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Municipal Client Advisory
July 2011

Governor Patrick Signs Emergency Law That Significantly Reforms Municipal Health Care

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On July 12, 2011, Governor Patrick signed "An Act Relative to Municipal Health Insurance" (H. 3580) into law. Originally part of the FY 2012 budget, significant reforms to the municipal health insurance system were proposed and adopted as separate emergency legislation. These reforms significantly loosen some of the strictures of collective bargaining, giving municipalities and other governmental entities[1] more flexibility to reform their health insurance benefits. Under this new legislation, municipalities will now have an increased ability to transfer employees to the state's Group Insurance Commission ("GIC"), reform their existing health insurance plans, and transfer members to Medicare, which may result in significant savings in many communities. However, as will become clear through this advisory, this reform requires several significant steps that may lessen the chance for savings to be realized in FY 2012.

❖ Traditional Status of Collective Bargaining in Municipal Health Care

In the past, the complicated and highly restrictive provisions of Chapter 32B, when combined with the stringent bargaining obligations imposed on public employers by Chapter 150E, have made it extremely difficult for municipalities to make changes to group medical insurance plans in order to achieve meaningful cost savings. Even a past effort by the Legislature, through changes to Chapter 32B, §19, to ease the way for municipalities to join the state's GIC, has not succeeded, largely because employee bargaining units have been able to wield a virtual veto over such decisions under the existing §19 language.[2]

[1] As is discussed, this reform affects various forms of local governments, districts, etc. For the convenience of the reader, all such "appropriate public authorities," as described in M.G.L. c. 32B, §2, will be referred to as "municipalities."

[2] Under §19, the public employee committee ("PEC"), a collective bargaining body composed of representatives from each collective bargaining unit and a retiree, must consent, via a 70% vote, before a municipality can make changes to its health insurance through this section.

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❖ The Final Municipal Health Insurance Reform[3]

Despite Governor Patrick's original proposal that the reform be mandatory, this reform must be adopted by the "appropriate public authority" in order to be implemented. For example, in a city, this requires adoption by the mayor, and in a town, this requires a vote of the Board of Selectmen.[4] If the municipality adopts this reform, it first must notify and engage in discussion with its "Insurance Advisory Committee," as established under M.G.L. c. 32B, §3, of its intentions to reform its health insurance, the estimated savings, and provide documentation relative to the savings and proposed changes.

No plan, whether a change in plan design or a proposed transfer to the GIC, can have co-pays, deductibles, tiered network co-payments, or other plan features that exceed the dollar amounts in the most subscribed-to plan in the GIC. Savings will be calculated as the difference between the total projected costs to the municipality under its existing plan for a twelve month period, and the total projected costs under the proposed plan for that same twelve month period.

After "discussion" with the Insurance Advisory Committee, the municipality then must provide notice to a public employee committee ("PEC") composed of a representative from each collective bargaining unit and a retiree representative chosen by the Retired State, County, and Municipal Employees Association.[5] The notice to the PEC must contain (1) a detailed account of the proposed changes, (2) the municipality's analysis and estimate of its proposed savings, and (3) the proposal to "mitigate, moderate or cap" the impact of these changes on low income subscribers or subscribers with high out-of-pocket costs

[3] This alert is intended only as a brief overview of this reform and is by no means exhaustive. The reform contains some very complicated statutory changes that warrant closer review and discussion than that attempted in this alert.

[4] This is not an exhaustive list. M.G.L. c. 32B, §2 contains a list of "appropriate public authorities" for each type of governmental body.

[5] The language of the legislation does not expressly state that each bargaining unit will designate a representative. This silence is strange considering that both the House and Senate versions of the proposed reform outlined the PEC membership in detail, specifying one representative from each collective bargaining unit, akin to the structure currently in place under §19. Municipalities which have already accepted M.G.L. c. 32B, §19, and formed a PEC according to those guidelines, may continue to negotiate with that group. However, for municipalities who have not yet formed a PEC, the exact composition of such group may be the subject of regulations that are to be promulgated by the Secretary of Administration and Finance under the reform amendments.

through cost sharing techniques, such as using a portion of first year savings for health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care, out-of-pocket caps, or Medicare Part B reimbursements for other qualified medical expenses.

