
**Massachusetts Department of Revenue
Division of Local Services**

**LOCAL EMPLOYEES
Current Employment Benefit Issues**



2011

Workshop C

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www.mass.gov/dls

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Local Employees – Current Employment Benefit Issues

Table of Contents

New Municipal Health Insurance Reform Law Slides	1
Case Study 1 – Conflict of Interest	10
Case Study 2 – Health Care Reform	11
Case Study 3 - OPEB Fund	12
References	13
Chapter 69 of the Acts of 2011	13
Notice of Public Comment Period for Final Health Reform Regs	25
Emergency Health Reform Regulations	26
Specific Legal References for Case Study 1 – Conflict of Interest	42
State Ethics Commission Response on Conflict of Interest 9/2/2011	42
MGL c. 268A, §19	45
Ethics Commission Advisory 05-05: The Rule of Necessity	46
Specific Legal References for Case Study 2 – Health Care Reform	49
MGL c. 30A, §§18 & 20	49
MGL c. 44, §31	49
MGL c. 71, §34	50
MGL c. 150E, §§1 & 7	50
MGL c. 32B, §§2, 3, 7A & 16	52
Email Response 2010-855-Group Insurance Issues	54
<u>Watertown Firefighters, Local 1347, IAFF, AFL-CIO v Town of Watertown</u> , 376 Mass. 706 (1978)	57
Chapter 68 of the Acts of 2011 – Sections on Health Ins. Reform	67
Specific Legal References for Case Study 3 – OPEB Fund	68
MGL c. 32B, §20 as added by c. 479 of the Acts of 2008	68
Chapter 68 of the Acts of 2011: OPEB Fund Amendments	68
Email Response 2011-409 – Middleborough OPEB Issue	70
Email Response 2011-589 – Sudbury – OPEB Trust Document	71
Email Response 2009-1278 – Retiree Health Insurance Fund	73
Chapter 72 of the Acts of 2006 – Sudbury OPEB Special Act	74
Chapter 88 of the Acts of 2004 – Wellesley OPEB Special Act	74

The New Municipal Health Insurance Reform Law

Presentation for
Division of Local Services
Department of Revenue
Municipal Law Seminar
September 30, 2011 &
October 4, 2011

The New Municipal Health Insurance Reform Law

- Signed into law by Governor Patrick on July 12, 2011
- Administration & Finance charged with regulations for implementing changes in health insurance plan design under the new law.
 - Emergency Regulations in effect
 - Comment period on regulations ends October 10th
 - A&F then issues Permanent Regulations
 - Regulations online at: www.mass.gov/eoaf

Benefits

- Significant and immediate savings to local governments
- Greater flexibility for local governments over their health insurance decisions
- Preserves meaningful role for labor in the process
- Protects health care quality for retirees and municipal employees
- Provides process for changes in co-pays, deductibles and other cost-sharing features only; changes in contribution rates still subject to collective bargaining
- Savings will be shared with subscribers who are most affected by changes, including retirees, low-income subscribers and those with high out-of-pocket costs

Local Options

- Local option process for cities and towns to implement health care plan design changes
 - Adjust local plan co-pays, deductibles, other cost-sharing plan design features
- OR
 - Join the GIC

Local Option: Change local plans

- Adjust local plan co-pays, deductibles, other cost-sharing plan design features
 - So long as those features are not higher than those offered by GIC
 - GIC benchmark is the most-subscribed GIC plan
 - Benchmark plans available on GIC Web site
 - Most-subscribed Non-Medicare plan
 - Most-subscribed Medicare plan

Local Option: GIC

- Join the GIC
 - Transfer to GIC so long as it would result in 5% more savings than could be achieved through adjustments to your local plans
 - Make this assessment by comparing the savings that would result from adjusting your plan's co-pays, deductibles, other cost-sharing plan design features to same co-pays, deductibles, etc. of GIC benchmark plan

The Process

1. Adopt new law (G.L.c.32B, Sections 21-23) creating process for changing health insurance plan design
 - Vote of Board of Selectmen or City Council
 - Adoption only required once; then use process as often as desired
2. Prepare proposal.
3. Discussion with IAC
4. 30-day negotiation period with PEC
5. 3-person review panel (if necessary)

NOTE: The administrative task of organizing the review panel occurs during the 30-day negotiation period, so the process can move expeditiously to the panel stage if needed (details in the regulations).

The Process: Notices

- Proper and timely notification at each stage of the process is critical.
 - A duly noticed process, with all necessary information provided, will make for a smoother, more efficient and effective process for all involved
- The A&F regulations lay out the notice requirements, including timing and content.
- Copies of all notices, written agreements, and decisions must be submitted to A&F at:
MunicipalHealth@state.ma.us

The Process: Proposal

- Prepare proposal
 - Proposed changes in plan design OR proposed transfer to GIC
 - Estimated savings in first 12 months of implementation of those changes
 - Analysis that supports the savings estimate
 - Proposed mitigation plan for disproportionately affected subscribers
 - Proposed sharing of up to 25% of savings with subscribers by funding mitigation plan

The Process: IAC

- Discussion with IAC
 1. Notify IAC
 2. Provide IAC with estimated savings and documentation
 3. Hold discussion with IAC on proposed changes and estimated savings

The Process: PEC

- Negotiation with PEC
 1. Notification to bargaining units and retiree organization
 2. Provide the proposal to PEC (as part of "Implementation Notice")
 3. 30-day negotiation period with PEC
 - Option for extension of negotiations if both sides agree

✓ Achieve written agreement

 - plan design changes or transfer to GIC, estimated savings, savings sharing, mitigation plan, timeframe for implementing changes, etc.
 - PEC vote is simple majority, by weighted vote using the same allocation that is currently used in Chapter 32B, Section 19, including retiree representative has 10% vote

The Process: Review Panel

- Review Panel
 - If negotiation period does not result in agreement, the matter is referred to a review panel
 - Panel has 10 days to reach a decision
 - 3- member panel
 - PEC appointee
 - Public authority appointee
 - Neutral chosen from list of 3 candidates
 - » List of 3 candidates provided by A&F
 - » Selection made by PEC and public authority appointees or by A&F if appointees cannot agree
 - » Neutral serves as panel chair
 - Panel meetings are subject to Open Meeting Law

The Process: Review Panel

- Panel's tasks during 10 day period:
 1. Confirm that proposed changes don't exceed GIC benchmark
 2. Confirm estimated savings
 3. Review and approve mitigation proposal
- ✓ Panel produces written decision

The Process: Review Panel

- Panel's tasks:
 1. Confirm that proposed changes don't exceed GIC benchmark
- ✓ If don't exceed GIC benchmark, panel approves implementation of changes
- If exceed GIC benchmark, public authority must submit new proposal to PEC and start negotiation process over

The Process: Review Panel

- Panel's tasks:
 2. Confirm estimated savings
- ✓ Panel confirms estimated savings
- OR
- Panel finds savings estimate unsubstantiated
 - Panel can request additional info on savings estimate
 - Panel can request PEC response to savings estimate
- Actuarial assistance provided to Panel

