801 CMR 52.00: MUNICIPAL HEALTH INSURANCE

Section

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52.01: General Provisions

(1) Authority.

(a) 801 CMR 52.00 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 through 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 through 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 three 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

47 or general provider network for the purpose of reducing premium costs but which offers the
48 same benefits to those provided by the carrier's general provider network.
49
50 Maximum Possible Savings is used to determine whether a proposal to transfer subscribers
51 to the Commission would achieve at least 5% greater savings than the maximum possible
52 savings that would be attained by plan design changes authorized under M.G.L. c. 32B, § 22
53 and means the savings that would be realized for the first 12 months if a political
54 subdivision were to provide health insurance coverage to its subscribers by implementing
55 changes to health insurance benefits that equal the dollar amounts of the most-subscribed
56 plan's design features for the same or most similar benefits offered by the commission for a
57 non-Medicare plan under M.G.L. c. 32A, § 4 and for a Medicare-extension plan under
58 M.G.L. c. 32A, §§ 10C and 14. Where the political subdivision currently does not offer a
59 tiered provider network, the maximum possible savings shall be calculated by comparing
60 the savings that would result if the dollar amounts of the co-pays, deductibles and other
61 cost-sharing plan design features in the political subdivision's plan equaled the dollar
62 amounts of the co-pays, deductibles and other cost-sharing plan design features under tier 2
63 of the commission's most-subscribed plan. Where the political subdivision currently offers
64 a tiered provider network that is tiered differently from the tiering in the commission's
65 most-subscribed plan, the maximum possible savings shall be calculated by assuming the
66 co-pays, deductibles and cost-sharing plan design features in each tier of the political
67 subdivision's plan are equal to those in the same tier of the commission's most-subscribed
68 plan, beginning with a comparison of the highest tier. If the political subdivision's plan has
69 fewer tiers than the commission's plan, the political subdivision's highest tier shall be
70 compared to the commission's tier 3, and the second highest tier to the commission's tier 2.
71
72 Mitigation Proposal means a proposal to mitigate, moderate or cap the impact of these
73 changes for subscribers, including retirees, low income subscribers and subscribers with
74 high out-of-pocket health care costs, who would otherwise be disproportionately affected.
75
76 Public Employee Committee means the committee established under M.G.L. c. 32B, § 19 or
77 21. If a public employee committee has not been established under M.G.L. c. 32B, § 19, a
78 public employee committee shall be established exclusively to negotiate changes under
79 M.G.L. c. 32B, §§ 21 through 23, and shall be established in the same form and with the
80 same percent votes as prescribed in M.G.L. c. 32B, § 19(a), fifth paragraph. A public
81 employee committee established under M.G.L. c. 32B, § 21 exclusively to negotiate
82 changes under M.G.L. c. 32B, §§ 21 through 23 shall be considered dissolved upon
83 completion of the process described in M.G.L. c. 32B, §§ 21 through 23.
84
85 RSCME means the Retired State, County and Municipal Employees Association, located at
86 11 Beacon Street, Suite 321, Boston, MA 02108.
87
88 Review Panel means the municipal health insurance review panel comprised of three
89 members, one of whom shall be appointed by the public employee committee, one of whom
90 shall be appointed by the public authority and one of whom shall be selected under the
91 process set forth in 801 CMR 52.05(1).
92

