H 3580

Chapter 69

THE COMMONWEALTH OF MASSACHUSETTS

In the Year Two Thousand and Eleven

AN ACT RELATIVE TO MUNICIPAL HEALTH INSURANCE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is immediately to authorize municipalities to implement local health insurance changes, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 32B of the General Laws is hereby amended by striking out section 2, as appearing in the 2008 Official Edition, and inserting in place thereof the following section:-

Section 2. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Appropriate public authority", as to a county, except Worcester county, the county commissioners; as to a city, the mayor; as to a town, the selectmen; as to a district, the governing board of the district and for the purposes of this chapter if a collective bargaining agreement is in place, as to a commonwealth charter school as defined by section 89 of chapter 71, the board of trustees; and as to an education collaborative, as defined by section 4E of chapter 40, the board of directors.

"Commission", the group insurance commission established by section 3 of chapter 32A.

"Dependent", an employee's spouse, an employee's unmarried children under 19 years of age and any child 19 years of age or over who is mentally or physically incapable of earning the child's own living; provided, however, that any additional premium which may be required shall be paid for the coverage of such child 19 years of age or over; provided further, that "dependent" shall also include an unmarried child 19 years of age or over who is a full-time student in an educational or vocational institution and whose program of education has not been substantially interrupted by full-time gainful employment, excluding service in the armed forces; provided further, that any additional premium which may be required for the coverage of such student shall be paid in full by the employee. The standards for such full-time instruction and the time required to complete such a program of education shall be determined by the appropriate public authority.

"District", any water, sewer, light, fire, veterans' services or other improvement district or public unit created within 1 or more political subdivisions of the commonwealth to provide public services or conveniences.

"Employee", any person in the service of a governmental unit or whose services are divided between 2 or more governmental units or between a governmental unit and the commonwealth, and who receives compensation for any such service, whether such person is employed, appointed or elected by popular vote, and any employee of a free public library maintained in a city or town to the support of which that city or town annually contributes not less than one-half of the cost; provided, however, that the duties of such person require not less than 20 hours, regularly, in the service of the governmental unit during the regular work week of permanent or temporary employment; provided further, that no seasonal employee or emergency employees shall be included, except that persons elected by popular vote may be considered eligible employees during the entire term for which they are elected regardless of the number of hours devoted to the service of the governmental unit. A member of a call fire department or other volunteer emergency service agency serving a municipality shall be considered an employee, if approved by vote of the municipal legislative body, and the municipality shall charge such individual 100 per cent of the premium. If an employee's services are divided between governmental units, the employee shall, for the purposes of this chapter, be considered an employee of the governmental unit which pays more than 50 per cent of the employee's salary. But, if no one governmental units pays more than 50 per cent of that employee's salary, the governmental unit paying the largest share of the salary shall consider the employee as its own for membership purposes, and that governmental unit shall contribute 50 per cent of the cost of the premium. If the payment of an employee's salary is equally divided between governmental units, the governmental unit having the largest population shall contribute 50 per cent of the cost of the premium. If an employee's salary is divided in any manner between a governmental unit and the commonwealth, the governmental unit shall contribute 50 per cent of the cost of the premium. An employee eligible for coverage under this chapter shall not be eligible for coverage as an employee under chapter 32A. Teachers and all other public school employees shall be deemed to be employees during the months of July and August under this chapter; provided, however, that employee contributions for such health insurance for those 2 months are deducted from the compensation paid for services rendered during the previous school year. A determination by the appropriate public authority that a person is eligible for participation in the plan of insurance shall be final. Nothing in this paragraph shall apply to Worcester county or its employees.

"Employer", the governmental unit.

"Governmental unit", any political subdivision of the commonwealth.

"Health care flexible spending account", a federally-recognized tax-exempt health benefit program that allows an employee to set aside a portion

of earnings to pay for qualified expenses as established in an employer's benefit plan.

"Health care organization", an organization for the group practice of medicine, with or without hospital or other medical institutional affiliations, which furnishes to the patient a specified or unlimited range of medical, surgical, dental, hospital and other types of health care services.

"Health reimbursement arrangement", a federally-recognized tax-exempt health benefit program funded solely by an employer to reimburse subscribers for qualified medical expenses.

"Optional Medicare extension", a program of hospital, surgical, medical, dental and other health insurance for such active employees and their dependents and such retired employees and their dependents, except elderly governmental retirees insured under section 11B, as are eligible or insured under the federal health insurance for the aged act, as may be amended from time to time.

"Political subdivision", any county, except Worcester county, city, town or district.

"Savings", for the purposes of sections 21, 22 and 23, shall mean the difference between the total projected premium costs for health insurance benefits provided by a political subdivision with changes made to health insurance benefits under section 22 or 23 for the first 12 months after the implementation of such changes and the total projected premium costs for health insurance benefits provided by that subdivision without such changes for the same 12 month period.

"Subscribers", employees, retirees, surviving spouses and dependents of the political subdivision and may include employees, retirees, surviving spouses and dependents of a district who previously received health insurance benefits through the political subdivision.