The Process: Review Panel

- Panel's tasks:
 - 3. Review mitigation proposal and any alternative mitigation proposal from PEC
 - ✓ Panel approves proposal for mitigating impact of changes on subscribers and sharing of cost savings for mitigation OR
 - Panel determines proposal insufficient and requires additional savings sharing with subscribers
 - Maximum of 25% of estimated savings can be shared with subscribers through mitigation

The Process: Review Panel

- Panel's tasks:
 - ✓ Panel produces written decision
 - Decision constitutes written agreement between PEC and public authority and is binding on all parties.
 - Panel is dissolved

Implementation of changes

- How soon can a public authority make changes?
 - As soon as practicable after completing the process
 - Then Federal law requires 60 days notice to subscribers before changes implemented
 - In FY2012 only, there are three opportunities to transfer to GIC

Implementation of changes

- Impact of existing labor contracts
 - No changes for subscribers covered under an existing collective bargaining agreement (CBA) that specifies a particular co-pay, deductible or other cost-sharing plan design feature until their CBA expires

Implementation of changes

Reporting on implementation

- Regulations require reporting by each political subdivision
 - health insurance plans offered
 - If took advantage of the new process
 - If didn't take advantage of new process, savings that would have been achieved if took advantage of process to maximum benefit

Implementation of changes

Can a limited network be part of changes?

- Only if also provides a plan without a reduced or selective network.

Implementation of changes

Can a public authority in GIC use the new process to implement benefit changes?

•Entities in GIC must remain in GIC coverage for a minimum of three years, and may withdraw from GIC coverage at three or six year intervals. If an entity withdraws from GIC in compliance with GIC requirements, it may use the new process or the process provided in Chapter 150E (collective bargaining) to make changes in health care plan design.

Implementation of changes

Can a municipality in a health insurance joint purchasing group use the new process to implement benefit changes?

•Review your joint purchasing group's existing decision-making process for making plan design changes to determine if the new process is a good alternative to your existing process.

Implementation of changes

Can a Regional School District use the new process to implement benefit changes?

•If your RSD participates in a joint purchasing group: review the group's existing decision-making process for making plan design changes to determine if the new process is a good alternative to your existing process.

•If your RSD is not in a purchasing group: review you RSD's process to determine if the new process is a good alternative to your existing process. Identify the entities which would serve as the public authority and employee committee.

Compare cost-sharing features of local plan to GIC benchmark plan

Example A: 1 tier local plan

1. \$5	→	GIC
		1. \$10
		2. \$20
		3. \$30

Example B: 2 tier local plan

1. \$5	→	GIC
2. \$10	→	1. \$10
		2. \$20
		3. \$30

Example C: 3 tier local plan

1. \$5	→	GIC
2. \$10	→	1. \$10
3. \$15	→	2. \$20
		3. \$30

Case Study 1

Conflict of Interest

The selectboard of the town of Great Deficit added an item to its agenda for its September 12, 2011 board meeting to accept the new health care reform provisions of Chapter 32B pursuant to M.G.L. c. 32B, §21(a). Of the five members, two were covered under the town's health care plan and another was out of town on that date. One of the members declared at the meeting that he had a conflict of interest as a health plan member and could not vote on the proposed acceptance provision. The other covered member did not believe he had a conflict and asked town counsel, who was present, if he could vote on the measure. Town counsel opined that neither member had a conflict of interest under a general exception to the conflict of interest law based on receipt of a benefit generally provided to the town, and both members could vote. As a result all four members present voted on the measure. The members covered by the health plan voted in favor of accepting the statute, but the other two selectmen voted against and the measure failed. After the meeting, one of the members who had voted against accepting the statute admitted that her husband had just lost his job and she was considering getting on the town's plan.

1. Did the two members covered by the health plan have a conflict of interest?
2. Did the member who was considering to be covered by the town's plan have a conflict of interest?
3. Did the general exception to the conflict law apply in this case?
4. Did any other exception to the conflict law apply in this case?
5. Did the member who was considering being coverage under the town's plan have a conflict by reason of voting against acceptance of the statute?

Case Study 2 Health Care Reform

The small city of Hava Falls accepted the new health care reform provisions of Chapter 32B pursuant to M.G.L. c. 32B, §21(a) on July 12, 2011. The city council meeting to accept the provision had been called on July 11, 2011 as an emergency meeting in anticipation of the enactment of Chapter 69 of the Acts of 2011, which was signed by the Governor earlier in the 12th, with an emergency preamble. The mayor approved the measure the same day and commenced proceedings to implement the reforms by sending a notice to the public employee committee already in existence to convene on July 19, 2011. The mayor's plan as stated in the notice is to ultimately remove the employees to the state's GIC plan. The municipal side employee representatives (police, fire and DPW) and the retiree representative appeared at the meeting on July 19, but the teacher union representative did not appear. The teacher union rep had a 35% weighted vote in the committee. The municipal representatives (55% weighted vote) voted in favor of accepting the mayor's plan, but the retiree representative (10% weighted vote) voted against it. Nothing in the plan required any change in the percentage contributions of the employees for health insurance premiums.

The Hava Falls School Committee had been in negotiations with the teachers' union over a new three year contract, with the current contract due to expire on August 31, 2011. The last offer of the school committee on June 15th had included references to the current health insurance benefits plans of the city, but requiring an increased contribution from the teachers for the indemnity plan from 20% to 25%, and an increased contribution for the HMO plan from 25% to 30%. In exchange the committee had offered a 5% pay increase implemented over the three years, with 2% coming in the first year. The teacher's union accepted the offer on July 15, 2011 and the contract was executed by the parties on July 20, 2011, over the mayor's objection. The school committee budget for FY2012 included only sums necessary to level fund the salaries of its employees and the health insurance premium contributions for the city are included in a general budgeted provision outside the school department budget.

1. Is the teacher contract binding on the parties with respect to the wage increases? Is the teacher contract with respect to providing health insurance using the city's current health plans binding on the parties?
2. Was the city council meeting of July 12th consistent with the open meeting law requirements?
3. Did the vote of the public employee committee on July 19, 2011 bind the city and the employees to take all necessary steps to join the GIC health plan? Did that vote implement the plan?
4. May the school committee contract change the percentage contribution of the teachers for the indemnity plan? For the HMO plan?
5. If the teacher contract contains any provisions that are specifically prohibited by law, or the contract cost items are not fully funded, does the remainder of the contract still govern?

Case Study 3 OPEB Fund

The town of Forsite accepted Massachusetts General Law Chapter 32B, §20 at its March 2011 annual town meeting and appropriated \$100,000 from the levy to the Other Post Employment Benefits (OPEB) fund, to cover future retiree group health insurance obligations of the town. Also at that town meeting it appropriated \$20,000 in its FY2012 town budget for the actuarial study necessary for the initial funding schedule required by the statute. The town's municipal light plant has not accepted Chapter 32B §20 but has proposed to do so at its November 2011 Board meeting and proposes to designate the Light Department Manager to be its custodian.