93 Secretary means the Secretary of Administration and Finance.
94
95 Tiered Provider Network means a provider network in which a carrier assigns providers to
96 different benefit tiers based on the carrier's assessment of a provider's cost efficiency and
97 quality, and in which insureds pay the cost-sharing (copayment, coinsurance or deductible)
98 associated with a provider's assigned benefit tiers.
99
100 (3) Notices.
101 (a) The advance notice of intent to vote sent by an appropriate public authority under
102 801 CMR 52.02(1) shall be sent:
103 1. by certified mail, delivery confirmation and return receipt requested; or
104 2. delivered by hand with a certification of delivery signed by the deliverer, and a
105 copy shall be sent to the Secretary. If the notice is sent by certified mail, either post
106 office evidence of attempted delivery or return receipts shall be *prima facie* evidence
107 of the time of receipt. The appropriate public authority may include in this notice a
108 statement of its intent to provide further notices by email, along with a requirement
109 that each recipient of the notice provide an email address for future notices. If any
110 recipient of this notice does not provide an email address, the appropriate public
111 authority shall provide notice to that recipient by:
112 a. certified mail, delivery confirmation and return receipt requested; or
113 b. delivered by hand with a certification of delivery signed by the deliverer.
114 (b) Additional notices may be sent by any of the following three methods:
115 1. by certified mail, delivery confirmation and return receipt requested;
116 2. delivered by hand with a certification of delivery signed by the deliverer; or
117 3. by email address if a requirement for email addresses was included in notice sent
118 under 801 CMR 52.01(3)(a). Any notices sent by email will be presumed received
119 unless the email is returned as undeliverable within 24 hours of sending. Notices
120 sent to subscribers under 801 CMR 52.07 may be sent by regular mail and are not
121 subject to the requirements of 801 CMR 52.01(3)(b).
122
123 (c) A copy of all notices shall be sent to the Secretary electronically at:
124 MunicipalHealth@state.ma.us.
125 (d) Notices sent by the Secretary may be sent by regular mail or by any of the methods
126 specified in 801 CMR 52.01(3)(b).
127
128 52.02: The Vote by a Political Subdivision to Implement Changes in Group Health Insurance Benefits
129 Under
130 M.G.L. c. 32B, §§ 21 through 23
131
132 (1) Advance Notice of Intent to Vote. At least two calendar days in advance of any vote
133 electing to change group health insurance under the process authorized by M.G.L. c. 32B,
134 §§ 21 through 23, the appropriate public authority shall send a notice to each collective
135 bargaining unit to which the authority provides health insurance benefits and to the Retired
136 State, County Municipal Employees Association (RSCME) that the political subdivision
137 intends to vote on whether to implement the process. The vote of the political subdivision
138 under M.G.L. c. 32B, § 21(a) may be in the following form: "The [name of political

139 subdivision] elects to engage in the process to change health insurance benefits under
140 M.G.L. c. 32B, §§ 21 through 23."
141
142 (2) Notice of Vote, Request for Name and Contact Information for Public Employee
143 Committee Representatives, and Number of Eligible Unit Members.
144 (a) A political subdivision which has elected under M.G.L. c. 32B, § 21(a) to change
145 health insurance benefits under M.G.L. c. 32B, §§ 22 through 23, shall, before
146 implementing any changes, evaluate its health insurance coverage and determine the
147 savings that may be realized after the first 12 months of implementation of cost-sharing
148 plan design changes or upon transfer of its subscribers to the commission. The
149 appropriate public authority shall then notify its insurance advisory committee, or such
150 committee's regional or district equivalent, of its estimated savings. The notice shall
151 include all the information required in 801 CMR 52.03. In any political subdivision in
152 which an insurance advisory committee has not already been established under M.G.L.
153 c. 32B, § 3, the appropriate public authority shall notify the president of each
154 organization of employees affected and shall designate and notify a retiree of a
155 governmental unit as a member of the committee. The insurance advisory committee,
156 within ten days after receiving this notice, shall meet with the appropriate public
157 authority to discuss its estimated savings and any reports or other documentation
158 requested by the insurance advisory committee before that meeting. If the committee
159 does not meet within ten days after receiving proper notice, it shall be considered to
160 have discussed the matter with the appropriate public authority.
161 (b) Not later than two business days after the insurance advisory committee meets with
162 the appropriate public authority or ten days after the insurance advisory committee
163 receives notice from the appropriate public authority, whichever occurs first, a political
164 subdivision which has elected under M.G.L. c. 32B, § 21(a) to make changes under
165 M.G.L. c. 32B, § 22 or 23 shall, provide a notice of its decision, in writing, to the
166 president or designee of each collective bargaining unit and to the RSCME and shall
167 include the number of employees eligible for health insurance under M.G.L. c. 32B
168 employed in each bargaining unit of the political subdivision.
169 (c) In any political subdivision which has not previously formed a public employee
170 committee under M.G.L. c. 32B, § 19, the notice shall request that each of the collective
171 bargaining units and the RSCME provide the name, address, phone number, and email
172 address of its designated public employee committee representative.
173 (d) Where a public employee committee already exists under M.G.L. c. 32B, § 19,
174 each collective bargaining unit and RSCME shall, within two business days of receipt of
175 notice under 801 CMR 52.02(2)(d), provide the appropriate public authority with the
176 name, address, phone number and email address of its designated public employee
177 committee representative. If no public employee committee exists at the time of receipt
178 of the notice, each collective bargaining unit and RSCME shall designate a
179 representative to a public employee committee exclusively to negotiate changes under
180 M.G.L. c. 32B, §§ 21 through 23 and provide the appropriate public authority with the
181 name, address, phone number and email address of its designated public employee
182 committee representative within five business days after receipt of notice under 801
183 CMR 52.02(3). If no public employee committee exists at the time of receipt of notice
184 from the political subdivision and the appropriate public authority has not received this