SECTION 2. Section 12 of said chapter 32B is hereby amended by adding the following paragraph:-

The board of a trust or joint purchase group established by 2 or more governmental units may vote to implement changes to co-payments, deductibles, tiered provider network copayments and other cost-sharing plan design features which do not exceed those which an appropriate public authority may offer under section 22; provided, however, that each governmental unit that is a member of a trust or group shall comply with the requirements set forth in section 21 before any such changes may be applied to the health insurance coverage of such governmental unit's subscribers. If such changes to the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features do not exceed those permitted under section 22, such changes shall be approved in accordance with the provisions of section 21.

SECTION 3. Said chapter 32B is hereby further amended by adding the following 9 sections:-

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. 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.

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.

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 and the transfer of subscribers to the commission shall take effect on the following July 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.

Section 24. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter may provide health care flexible spending accounts to allow certain subscribers, as determined by the appropriate public authority, to set aside a portion of earnings to pay for qualified expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 25. Notwithstanding any general or special law or regulation to the contrary, the appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter or transfer its subscribers to the commission under this chapter may provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 26. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter shall conduct an enrollment audit not less than once every 2 years. The audit shall be completed in order to ensure that members are appropriately eligible for coverage.

Section 27. An insurance carrier, third party purchasing group or administrator or the commission in the case of a governmental unit, which has undertaken to provide health insurance coverage to its subscribers by acceptance of sections 19 or 23, shall, upon written request, provide the governmental unit or public employee committee with its historical claims data within 45 days of such request; provided, that all personally identifying information within such claims shall be redacted and released in a form and manner compliant with all applicable state and federal privacy statutes and regulations including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996.

Section 28. Nothing in section 21, 22 or 23 shall be construed to prevent 2 or more governmental units under a joint purchase or trust agreement from jointly negotiating and purchasing coverage as authorized in section 12.

Section 29. Each fiscal year, the commission shall prepare and place on its website a report delineating the dollar amount of the copayments, deductibles, tiered provider network co-payments and other design features offered by the commission in the non-Medicare plan with the largest subscriber enrollment and the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the commission in the Medicare extension plan with the largest subscriber

enrollment. The commission shall also provide information on its plans with the largest subscriber enrollment upon request of any appropriate public authority or political subdivision.

SECTION 4. Notwithstanding any general or special law to the contrary, an appropriate public authority that implements changes to health insurance benefits pursuant to sections 22 and 23 of chapter 32B of the General Laws shall delay implementation of such changes, as to those subscribers covered by a collective bargaining agreement or section 19 agreement that is in effect on the date of implementation of such changes, of any changes to the dollar amounts of copayments, deductibles or other cost-sharing plan design features that are inconsistent with any dollar limits on copayments, deductibles or other cost-sharing plan design features that are specifically included in the body of that collective bargaining agreement or section 19 agreement, until the initial term stated in that collective bargaining agreement or section 19 agreement has ended.

SECTION 5. Nothing in this act shall be construed to alter, amend or affect chapter 36 of the acts of 1998, chapter 423 of the acts of 2002, chapter 27 of the acts of 2003 or chapter 247 of the acts of 2004.

SECTION 6. Notwithstanding any general or special law to the contrary, the group insurance commission shall prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before January 1, 2012, if such political subdivision provides notice to the group insurance commission on or before September 1, 2011, that it is transferring its subscribers to the group insurance commission under sections 19 or 23 of chapter 32B of the General Laws; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before April 1, 2012, if such political subdivision provides notice to the group insurance commission on or before December 1, 2011, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before July 1, 2012, if such political subdivision provides notice to the group insurance commission on or before March 1, 2012, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B.

SECTION 7. Notwithstanding any general or special law to the contrary, unless otherwise agreed, a governmental unit transferring its subscribers to the group insurance commission under section 23 of chapter 32B of the General Laws shall use current contribution ratios in existence for each class of plan for each collective bargaining unit in order to transfer to the commission.

If a governmental unit was not offering both a preferred provider organization plan or an indemnity plan on the date of transfer to the commission, the governmental unit's initial contribution ratio toward the commission's preferred provider organization plans and indemnity plans shall be the ratio that the governmental unit was contributing toward its preferred provider organization plan or indemnity plan for each collective bargaining unit on that date. Except as specifically provided in this section, all contribution ratios shall remain subject to bargaining pursuant to chapter 32B of the General Laws and chapter 150E of the General Laws.

House of Representatives, July 11, 2011.

Preamble adopted, Paul J. Donato, Speaker.

In Senate, July 11, 2011.

Preamble adopted, Kenneth I. Donnelly, President.

House of Representatives, July 11, 2011.

Bill passed to be re-enacted, Paul J. Donato, Speaker.

In Senate, July 11, 2011.

Bill passed to be re-enacted, Kenneth I. Donnelly, President.

12 July, 2011.

Approved,

at 11 o'clock and 36 minutes, A. M.

Deval L. Patrick, Governor.

SECRETARY OF STATE
REGULATIONS DIVISION
2011 JUL 12 PM 12:47