The board of selectmen voted at its September 12, 2011 board meeting not to expend the funds appropriated for the funding schedule because a July 11, 2011 amendment to the statute eliminated the requirement, effective July 1, 2011. On June 27, 2011 the town treasurer employed an outside custodial service, Trustme Bank, to hold the \$100,000 appropriated by town meeting, agreeing with Trustme that its reasonable fees be withheld from the fund investments, if any, or the fund principal, if necessary. On June 29, 2011 the treasurer transferred \$100,000 from one of the town's bank accounts to Trustme Bank. The treasurer wants the funds to be placed in certificates of deposit, but Trustme is advising diversification in stocks, mutual funds and collateral loans.

1. If the light plant votes to establish its own OPEB fund, may the town's fund be used to pay the future expenses of light plant retirees? May the town's fund be used to pay those expenses if the light plant does not establish its own fund?
2. Does the amended version of the OPEB law apply to the town's fund, which was accepted under the previous version of the statute? If not, doesn't the town have to adopt a funding schedule? If the amended law applies, does the town have any responsibility to provide a funding schedule?
3. May the Light Department Manager serve as the OPEB custodian for the light plant if the light board votes to designate her? If they do so, must the light manager be bonded once the light department appropriates amounts to the light department OPEB fund? May the treasurer legally refuse to transfer funds to the light plant custodian if the custodian is not bonded?
4. Did the treasurer have the authority to transfer \$100,000 to Trustme Bank as a custodian for the OPEB fund on June 29th? If not, would the treasurer have such authority on September 9th? Can the agreement allow for Trustme to withhold its fees for service from the fund? Who has the authority to direct how the funds are invested, the treasurer or Trustme? Which investment is more consistent with the prudent investor rule? Does the treasurer's bond protect the OPEB funds being held by Trustme?

Chapter 69 of the Acts of 2011

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 unit 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 of 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.

Approved, July 12, 2011.

Public Comment Period for Final Municipal Health Reform Regulations

Under the new municipal health care reform legislation (Chapter 69 of the Acts of 2011), A&F is responsible for adopting regulations as guidance to communities seeking to implement changes in health insurance plans under the process created by the new law. The regulation establishes administrative procedures for the expedited negotiations that will occur between municipalities and public employee committees and for the process to be followed by a municipal health insurance review panel if the matter is not resolved during the expedited negotiations.

The Executive Office for Administration and Finance filed emergency regulations on August 12, 2011 because of the urgent need to provide guidance to communities choosing to take advantage of this new tool.

Emergency regulations are effective for no longer than three months from the time of the filing date. A&F is now taking the required steps to transition the regulations from emergency to permanent status, including an additional opportunity for public comment.

Written comments on the current emergency regulation will be accepted between September 19, 2011 and October 10, 2011 in preparation for transitioning the emergency regulation to permanent status. Comments should be sent to MunicipalHealth@state.ma.us

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3 **NEW REGULATIONS –**
4 **801 CMR 52.00 MUNICIPAL HEALTH INSURANCE**
5

6 52.01 General provisions

7 (1) Authority

8 (2) Definitions

9 (3) Notices

10
11 52.02 The vote by a political subdivision to implement changes in group health insurance
12 benefits pursuant to M.G.L. c. 32B, §§ 21-23

13 (1) Advance notice of intent to vote.

14 (2) Notice of vote, request for name and contact information for the public employee
15 committee representatives, and number of eligible unit members

16
17 52.03 The Implementation Notice

18
19 52.04 The thirty-day negotiation period

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21 52.05 Health insurance review panel

22
23 52.06 Health insurance review panel process

24
25 52.07 Implementation of agreements reached under M.G.L. c. 32B, §§ 21 to 23

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28
29 *52.01 General provisions*

30
31 *(1) Authority*

32
33 (a) 801 CMR 51.00 is adopted by the Secretary of Administration and Finance,
34 under the authority of M.G.L. c. 32B, §21 to carry out the process by which
35 political subdivisions elect to change health insurance benefits under M.G.L. c.
36 32B, §§ 21-23.

37
38 (b) The process set forth in 801 CMR 52.00 shall be followed each time a political
39 subdivision elects to change health insurance benefits under the process
40 authorized by M.G.L. c. 32B, §§21- 23 (the implementation process), except that
41 acceptance under M.G.L. c. 32B, § 21(a) need only occur once.

42
43 *(2) Definitions*

44
45 Unless otherwise provided, terms shall have the meanings assigned to them in
46 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

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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*
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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

185
186 (b) Not later than 2 business days after the insurance advisory committee meets
187 with the appropriate public authority or 10 days after the insurance advisory
188 committee receives notice from the appropriate public authority, whichever
189 occurs first, a political subdivision which has elected under M.G.L. c. 32B, §
190 21(a) to make changes under M.G.L. c. 32B, §§ 22 or 23 shall, provide a notice of
191 its decision, in writing, to the president or designee of each collective bargaining
192 unit and to the RSCME and shall include the number of employees eligible for
193 health insurance under M.G.L. c. 32B employed in each bargaining unit of the
194 political subdivision.
195

196 (c) In any political subdivision which has not previously formed a public
197 employee committee under M.G.L. c. 32B, §19 of this chapter, the notice shall
198 request that each of the collective bargaining units and the RSCME provide the
199 name, address, phone number, and email address of its designated public
200 employee committee representative.
201

202 (d) Where a public employee committee already exists under M.G.L. c. 32B, §
203 19, each collective bargaining unit and RSCME shall, within 2 business days of
204 receipt of notice under this section, provide the appropriate public authority with
205 the name, address, phone number and email address of its designated public
206 employee committee representative. If no public employee committee exists at
207 the time of receipt of the notice, each collective bargaining unit and RSCME shall
208 designate a representative to a public employee committee exclusively to
209 negotiate changes under M.G.L. c. 32B, §§21-23 and provide the appropriate
210 public authority with the name, address, phone number and email address of its
211 designated public employee committee representative within 5 business days after
212 receipt of notice under 801 CMR 52.02(3). If no public employee committee
213 exists at the time of receipt of notice from the political subdivision and the
214 appropriate public authority has not received this information from a collective
215 bargaining unit or RSCME within 5 business days, the collective bargaining unit's
216 principal officer shall be the unit's representative on the public employee
217 committee, the president of the RSCME shall be its representative on the public
218 employee committee, and the appropriate public authority shall send the notice
219 specified under 801 CMR 52.03 to the collective bargaining unit's principal
220 officer and to RSCME's president.
221

222 *52.03 The Implementation Notice/(Notification by public authority to its public employee*
223 *committee of its intention to enter into negotiations to implement changes to its health insurance*
224 *benefits under M.G.L. c. 32B, §21)*
225

226 The appropriate public authority shall give the written notice required in M.G.L. c. 32B,
227 § 21(b) to the insurance advisory committee in accordance with Section 52.02(2)(a) and,
228 not later than 2 business days following the appropriate public authority's receipt of
229 notice of the representatives of the public employee committee under Section
230 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:

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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,
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ii. the anticipated total projected premium costs of plans, including plans with the proposed changes, and anticipated enrollment for the same 12-month period,

iii. the analysis that the appropriate public authority has to support its estimate of savings and the projected premium costs which may include quotes or bids from any insurance plan, third party administrator or insurance broker regarding the total premium cost of such plans with and without the proposed changes; demographic data regarding the number of employees, the number of subscribers, the number of subscribers enrolled in non-Medicare plans (by coverage -family or individual) and Medicare-extension plans; any data regarding out-of-pocket costs paid by subscribers; and any other factors relied upon by the appropriate public authority, including any information provided by an actuary or other consultant in developing the savings estimate.