185 information from a collective bargaining unit or RSCME within five business days, the
186 collective bargaining unit's principal officer shall be the unit's representative on the
187 public employee committee, the president of the RSCME shall be its representative on
188 the public employee committee, and the appropriate public authority shall send the
189 notice specified under 801 CMR 52.03 to the collective bargaining unit's principal
190 officer and to RSCME's president.
191
192 52.03: The Implementation Notice
193
194 The appropriate public authority shall give the written notice required in M.G.L. c. 32B,
195 § 21(b) to the insurance advisory committee in accordance with 801 CMR 52.02(2)(a) and,
196 not later than two business days following the appropriate public authority's receipt of
197 notice of the representatives of the public employee committee under 801 CMR 52.02(2)(d),
198 to each public employee committee representative identified by the collective bargaining
199 units and the RSCME. The notice shall include the following information:
200 (a) the proposed changes to the political subdivision's health insurance benefits,
201 including:
202 1. a description of the political subdivision's current health insurance plans and
203 each plan's co-pays, deductibles and other cost-sharing plan design features,
204 enrollment (broken out by enrollment in individual, individual plus one, and family
205 plans), annual premium total cost, and percentage of premium total cost paid by
206 political subdivision;
207 2. a description of the proposed changes, including:
208 a. the earliest practical date for implementing the changes under law;
209 b. each plan to be offered, and the projected enrollment under each plan,
210 including continued projected enrollment for subscribers covered by existing
211 collective bargaining agreements that specify plan design features; retirees
212 enrolled and being transferred for the first time to Medicare under M.G.L. c.
213 32B, § 18A and Medicare supplemental health insurance plans; and subscribers
214 moved to the new, proposed insurance plans; and
215 c. the proposed dollar amounts for each plan's co-pays, deductibles and other
216 cost-sharing plan design features. A proposal shall not include a health benefit
217 plan design feature which seeks to achieve premium savings by offering a
218 limited network of providers unless the appropriate public authority also offers a
219 health benefit plan to all subscribers that does not contain a limited network of
220 providers.
221 (b) the co-payments, deductibles, tiered provider network co-payments and other
222 cost-sharing plan design features for the same or most similar benefits of the
223 non-Medicare plan and the co-payments, deductibles, and other cost-sharing plan design
224 features for the same or most similar benefits of the Medicare-extension plan with the
225 largest subscriber enrollment offered by the Commission, as provided by the
226 Commission under M.G.L. c. 32B, § 28;
227 (c) the appropriate public authority's estimate of anticipated savings of such changes
228 and the supporting information and analysis, including but not limited to:
229 1. the total projected premium costs and enrollment of plans under the existing
230 coverage for the first 12-month period in which the appropriate public authority

