PACKET
SEP 21
2015
ITEM 10
HEALTHCARE

COOK & COMPANY
Insurance Services, Inc.

August 25, 2015

Mr. John Senchyshyn
Assistant Town Administrator
Town of Wayland
41 Cochituate Road
Wayland, MA 01778

Dear John:

We have evaluated the Town of Wayland's health insurance program under the West Suburban Health Group (WSHG) versus the Group Insurance Commission (GIC) and are providing the following information:

1. A benefit comparison of the WSHG health plans versus the GIC health plans (both active and Medicare plans).
2. List of the networks for each limited network plan in the GIC.
3. A financial comparison of the premiums costs (total as well as employer/employee split) for the current WSHG plans and enrollments and the projected GIC costs based on different migration assumptions.
4. A copy of the GIC municipal regulations.

Currently the WSHG retiree plans offer prescription drug coverage through a Medicare Prescription Drug Plan. This is in lieu of the Retiree Drug Subsidy (RDS) that the group previously obtained. As of 1-1-16, the GIC's Medicare indemnity plan (Unicare OME) will also offer their prescription drug plan in the same manner. Therefore, the premiums for that plan (which is the plan that most closely resembles Medex), will be reduced. However, since we don't yet know the new rates, I have not built the reduction into the projection. One additional benefit to these types of plans is that they reduce the town's OPEB liability.

Some points regarding the GIC:

1. You will no longer negotiate benefit levels with the unions. The GIC decides what the carriers, plans, benefits, copayments, etc. will be.
2. The Town would negotiate with a Public Employee Committee (PEC) either through Section 19 or Sections 21-23 to enter the GIC. The Town's initial agreement must be for either 3 or 6 years. Subsequent agreements can be for no less than 2 years. If the Town opts out of the GIC after the expiration of an agreement, you can't enroll again for 3 years.

1025 Plain Street ■ P.O. Box 1068 ■ Marshfield, MA 02050-1068 ■ Tel. 781.837.7300 ■ www.cookandcompany.com

3. The Town is able to obtain their specific utilization one time prior to the expiration of the PEC agreement. The information that you can obtain is specified in the GIC regulations.
4. The WSHG currently provides a prescription drug program through CanaRx whereby members can obtain prescription drugs with no copayment. This program is not offered through the GIC. In addition, the WSHG offers wellness programs that would not be offered through the GIC.

Please let me know if you need have any questions regarding this information. I look forward to presenting it to the Board of Selectmen and School Committee.

Sincerely,

COOK & COMPANY INSURANCE SERVICES, INC.

Susan H. Shillue
President

GIC MONTHLY FULL COST RATES

Effective July 1, 2015

Full Cost Rates Including the 0.4% Administrative Fee

! For the rate you will pay as a municipal employee or retiree/survivor, see separate rate chart from your municipality or the GIC's website: www.mass.gov/gic/munirates.

Employee and Non-Medicare Retiree/Survivor Health Plans

HEALTH PLAN	PLAN TYPE	INDIVIDUAL	FAMILY
Fallon Health Direct Care	HMO	$492.89	$1,182.96
Fallon Health Select Care	HMO	654.98	1,571.91
Harvard Pilgrim Independence Plan	POS	749.39	1,828.49
Harvard Pilgrim Primary Choice Plan	HMO	599.51	1,462.80
Health New England	HMO	494.17	1,225.14
NHP Prime *(Neighborhood Health Plan)*	HMO	470.71	1,247.36
Tufts Health Plan Navigator	POS	659.25	1,609.60
Tufts Health Plan Spirit	HMO-type	501.40	1,207.85
UniCare State Indemnity Plan/Basic with CIC (Comprehensive)	Indemnity	974.65	2,281.72
UniCare State Indemnity Plan/Basic without CIC (Non-Comprehensive)	Indemnity	932.32	2,183.55
UniCare State Indemnity Plan/Community Choice	PPO-type	472.29	1,136.29
UniCare State Indemnity Plan/PLUS	PPO-type	655.64	1,566.91

Medicare Plans

Health Plan	Plan Type	Per Person
Fallon Senior Plan*	Medicare *(HMO)*	$302.13
Harvard Pilgrim Medicare Enhance	Medicare *(Indemnity)*	392.24
Health New England MedPlus	Medicare *(HMO)*	360.95
Tufts Health Plan Medicare Complement	Medicare *(HMO)*	353.91
Tufts Health Plan Medicare Preferred*	Medicare *(HMO)*	275.60
UniCare State Indemnity Plan/Medicare Extension (OME) with CIC *(Comprehensive)*	Medicare *(Indemnity)*	403.98
UniCare State Indemnity Plan/Medicare Extension (OME) without CIC *(Non-Comprehensive)*	Medicare *(Indemnity)*	393.47

**Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2016.*

WEST SUBURBAN HEALTH GROUP

Non-Medicare Plan Rates effective July 1, 2015

Health Plans	Plan Type	FY 16	
		Monthly Rate	
		Individual	Family
HPHC PPO	PPO	$ 2,268.00	$ 5,036.00
HPHC Rate Saver	HMO	$ 736.00	$ 1,918.00
Blue Choice Rate Saver	HMO	$ 843.00	$ 2,261.00
Tufts Navigator Rate Saver	HMO	$ 797.00	$ 2,088.00
Fallon Select Rate Saver	HMO	$ 611.00	$ 1,647.00
Fallon Direct Rate Saver	HMO	$ 570.00	$ 1,531.00

Medicare Plan Rates effective January 1, 2015

Health Plans		CY15
		Monthly Rate
		Individual
BCBS Medex	MEDICARE INDEMNITY	$ 340.00
HPHC Medicare Enhance	MEDICARE INDEMNITY	$ 328.33
Managed Blue for Seniors	MEDICARE HMO	$ 295.63
Fallon Senior Plan	MEDICARE HMO	$ 299.00
Tufts Medicare Prime Supplement	MEDICARE INDEMNITY	$ 330.00
Tufts Medicare Preferred HMO	MEDICARE HMO	$ 262.00

COMPARISON OF WSHG RATE SAVER PLANS VS WSHG CURRENT BENCHMARK PLANS

FY '16

		WSHG RATE SAVER PLANS				WSHG BENCHMARK PLANS			
		WSHG HPHC RATE SAVER HMO	WSHG TUFTS RATE SAVER HMO	WSHG NETWORK BLUE RATE SAVER HMO	FALLON RATE SAVER HMO	WSHG HPHC BENCHMARK HMO	WSHG TUFTS BENCHMARK HMO	WSHG NETWORK BLUE BENCHMARK HMO	WSHG FALLON BENCHMARK HMO
Calendar Year Deductible	IND FAM	N/A	N/A	N/A	N/A	$250 $750	$250 $750	$250 $750	$250 $750
Primary Care Office Visit	Tier 1 Tier 2 Tier 3	$20	$20	$15 $25 $45	$20	$20	$20	$20	$20
Specialist Office Visit	Tier 1 Tier 2 Tier 3	$35 N/A N/A	$35 N/A N/A	$45 N/A N/A	$35 N/A N/A	$25 $35 $45	$35 N/A N/A	$35 N/A N/A	$35 N/A N/A
Emergency Room		$75	$75	$75	$75	$100	$75	$100	$100
Hospital Admission	Tier 1 Tier 2 Tier 3	$250 N/A N/A	$150 $250 N/A	$250 $500 $500	$250 N/A N/A	$300 $300 $700	$300 $700 N/A	$300 $700 N/A	$300 N/A N/A
Hospital Outpatient Surgery		$125	$125	$150 $250 $250	$125	$150	$150	$150	$150
High Tech Imaging (MRI, CT, PET)	Tier 1 Tier 2 Tier 3	Covered in Full	$75	$75 $150 $150	Covered in Full	$100	$100	$100	$100
Prescriptions									
Retail 30-day supply	Tier 1 Tier 2 Tier 3	$10 $25 $45	$10 $25 $45	$15 $30 $50	$10 $25 $45	$10 $25 $50	$10 $25 $50	$15 $30 $50	$10 $25 $50
Mail Order 90-day supply	Tier 1 Tier 2 Tier 3	$20 $50 $90	$20 $50 $90	$30 $60 $100	$20 $50 $90	$20 $50 $110	$20 $50 $110	$20 $50 $110	$20 $50 $110

COMPARISON OF WSHG RATE SAVER PLANS VS GIC PLANS
FY '16

		WSHG RATE SAVER PLANS				GIC PLANS										
		WSHG HPHC RATE SAVER HMO	WSHG TUFTS RATE SAVER HMO	WSHG NETWORK BLUE RATE SAVER HMO	FALLON RATE SAVER HMO	GIC TUFTS NAVIGATOR POS	GIC TUFTS SPIRIT HMO	GIC HPHC INDEPENDENCE POS	GIC HPHC PRIMARY CHOICE HMO	GIC FALLON SELECT HMO	GIC FALLON DIRECT HMO	NEIGHBORHOOD HEALTH HMO	HEALTH NEW ENGLAND HMO	UNICARE BASIC INDEMNITY	UNICARE COMM. CHOICE PPO	UNICARE PLUS PPO
Calendar Year Deductible	IND FAM	N/A	N/A	N/A	N/A	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900	$300 $900
Primary Care Office Visit	Tier 1 Tier 2 Tier 3	$20	$20	$15 $25 $45	$20	$20	$20	$20	$20	$20	$15	$20	$20	$20	$20	$15 OR $20
Specialist Office Visit	Tier 1 Tier 2 Tier 3	$35 N/A N/A	$35 N/A N/A	$45 N/A N/A	$35 N/A N/A	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90	$30 $60 $90
Emergency Room		$75	$75	$75	$75	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
Hospital Admission	Tier 1 Tier 2 Tier 3	$250 N/A N/A	$150 $250 N/A	$250 $500 $500	$250 N/A N/A	$275 $500 $1,500	$300 $700 N/A	$275 $500 $1,500	$250 $500 N/A	$275 $500 $1,500	$275 N/A N/A	$275 N/A N/A	$275 N/A N/A	$275 N/A N/A	$275 N/A N/A	$275 $500 $1,500
Hospital Outpatient Surgery		$125	$125	$150 $250 $250	$125	$250	$250	$250	$250	$250	$250	$250	$250	$250	$110	$110 Tier 1 & 2 $250 Tier 3
High Tech Imaging (MRI, CT, PET)	Tier 1 Tier 2 Tier 3	Covered in Full	$75	$75 $150 $150	Covered in Full	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100	$100
Prescriptions Retail 30-day supply	Tier 1 Tier 2 Tier 3	$10 $25 $45	$10 $25 $45	$15 $30 $50	$10 $25 $45	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65	$10 $30 $65
Mail Order 90-day supply	Tier 1 Tier 2 Tier 3	$20 $50 $90	$20 $50 $90	$30 $60 $100	$20 $50 $90	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165	$25 $75 $165

