and/or move to GIC and ensure that the savings are substantiated by documentation provided by the municipality. If the Panel finds the estimated savings to be unsubstantiated, the Panel may require the municipality to provide additional information to substantiate the estimated savings or submit a new estimate.

The Panel shall approve the immediate implementation of proposed plan design changes provided that they are compliant with the requirements of the new law. The Panel shall approve the immediate implementation of transferring subscribers to the GIC provided that the anticipated savings of transferring to the GIC would be at least 5% greater than the maximum possible savings under a plan design change.

If the Panel does not approve any implementation of plan design changes or transfer to the GIC, then the municipality may submit a new proposal to the PEC for consideration and confirmation.

Also within 10 days, the Panel must review the municipality's proposal to mitigate, moderate or cap

the impact of these changes for subscribers. The Panel must either concur with the municipality that the mitigation proposal is sufficient to mitigate, moderate, or cap the impact of these changes to subscribers, including those who would be disproportionately affected, or revise the proposal as set forth in the next paragraph.

The Panel may determine the mitigation proposal to be insufficient and may require additional savings to be shared, especially to those who would be disproportionately affected; however, the multi-year cost of the mitigation shall be no more than 25% of the estimated first year's cost savings. The Panel may consider an alternative mitigation proposal, with supporting documentation, from the PEC.

5. Transferring Subscribers to The GIC

The law allows three opportunities to transfer subscribers in GIC during FY2012 – on January 1 (with notice given to the GIC by September 1, 2011), April 1 (notice by December 1, 2011), and July 1, 2012 (notice by March 1). The GIC must establish procedures for the transfer. After FY2012, enrollment takes place only once a year, on July 1, with notification by the previous December 1.

Once transferred, only the contribution ratios are subject to collective bargaining.

Other Features of the New Municipal Health Care Law

- ◆ Beyond the fairly extensive process that must be followed according to this new law, there are no additional bargaining obligations.
- ◆ Any plan design changes or transfer to the GIC will be delayed for subscribers covered by a collective bargaining agreement in effect at the time of implementation that has specific plan design features expressly included in a collective bargaining agreement that are inconsistent with the proposed changes or transfer to the GIC. In that case, employees subject to the agreement will transfer upon the expiration of the initial term of the agreement (i.e. rollover or evergreen clauses have no effect). If an existing collective bargaining agreement does not have specific language about health insurance design inconsistent with the proposed changes or transfer, then implementation will take place at the same time as all other subscribers.
- ◆ A municipality can propose plan design features that are more expensive for subscribers than most-subscribed GIC plan but such a proposal is subject to traditional bargaining obligations pursuant to G.L. c. 150E and c. 32B, §19.
- ◆ The first time a municipality implements plan design changes pursuant to the new law, the municipality shall not increase the retiree percentage (including surviving spouses and their dependents) from the percentage in effect on July 1, 2011 until July 1, 2014.
- ◆ Subscribers who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage.

- ◆ The municipality may include a plan design feature with a reduced or selective network of providers provided it also offer a plan to all subscribers that does not similarly reduce the provider network.
- ◆ The municipality can provide health care flexible spending accounts for subscribers to pay for qualified expenses.
- ◆ The municipality can also provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses.
- ◆ The law requires the GIC to annually post on its website a report delineating the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the GIC in its non-Medicare and Medicare plans with the most subscribers. The GIC must also provide information on its plan with the largest subscriber enrollment upon request of any municipality.
- ◆ Compared to the 2007 law that allowed municipalities to transfer subscribers to the GIC following coalition bargaining with the PEC, the municipal unions, in the form of the PEC, cannot effectively block a municipality from transferring subscribers to the GIC under this new law. Also, the PEC vote in this law is a simple majority, compared to 70% for the coalition bargaining in the 2007 law.
- ◆ The new law requires the Secretary of Administration and Finance to develop and promulgate regulations establishing administrative procedures for negotiations with both the PEC and the Municipal Health Insurance Review Panel.
- ◆ After at least three years in the GIC, a municipality can withdraw by providing notice to the GIC by October 1 of the year prior to withdrawal and following the GIC's requirements for withdrawal. Withdrawal will be effective as of July 1.
- ◆ The law requires municipalities to conduct an enrollment audit every two years to ensure that subscribers are still eligible for coverage.

James M. Pender is an attorney with Morgan, Brown & Joy, LLP. Jim may be reached at 617-523-6666 or at jpender@morganbrown.com. Morgan, Brown & Joy, LLP focuses exclusively on representing employers in employment and labor matters.

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