231 seeks to make changes as if no such changes were made,
232 2. the anticipated total projected premium costs of plans, including plans with the
233 proposed changes, and anticipated enrollment for the same 12-month period,
234 3. the analysis that the appropriate public authority has to support its estimate of
235 savings and the projected premium costs which may include quotes or bids from any
236 insurance plan, third party administrator or insurance broker regarding the total
237 premium cost of such plans with and without the proposed changes; demographic
238 data regarding the number of employees, the number of subscribers, the number of
239 subscribers enrolled in non-Medicare plans (by coverage - family or individual) and
240 Medicare-extension plans; any data regarding out-of-pocket costs paid by
241 subscribers; and any other factors relied upon by the appropriate public authority,
242 including any information provided by an actuary or other consultant in developing
243 the savings estimate.
244 If the appropriate public authority has indicated that it is considering transferring to
245 the commission, it shall include in its analysis the estimates regarding plan choice
246 that subscribers will make if transferred to the commission.
247
248 The savings estimate shall not take into account: savings resulting from transferring
249 eligible retirees to Medicare under M.G.L. c. 32B, § 18A, but the savings estimate shall
250 include savings due to proposed increases in dollar amounts for co-pays and deductibles
251 for Medicare-extension plans under M.G.L. c. 32B, § 22 or the savings resulting from
252 the transfer to Commission's medicare extension plans under M.G.L. c. 32B, § 23.
253 The savings estimate shall be calculated based on the number of subscribers who
254 will be covered under the proposed plans, including subscribers covered by existing
255 collective bargaining agreements for whom implementation of the proposed changes
256 would be delayed under St. 2011, c. 69, § 4. The appropriate public authority shall
257 allocate funds to the mitigation plan in proportion to the number of total subscribers
258 who will be covered under the proposed plan, with additional funds allocated when the
259 plan changes are implemented for additional subscribers. Subscribers will not be
260 eligible for mitigation funds before they are transferred to the new plans.
261 If the proposed change involves a transfer of health insurance coverage of
262 subscribers to the commission, the savings estimate shall be based on a determination of
263 maximum possible savings.
264 (d) the mitigation proposal, including:
265 1. the estimate of the cost to fund the proposal and what percentage that cost is of
266 the savings;
267 2. an explanation and rationale for the proposal;
268 3. the manner in which it affects various subscribers, including those
269 disproportionately affected;
270 4. the manner of distribution or allocation of estimated savings from the proposal.
271
272 52.04: The 30-day Negotiation Period
273
274 (1) The 30 (calendar) day negotiation period shall commence when each member of the
275 public employee committee has received the implementation notice, with the information
276 required under 801 CMR 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 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 801 CMR 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 three 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 801 CMR 52.04(5) or a written decision of the review panel under 801 CMR 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 805 CMR 8.00: *Municipal Health Coverage* 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 by email within three 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,

323 and the name and contact information of the public authority's representative for the
324 health insurance review panel. The appropriate public authority shall provide each
325 member of the public employee committee with a copy of the notice to the Secretary.
326 (b) Within three business days after receiving copies of notice to the Secretary under
327 801 CMR 52.05(1)(a), the public employee committee shall select one representative for
328 the panel and give notice to the appropriate public authority and the Secretary. If the
329 public employee committee does not select a representative within three days, the
330 representative shall be deemed to be the member of the public employee committee who
331 represents the collective bargaining unit with the largest number of subscribers. Within
332 ten days after receiving notice from the public employee committee, or, if no such
333 notice is received, within 13 days of receiving notice from the appropriate public
334 authority, the Secretary shall provide the appropriate public authority, the public
335 employee committee, and the designated panel representatives (the parties) with a list
336 (the list) of three qualified, impartial potential members available to serve on the review
337 panel. Impartial members shall have professional experience in dispute mediation and
338 professional experience in municipal finance or municipal health benefits. The
339 Secretary shall also provide the parties with the name of an actuary selected by the
340 Commission to assist the panel in verifying the savings calculations if no agreement is
341 reached within the 30-day period and a panel is convened.
342 (c) Within three business days after receiving the list, the appropriate public authority
343 and the public employee committee shall jointly select the third member for the panel
344 from the list and shall notify the Secretary of their joint selection.
345 (d) If the appropriate public authority and the public employee committee cannot agree
346 within three business days on which person from the list to select as the third member of
347 the review panel, the notice by the public authority to the Secretary shall include
348 notification that the parties have been unable to reach agreement on the selection of a
349 name from the list of potential impartial panel members. If the public authority and the
350 public employee committee cannot agree, the Secretary shall appoint the impartial
351 member from the list and notify the parties not later than the end of the 30-day
352 negotiation period.
353
354 (2) If the appropriate public authority and the public employee committee are unable to
355 reach a written agreement on the public authority's proposal within 30 calendar days, the
356 matter shall be submitted to the municipal health insurance review panel. The appropriate
357 public authority shall submit its original proposal to the panel within three business days
358 after the end of the 30-day negotiation period, with a copy sent to the Secretary and each
359 member of the public employee committee. The appropriate public authority shall submit
360 to the panel the same proposal that it made to the public employee committee. If the
361 proposal includes the introduction of a limited network plan, the appropriate public
362 authority shall provide an enrollment survey, a determination of which subscribers would
363 enroll in a broad plan and which subscribers would enroll in a limited network plan, and the
364 effect that the addition of a limited network plan would have on total premium costs and on
365 disproportionately affected subscribers. The results of the enrollment survey shall be
366 considered in the savings analysis.
367
368 (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 three 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: Health Insurance Review Panel Review Process