COMPARISON OF WSHG MEDICARE PLANS VS GIC MEDICARE PLANS
FY '16

	WSHG MEDICARE PLANS						GIC MEDICARE PLANS					
	MEDEX	HPHC ENHANCE	TUFTS MEDICARE SUPPLEMENT	TUFTS MEDICARE PREFERRED	MANAGED BLUE FOR SENIORS	FALLON SENIOR	GIC UNICARE OME	GIC HPHC ENHANCE	GIC TUFTS COMPLEMENT	GIC TUFTS PREFERRED	GIC FALLON SENIOR	GIC HEALTH NEW ENGLAND
Calendar Year Deductible	N/A	N/A	N/A	N/A	N/A	N/A	$35	N/A	N/A	N/A	N/A	N/A
Office Visit	Covered in Full	$5	$10	$10	$10	$15	Covered in Full Mental Health - $10 for visits >4	$10	$10	$10	$10	$10
Specialist Office Visit	Covered in Full	$5	$10	$15	$10	$25	Coverd in Full	$10	$10	$10	$10	$10
Emergency Room	Covered in Full	$30	$50	$50	$50	$50	$25	$50	$50	$50	$50	$50
Hospital Admission	Covered in Full	Covered in Full	Covered in Full	$300 deductible	Covered in Full	Covered in Full	$50 (max of one per quarter)	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Prescriptions												
Retail 30-day supply Tier 1	$5	$5	$10	$10	$5	$10	$10	$10	$10	$10	$10	$10
Tier 2	$15	$10	$20	$25	$15	$25	$30	$30	$30	$30	$30	$30
Tier 3	$30	$25	$35	$50	$30	$50	$65	$65	$65	$65	$65	$65
Mail Order 90-day supply Tier 1	$10	$10	$20	$20	$10	$20	$25	$25	$25	$25	$25	$25
Tier 2	$30	$20	$40	$50	$30	$50	$75	$75	$75	$75	$75	$75
Tier 3	$60	$75	$70	$100	$60	$100	$165	$165	$165	$165	$165	$165

GIC plans are converting to a Medicare PDP effective 1-1-16

WAYLAND - FISCAL YEAR 2016
HEALTH INSURANCE OPTIONS SUMMARY

ALL DATA REPORTED ON AN ANNUAL BASIS
DATA EXCLUDES INCREASED OUT-OF-POCKET EXPENSES

	Employer Cost	Emp/Retiree Cost	Total Cost
Option #1 - Current WSHG Plans			
Non-Medicare Plans	5,744,407	2,944,325	8,688,732
Medicare Plans	664,609	664,609	1,329,218
Total	6,409,016	3,608,934	10,017,950
Option #2 - Move to New WSHG Benchmark Plans			
Non-Medicare Plans	5,353,944	2,745,297	8,099,241
Medicare Plans	664,609	664,609	1,329,218
Total	6,018,553	3,409,906	9,428,459
Savings	390,463	199,028	589,491
Option # 3 - Move to GIC Plans; All enroll in Same Carrier using HPHC Independence and Tufts Navigator; BC to Tufts Navigator			
Non-Medicare Plans	5,138,638	2,614,828	7,753,466
Medicare Plans	766,638	766,638	1,533,276
Total	5,905,276	3,381,466	9,286,742
Savings	503,740	227,468	731,208
25% Mitigation	-182,802	182,802	
Net 1st Year Savings	320,938	410,270	731,208
Option #4 - Move to GIC Plans; HP, Tufts, BCBS Enroll in Tufts Navigator; Fallon Enrolls in Fallon			
Non-Medicare Plans	4,779,350	2,428,683	7,208,033
Medicare Plans	766,638	766,638	1,533,276
Total	5,545,988	3,195,321	8,741,309
Savings	863,028	413,613	1,276,641
25% Mitigation	-319,160	319,160	
Net 1st Year Savings	543,868	732,773	1,276,641
Option # 5 - Move to GIC Plans; Hybrid Model			
Non-Medicare Plans	4,765,943	2,429,607	7,195,550
Medicare Plans	766,638	766,638	1,533,276
Total	5,532,581	3,196,245	8,728,826
Savings	876,435	412,689	1,289,124
25% Mitigation	-322,281	322,281	
Net 1st Year Savings	554,154	734,970	1,289,124

WAYLAND - FISCAL YEAR 2016
Current WSHG Plans

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE/RETIREE Share	EMPLOYEE/RETIREE Cost	TOTAL Cost	Employer %
HPHC PPO	1	I	12	2268.00	1134.00	13,608	1134.00	13,608	27,216	50.00
	1	F	12	5036.00	2518.00	30,216	2518.00	30,216	60,432	50.00
		TOTALS:				**43,824**		**43,824**	**87,648**	
HPHC EPO	104	I	12	736.00	544.64	679,711	191.36	238,817	918,528	74.00
RATE SAVER	162	F	12	1918.00	1227.52	2,386,299	690.48	1,342,293	3,728,592	64.00
		TOTALS:				**3,066,010**		**1,581,110**	**4,647,120**	
HPHC EPO	2	I	12	736.00	368.00	8,832	368.00	8,832	17,664	50.00
RATE SAVER	2	F	12	1918.00	959.00	23,016	959.00	23,016	46,032	50.00
		TOTALS:				**31,848**		**31,848**	**63,696**	
TUFTS EPO	54	I	12	797.00	589.78	382,177	207.22	134,279	516,456	74.00
RATE SAVER	50	I	12	2088.00	1336.32	801,792	751.68	451,008	1,252,800	64.00
		TOTALS:				**1,183,969**		**585,287**	**1,769,256**	
NETWORK BLUE	37	I	12	843.00	623.82	276,976	219.18	97,316	374,292	74.00
RATE SAVER	28	F	12	2261.00	1447.04	486,205	813.96	273,491	759,696	64.00
		TOTALS:				**763,182**		**370,806**	**1,133,988**	
FALLON SELECT	32	I	12	611.00	452.14	173,622	158.86	61,002	234,624	74.00
RATE SAVER	24	F	12	1647.00	1054.08	303,575	592.92	170,761	474,336	64.00
		TOTALS:				**477,197**		**231,763**	**708,960**	
FALLON SELECT	1	I	12	611.00	305.50	3,666	305.50	3,666	7,332	50.00
RATE SAVER	2	F	12	1647.00	823.50	19,764	823.50	19,764	39,528	50.00
		TOTALS:				**23,430**		**23,430**	**46,860**	
FALLON DIRECT	13	I	12	570.00	421.80	65,801	148.20	23,119	88,920	74.00
RATE SAVER	7	F	12	1531.00	979.84	82,307	551.16	46,297	128,604	64.00
		TOTALS:				**148,107**		**69,417**	**217,524**	
FALLON DIRECT	2	I	12	570.00	285.00	6,840	285.00	6,840	13,680	50.00
RATE SAVER	0	F	12	1531.00	765.50	-	765.50	-	-	50.00
		TOTALS:				**6,840**		**6,840**	**13,680**	
		SUBTOTAL NON-MEDICARE				**5,744,407**		**2,944,325**	**8,688,732**	
MEDEX	87	I	12	340.00	170.00	177,480	170.00	177,480	354,960	50.00
HPHC ENHANCE	93	I	12	328.33	164.17	183,208	164.17	183,208	366,416	50.00
TUFTS MED PLUS	72	I	12	330.00	165.00	142,560	165.00	142,560	285,120	50.00
TUFTS MED PREF	62	I	12	262.00	131.00	97,464	131.00	97,464	194,928	50.00
MGD BLUE FOR SRS	34	I	12	295.63	147.82	60,309	147.82	60,309	120,617	50.00
FALLON SENIOR	2	I	12	299.00	149.50	3,588	149.50	3,588	7,176	50.00
		SUBTOTAL MEDICARE:				**664,609**		**664,609**	**1,329,217**	
		Budget Totals All Plans:				**6,409,015**	-	**3,608,934**	**10,017,949**	