If the appropriate public authority has indicated that it is considering transferring to the commission, it shall include in its analysis the estimates regarding plan choice that subscribers will make if transferred to the commission.

The savings estimate shall not take into account: savings resulting from transferring eligible retirees to Medicare under M.G.L. c. 32B, § 18A, but the savings estimate shall include savings due to proposed increases in dollar amounts for co-pays and deductibles for Medicare-extension plans under M.G.L. c. 32B, § 22 or the savings resulting from the transfer to Commission’s medicare extension plans under M.G.L. c. 32B, §23.

The savings estimate shall be calculated based on the number of subscribers who will be covered under the proposed plans, including subscribers covered by existing collective bargaining agreements for whom implementation of the proposed changes would be delayed under St. 2011, c. 69, § 4. The appropriate public authority shall allocate funds to the mitigation plan in proportion to the number of total subscribers who will be covered under the proposed plan, with additional funds allocated when the plan changes are implemented for additional subscribers. Subscribers will not be eligible for mitigation funds before they are transferred to the new plans.

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.
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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

366 (5) All subscribers shall be provided with at least 60 days advance notice in accordance
367 with M.G.L. c. 175, §24B, of any changes in plan design, including an agreement to
368 transfer to the Commission. Notice shall not be effective until the changes are included
369 in a written agreement between the appropriate public authority and the public employee
370 committee under this section or a written decision of the review panel under Section
371 52.06.

372
373 (6) If the appropriate public authority and the public employee committee are able to
374 reach a written agreement within 30 calendar days, the agreement shall be binding on all
375 subscribers and their representatives, and the public authority shall implement the
376 changes agreed to in the written agreement as quickly as practicable and in observance of
377 the 60-day notice requirement identified above in 801 CMR 52.04(4)(b).

378
379 (7) If the change is to transfer subscribers to the Commission, the notice shall include
380 information about the Commission plans, the enrollment process, and any other
381 information specified by the Commission in its rules and regulations issued under M.G.L.
382 c. 32B, §23 relating to the process by which subscribers shall be transferred to the
383 Commission.

384
385 *52.05 Health insurance review panel*

386
387 *(1) Creation of the panel*

388
389 (a) The appropriate public authority shall notify the Secretary in writing within 3
390 business days after the beginning of the 30-day negotiation period under 801
391 CMR 52.04. The notice shall include the start and end dates of the 30-day
392 negotiation period, and the name and contact information of the public authority's
393 representative for the health insurance review panel. The appropriate public
394 authority shall provide each member of the public employee committee with a
395 copy of the notice to the Secretary.

396
397 (b) Within 3 business days after receiving copies of notice to the Secretary under
398 (a), the public employee committee shall select one representative for the panel
399 and give notice to the appropriate public authority and the Secretary. Within 10
400 days after receiving this notice, the Secretary shall provide the appropriate public
401 authority, the public employee committee, and the public authority and public
402 employee committee representatives ("the parties") with a list ("the list") of 3
403 qualified, impartial potential members available to serve on the review panel.
404 Impartial members shall have professional experience in dispute mediation and
405 professional experience in municipal finance or municipal health benefits. The
406 Secretary shall also provide the parties with the name of an actuary selected by
407 the Commission to assist the panel in verifying the savings calculations if no
408 agreement is reached within the 30-day period and a panel is convened.
409

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

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network that is tiered differently from the tiering in the commission's most-subscribed plan, the determination shall be made by assuming the co-pays, deductibles and cost-sharing plan design features in each tier of the political subdivision's plan are equal to those in the same tier of the commission's most-subscribed plan, beginning with a comparison of the highest tier. If the political subdivision's plan has fewer tiers than the commission's plan, the political subdivision's highest tier shall be compared to the commission's tier 3, and the second highest tier to the commission's tier 2.

(2) Determine within 10 days whether the proposed increased dollar amounts for co-payments and deductibles proposed for a Medicare-extension plan under M.G.L. c. 32B, §22 exceed the dollar amounts of the plan design features for the same or most similar benefits offered by the commission for the Medicare-extension plan under section 10C and section 14 of M.G.L. c.32A with the largest subscriber enrollment. If such increased amounts do not exceed the dollar amounts of the plan design features for the same or most similar benefits offered by the commission for the Medicare-extension plan under section 4 of chapter 32A with the largest subscriber enrollment, the panel shall approve the appropriate public authority's immediate implementation of the proposed changes under M.G.L. c. 32B, § 22, subject to Section 52.07. Where the political subdivision is not proposing a tiered provider network, the determination shall be made by comparing the savings that would result if the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features in the political subdivision's plan equaled the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features under tier 2 of the commission's most-subscribed plan. Where the political subdivision currently is proposing a tiered provider network that is tiered differently from the tiering in the commission's most-subscribed plan, the determination shall be made by assuming the co-pays, deductibles and cost-sharing plan design features in each tier of the political subdivision's plan are equal to those in the same tier of the commission's most-subscribed plan, beginning with a comparison of the highest tier. If the political subdivision's plan has fewer tiers than the commission's plan, the political subdivision's highest tier shall be compared to the commission's tier 3, and the second highest tier to the commission's tier 2.

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 *52.07 Implementation of agreements reached pursuant to M.G.L. c. 32B, §§ 21- 23*
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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.
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Specific Legal References for Case Study 1 - Conflict of Interest

Commonwealth of Massachusetts

STATE ETHICS COMMISSION

John W. McCormack Office Building - One Ashburton Place - Room 619

Boston, Massachusetts 02108-1501

PHONE: 617-371-9500 or 888-485-4766 FAX: 617-723-5851

www.mass.gov/ethics

September 2, 2011

David E. Sullivan
General Counsel
Executive Office for Administration and Finance
State House, Room 373
Boston, MA 02133

Dear David,

This is in response to your inquiry about how the conflict of interest law, G.L. c. 268A, applies to the acceptance by municipalities of Chapter 69 of the Acts of 2011. Chapter 69 allows municipalities and other political subdivisions of the Commonwealth to change the health insurance coverage that they offer to their subscribers if certain requirements are met. Cities must make such changes by majority vote of the city council and approval by the manager or mayor; towns must make such changes by vote of the board of selectman. You ask how this process should proceed if the city councilors or selectmen are eligible to receive health insurance from their municipalities, potentially giving them a financial interest in the matter; and you also ask whether the exemption in § 19(b)(3) of c. 268A, or alternatively the rule of necessity, would allow them to participate. Your Executive Office is charged with implementing parts of Chapter 69, so I view your request for advice as consistent with G.L. c. 268B § 3(g), authorizing us to give advisory opinions to persons subject to the conflict law.