(1) At any time before the panel has made decisions in accordance with 801 CMR 52.06, 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 801 CMR 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 two 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 serve as chair of the panel 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) The panel has ten days to complete its required task once the panel members receive the appropriate public authority's original proposal. 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. Within ten calendar days of receiving proposed changes under M.G.L. c. 32B, §§ 22 or 23, the panel shall determine 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 M.G.L. c. 32A, § 4 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 M.G.L. c. 32A, § 4 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 801 CMR 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

415 if the dollar amounts of the co-pays, deductibles and other cost-sharing plan design
416 features in the political subdivision's plan equaled the dollar amounts of the co-pays,
417 deductibles and other cost-sharing plan design features under tier 2 of the
418 commission's most-subscribed plan. Where the political subdivision currently is
419 proposing a tiered provider network that is tiered differently from the tiering in the
420 commission's most-subscribed plan, the determination shall be made by assuming
421 the co-pays, deductibles and cost-sharing plan design features in each tier of the
422 political subdivision's plan are equal to those in the same tier of the commission's
423 most-subscribed plan, beginning with a comparison of the highest tier. If the
424 political subdivision's plan has fewer tiers than the commission's plan, the political
425 subdivision's highest tier shall be compared to the commission's tier 3, and the
426 second highest tier to the commission's tier 3.
427
428 2. Within ten calendar days of receiving proposed changes under M.G.L. c. 32B, §§
429 22 or 23, the panel shall determine whether the proposed increased dollar amounts
430 for co-payments and deductibles proposed for a Medicare-extension plan under
431 M.G.L. c. 32B, § 22 exceed the dollar amounts of the plan design features for the
432 same or most similar benefits offered by the commission for the Medicare-extension
433 plan under M.G.L. c. 32A, §§ 10C and 14 with the largest subscriber enrollment. If
434 such increased amounts do not exceed the dollar amounts of the plan design features
435 for the same or most similar benefits offered by the commission for the
436 Medicare-extension plan under M.G.L. c. 32A, § 4 with the largest subscriber
437 enrollment, the panel shall approve the appropriate public authority's immediate
438 implementation of the proposed changes under M.G.L. c. 32B, § 22, subject to 801
439 CMR 52.07.
440 3. Where the political subdivision is not proposing a tiered provider network, the
441 determination shall be made by comparing the savings that would result if the dollar
442 amounts of the co-pays, deductibles and other cost-sharing plan design features in
443 the political subdivision's plan equaled the dollar amounts of the co-pays,
444 deductibles and other cost-sharing plan design features under tier 2 of the
445 commission's most-subscribed plan. Where the political subdivision currently is
446 proposing a tiered provider network that is tiered differently from the tiering in the
447 commission's most-subscribed plan, the determination shall be made by assuming
448 the co-pays, deductibles and cost-sharing plan design features in each tier of the
449 political subdivision's plan are equal to those in the same tier of the commission's
450 most-subscribed plan, beginning with a comparison of the highest tier. If the
451 political subdivision's plan has fewer tiers than the commission's plan, the political
452 subdivision's highest tier shall be compared to the commission's tier 3, and the
453 second highest tier to the commission's tier 2.
454 4. If the panel does not approve implementation because the appropriate public
455 authority's proposal fails to meet the criteria detailed in 801 CMR 52.06(4)(a)1. and
456 2., the appropriate public authority may submit a new proposal to the public
457 employee committee and restart the process from that point pursuant to 801 CMR
458 52.03.
459 (b) Review the public authority's estimated monetary savings due to proposed changes,
460 after consulting the Commission's actuary:

461 1. Within ten calendar days of receiving proposed changes under M.G.L. c. 32B, §
462 22 or 23, the panel shall confirm, the appropriate public authority's estimated
463 monetary savings due to proposed changes under M.G.L. c. 32B, § 22 or 23.
464 2. If the proposal is to transfer subscribers to the Commission, the panel shall
465 determine if the anticipated savings by doing so would be at least five percent
466 greater than the maximum possible savings amount that would be attained by plan
467 design changes authorized under M.G.L. c. 32B, § 22. If the panel confirms these
468 savings, the panel shall approve the appropriate public authority's immediate
469 implementation of the proposed changes under M.G.L. c. 32B, § 23, subject to
470 procedures adopted by the commission for transfer of subscribers.
471 3. The appropriate public authority's estimate of savings due to the proposed
472 changes shall be confirmed by the panel after consultation with the actuary selected
473 by the Commission.
474 4. If the panel finds that the savings estimate is unsubstantiated, it may require the
475 public authority to provide additional information or submit a new savings estimate
476 for the panel's review and confirmation. It may also require the public employee
477 committee to submit a response to the new estimate.
478 5. A certified copy of the vote confirming the savings estimate and, if the proposal
479 is to transfer subscribers to the Commission, approval or rejection of the proposal,
480 and explanation of the basis for any such change or disapproval shall be sent to the
481 parties and the Secretary.
482 (c) Review the public authority's mitigation proposal:
483 1. Within ten calendar days of receiving proposed changes under M.G.L. c. 32B, §
484 22 or 23, the panel shall review the proposal to mitigate, moderate or cap the impact
485 of these changes for subscribers, including retirees, low-income subscribers and
486 subscribers with high out-of-pocket health care costs, who would otherwise be
487 disproportionately affected.
488
489 2. The municipal health insurance review panel may approve the mitigation
490 proposal, or it may determine the proposal to be insufficient and may require
491 additional savings to be shared with subscribers in the form of health reimbursement
492 arrangements, wellness programs, health care trust funds for emergency medical
493 care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements
494 or reimbursements for other qualified medical expenses, as determined by the panel.
495 Premium reductions for subscribers that result from the plan design changes shall
496 not be credited against the total amount determined to be required to fund the
497 mitigation proposal. Any health reimbursement arrangements created under a
498 mitigation proposal shall be administered by the appropriate public authority and
499 shall not be the responsibility of the Commission.
500 3. In no case shall the municipal health insurance review panel designate more than
501 25% of the estimated savings to subscribers.
502 4. All obligations on behalf of the appropriate public authority related to the
503 mitigation proposal shall expire after the initial amount of estimated savings
504 designated by the panel to be distributed to subscribers has been expended.
505 5. In reaching a decision on the proposal under this subsection, the municipal
506 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 under 801 CMR 52.06, the panel shall be considered dissolved.

52.07: Implementation of Agreements Reached Pursuant to M.G.L. c. 32B, §§ 21 Through 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 801 CMR 52.00, but the public authority shall give subscribers at least 60 days notice before implementing any changes in health insurance benefits under 801 CMR 52.00. 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 through 23, including any political subdivision which votes against adopting M.G.L. c. 32B, §§ 21 through 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 through 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 30th of each year with the Secretary showing:

(a) the health insurance plans that it offers and the number of subscribers in each;
(b) whether it made use of M.G.L. c. 32B, § 19 or §§ 21 through 23;
(c) 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 through 23.

553
554 (3) A political subdivision whose subscribers are currently covered by the commission
555 shall not implement changes under this procedure until it has followed the procedure for
556 withdrawal from coverage by the commission under the process set forth in 805 CMR 5.00:
557 *Miscellaneous*.
558
559 (4) If a political subdivision initiated the process for implementing changes in its group
560 health insurance benefits under M.G.L. c. 32B, §§ 21 through 23 before August 12, 2011
561 and has proceeded in a manner inconsistent with any provision of 801 CMR 52.00, the
562 Secretary may waive or modify those inconsistent provisions for that political subdivision
563 provided that the political subdivision comply with all requirements of M.G.L. c. 32B, §§
564 21 through 23. An appropriate public authority shall seek such waiver from the Secretary in
565 writing, with a copy to the public employee committee. Any member of the public
566 employee committee may present the Secretary with its position on the waiver request
567 within three business days of receipt of the request.
568
569
570 REGULATORY AUTHORITY
571
572 801 CMR 52.00: M.G.L. c. 32B, § 21(h).