OPTION #1

WAYLAND - FISCAL YEAR 2016
Projection on New WSHG Benchmark Benefit

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE/RETIREE Share	EMPLOYEE/RETIREE Cost	TOTAL Cost	Employer %
HPHC PPO	1	I	12	2268.00	1134.00	13,608	1134.00	13,608	27,216	50.00
	1	F	12	5036.00	2518.00	30,216	2518.00	30,216	60,432	50.00
		TOTALS:				**43,824**		**43,824**	**87,648**	
HPHC EPO	104	I	12	681.83	504.55	629,684	177.28	221,240	850,924	74.00
RATE SAVER	162	F	12	1776.84	1137.18	2,210,673	639.66	1,243,504	3,454,177	64.00
		TOTALS:				**2,840,357**		**1,464,744**	**4,305,101**	
HPHC EPO	2	I	12	681.83	340.92	8,182	340.92	8,182	16,364	50.00
RATE SAVER	2	F	12	1776.84	888.42	21,322	888.42	21,322	42,644	50.00
		TOTALS:				**29,504**		**29,504**	**59,008**	
TUFTS EPO	54	I	12	734.83	543.77	352,366	191.06	123,804	476,170	74.00
RATE SAVER	50	I	12	1925.14	1232.09	739,254	693.05	415,830	1,155,084	64.00
		TOTALS:				**1,091,619**		**539,634**	**1,631,254**	
NETWORK BLUE	37	I	12	799.08	591.32	262,546	207.76	92,246	354,792	74.00
RATE SAVER	28	F	12	2143.20	1371.65	460,874	771.55	259,241	720,115	64.00
		TOTALS:				**723,419**		**351,487**	**1,074,907**	
FALLON SELECT	32	I	12	582.71	431.21	165,583	151.50	58,178	223,761	74.00
RATE SAVER	24	F	12	1570.74	1005.27	289,519	565.47	162,854	452,373	64.00
		TOTALS:				**455,102**		**221,032**	**676,134**	
FALLON SELECT	1	I	12	582.71	291.36	3,496	291.36	3,496	6,993	50.00
RATE SAVER	2	F	12	1570.74	785.37	18,849	785.37	18,849	37,698	50.00
		TOTALS:				**22,345**		**22,345**	**44,690**	
FALLON DIRECT	13	I	12	543.61	402.27	62,754	141.34	22,049	84,803	74.00
RATE SAVER	7	F	12	1460.11	934.47	78,496	525.64	44,154	122,649	64.00
		TOTALS:				**141,250**		**66,203**	**207,452**	
FALLON DIRECT	2	I	12	543.61	271.81	6,523	271.81	6,523	13,047	50.00
RATE SAVER	0	F	12	1460.11	730.06	-	730.06	-	-	50.00
		TOTALS:				**6,523**		**6,523**	**13,047**	
		SUBTOTAL NON-MEDICARE				**5,353,944**		**2,745,297**	**8,099,241**	
MEDEX	87	I	12	340.00	170.00	177,480	170.00	177,480	354,960	50.00
HPHC ENHANCE	93	I	12	328.33	164.17	183,208	164.17	183,208	366,416	50.00
TUFTS MED PLUS	72	I	12	330.00	165.00	142,560	165.00	142,560	285,120	50.00
TUFTS MED PREF	62	I	12	262.00	131.00	97,464	131.00	97,464	194,928	50.00
MGD BLUE FOR SRS	34	I	12	295.63	147.82	60,309	147.82	60,309	120,617	50.00
FALLON SENIOR	2	I	12	299.00	149.50	3,588	149.50	3,588	7,176	50.00
		SUBTOTAL MEDICARE:				**664,609**		**664,609**	**1,329,217**	
Budget Totals All Plans:						**6,018,553**		**3,409,906**	**9,428,458**	
Total Savings from WSHG Current Plans:						**390,463**		**199,028**	**589,491**	

Note: Employee/retiree savings do not reflect increased out-of pocket expenses

OPTION #2

COOK

WAYLAND - FISCAL YEAR 2016
WSHG TO GIC PLANS - Enroll in Same Carrier, BC to Tufts

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE/RETIREE Share	EMPLOYEE/RETIREE Cost	TOTAL Cost	Employer %
HPHC PPO	1	I	12	932.32	466.16	5,594	466.16	5,594	11,188	50.00
to Unicare Basic	1	F	12	2183.55	1091.78	13,101	1091.78	13,101	26,203	50.00
		TOTALS:				18,695		18,695	37,390	
HPHC EPO	104	I	12	749.39	554.55	692,077	194.84	243,162	935,239	74.00
RATE SAVER	162	F	12	1828.49	1170.23	2,274,934	658.26	1,279,650	3,554,585	64.00
to HPHC Independence		TOTALS:				2,967,011		1,522,813	4,489,823	
HPHC EPO	2	I	12	749.39	374.70	8,993	374.70	8,993	17,985	50.00
RATE SAVER	2	F	12	1828.49	914.25	21,942	914.25	21,942	43,884	50.00
to HPHC Independence		TOTALS:				30,935		30,935	61,869	
TUFTS EPO	54	I	12	659.25	487.85	316,124	171.41	111,070	427,194	74.00
RATE SAVER	50	F	12	1609.60	1030.14	618,086	579.46	347,674	965,760	64.00
to Tufts Navigator		TOTALS:				934,210		458,744	1,392,954	
NETWORK BLUE	37	I	12	659.25	487.85	216,603	171.41	76,104	292,707	74.00
RATE SAVER	28	F	12	1609.60	1030.14	346,128	579.46	194,697	540,826	64.00
to Tufts Navigator		TOTALS:				562,732		270,801	833,533	
FALLON SELECT	32	I	12	654.98	484.69	186,119	170.29	65,393	251,512	74.00
RATE SAVER	24	F	12	1571.91	1006.02	289,734	565.89	162,976	452,710	64.00
to Fallon Select		TOTALS:				475,854		228,369	704,222	
FALLON SELECT	1	I	12	654.98	327.49	3,930	327.49	3,930	7,860	50.00
RATE SAVER	2	F	12	1571.91	785.96	18,863	785.96	18,863	37,726	50.00
to Fallon Select		TOTALS:				22,793		22,793	45,586	
FALLON DIRECT	13	I	12	492.89	364.74	56,899	128.15	19,992	76,891	74.00
RATE SAVER	7	F	12	1182.96	757.09	63,596	425.87	35,773	99,369	64.00
to Fallon Direct		TOTALS:				120,495		55,764	176,259	
FALLON DIRECT	2	I	12	492.89	246.45	5,915	246.45	5,915	11,829	50.00
RATE SAVER	0	F	12	1182.96	591.48	-	591.48	-	-	50.00
to Fallon Direct		TOTALS:				5,915		5,915	11,829	
		SUBTOTAL NON-MEDICARE				5,138,638		2,614,828	7,753,466	
MEDEX *	87	I	12	403.98	201.99	210,878	201.99	210,878	421,755	50.00
HPHC ENHANCE	93	I	12	392.24	196.12	218,870	196.12	218,870	437,740	50.00
TUFTS MED PLUS *	72	I	12	403.98	201.99	174,519	201.99	174,519	349,039	50.00
TUFTS MED PREF	62	I	12	275.60	137.80	102,523	137.80	102,523	205,046	50.00
MGD BLUE FOR SRS **	34	I	12	275.60	137.80	56,222	137.80	56,222	112,445	50.00
FALLON SENIOR	2	I	12	302.13	151.07	3,626	151.07	3,626	7,251	50.00
* to Unicare OME										
** to Tufts Med Pref		MEDICARE TOTAL:				766,638		766,638	1,533,276	
		Budget Totals All Plans:				5,905,276		3,381,466	9,286,742	
		Total Savings from WSHG Current Plans:				503,739		227,468	731,207	
		25% Mitigation*:				(182,802)		182,802		
		Net 1st Year Savings:				320,937		410,270	731,207	

*If negotiating under Sections 21-23, the Town must provide a mitigation fund of up to 25% of the total first year savings.

Note: Employee/retiree savings do not reflect increased out-of pocket expenses

OPTION #3

WAYLAND - FISCAL YEAR 2016
WSHG TO GIC PLANS - HPHC, Tufts and BC Enroll in Tufts

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE/RETIREE Share	EMPLOYEE/RETIREE Cost	TOTAL Cost	Employer %
HPHC PPO	1	I	12	932.32	466.16	5,594	466.16	5,594	11,188	50.00
to Unicare Basic	1	F	12	2183.55	1091.78	13,101	1091.78	13,101	26,203	50.00
		TOTALS:				18,695		18,695	37,390	
HPHC EPO	104	I	12	659.25	487.85	608,831	171.41	213,913	822,744	74.00
RATE SAVER	162	F	12	1609.60	1030.14	2,002,600	579.46	1,126,462	3,129,062	64.00
to Tufts Navigator		TOTALS:				2,611,430		1,340,376	3,951,806	
HPHC EPO	2	I	12	659.25	329.63	7,911	329.63	7,911	15,822	50.00
RATE SAVER	2	F	12	1609.60	804.80	19,315	804.80	19,315	38,630	50.00
to Tufts Navigator		TOTALS:				27,226		27,226	54,452	
TUFTS EPO	54	I	12	659.25	487.85	316,124	171.41	111,070	427,194	74.00
RATE SAVER	50	F	12	1609.60	1030.14	618,086	579.46	347,674	965,760	64.00
to Tufts Navigator		TOTALS:				934,210		458,744	1,392,954	
NETWORK BLUE	37	I	12	659.25	487.85	216,603	171.41	76,104	292,707	74.00
RATE SAVER	28	F	12	1609.60	1030.14	346,128	579.46	194,697	540,826	64.00
to Tufts Navigator		TOTALS:				562,732		270,801	833,533	
FALLON SELECT	32	I	12	654.98	484.69	186,119	170.29	65,393	251,512	74.00
RATE SAVER	24	F	12	1571.91	1006.02	289,734	565.89	162,976	452,710	64.00
to Fallon Select		TOTALS:				475,854		228,369	704,222	
FALLON SELECT	1	I	12	654.98	327.49	3,930	327.49	3,930	7,860	50.00
RATE SAVER	2	F	12	1571.91	785.96	18,863	785.96	18,863	37,726	50.00
to Fallon Select		TOTALS:				22,793		22,793	45,586	
FALLON DIRECT	13	I	12	492.89	364.74	56,899	128.15	19,992	76,891	74.00
RATE SAVER	7	F	12	1182.96	757.09	63,596	425.87	35,773	99,369	64.00
to Fallon Direct		TOTALS:				120,495		55,764	176,259	
FALLON DIRECT	2	I	12	492.89	246.45	5,915	246.45	5,915	11,829	50.00
RATE SAVER	0	F	12	1182.96	591.48	-	591.48	-	-	50.00
to Fallon Direct		TOTALS:				5,915		5,915	11,829	
		SUBTOTAL NON-MEDICARE				4,779,350		2,428,683	7,208,033	
MEDEX *	87	I	12	403.98	201.99	210,878	201.99	210,878	421,755	50.00
HPHC ENHANCE	93	I	12	392.24	196.12	218,870	196.12	218,870	437,740	50.00
TUFTS MED PLUS *	72	I	12	403.98	201.99	174,519	201.99	174,519	349,039	50.00
TUFTS MED PREF	62	I	12	275.60	137.80	102,523	137.80	102,523	205,046	50.00
MGD BLUE FOR SRS **	34	I	12	275.60	137.80	56,222	137.80	56,222	112,445	50.00
FALLON SENIOR	2	I	12	302.13	151.07	3,626	151.07	3,626	7,251	50.00
* to Unicare OME										
** to Tufts Med Pref		TOTALS:				766,638		766,638	1,533,276	
Budget Totals All Plans:						5,545,988		3,195,321	8,741,309	
Total Savings from WSHG Current Plans:						863,028		413,613	1,276,641	
25% Mitigation*:						(319,160)		319,160		
Net 1st Year Savings:						543,868		732,773	1,276,641	

*If negotiating under Sections 21-23, the Town must provide a mitigation fund of up to 25% of the total first year savings.