Section 19 of c. 268A prohibits municipal employees, including city councilors and selectmen, from participating in particular matters in which they have a direct and immediate, or a reasonably foreseeable, financial interest. Chapter 69 gives municipalities the power to change their subscribers' health insurance benefits in ways that will affect, among other things, the amount of copayments, deductibles, and other cost-sharing plan elements. Clearly, any current subscriber of a municipal health insurance plan has a reasonably foreseeable financial interest in the acceptance or not of Chapter 69, and is therefore subject to the restrictions of Section 19.

Your August 29th email to me states that a town received an informal opinion from an attorney in this office that selectmen in towns that provide health insurance coverage to selectmen may not vote on the acceptance of Chapter 69, presumably on the ground that they have a reasonably foreseeable financial interest in the matter, and are therefore precluded from participating by Section 19. In my opinion, that statement is too

broad. A city councilor or selectman who has health insurance coverage from her city or town clearly has a foreseeable financial interest in the acceptance of Chapter 69, as does a councilor or selectman who intends to obtain such coverage. However, a city councilor or selectman who does not have municipal health insurance coverage and has no intention of obtaining it – for instance, because he or she is covered under a spouse’s private health insurance coverage – would not have a foreseeable financial interest in the acceptance of Chapter 69, and would therefore be able to participate in deciding and voting on such acceptance.

Section 19 only presents a potential issue for cities and towns that lack a quorum of councilors or selectmen who may vote on acceptance of Chapter 69 because some councilors or selectmen cannot participate due to conflicts of interest. Any city or town that has a quorum of councilors or selectmen who do not have municipal health insurance coverage, and do not intend to obtain such coverage, has no issue under Section 19 with respect to acceptance of Chapter 69.

Turning to those cities and towns that lack a quorum to vote on acceptance because their councilors and selectmen have municipal health insurance coverage, you ask whether the general policy exception set forth in Section 19(b)(3) applies here. That exception allows municipal employees to participate in particular matters in which they have a financial interest “if the particular matter involves a determination of general policy and the interest of the municipal employee or members of his immediate family is shared with a substantial segment of the population of the municipality.” The Commission interprets the phrase “substantial segment” to mean at least 10% of a town’s population, *EC-COI-93-20 n. 8*. The 19(b)(3) exemption will therefore only be available in municipalities in which more than 10% of the population has municipal health insurance coverage.

In municipalities that lack a quorum of councilors or selectmen due to Section 19 conflicts, and which do not cover 10% of their population with municipal health insurance coverage, the rule of necessity gives a way to proceed. As explained in Commission Advisory 05-05, *The Rule of Necessity*, the rule of necessity may be used to allow public employees who would otherwise be disqualified by conflicts of interest to act when five requirements are met:

1. An elected board must be legally required to act on a matter, and lack a quorum solely due to members being disqualified by conflicts of interest.
2. Before invoking the rule of necessity, every effort must be made to find another board or legal authority with the power to act in place of the board that lacks a quorum.
3. The board must be legally required to act by a certain time, and be unable to do so because of the lack of a quorum.
4. The rule must be invoked by one or more of the disqualified board members, upon advice of town counsel or the Commission.

David E. Sullivan
September 2, 2011
Page 3

5. The minutes must reflect that the board lacks a quorum because of conflicts of interest of members and specifically state the facts that give rise to those conflicts, and that the rule of necessity is being used to allow the board to take a valid vote.

Here, Chapter 69 and its preamble establish that city councils and boards of selectmen are legally required to act to accept the law; specifically, Section 3 of Chapter 69 adopts new G.L. c. 32B, Section 21(a), providing that changes to health insurance benefits pursuant to Chapter 69 must be approved by majority vote of a city council or board of selectmen. The law does not give any other board or authority the legal authority to approve acceptance of Chapter 69. The preamble to Chapter 69 states that its purpose is “immediately to authorize” municipalities to implement health law changes. I interpret this as a requirement that city councils and boards of selectmen are required to act as soon as possible, satisfying the third requirement listed above for invoking the rule of necessity.

Accordingly, in municipalities which lack a quorum of councilors or selectmen to approve acceptance of Chapter 69 because of conflicts of interest, it is my opinion that the rule of necessity may be invoked by one or more of the disqualified members to allow them to participate in deciding whether to accept that Chapter. When this is done, the minutes must reflect that the board lacks a quorum because of conflicts of interest of members and specifically state the facts that give rise to those conflicts, and that the rule of necessity is being used to allow the board to take a valid vote.

I hope that this advice is helpful. You are free to disclose this letter to anyone you want. The Ethics Commission is required by law to keep your request and this letter confidential; under our regulations, the only circumstances in which we would not keep an advice letter confidential would be if a requestor materially misrepresents the contents of a letter, or if court orders us to produce it. Don't hesitate to contact me if you have further questions.

Very truly yours,

Deirdre Roney
General Counsel

M.G.L. c. 268A Section 19

Section 19. (a) Except as permitted by paragraph (b), a municipal employee who participates as such an employee in a particular matter in which to his knowledge he, his immediate family or partner, a business organization in which he is serving as officer, director, trustee, partner or employee, or any person or organization with whom he is negotiating or has any arrangement concerning prospective employment, has a financial interest, shall be punished by a fine of not more than \$10,000, or by imprisonment in the state prison for not more than 5 years, or in a jail or house of correction for not more than 2 ½ years, or both.

(b) It shall not be a violation of this section (1) if the municipal employee first advises the official responsible for appointment to his position of the nature and circumstances of the particular matter and makes full disclosure of such financial interest, and receives in advance a written determination made by that official that the interest is not so substantial as to be deemed likely to affect the integrity of the services which the municipality may expect from the employee, or (2) if, in the case of an elected municipal official making demand bank deposits of municipal funds, said official first files, with the clerk of the city or town, a statement making full disclosure of such financial interest, or (3) if the particular matter involves a determination of general policy and the interest of the municipal employee or members of his immediate family is shared with a substantial segment of the population of the municipality.

Advisory 05-05: The Rule of Necessity

If an elected member of a town or city board has a conflict of interest with respect to a matter before the board that involves his own financial interest or that of a partner, an immediate family member or a business organization with which the board member has certain affiliations, that member will be disqualified from acting as a board member on that matter.^{2f} In some cases, especially when more than one member is disqualified, a board cannot act because it does not have a quorum or some other number of members required to take a valid affirmative vote. (If the number for a quorum is not set by law, a quorum is generally a majority of the board members.) In these circumstances, the board may be able to use what is called the Rule of Necessity to permit the participation of the disqualified member(s) in order to allow the board to act.

The Rule of Necessity is not a law written and passed by the Legislature. Rather, the Rule of Necessity was developed by judges who applied it in their court decisions. The Rule of Necessity may only be used as a last resort. We strongly suggest that the rule be used only upon prior written advice from town or city counsel since improper use of the rule could result in a violation of the conflict of interest law.

The Rule of Necessity works in the following way:

1. The Rule of Necessity may only be used when an elected board is legally required to act on a matter and it lacks enough members to take valid official action solely due to board members being disqualified by conflicts of interest from participating in the matter.

Example: A five member elected board has a meeting and all members are present. Three of the five members have conflicts in a matter before the board. Three members are the quorum necessary for a decision. The two members without conflicts do not make a quorum. The board cannot act. The Rule of Necessity will permit all members to participate in that matter.