The municipality has 30 days to reach an agreement with the PEC regarding the proposal. The final proposal must be approved by a majority vote of the PEC.[6] If no agreement is reached, a three member panel (referred to as the "municipal health insurance review panel") will be established. The panel members must include: one member appointed by the PEC, one member appointed by the "appropriate public authority," and one person chosen by those two parties from a list of three neutral persons provided by the Secretary of Administration and Finance. If the two parties cannot agree on the third representative within three business days, the Secretary will choose.

The panel then has 10 days to accomplish the following tasks: (1) confirm the municipality's estimated monetary savings and ensure they are well documented, (2) review the proposal to mitigate impact, and (3) concur that the plan to mitigate is sufficient. If the mitigation proposal is found to be insufficient, the panel can require the diversion of additional first year savings (up to a total of 25%) to offset costs. Once the mitigation funds (which are derived from first year savings only) are expended, all such obligations on the part of the municipality expire.

If the proposal does not achieve these three benchmarks, the panel will reject the proposal, and the municipality must begin the process anew. The panel cannot approve a transfer to the GIC unless the projected savings are 5% more than what would be achieved through the maximum possible increases in copayments, deductibles, and other cost saving changes that might be made to the existing health insurance plan. The panel's decision will be binding on all the parties. The Secretary of Administration and Finance will promulgate guidelines and rules for this process.

This reform requires a mandatory Medicare transfer for all eligible subscribers. Any proposed plan that would raise co-pays or deductibles higher than the most subscribed-to GIC plan is reserved for collective bargaining. Additionally, contribution rates for retirees, surviving spouses, and their dependents shall not be increased before July 1, 2014, unless an increase was approved before July 1, 2011.

[6] The presumption is that all PEC members will have an equal vote, except the retiree representative, who will have a 10% vote. The language of the reform legislation implies a movement away from the weighted voting that currently occurs under §19, but this too may require clarification by the Secretary of Administration and Finance.

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Regional and joint purchasing groups are allowed to establish a common plan design structure, although participating communities must each go through the described steps above to notify unions and retirees of the estimated savings, engage in the 30-day negotiation process, and fulfil the 10-day review panel process (if necessary) regarding the plan design changes and structuring the mitigation plan.

After a municipality completes the process, the plan design changes can be implemented immediately. The only exception to this rule concerns existing collective bargaining and §19 agreements that specifically set forth the dollar limits on co-pays, deductibles or other cost-sharing plan design features in the body of the agreement. For these agreements, no changes can occur under this reform until the initial term of the agreement has expired. The exact language of the reform is as follows:

> "Notwithstanding any general or special law to the contrary, an appropriate public authority that implements changes to health insurance benefits pursuant to sections 22 and 23 of chapter 32B of the General Laws shall delay implementation of such changes, as to those subscribers covered by a collective bargaining agreement or section 19 agreement that is in effect on the date of implementation of such changes, of any changes to the dollar amounts of copayments, deductibles or other cost-sharing plan design features that are inconsistent with any dollar limits on copayments, deductibles or other cost-sharing plan design features that are specifically included in the body of that collective bargaining agreement or section 19 agreement, until the initial term stated in that collective bargaining agreement or section 19 agreement has ended." (Underlining supplied).

For FY 2012, the reform plan will give municipalities three opportunities to transfer subscribers to the GIC – on January 1, April 1 and July 1 – after a four month notification to the GIC. After FY 2012, enrolment in the GIC is permitted each July 1, with notification by the previous December 1. Premium contribution ratios remain subject to collective bargaining and, unless otherwise agreed, must remain the same upon transfer of subscribers to the GIC.

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If you have any questions about this issue, or are interested in discussing these changes further, please contact the attorney responsible for your account, or call (617) 479-5000.

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