Note: Employee/retiree savings do not reflect increased out-of pocket expenses

OPTION #4

WAYLAND - FISCAL YEAR 2016

WSHG HPHC TO GIC 3/4 HPHC INDEPENDENCE; 1/4 HPHC PRIMARY CHOICE
WSHG TUFTS TO GIC 3/4TUFTS NAVIGATOR; 1/4 TUFTS SPIRIT
WSHG BCBS TO GIC UNICARE COMMUNITY CHOICE
WSHG FALLON TO GIC FALLON

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE/RETIREE Share	EMPLOYEE/RETIREE Cost	TOTAL Cost	Employer %
HPHC PPO	1	I	12	932.32	466.16	5,594	466.16	5,594	11,188	50.00
to Unicare Basic	1	F	12	2183.55	1091.78	13,101	1091.78	13,101	26,203	50.00
		TOTALS:				18,695		18,695	37,390	
HPHC EPO	78	I	12	749.39	554.55	519,057	194.84	182,372	701,429	74.00
RATE SAVER	121	F	12	1828.49	1170.23	1,699,179	658.26	955,788	2,654,967	64.00
3/4 to HPHC Independence		TOTALS:				2,218,237		1,138,160	3,356,397	
HPHC EPO	26	I	12	599.51	443.64	138,415	155.87	48,632	187,047	74.00
RATE SAVER	41	F	12	1462.80	936.19	460,606	526.61	259,091	719,698	64.00
1/4 to HPHC Primary Choice		TOTALS:				599,021		307,723	906,745	
HPHC EPO	2	I	12	749.39	374.70	8,993	374.70	8,993	17,985	50.00
RATE SAVER	2	F	12	1828.49	914.25	21,942	914.25	21,942	43,884	50.00
to HPHC Independence		TOTALS:				30,935		30,935	61,869	
TUFTS EPO	40	I	12	659.25	487.85	234,166	171.41	82,274	316,440	74.00
RATE SAVER	37	F	12	1609.60	1030.14	457,384	579.46	257,278	714,662	64.00
3/4 to Tufts Navigator		TOTALS:				691,550		339,553	1,031,102	
TUFTS EPO	14	I	12	501.40	371.04	62,334	130.36	21,901	84,235	74.00
RATE SAVER	13	F	12	1207.85	773.02	120,592	434.83	67,833	188,425	64.00
1/4 to Tufts Spirit		TOTALS:				182,926		89,734	272,660	
NETWORK BLUE	37	I	12	472.29	349.49	155,176	122.80	54,521	209,697	74.00
RATE SAVER	28	F	12	1136.29	727.23	244,348	409.06	137,446	381,793	64.00
Unicare Community Choice		TOTALS:				399,523		191,967	591,490	
FALLON SELECT	32	I	12	654.98	484.69	186,119	170.29	65,393	251,512	74.00
RATE SAVER	24	F	12	1571.91	1006.02	289,734	565.89	162,976	452,710	64.00
to Fallon Select		TOTALS:				475,854		228,369	704,222	
FALLON SELECT	1	I	12	654.98	327.49	3,930	327.49	3,930	7,860	50.00
RATE SAVER	2	F	12	1571.91	785.96	18,863	785.96	18,863	37,726	50.00
to Fallon Select		TOTALS:				22,793		22,793	45,586	
FALLON DIRECT	13	I	12	492.89	364.74	56,899	128.15	19,992	76,891	74.00
RATE SAVER	7	F	12	1182.96	757.09	63,596	425.87	35,773	99,369	64.00
to Fallon Direct		TOTALS:				120,495		55,764	176,259	
FALLON DIRECT	2	I	12	492.89	246.45	5,915	246.45	5,915	11,829	50.00
RATE SAVER	0	F	12	1182.96	591.48	-	591.48	-	-	50.00
to Fallon Direct		TOTALS:				5,915		5,915	11,829	
		SUBTOTAL NON-MEDICARE				4,765,943		2,429,607	7,195,550	
MEDEX *	87	I	12	403.98	201.99	210,878	201.99	210,878	421,755	50.00
HPHC ENHANCE	93	I	12	392.24	196.12	218,870	196.12	218,870	437,740	50.00
TUFTS MED PLUS *	72	I	12	403.98	201.99	174,519	201.99	174,519	349,039	50.00
TUFTS MED PREF	62	I	12	275.60	137.80	102,523	137.80	102,523	205,046	50.00
MGD BLUE FOR SRS **	34	I	12	275.60	137.80	56,222	137.80	56,222	112,445	50.00
FALLON SENIOR	2	I	12	302.13	151.07	3,626	151.07	3,626	7,251	50.00
* to Unicare OME										
** to Tufts Med Pref		TOTALS:				766,638		766,638	1,533,276	
Budget Totals All Plans:						5,532,581		3,196,245	8,728,826	
Total Savings from WSHG Current Plans:						876,435		412,689	1,289,123	
25% Mitigation*:						(322,281)		322,281		
Net 1st Year Savings:						554,154		734,969	1,289,123	

*If negotiating under Sections 21-23, the Town must provide a mitigation fund of up to 25% of the total first year savings.

Note: Employee/retiree savings do not reflect increased out-of pocket expenses

OPTION #5

Town of Wayland

Non-Medicare Employee/Retiree Out-of-Pocket Comparison

WSHG HPHC Rate Saver vs GIC HPHC Independence, Tufts Navigator & HPHCPrimary Choice

Example 1 - Family (Annual Costs)	WSHG Rate Saver	** Wide Network Plan ** GIC HPHC Independence	Out-of-Pocket Difference WSHG RSP vs. GIC HP Independence	WSHG Rate Saver	** Wide Network Plar* GIC Tufts Navigator	Out-of-Pocket Difference WSHG RSP vs. GIC Tufts Navigator	WSHG Rate Saver	** Limited Network Pla* GIC HPHC Primary Choice	Difference WSHG RSP vs. GIC HP Primary Choice
Premium Share	$8,280	$7,896	-$384	$8,280	$6,948	-$1,332	$8,280	$6,324	-$1,956
Deductible*	$0	$900	$900	$0	$900	$900	$0	$900	$900
4 Primary Care Visits	$80	$80	$0	$80	$80	$0	$80	$80	$0
2 Specialist Visits-tier 2	$70	$120	$50	$70	$120	$50	$70	$120	$50
1 MRI	$0	$100	$100	$0	$100	$100	$0	$100	$100
1 outpatient surgery	$125	$250	$125	$125	$250	$125	$125	$250	$125
3 retail RX-tier 2	$75	$90	$15	$75	$90	$15	$75	$90	$15
2 mail-order RX- tier 1 (annual)	$160	$200	$40	$160	$200	$40	$160	$200	$40
TOTAL	**$8,790**	**$9,636**	***10% (Employee or Retiree Increase)***	**$8,790**	**$8,688**	***-1% (Employee or Retiree Decrease)***	**$8,790**	**$8,064**	***-8% (Employee or Retiree Decrease)***

*Member does not need to satisfy the deductible for office visits and RX
Assumes 3+ family members satisfy deductible (Note: 2 Person Family Deductible is $600)

Example 2 - Individual (Annual Costs)	WSHG Rate Saver	GIC HPHC Independence	Out-of-Pocket Difference WSHG RSP vs. GIC HP Independence	WSHG Rate Saver	GIC Tufts Navigator	Out-of-Pocket Difference WSHG RSP vs. GIC Tufts Navigator	WSHG Rate Saver	GIC HPHC Primary Choice	Out-of-Pocket Difference WSHG RSP vs. GIC HP Primary Choice
Premium Share	$2,296	$2,340	$44	$2,296	$2,052	-$244	$2,296	$1,872	-$424
Deductible	$0	$300	$300	$0	$300	$300	$0	$300	$300
2 Primary Care Visits	$40	$40	$0	$40	$40	$0	$40	$40	$0
1 Specialist Visits-tier 2	$35	$60	$25	$35	$60	$25	$35	$60	$25
1 MRI	$0	$100	$100	$0	$100	$100	$0	$100	$100
1 outpatient surgery	$125	$250	$125	$125	$250	$125	$125	$250	$125
1 retail RX-tier 2	$25	$30	$5	$25	$30	$5	$25	$30	$5
1 mail-order RX- tier 2 (annual)	$200	$300	$100	$200	$300	$100	$200	$300	$100
TOTAL	**$2,721**	**$3,420**	***26% (Employee or Retiree Increase)***	**$2,721**	**$3,132**	***15% (Employee or Retiree Increase)***	**$2,721**	**$2,952**	***8% (Employee or Retiree Increase)***

Note: The GIC plans identified above reflect the 3 highest municipal enrollments.

HPHC Independence	21.3%
Tufts Navigator	26.8%
HPHC Primary Choice	10.7%

Step 1	**Advance notice of intent to vote for local acceptance**	**Time Frame:** At least 2 calendar days in advance of any vote electing to change group health insurance pursuant to G.L. c. 32B, §§21-23. *801 CMR 52.02(1).*	**Notice:** To be sent by Appropriate Public Authority to each collective bargaining unit and the Retired State, County Municipal Employees Association (RSCME) of Political Subdivision's intent to vote to change group health insurance pursuant to G.L. c. 32B, §§21-23. *801 CMR 52.02(1).*	
Step 2	**Local acceptance**	**Vote:** Must be taken by Political Subdivision in order to change health insurance benefits under G.L. c. 32B, §§ 22 or 23. *G.L. c. 32B, §21(a)and 801 CMR 52.02(1).*	**Sample vote:** "The [name of political subdivision] elects to engage in the process to change insurance benefits under MGL c.32B, §§21-23". *801 CMR 52.02(1).*	