Example: A five member elected board has a meeting and four members are present (one member is sick at home). Two of the four present members have conflicts. A quorum is three. The one member who is sick at home does not have a conflict. The Rule of Necessity may not be used because there is a quorum of the board which is able to act. The absence of one member does not permit use of the Rule of Necessity.

Example: A five member elected board has a meeting and all members are present. One member has a conflict and is disqualified. The vote is a two-to-two tie. The Rule of Necessity may not be used to break the tie. In general, a tie vote defeats the issue being voted on. (Stated differently, a tie vote will maintain the status quo.)

Example: A five member elected board has a meeting and all members are present. A quorum is three. However, one agenda item, on which board action is legally required, needs four votes, rather than the usual simple majority, for an affirmative decision. Two of the board members have conflicts. Although a quorum is available, the required four votes needed for this particular matter cannot be obtained without the

participation of one or both of the members who have conflicts. The Rule of Necessity may be invoked and all five of the board members could participate.

If one or more members of an elected board have 'appearances' of conflicts of interest that can be dispelled by making a written disclosure, the Rule of Necessity may not be invoked. Section 23(b)(3) of the conflict law prohibits a public official from acting in a manner which would cause a reasonable person, having knowledge of the relevant circumstances, to conclude that the public official is likely to act or fail to act as a result of kinship, rank or position. It shall be unreasonable to so conclude if such officer or employee has disclosed in writing to his or her appointing authority or, if no appointing authority exists, discloses in a manner which is public in nature, the facts which would otherwise lead to such a conclusion.

Example: One member of a three member elected board has a daughter who is a candidate for a police officer position. A second member has a niece who is a candidate for the same position. This member can make a disclosure to dispel the appearance of a conflict of interest and may then participate in the matter. Thus, the three member board has a quorum and is able to act and the Rule of Necessity may not be invoked.

2. Before invoking the Rule of Necessity, every effort must be made to find another board or other authority in the municipality with the legal power to act in place of the board that could not obtain a quorum due to conflicts of interest. (Municipal counsel should be consulted to identify another municipal board or authority to act.)

3. While the absence of one or more board members is generally not sufficient cause to invoke the Rule of Necessity, when a board is legally required to take action by a certain time and is unable to do so because of the lack of a quorum, the Rule of Necessity may be invoked.

Example: A statute requires selectmen to approve payroll warrants on a weekly basis. One selectman of a three member board is absent and the board cannot otherwise obtain a quorum due to the disqualification of one selectman whose immediate family member works for the town. The Rule of Necessity may be invoked.

4. The Rule of Necessity should be invoked by one or more of the otherwise disqualified members, upon advice from town or city counsel or the State Ethics Commission.

5. If it is proper for the Rule of Necessity to be used, it should be clearly indicated in the minutes of the meeting that as a result of disqualification of members due to conflicts of interests, the board lacked a sufficient number of members necessary to take a valid vote and, as a last resort, that all those disqualified may now participate under the Rule of Necessity. Each disqualified member who wishes to participate under the Rule of Necessity must first disclose publicly the facts that created the conflict.

Example: Two members of a three member elected board have conflicts of interest that prohibit them from participating in a matter involving property owned by a private school for which they serve as trustees. No other board exists which can act on the matter before the board. One of the board members with a conflict should invoke the Rule of Necessity and direct that it be included in the minutes. Both of the board members who had been prohibited from participating may then do so. Prior to such participation, however, they must disclose the fact that they serve as trustees and may then participate in the matter.

It should be noted that invoking the Rule of Necessity does not require all previously disqualified members to participate; it merely permits their participation.

In some instances, where a single elected official is the only person who, by law, can take a specific action, and that elected official has a conflict of interest, the rule of necessity may be invoked for the limited purpose of designating another person to carry out the action.

Example: A mayor, whose spouse is a firefighter, is the sole collective bargaining authority for the city. She may invoke the rule of necessity to designate an alternate to serve as the city's collective bargaining representative with the firefighter's union.

* * *

For more information about the state conflict of interest and financial disclosure laws (G.L. c. 268A & c. 268B), including the subjects discussed in this Advisory, please contact:

State Ethics Commission (Ethics Comm.)
One Ashburton Place, Room 619
Boston, MA 02108
(617)371-9500

ISSUED: March 1987

REVISED: January 1991

REVISED: February 1993

REVISED: December 2005 [as an Advisory]

FOOTNOTE

Elected state and county officials and appointed municipal officials who cannot participate in matters because of a conflict of interest should contact the Ethics Commission for advice regarding the rule of necessity.

Specific Legal References for Case Study 2 – Health Care Reform

M.G.L. c. 30A, §18

Section 18. As used in this section and sections 19 to 25, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Emergency" a sudden, generally unexpected occurrence or set of circumstances demanding immediate action.

M.G.L. c. 30A, §20

Section 20. (a) Except as provided in section 21, all meetings of a public body shall be open to the public.

(b) Except in an emergency, in addition to any notice otherwise required by law, a public body shall post notice of every meeting at least 48 hours prior to such meeting, excluding Saturdays, Sundays and legal holidays. In an emergency, a public body shall post notice as soon as reasonably possible prior to such meeting. Notice shall be printed in a legible, easily understandable format and shall contain the date, time and place of such meeting and a listing of topics that the chair reasonably anticipates will be discussed at the meeting.

M.G.L. c. 44, §31

Section 31. No department financed by municipal revenue, or in whole or in part by taxation, of any city or town, except Boston, shall incur a liability in excess of the appropriation made for the use of such department, each item recommended by the mayor and voted by the council in cities, and each item voted by the town meeting in towns, being considered as a separate appropriation, except in cases of major disaster, including, but not limited to, flood, drought, fire, hurricane, earthquake, storm or other catastrophe, whether natural or otherwise, which poses an immediate threat to the health or safety of persons or property, and then only by a vote in a city of two-thirds of the members of the city council, and in a town by a majority vote of all the selectmen. Payments of liabilities incurred under authority of this section may be made, with the written approval of the director, from any available funds in the treasury, and the amounts of such liabilities incurred shall be reported by the auditor or accountant or other officer having similar duties, or by the treasurer if there be no such officer, to the assessors who shall include the amounts so reported in the aggregate appropriations assessed in the determination of the next subsequent annual tax rate, unless the city or town has appropriated amounts specified to be for such liabilities; provided, that, if proceedings are brought in accordance with provisions of section fifty-three of chapter forty, no payments shall be made and no amounts shall be certified to the assessors until the termination of such

proceedings. Payments of final judgments and awards or orders of payment approved by the industrial accident board rendered after the fixing of the tax rate for the current fiscal year may, with the approval of the director of accounts if the amount of the judgment or award is over ten thousand dollars, be made from any available funds in the treasury, and the payments so made shall be reported by the auditor or accountant or other officer having similar duties, or by the treasurer if there be no such officer, to the assessors, who shall include the amount so reported in the aggregate appropriations assessed in the determination of the next subsequent annual tax rate, unless the city or town has otherwise made provision therefor. ...