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Step 3(a)	**Development of documents to be submitted to the Insurance Advisory Committee ("IAC")**	**<u>Requirement:</u>** The Appropriate Public Authority must evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of plan design changes or upon transfer of subscribers to the Group Insurance Commission ("GIC"). *G.L. c. 32B, §21(b) and 801 CMR 52.02(2).*	**<u>Documents/Information:</u>** To be submit to the IAC: (1) The proposed changes to health insurance benefits; (2) Cost sharing plan design features of plan with largest subscriber enrollment offered by GIC. (3) A report and documentation with respect to the determination of the estimated savings. (4) A mitigation proposal. *G.L. c. 32B, §21(b) and 801 CMR 52.03.*	
Step 3(b)	**Notification to IAC**	**<u>Notice:</u>** The Appropriate Public Authority must notify the IAC of the health insurance coverage evaluation and assessment of savings as well as provide the IAC with the required documents. *G.L. c. 32B, §21(b) and 801 CMR 52.02(2).*	**<u>Documents/Information:</u>** To be submit to the IAC: (1) The proposed changes to health insurance benefits; (2) Cost sharing plan design features of plan with largest subscriber enrollment offered by GIC. (3) A report and documentation with respect to the determination of the estimated savings. (4) A mitigation proposal. *G.L. c. 32B, §21(b) and 801 CMR 52.03.*	**<u>Composition of IAC:</u>** The IAC shall be comprised of eight members as follows: seven persons to be duly elected or appointed to membership on such committee by organizations of the employees affected, and one person who shall be a retiree of a governmental unit who shall be duly appointed to membership on said committee by the Appropriate Public Authority. *G.L. c. 32B, §3.*

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Step 3(c)	**Meeting with IAC**	**<u>Time Frame:</u>** Within 10 days after IAC receives notice it shall meet with Appropriate Public Authority to discuss estimated savings and any reports or other documentation requested by IAC prior to the meeting. *G.L. c. 32B, §21(b) and 801 CMR 52.02(2).*	**<u>Failure to meet:</u>** If the IAC does not meet with Appropriate Public Authority within 10 days after receiving notice, it will be considered to have met with the Appropriate public Authority. *801 CMR 52.02(2).*	
Step 4(a)	**Notification to Public Employee Committee ("PEC") to enter into negotiations to implement changes to health insurance benefits**	**<u>Time Frame:</u>** Within 2 business days of meeting with IAC or 10 days after IAC received notice (whichever occurs first), Appropriate Public Authority shall provide notice of its decision, in writing, to president or designee of each collective bargaining unit and to the RSCME. *801 CMR 52.02(2).*	**<u>Documents/Information:</u>** To be submit to the PEC **<u>within 2 business days</u>** following the appropriate public authority's receipt of notice of reps for the PEC: (1) The proposed changes to health insurance benefits; (2) Cost sharing plan design features of plan with largest subscriber enrollment offered by GIC. (3) A report and documentation with respect to the determination of the estimated savings. (4) A mitigation proposal. *G.L. c. 32B, §21(b) and 801 CMR 52.03.*	**<u>Composition of PEC:</u>** If no existing PEC, notice shall request designated representatives for PEC from collective bargaining units and RSCME. If not response within 5 business days, collective bargaining units principal officer and president of RSCME shall be the representatives. *801 CMR 52.02(2).* If PEC already exists, within 2 business days of receipt of notice collective bargaining units and RSCME provide information regarding designated representatives for PEC. *G.L. c. 32B, §21(b) and 801 CMR 52.02(2).*

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Step 4(b)	**Negotiations between the Appropriate Public Authority and PEC**	**Time Frame:** The parties shall have 30 days from the date of receipt of notice to negotiate all aspects of the Appropriate Public Authority's proposal. *G.L. c. 32B, §21(c) and 801 CMR 52.04.* **Appropriate Public Authority and PEC should remember to comply with requirement of 801 CMR 52.05 regarding creation of Review panel during 30 days of negotiations. *801 CMR 52.05.*	**Terms of Agreement:** Agreement shall be in writing, include plan design changes or transfer to GIC. Copy of Agreement shall be sent to Secretary of A&F within 3 business days after execution and notify municipal review panel. All subscribers shall be provided 60 days notice of changes in plan design or transfer to GIC. *801 CMR 52.04.*	**Weighing of Votes on PEC:** Any agreement shall be approved by a **majority vote** of the PEC. Vote shall be weighted in accordance with G.L. c. 32B, §19. *G.L. c. 32B, §21(c)*
Step 5(a)	**Review Panel if agreement is NOT reached between the Appropriate Public Authority and the PEC**	**Time frame:** If the parties have not entered into a written agreement after 30 days, the matter shall be submitted to a municipal health insurance review panel ("Panel") within 3 business days after end of 30 day negotiation period. *G.L. c. 32B, §21(c) and 801 CMR 52.05.*	**Composition of Panel:** The Panel is created during the 30 day negotiation period between the Appropriate Public Authority and PEC; the Panel is comprised of 3 members; 1 member appointed by the PEC, 1 member appointed by the Appropriate Public Authority and 1 neutral member. The third member will be selected from a potential list of three, provided by the Secretary of Administration and Finance. The parties shall have 3 business days to select the member before the Secretary is given the authority to do so. *G.L. c. 32B, §21(c) and 801 CMR 52.05.*	**Fees:** Any fee or compensation provided to panel members shall be shared equally between the PEC and the Appropriate Public Authority. *G.L. c. 32B, §21(c) and 801 CMR 52.05.*

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Step 5(b)	**Review Panel Process**	**<u>Suspension of Panel:</u>** At any time prior to the Panel decision the parties may agree to terminate or suspend the Panel process to extend negotiations, reach an agreement or resume negotiations pursuant to G.L. c. 150E or GL. c. 32B, §19. *801 CMR 52.06.* **<u>Panel Convenes</u>:** Otherwise, panel convenes within 2 business days of notice of submission to Panel. *801 CMR 52.06.*		
Step 6	**Implementation of Changes**	Subscribers shall receive at least **<u>60 days notice</u>** before changes in plan design or transfer to GIC. *801 CMR 52.07.*	Implementation of changes pursuant to G.L. c. 32B, §22 shall occur **<u>no later than 90 days</u>** after agreement or, if agreed, at the end of the current health insurance policy year. *801 CMR 52.07.* Implementation of changes pursuant to G.L. c. 32B, §23 (transfer to GIC) shall occur in accordance with GIC procedures. *801 CMR 52.07.*	

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Things to Remember		*Any changes in the health benefits shall be delayed if changes would alter the dollar amounts of copayments, deductibles or other plan design features which are specifically included in the body of the collective bargaining agreement or a section 19 agreement which is currently in effect. These changes may only be implemented after the initial term stated in the collective bargaining agreement or section 19 agreement has ended. *Acts 2011, Ch. 69, §4.*	*In most cases, contribution ratios remain an issue to be negotiated by the parties. *G.L. c. 32B, §21(f), §23(a) and Acts 2011, Ch. 69, §7.*	

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PART I ADMINISTRATION OF THE GOVERNMENT
TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS
CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 21 Manner of changing health insurance benefits; estimation of savings; approval of agreement; immediate implementation; time for review; distribution of savings; regulations

Section 21. (a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting or by vote of the district's governing board. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

(b) Prior to implementing any changes authorized under sections 22 or 23, the appropriate public authority shall evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of 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 the estimated savings and provide any reports or other documentation with respect to the determination of estimated savings as requested by the insurance advisory committee. After discussion with the insurance advisory committee as to the estimated savings, the appropriate public authority shall give notice to each of its collective bargaining units to which the authority provides health insurance benefits and a retiree representative, hereafter called the public employee committee, of its intention to enter into negotiations to implement changes to health insurance benefits provided by the appropriate public authority. The retiree representative shall be designated by the Retired State, County and Municipal Employees Association. A political subdivision which has previously established a public employee committee under section 19 may implement changes to its health insurance benefits pursuant to this section and sections 22 and 23.

Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and 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.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be 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 through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

(d) The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 22; provided, however, that any increases to plan design features have been made in accordance with the provisions of section 22. The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 23; provided, that the panel confirms that the anticipated savings under those changes would be at least 5 per cent greater than the maximum possible savings under section 22. If the panel does not approve implementation of changes made pursuant to section 22 or section 23, the public authority may submit a new proposal to the public employee committee for consideration and confirmation under this section.

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional

information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority 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; and (iii) concur with the appropriate public authority that the proposal is sufficient 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 or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to 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; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

(g) The decision of the municipal health insurance review panel shall be binding upon all parties.

(h) The secretary of administration and finance shall promulgate regulations establishing administrative procedures for the negotiations with the public employee committee and the municipal health insurance review panel, and issue guidelines to be utilized by the appropriate public authority and the municipal health insurance review panel in evaluating which subscribers are disproportionately affected, subscriber income and subscriber out-of-pocket costs associated with health insurance benefits.

PART I ADMINISTRATION OF THE GOVERNMENT
TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS
CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 22 Copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; increases

Section 22. (a) Upon meeting the requirements of section 21, an appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers by acceptance of any other section of this chapter may include, as part of the health plans that it offers to its subscribers not enrolled in a Medicare plan under section 18A, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment; provided, however, that for subscribers enrolled in a Medicare plan pursuant to section 18A the appropriate public authority may include, as part of the health plans that it offers to its subscribers, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment. The appropriate public authority shall not include a plan design feature which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network or providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

(b) An appropriate public authority may increase the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; provided that, for subscribers enrolled in a non-Medicare plan, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment and, for subscribers enrolled in a Medicare plan under section 18A, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment; provided, however, that the public authority need only satisfy the requirements of subsection (a) of section 21 the first time changes are implemented pursuant to this section; and provided, further that the public authority meet its obligations

under subsections (b) to (h), inclusive, of section 21 each time an increase to a plan design feature is proposed.

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

(c) The decision to accept and implement this section shall not be subject to bargaining pursuant to chapter 150E or section 19. Nothing in this section shall preclude the implementation of plan design changes pursuant to this section in communities that have adopted section 19 of this chapter or by the governing board of a joint purchasing group established pursuant to section 12.

(d) Nothing in this section shall relieve an appropriate public authority from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter.

(e) The first time a public authority implements plan design changes under this section or section 23, the public authority shall not increase before July 1, 2014, the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums from the percentage that was approved by the public authority prior to and in effect on July 1, 2011; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before July 1, 2011, but to take effect on a date after July 1, 2011, said percentage increase may take effect upon the approval of the secretary of administration and finance based on documented evidence satisfactory to the secretary that the public authority approved the increase prior to July 1, 2011.

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PART I ADMINISTRATION OF THE GOVERNMENT
TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS
CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 23 Transfer of subscribers to commission; notice; transfer to Medicare of eligible subscribers; withdrawal from commission coverage; group coverage provided by commission; deficit in claims trust fund by self-insured political subdivision; administration of coverage for transferred subscribers by commission; reimbursement of commission for coverage costs; withdrawal from commission

Section 23. (a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year for the transfer of subscribers to the commission effective the following July 1, or on or before July 1 of each year for the transfer of subscribers to the commission effective the following January 1. On the effective date of the transfer, the health insurance of all subscribers, including elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers

may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150E and this chapter; provided, however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150E, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility

requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

(d) The commission shall negotiate and purchase health insurance coverage for subscribers transferred under this section and shall promulgate regulations, policies and procedures for coverage of the transferred subscribers. The schedule of benefits available to transferred subscribers shall be determined by the commission pursuant to chapter 32A. The commission shall offer those subscribers the same choice as to health insurance carriers and benefits as those provided to state employees and retirees. The political subdivision's contribution to the cost of health insurance coverage for transferred subscribers shall be as determined under this section, and shall not be subject to the provisions on contributions in said chapter 32A. Any change to the premium contribution ratios shall become effective on July 1 of each year, with notice to the commission of such change not later than January 15 of the same year.

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may inform the state treasurer who shall issue a warrant in the manner provided by section 20 of chapter 59 requiring the respective political subdivision to pay into the treasury of the commonwealth as prescribed by the commission the amount of the premium and administrative expenses attributable to the political subdivision. The state treasurer shall recoup any past due costs from the political subdivision's cherry sheet under section 20A of chapter 58 and transfer that money to the commission. If a governmental unit fails to pay to the commission the costs of coverage for more than 90 days and the cherry sheet provides an inadequate source of payment, the commission may, at its discretion, cancel the coverage of subscribers of the political subdivision. If the cancellation of coverage is for nonpayment, the political subdivision shall provide all subscribers health insurance coverage under plans which are the actuarial equivalent of plans offered by the commission in the preceding year until there is an agreement with the public employee committee providing for replacement coverage.

The commission may charge the political subdivision an administrative fee, which shall not be more than 1 per cent of the cost of total premiums for the political subdivision, to be determined by the commission which shall be considered as part of the cost of coverage to

determine the contributions of the political subdivision and its employees to the cost of health insurance coverage by the commission.

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare part A at no cost to the retiree, spouse or dependents, shall be required to be insured by a Medicare extension plan offered by the political subdivision under section 11C or section 16. A retiree shall provide the political subdivision, in such form as the political subdivision shall prescribe, such information as is necessary to transfer to a Medicare extension plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health insurance coverage. The political subdivision may from time to time request from a retiree, a retiree's spouse and dependents, proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare part A and part B coverage. The political subdivision shall pay the Medicare part B premium penalty assessed by the federal government on those retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan.

(g) The decision to implement this section shall not be subject to collective bargaining pursuant to chapter 150E or section 19.

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or change eligibility standards for health insurance under the definition of "employee" in section 2.

(i) Notwithstanding any other general or special law to the contrary, in the event that an agreement, either executed or modified, was reached by an appropriate public authority and the public employee committee to transfer all subscribers, for whom the authority provides health insurance coverage, to the commission under this section, its retirees, surviving spouses and their dependents may enroll in the dental insurance plan provided by the commission to retirees, surviving spouses and their dependents insured under chapter 32A, at premium contribution ratios that requires retirees, surviving spouses and their dependents to contribute 100 per cent of the dental insurance premium and administrative fee. The commission shall provide dental insurance coverage, under its plan for retirees, surviving spouses and their dependents insured under chapter 32A, to retirees, surviving spouses and their dependents who elect the coverage under this subsection, as it so provides health insurance coverage under this section. The commission may charge an administrative fee, which shall not be more than 1 per cent of the cost of total dental insurance premiums for the retirees, surviving spouses and their dependents who enroll in the dental insurance plan under this subsection, to be determined by the commission which shall be considered as part

of the cost of coverage for purposes of determining the contributions of the political subdivision and its retirees, surviving spouses and their dependents to the cost of insurance coverage by the commission.

NEW REGULATIONS –
801 CMR 52.00 MUNICIPAL HEALTH INSURANCE

52.01 General provisions
- (1) Authority
- (2) Definitions
- (3) Notices

52.02 The vote by a political subdivision to implement changes in group health insurance benefits pursuant to M.G.L. c. 32B, §§ 21-23
- (1) Advance notice of intent to vote.
- (2) Notice of vote, request for name and contact information for the public employee committee representatives, and number of eligible unit members

52.03 The Implementation Notice

52.04 The thirty-day negotiation period

52.05 Health insurance review panel

52.06 Health insurance review panel process

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

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:

47
48 "Collective bargaining unit" means an employee organization as defined in
49 M.G.L. c. 150E, §1 that is acting as the exclusive bargaining representation of the
50 bargaining unit. Notice to a collective bargaining unit under 801 CMR 52.02 shall
51 be made to the principal officer of each bargaining unit.
52
53
54 "Impartial member" means the member of the review panel selected from a list of
55 3 potential members provided by the Secretary of Administration and Finance
56 under the process set forth in 801 CMR 52.05(1).
57
58 "Implementation notice" means the notice required under M.G.L. c. 32B, §21(b)
59 of the intent to enter into negotiations to implement proposed changes to health
60 insurance benefits.
61
62 "Insurance advisory committee" means an advisory committee established by a
63 public authority as specified in M.G.L. c. 32B, §3.
64
65 "Limited provider network" means a reduced or selective provider network which
66 is smaller than a carrier's general provider network and from which the carrier
67 may choose to exclude from participation other providers who participate in the
68 carrier's regional provider network or general provider network for the purpose of
69 reducing premium costs but which offers the same benefits to those provided by
70 the carrier's general provider network .
71
72 "Maximum possible savings" is used to determine whether a proposal to transfer
73 subscribers to the Commission would achieve at least five percent greater savings
74 than the maximum possible savings that would be attained by plan design changes
75 authorized under M.G.L. c. 32B, § 22 and means the savings that would be
76 realized for the first 12 months if a political subdivision were to provide health
77 insurance coverage to its subscribers by implementing changes to health insurance
78 benefits that equal the dollar amounts of the most-subscribed plan's design
79 features for the same or most similar benefits offered by the commission for a
80 non-Medicare plan under section 4 of M.G.L. c. 32A and for a Medicare-
81 extension plan under section 10C and section 14 of M.G.L. c. 32A. Where the
82 political subdivision currently does not offer a tiered provider network, the
83 maximum possible savings shall be calculated by comparing the savings that
84 would result if the dollar amounts of the co-pays, deductibles and other cost-
85 sharing plan design features in the political subdivision's plan equaled the dollar
86 amounts of the co-pays, deductibles and other cost-sharing plan design features
87 under tier 2 of the commission's most-subscribed plan. Where the political
88 subdivision currently offers a tiered provider network that is tiered differently
89 from the tiering in the commission's most-subscribed plan, the maximum possible
90 savings shall be calculated by assuming the co-pays, deductibles and cost-sharing
91 plan design features in each tier of the political subdivision's plan are equal to
92 those in the same tier of the commission's most-subscribed plan, beginning with a

93 comparison of the highest tier. If the political subdivision's plan has fewer tiers
94 than the commission's plan, the political subdivision's highest tier shall be
95 compared to the commission's tier 3, and the second highest tier to the
96 commission's tier 2.
97
98
99 "Mitigation proposal" means a proposal to mitigate, moderate or cap the impact
100 of these changes for subscribers, including retirees, low income subscribers and
101 subscribers with high out-of-pocket health care costs, who would otherwise be
102 disproportionately affected.
103
104
105 "Public Employee Committee" means the committee established under M.G.L. c.
106 32B, §19 or § 21. If a public employee committee has not been established under
107 Section 19, a public employee committee shall be established exclusively to
108 negotiate changes under Sections 21 to 23, and shall be established in the same
109 form and with the same percent votes as prescribed in the fifth paragraph of
110 subsection (a) of Section 19. A public employee committee established under
111 Section 21 exclusively to negotiate changes under M.G.L. c. 32B, §§ 21 to 23
112 shall be considered dissolved upon completion of the process described in those
113 sections.
114
115 "RSCME" means the Retired State, County and Municipal Employees
116 Association, located at 11 Beacon Street, Suite 321, Boston, MA 02108.
117
118 "Review panel" means the municipal health insurance review panel comprised of
119 3 members, 1 of whom shall be appointed by the public employee committee, 1 of
120 whom shall be appointed by the public authority and 1 of whom shall be selected
121 under the process set forth in 801 CMR 52.05(1).
122
123
124 "Secretary" means the Secretary of Administration and Finance.
125
126 "Tiered provider network" means a provider network in which a carrier assigns
127 providers to different benefit tiers based on the carrier's assessment of a
128 provider's cost efficiency and quality, and in which insureds pay the cost-sharing
129 (copayment, coinsurance or deductible) associated with a provider's assigned
130 benefit tiers.
131
132
133 *(3) Notices.*
134
135 (a) All notices provided under 801 CMR 52.00 shall be sent by certified mail,
136 delivery confirmation and return receipt requested, and a copy shall be sent to the
137 Secretary. Either post office evidence of attempted delivery or return receipts shall be
138 prima facie evidence of the time of receipt.