M.G.L. c. 71, §34

Section 34. Every city and town shall annually provide an amount of money sufficient for the support of the public schools as required by this chapter, provided however, that no city or town shall be required to provide more money for the support of the public schools than is appropriated by vote of the legislative body of the city or town. In acting on appropriations for educational costs, the city or town appropriating body shall vote on the total amount of the appropriations requested and shall not allocate appropriations among accounts or place any restriction on such appropriations. ... The city or town appropriating body may make nonbinding monetary recommendations to increase or decrease certain items allocating such appropriations.

The vote of the legislative body of a city or town shall establish the total appropriation for the support of the public schools, but may not limit the authority of the school committee to determine expenditures within the total appropriation.

M.G.L. c. 150E Section 1

Section 1. The following words and phrases as used in this chapter shall have the following meaning unless the context clearly requires otherwise:--

...
"Employer" or "public employer", ... any county, city, town, district, or other political subdivision acting through its chief executive officer In the case of school employees, the municipal employer shall be represented by the school committee or its designated representative or representatives. For this purpose, the chief executive officer of a city or town or his designee shall participate and vote as a member of the city or town school committee; provided, however, that if there is no town manager or town administrator in a town, the chairman of the board of selectmen or his designee shall so participate and vote. ...

M.G.L. c. 150E Section 7

Section 7. (a) Any collective bargaining agreement reached between the employer and the exclusive representative shall not exceed a term of three years. The agreement shall be reduced to writing, executed by the parties, and a copy of such agreement shall be

filed with the commission and with the house and senate committees on ways and means forthwith by the employer.

(b) The employer ... shall submit to the appropriate legislative body within thirty days after the date on which the agreement is executed by the parties, a request for an appropriation necessary to fund the cost items contained therein.... If the appropriate legislative body duly rejects the request for an appropriation necessary to fund the cost items, such cost items shall be returned to the parties for further bargaining. The provisions of the preceding two sentences shall not apply to agreements reached by school committees in cities and towns in which the provisions of section thirty-four of chapter seventy-one are operative.

...

(d) If a collective bargaining agreement reached by the employer and the exclusive representative contains a conflict between matters which are within the scope of negotiations pursuant to section six of this chapter and any municipal personnel ordinance, by-law, rule or regulation; the regulations of a police chief pursuant to section ninety-seven A of chapter forty-one or of a police commissioner or other head of a police or public safety department of a municipality; the regulations of a fire chief or other head of a fire department pursuant to chapter forty-eight; any of the following statutory provisions or rules or regulations made thereunder:

(a) the second paragraph of section twenty-eight of chapter seven;

(a 1/2) section six E of chapter twenty-one;

(b) sections fifty to fifty-six, inclusive, of chapter thirty-five;

(b 1/2) section seventeen *I* of chapter one hundred and eighty;

(c) section twenty-four A, paragraphs (4) and (5) of section forty-five, paragraphs (1), (4) and (10) of section forty-six, section forty-nine, as it applies to allocation appeals, and section fifty-three of chapter thirty;

(d) sections twenty-one A and twenty-one B of chapter forty;

(e) sections one hundred and eight D to one hundred and eight *I*, inclusive, and sections one hundred and eleven to one hundred and eleven *I*, inclusive, of chapter forty-one;

(f) section thirty-three A of chapter forty-four;

(g) sections fifty-seven to fifty-nine, inclusive, of chapter forty-eight;

(g 1/2) section sixty-two of chapter ninety-two;

- (h) sections fourteen to seventeen E, inclusive, of chapter one hundred and forty-seven;
- (i) sections thirty to forty-two, inclusive, of chapter one hundred and forty-nine;
- (j) section twenty-eight A of chapter seven;
- (k) sections forty-five to fifty, inclusive, of chapter thirty;
- (l) sections thirty, thirty-three and thirty-nine of chapter two hundred and seventeen;
- (m) sections sixty-one, sixty-three and sixty-eight of chapter two hundred and eighteen;
- (n) sections sixty-nine to seventy-three, inclusive, and seventy-five, eighty and eighty-nine of chapter two hundred and twenty-one;
- (o) section fifty-three C of chapter two hundred and sixty-two;
- (p) sections eighty-four, eighty-five, eighty-nine, ninety-four and ninety-nine B of chapter two hundred and seventy-six;
- (q) section eight of chapter two hundred and eleven B.

the terms of the collective bargaining agreement shall prevail.

M.G.L. c. 32B, §2

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 thereof 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. ...

Chapter 32B Section 3

Section 3. Upon acceptance of this chapter as hereinafter provided, the appropriate public authority of the governmental unit shall negotiate with and purchase, on such terms as it deems to be in the best interest of the governmental unit and its employees, from one or more insurance companies, savings banks or non-profit hospital, medical, dental or other, service corporations, a policy or policies of group life and accidental death and dismemberment insurance covering employees, and group general or blanket insurance providing hospital, surgical, medical and dental benefits covering employees and their

dependents as provided under section eleven and section eleven A if applicable and shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf and in the name of such governmental unit. ...

Prior to the purchase of said insurance, and execution of all such agreements or contracts within the limits established by said sections, the appropriate public authority shall consult with an advisory committee for the purpose of securing the written recommendations of a majority of the membership of said committee. Said committee shall consist 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. If the appropriate public authority finds that the committee's recommendations in whole or in part cannot be included within the aforementioned agreements or contracts, at the written request of any member of said committee within thirty days from the effective date of the agreements or contracts, the appropriate public authority shall submit to said member, in writing, the reasons for the rejection of any or all of the recommendations and a copy shall be filed with the commission. ...

Chapter 32B Section 7A

Section 7A. A governmental unit which has accepted the provisions of section ten and which accepts the provisions of this section may, as a part of the total monthly cost of contracts of insurance authorized by sections three and eleven C, with contributions as required by section seven, make payment of a subsidiary or additional rate which may be lower or higher than a premium determined by the governmental unit to be paid by the insured, the combination of which shall result in the governmental unit making payment of more, but not less, than fifty per cent of the total monthly cost for such insurance. No governmental unit, however, shall provide different subsidiary or additional rates to any group or class within that unit.

...

Chapter 32B Section 16

Section 16. Upon acceptance of this section as hereinafter provided, the appropriate public authority of the governmental unit shall enter into a contract, hereinafter described, to make available the services of a health care organization to certain eligible and retired employees and dependents, including the surviving spouse and dependents of such active and retired employees, on a voluntary and optional basis, as it deems to be in the best interest of the governmental unit and such eligible persons as aforesaid ...

The appropriate public authority shall negotiate such a contract of insurance for and on behalf and in the name of the governmental unit for such a period of time not exceeding five years as it may in its discretion, deem to be the most advantageous to the governmental unit and the persons insured hereunder.

All persons eligible for the insurance provided under section five shall have the option to be insured for the services of a health care organization under this section but shall not be insured for both. Eligible persons, having elected coverage under this section by making application as provided in section six, shall pay a minimum of ten percent of the total monthly premium cost or rate for coverage under this section, and the governmental unit shall pay the remainder of the total monthly premium cost or rate; provided, however, that nothing in this chapter shall preclude the parties to a collective bargaining agreement under chapter one hundred and fifty E from agreeing that such eligible persons shall pay a percent share of such total monthly premium cost or rate which is higher than said ten percent; provided, further, that such eligible persons shall in no event be required to pay more than fifty percent of such total monthly premium cost or rate. Such payment by the insured shall be made to the governmental unit as provided in sections seven, seven A, nine A, nine B, nine C, nine D and nine E, as may be applicable.