139
140 (b) All notices to the Secretary shall be sent electronically to:
141 MunicipalHealth@state.ma.us.
142
143
144
145
146
147 *52.02 The vote by a political subdivision to implement changes in group health insurance*
148 *benefits under M.G.L. c. 32B, §§ 21-23*
149
150
151 *(1) Advance notice of intent to vote.*
152
153 At least two calendar days in advance of any vote electing to change group health
154 insurance under the process authorized by M.G.L. c. 32B, §§ 21-23, the
155 appropriate public authority shall send a notice to each collective bargaining unit
156 to which the authority provides health insurance benefits and to the Retired State,
157 County Municipal Employees Association (RSCME) that the political subdivision
158 intends to vote on whether to implement the process. The vote of the political
159 subdivision under M.G.L. c. 32B, § 21(a) may be in the following form: "The
160 [name of political subdivision] elects to engage in the process to change health
161 insurance benefits under M.G.L. c. 32B, §§ 21-23."
162
163 (2) *Notice of vote, request for name and contact information for public employee*
164 *committee representatives, and number of eligible unit members.*
165
166 (a) A political subdivision which has elected under M.G.L. c. 32B, §21(a) to
167 change health insurance benefits under M.G.L. c. 32B, §§ 22-23, shall, before
168 implementing any changes, evaluate its health insurance coverage and determine
169 the savings that may be realized after the first 12 months of implementation of
170 cost-sharing plan design changes or upon transfer of its subscribers to the
171 commission. The appropriate public authority shall then notify its insurance
172 advisory committee, or such committee's regional or district equivalent, of its
173 estimated savings. The notice shall include all the information required in
174 section 52.03. In any political subdivision in which an insurance advisory
175 committee has not already been established under M.G.L. c. 32B, §3, the
176 appropriate public authority shall notify the president of each organization of
177 employees affected and shall designate and notify a retiree of a governmental unit
178 as a member of the committee. The insurance advisory committee, within 10 days
179 after receiving this notice, shall meet with the appropriate public authority to
180 discuss its estimated savings and any reports or other documentation requested by
181 the insurance advisory committee before that meeting. If the committee does not
182 meet within 10 days after receiving proper notice, it shall be considered to have
183 discussed the matter with the appropriate public authority.
184

(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

231 collective bargaining units and the RSCME. The notice shall include the following
232 information:
233
234
235 (a) the proposed changes to the political subdivision's health insurance benefits,
236 including:
237 (i) a description of the political subdivision's current health
238 insurance plans and each plan's co-pays, deductibles and other
239 cost-sharing plan design features, enrollment (broken out by
240 enrollment in individual, individual plus one, and family plans),
241 annual premium total cost, and percentage of premium total cost
242 paid by political subdivision;
243 (ii) a description of the proposed changes, including:(a) the
244 earliest practical date for implementing the changes under law;(b)
245 each plan to be offered, and the projected enrollment under each
246 plan, including continued projected enrollment for subscribers
247 covered by existing collective bargaining agreements that specify
248 plan design features; retirees enrolled and being transferred for the
249 first time to Medicare under M.G. L. c. 32B, § 18A and Medicare
250 supplemental health insurance plans; and subscribers moved to the
251 new, proposed insurance plans; and (c) the proposed dollar
252 amounts for each plan's co-pays, deductibles and other cost-
253 sharing plan design features. A proposal shall not include a health
254 benefit plan design feature which seeks to achieve premium
255 savings by offering a limited network of providers unless the
256 appropriate public authority also offers a health benefit plan to all
257 subscribers that does not contain a limited network of providers.
258
259
260 (b). the co-payments, deductibles, tiered provider network co-payments and other
261 cost-sharing plan design features for the same or most similar benefits of the non-
262 Medicare plan and the co-payments, deductibles, and other cost-sharing plan
263 design features for the same or most similar benefits of the Medicare-extension
264 plan with the largest subscriber enrollment offered by the Commission, as
265 provided by the Commission under M.G.L. c. 32B, §28;
266
267 (c). the appropriate public authority's estimate of anticipated savings of such
268 changes and the supporting information and analysis, including but not limited to:
269
270 i. the total projected premium costs and enrollment of plans under
271 the existing coverage for the first 12-month period in which the
272 appropriate public authority seeks to make changes as if no such
273 changes were made,
274

275 ii. the anticipated total projected premium costs of plans, including
276 plans with the proposed changes, and anticipated enrollment for
277 the same 12-month period,
278
279 iii. the analysis that the appropriate public authority has to support
280 its estimate of savings and the projected premium costs which may
281 include quotes or bids from any insurance plan, third party
282 administrator or insurance broker regarding the total premium cost
283 of such plans with and without the proposed changes; demographic
284 data regarding the number of employees, the number of
285 subscribers, the number of subscribers enrolled in non-Medicare
286 plans (by coverage -family or individual) and Medicare-extension
287 plans; any data regarding out-of-pocket costs paid by subscribers;
288 and any other factors relied upon by the appropriate public
289 authority, including any information provided by an actuary or
290 other consultant in developing the savings estimate.
291
292 If the appropriate public authority has indicated that it is
293 considering transferring to the commission, it shall include in its
294 analysis the estimates regarding plan choice that subscribers will
295 make if transferred to the commission.
296
297
298
299
300
301 The savings estimate shall not take into account: savings resulting
302 from transferring eligible retirees to Medicare under M.G.L. c.
303 32B, § 18A, but the savings estimate shall include savings due to
304 proposed increases in dollar amounts for co-pays and deductibles
305 for Medicare-extension plans under M.G.L. c. 32B, § 22 or the
306 savings resulting from the transfer to Commission's medicare
307 extension plans under M.G.L. c. 32B, §23.
308
309 The savings estimate shall be calculated based on the number of
310 subscribers who will be covered under the proposed plans,
311 including subscribers covered by existing collective bargaining
312 agreements for whom implementation of the proposed changes
313 would be delayed under St. 2011, c. 69, § 4. The appropriate public
314 authority shall allocate funds to the mitigation plan in proportion to
315 the number of total subscribers who will be covered under the
316 proposed plan, with additional funds allocated when the plan
317 changes are implemented for additional subscribers Subscribers
318 will not be eligible for mitigation funds before they are transferred
319 to the new plans.
320

321 If the proposed change involves a transfer of health insurance
322 coverage of subscribers to the commission, the savings estimate
323 shall be based on a determination of maximum possible savings.
324
325 (d) the mitigation proposal, including:
326 (i) the estimate of the cost to fund the proposal and what
327 percentage that cost is of the savings;
328 (ii) an explanation and rationale for the proposal;
329 (iii) the manner in which it affects various subscribers, including
330 those disproportionately affected;
331 (iv) the manner of distribution or allocation of estimated savings
332 from the proposal.
333
334
335
336
337
338 *52.04 The 30-day negotiation period*
339
340 (1) The 30 (calendar) day negotiation period shall commence when each member of the
341 public employee committee has received the implementation notice, with the information
342 required under Section 52.03, in the manner specified under 801 CMR 52.01(3).
343
344 (2) The negotiations between the public employee committee and the appropriate public
345 authority may include all aspects of the public authority's proposal. The parties are
346 encouraged to negotiate in good faith.
347
348 (3) The public authority shall not implement any changes in health insurance benefits
349 during negotiations absent mutual agreement of the public employee committee and the
350 appropriate public authority.
351
352 (4) Any agreements reached between the public employee committee and the appropriate
353 public authority shall be reduced to writing, and executed by the parties within the 30-day
354 period.
355
356 (a) A written agreement shall include the plan design changes or transfer to the
357 Commission, the process to notify subscribers of the changes, the timeframe to
358 implement the changes and the mitigation plan. The same information required
359 for the appropriate public authority's proposal under Section 52.03 shall be
360 included in the agreement or in a separate document accompanying it. The
361 appropriate public authority shall send a copy of the agreement and other
362 documents accompanying it to the Secretary within 3 business days after
363 execution of the agreement, and shall send notice to the health insurance review
364 panel created under 801 CMR 52.05 that there is no need for its services.
365

(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.

410 (c) Within 3 business days after receiving the list, the appropriate public authority
411 and the public employee committee shall jointly select the third member for the
412 panel from the list and shall notify the Secretary of their joint selection.
413
414 (d) If the appropriate public authority and the public employee committee cannot
415 agree within 3 business days on which person from the list to select as the third
416 member of the review panel, the notice by the public authority to the Secretary
417 shall include notification that the parties have been unable to reach agreement of
418 the selection of a name from the list of potential impartial panel members. If the
419 public authority and the public employee committee cannot agree, the Secretary
420 shall appoint the impartial member from the list and notify the parties not later
421 than the end of the 30-day negotiation period.
422
423
424
425 (2) If the appropriate public authority and the public employee committee are
426 unable to reach a written agreement on the public authority's proposal within 30
427 calendar days, the matter shall be submitted to the municipal health insurance
428 review panel. The appropriate public authority shall submit its original proposal to
429 the panel within 3 business days after the end of the 30-day negotiation period,
430 with a copy sent to the Secretary and each member of the public employee
431 committee. The appropriate public authority shall submit to the panel the same
432 proposal that it made to the public employee committee. If the proposal includes
433 the introduction of a limited network plan, the appropriate public authority shall
434 provide an enrollment survey, a determination of which subscribers would enroll
435 in a broad plan and which subscribers would enroll in a limited network plan, and
436 the effect that the addition of a limited network plan would have on total premium
437 costs and on disproportionately affected subscribers. The results of the
438 enrollment survey shall be considered in the savings analysis.
439
440 (3) The public employee committee shall also submit any alternate mitigation
441 proposal to the panel and any other information the public employee committee
442 wants the panel to consider with respect to any other matters before them within 3
443 business days after the end of the 30-day negotiation period, with a copy sent to
444 the Secretary and the other parties.
445
446
447 (4) Any fee or compensation provided to the impartial panel member for service
448 on the panel shall be shared equally between the public employee committee and
449 the appropriate public authority. The impartial members selected from the lists
450 provided by the Secretary will be reimbursed only for reasonable travel expenses.
451
452 *52.06 The health insurance review panel review process*
453
454

455 (1) At any time before the panel has made decisions in accordance with this
456 section, the parties may agree in writing, with copies to the panel and the
457 Secretary, to terminate or suspend the review process for a stated period of time
458 because they have reached an agreement, would like additional time to negotiate
459 an agreement under Section 52.04, have mutually decided to return to collective
460 bargaining pursuant to M.G.L. c. 150E or have mutually decided to resume
461 negotiations under M.G.L. c. 32B, § 19.
462
463 (2) If both parties have not mutually agreed to terminate the review process,
464 within 2 business days after receipt of notice of submission to the panel, the
465 impartial member of the review panel shall fix a time, date, and place for the
466 panel to convene and shall give notice to the parties.
467
468 (3) Meetings of the panel shall be conducted under the Open Meeting Law. The
469 impartial member shall chair the panel's meetings and shall arrange for suitable
470 records to be kept. The impartial member shall ensure that each member receives
471 advance notice of the time, place and agenda for each meeting. All decisions
472 shall be by recorded vote.
473
474
475 (4)When the panel convenes on the date and time set by the impartial panel
476 member, the panel shall do the following:
477
478 *(a) Review the public authority's proposed changes*
479
480 (1) Determine within 10 days whether the proposed increased
481 dollar amounts for co-payments, deductibles, and other cost-
482 sharing plan design features for the non-Medicare plan under
483 M.G.L. c. 32B, § 22 exceed the dollar amounts of the plan design
484 features for the same or most similar benefits offered by the
485 commission for the non-Medicare plan under section 4 of M.G.L.
486 c.32A with the largest subscriber enrollment,. If such increased
487 amounts do not exceed the dollar amounts of the plan design
488 features for the same or most similar benefits offered by the
489 commission for the non-Medicare plan under section 4 of chapter
490 32A with the largest subscriber enrollment, the panel shall approve
491 the appropriate public authority's immediate implementation of the
492 proposed changes under M.G.L. c. 32b, § 22, subject to Section
493 52.07. Where the political subdivision is not proposing a tiered
494 provider network, the determination shall be made by comparing
495 the savings that would result if the dollar amounts of the co-pays,
496 deductibles and other cost-sharing plan design features in the
497 political subdivision's plan equaled the dollar amounts of the co-
498 pays, deductibles and other cost-sharing plan design features under
499 tier 2 of the commission's most-subscribed plan. Where the
500 political subdivision currently is proposing a tiered provider

501 network that is tiered differently from the tiering in the
502 commission's most-subscribed plan, the determination shall be
503 made by assuming the co-pays, deductibles and cost-sharing plan
504 design features in each tier of the political subdivision's plan are
505 equal to those in the same tier of the commission's most-
506 subscribed plan, beginning with a comparison of the highest tier.
507 If the political subdivision's plan has fewer tiers than the
508 commission's plan, the political subdivision's highest tier shall be
509 compared to the commission's tier 3, and the second highest tier to
510 the commission's tier 2.
511
512
513 (2) Determine within 10 days whether the proposed increased
514 dollar amounts for co-payments and deductibles proposed for a
515 Medicare-extension plan under M.G.L. c. 32B, §22 exceed the
516 dollar amounts of the plan design features for the same or most
517 similar benefits offered by the commission for the Medicare-
518 extension plan under section 10C and section 14 of M.G.L. c.32A
519 with the largest subscriber enrollment. If such increased amounts
520 do not exceed the dollar amounts of the plan design features for the
521 same or most similar benefits offered by the commission for the
522 Medicare-extension plan under section 4 of chapter 32A with the
523 largest subscriber enrollment, the panel shall approve the
524 appropriate public authority's immediate implementation of the
525 proposed changes under M.G.L. c. 32B, § 22, subject to Section
526 52.07. Where the political subdivision is not proposing a tiered
527 provider network, the determination shall be made by comparing
528 the savings that would result if the dollar amounts of the co-pays,
529 deductibles and other cost-sharing plan design features in the
530 political subdivision's plan equaled the dollar amounts of the co-
531 pays, deductibles and other cost-sharing plan design features under
532 tier 2 of the commission's most-subscribed plan. Where the
533 political subdivision currently is proposing a tiered provider
534 network that is tiered differently from the tiering in the
535 commission's most-subscribed plan, the determination shall be
536 made by assuming the co-pays, deductibles and cost-sharing plan
537 design features in each tier of the political subdivision's plan are
538 equal to those in the same tier of the commission's most-
539 subscribed plan, beginning with a comparison of the highest tier.
540 If the political subdivision's plan has fewer tiers than the
541 commission's plan, the political subdivision's highest tier shall be
542 compared to the commission's tier 3, and the second highest tier to
543 the commission's tier 2.
544
545

546 (3) If the panel does not approve implementation because the
547 appropriate public authority's proposal fails to meet the criteria
548 detailed in Section 52.06(4)(a)(1) and (2), above , the appropriate
549 public authority may submit a new proposal to the public employee
550 committee and restart the process from that point pursuant to
551 Section 52.03.
552
553 (b) Review the public authority's estimated monetary savings due to
554 proposed changes, after consulting the Commission's actuary:
555
556 (1) Within 10 calendar days of receiving proposed changes under
557 M.G.L. c. 32B, §§ 22 or 23, the panel shall confirm, the
558 appropriate public authority's estimated monetary savings due to
559 proposed changes under M.G.L. c. 32B, § 22 or § 23.
560
561 (2) If the proposal is to transfer subscribers to the Commission, the
562 panel shall determine if the anticipated savings by doing so would
563 be at least five percent greater than the maximum possible savings
564 amount that would be attained by plan design changes authorized
565 under M.G.L. c.32B, § 22. If the panel confirms these savings, the
566 panel shall approve the appropriate public authority's immediate
567 implementation of the proposed changes under M.G.L. c. 32B, §
568 23, subject to procedures adopted by the commission for transfer
569 of subscribers.
570
571 (3) The appropriate public authority's estimate of savings due to
572 the proposed changes shall be confirmed by the panel after
573 consultation with the actuary selected by the Commission.
574
575 (4) If the panel finds that the savings estimate is unsubstantiated, it
576 may require the public authority to provide additional information
577 or submit a new savings estimate for the panel's review and
578 confirmation. It may also require the public employee committee
579 to submit a response to the new estimate.
580
581 (5) A certified copy of the vote confirming the savings estimate
582 and, if the proposal is to transfer subscribers to the Commission,
583 approval or rejection of the proposal, and explanation of the basis
584 for any such change or disapproval shall be sent to the parties and
585 the Secretary.
586
587 (c) Review the public authority's mitigation proposal:
588
589 (1) Within 10 calendar days of receiving proposed changes under
590 M.G.L. c. 32B, § 22 or § 23, the panel shall review the proposal to
591 mitigate, moderate or cap the impact of these changes for

592 subscribers, including retirees, low-income subscribers and
593 subscribers with high out-of-pocket health care costs, who would
594 otherwise be disproportionately affected.
595
596 (2) The municipal health insurance review panel may approve the
597 mitigation proposal, or it may determine the proposal to be
598 insufficient and may require additional savings to be shared with
599 subscribers in the form of health reimbursement arrangements,
600 wellness programs, health care trust funds for emergency medical
601 care or inpatient hospital care, out-of-pocket caps, Medicare Part B
602 reimbursements or reimbursements for other qualified medical
603 expenses, as determined by the panel. Premium reductions for
604 subscribers that result from the plan design changes shall not be
605 credited against the total amount determined to be required to fund
606 the mitigation proposal. Any health reimbursement arrangements
607 created under a mitigation proposal shall be administered by the
608 appropriate public authority and shall not be the responsibility of
609 the Commission.
610
611 (3) In no case shall the municipal health insurance review panel
612 designate more than 25 percent of the estimated savings to
613 subscribers.
614
615 (4) All obligations on behalf of the appropriate public authority
616 related to the mitigation proposal shall expire after the initial
617 amount of estimated savings designated by the panel to be
618 distributed to subscribers has been expended.
619
620 (5) In reaching a decision on the proposal under this subsection,
621 the municipal health insurance review panel may consider: (a) any
622 alternative proposal from the public employee committee to
623 mitigate, moderate or cap the impact of these changes for
624 subscribers, (b) discrepancies between the percentage contributed
625 by retirees, surviving spouses and their dependent and the
626 percentage contributed by other subscribers, and (c) the impact of
627 the changes on subscribers, including in particular the impact on
628 retirees, low-income subscribers and subscribers with high out-of-
629 pocket costs.
630
631
632 (6) The panel's decision shall incorporate any agreements made
633 by the parties, and shall constitute the written agreement between
634 the public employee committee and the appropriate public
635 authority. The agreement shall be binding on all subscribers and
636 their representatives.
637

638 (d) Once the panel has taken the actions required above, the panel shall be
639 considered dissolved.
640
641 *52.07 Implementation of agreements reached pursuant to M.G.L. c. 32B, §§ 21- 23*
642
643
644 (1) Subject to St. 2011, c. 69, § 4, a political subdivision shall implement changes to benefits
645 for all subscribers as soon as practicable upon completing the process provided in M.G.L.
646 c. 32B, § 21 and these regulations, but the public authority shall give subscribers at least
647 60 days notice before implementing any changes in health insurance benefits under these
648 regulations. Implementation of changes under M.G.L. c. 32B, §22 shall occur not later
649 than 90 days after a written agreement has been signed under 801 CMR 52.04 or 52.06
650 or, if the appropriate public authority and the public employee committee mutually
651 determine that a mid-year change time would produce an undue burden, at the end of the
652 current health insurance policy year. Implementation of transfer of subscribers to the
653 commission shall be in accordance with the Commission's procedures. If a political
654 subdivision provides notice to the commission by October 1, 2011 that it is transferring
655 its subscribers to the commission and complies with the notice requirements provided by
656 the Commission, the Commission shall allow the political subdivision to transfer its
657 subscribers to the commission on or before January 1, 2012.
658
659 (2) Any political subdivision which does not seek to make changes under M.G.L. c. 32B,
660 §§ 21-23, including any political subdivision which votes against adopting G.L. c. 32B,
661 §§ 21-23, shall file with the Executive Office for Administration and Finance a report by
662 June 30, 2012 comparing existing plan design to the maximum possible savings available
663 if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23. To maintain
664 comprehensive records of political subdivisions that make use of this process, savings in
665 health insurance costs that resulted, and potential savings not achieved, and to measure
666 the extent to which political subdivisions took advantage of this process, each political
667 subdivision shall file an annual report by June 30 of each year with the Secretary
668 showing:
669 (i) the health insurance plans that it offers and the number of subscribers in each;
670 (ii) whether it made use of M.G.L. c. 32B, § 19 or §§ 21-23;
671 (iii) if it did not make use of these processes, the maximum possible savings available if
672 health benefit changes were made pursuant to M.G.L. c. 32B, §21-23.
673
674 (3) A political subdivision whose subscribers are currently covered by the commission shall
675 not implement changes under this procedure until it has followed the procedure for
676 withdrawal from coverage by the commission under the process set forth in the
677 commission's regulations.
678
679 (4) If a political subdivision initiated the process for implementing changes in its group
680 health insurance benefits under M.G.L. c. 32B, §§21 -23 before the effective date of these
681 regulations and has proceeded in a manner inconsistent with any provision of these
682 regulations, the Secretary may waive or modify those inconsistent provisions for that
683 political subdivision provided that the political subdivision comply with all requirements

684 of M.G.L. c. 32B, §§21-23. An appropriate public authority shall seek such waiver from
685 the Secretary in writing, with a copy to the public employee committee. Any member of
686 the public employee committee may present the Secretary with its position on the waiver
687 request within 3 business days of receipt of the request.
688
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