...

Email Response 2010-855 – Group Insurance Issues

From: Blau, Gary
Sent: Wednesday, July 14, 2010 9:33 AM
To: 'Josh Coleman'
Subject: 2010-855 - Group Insurance Issues

Attachments: 92-660.pdf; EM2007-191 - Request for legal advice.htm

Josh:

I thought we had published an article in our newsletter City & Town in the 1990s on collective bargaining for health insurance, but cannot find it in our publication archives and apparently we did not. I found four collective bargaining articles published in 1995 and 1996, but they did not include health insurance issues. With respect to your numbered statements, I have the following comments.

1) A community that has not accepted M.G.L. c. 32B, §7A is governed by c. 32B, §7 with respect to indemnity (and PPO) plans, and Section 7 requires a 50% contribution from the employer and employee toward health insurance premiums. It is only if the community has accepted Section 7A that it may pay a percentage contribution greater than 50% on such plans, and in that case the last sentence of the first paragraph specifies that "No governmental unit, however, shall provide different subsidiary or additional rates to any group or class within that unit." That has been interpreted as requiring uniformity of the rate of the governmental unit with respect to indemnity (and PPO) plans for its employees. See Watertown Firefighters, Local 1347, IAFF, AFL-CIO v. Town of Watertown, 376 Mass. 706 (1978). Note that this uniformity does not necessarily apply to the municipal contributions to premiums for retirees or surviving spouses because contribution rates are partially dependant on the acceptance of other sections of Chapter 32B. See, for example, Section 9 (default 0% contribution of town for retirees), Section

9A (local option 50% contribution of town for retirees, which by its specificity is uniform), Section 9E (local option - more than 50% contribution rate for retirees, uses same uniformity phrase as Section 7A), Section 9B (default 0% contribution of town for surviving spouses), Section 9D (local option 50% contribution of town for surviving spouse, which by its specificity is uniform), Section 9D½ (local option - more than 50% contribution of town for surviving spouses, no uniformity provision) and Section 9D¾ (local option - up to 50% contribution of town for surviving spouse, no uniformity provision)

2) Section 16 of Chapter 32B specifically provides that:

Eligible persons, having elected coverage under this section by making application as provided in section six, shall pay a minimum of ten percent of the total monthly premium cost or rate for coverage under this section, and the governmental unit shall pay the remainder of the total monthly premium cost or rate; provided, however, that nothing in this chapter shall preclude the parties to a collective bargaining agreement under chapter one hundred and fifty E from agreeing that such eligible persons shall pay a percent share of such total monthly premium cost or rate which is higher than said ten percent; provided, further, that such eligible persons shall in no event be required to pay more than fifty percent of such total monthly premium cost or rate.

(emphasis added)

Section 16 does not contain similar language to that in Section 7A requiring uniformity of rates for all town employees. The underscored language appears to authorize different town HMO contribution rates between 50% and 90% for employees with separate collective bargaining agreements for different unions, and we have suggested as much in a prior opinion (92-660) and email response EM2007-191, attached. Literally the language of Section 16 does not distinguish between town-side and school-side collective bargaining agreements, although the board of selectmen in a town is usually the bargaining agent for town-side agreements (as well as the appropriate public authority with the power to enter into municipal group health insurance contracts under M.G.L. c. 32B), while the school committee is the bargaining agent for school department employees (with no specific authority to enter into group health insurance contracts under chapter 32B). M.G.L.c. 150E, §1 (Definition of Employer); c. 4, §7 (Definition of Chief Executive Officer).

Unlike other town collective bargaining agreements which cannot be effective without a town meeting appropriation of the cost items, a school committee may negotiate agreements with school department employees without such an after-the-fact town meeting appropriation, at least to the extent it has sufficient unencumbered funds in its budget to cover the negotiated cost. School committees have line item autonomy to move otherwise budgeted and unencumbered school funds to school negotiated collective bargaining obligations payable from its budget, under M.G.L. c. 71, §34 and are excluded from the statutory obligation to seek cost item appropriations for collective bargaining agreements under M.G.L. c. 150E, §7(b). At least to the extent the school committee has sufficient unencumbered funds in its budget to cover the first year of a collective bargaining agreement, we think the committee may legally bind itself to such an agreement. However, we still believe the committee has no authority to bind itself

beyond its own unencumbered funds under M.G.L. c. 44, §31, which prohibits any town department, including the school department, from incurring liabilities in excess of its appropriations.

Since towns usually budget for their share of group health insurance contributions in a line item outside any town departmental budget, it may be argued that a town school department has no authority to negotiate a higher HMO health insurance rate for its employees, having no appropriation within its control from which to pay the increase. While the school committee has line item autonomy under M.G.L. c. 71, §34 it may not transfer amounts to an item outside its own budget without town meeting vote and arguably may not expend its own budgeted funds for any such negotiated rate increase, since the town has chosen to cover its health insurance obligations from an appropriation outside the school's budget.

Nevertheless, it is hard to say that health insurance contribution rates are not part of the terms and conditions of employment subject to collective bargaining or are not part of compensation for the services rendered by the school department employees. If the school committee refuses to bargain over such an issue raised by an employee union it may be subject to an unfair labor practice charge and the issue of authority to bargain may be decided by the Commonwealth Employment Relations Board (CERB).

Assuming arguendo the school committee may negotiate health insurance contribution rate increases for its employees and cannot or does not pay for the increased costs from its own budget, the town may legally be required to cover the employer's share of the cost

M.G.L. c. 32B, §3. In that case, in order to insure that the increased costs negotiated by the school committee are covered by the schools from its allocated funds, the town may reduce the school's overall appropriation and include the reduced amount in the general health insurance line to cover the additional costs for the school employees. Note that group health insurance costs for current school department employees is included in the net school spending requirements that must be met by the town, whether these amounts are budgeted to the school committee or to the general health insurance line. See 603 CMR 10.06(2)(g).

I hope this addresses your concerns.

Gary A. Blau, Tax Counsel
Bureau of Municipal Finance Law
PO Box 9569
Boston, MA 02114-9569
617-626-2400
blau@dor.state.ma.us

This e-mail response is intended to provide general information about the application of municipal tax and finance laws and Department of Revenue policies and procedures. It is not a public written statement, as defined in 830 CMR 62C.3.1, and does not state the

official position of the Department on the interpretation of the laws pertaining to local taxes and finance. It should be considered informational only.

From: Josh Coleman [mailto:jcoleman@long-law.com]
Sent: Friday, July 09, 2010 12:17 PM
To: Blau, Gary
Subject: Follow-up

Hi Gary, thanks for taking the time to speak with me.

I wanted to confirm my understanding of our conversation regarding a School District proposing different contribution rates for different bargaining units for the HMO plan.

1) Section 7 PPO requires uniformity in contribution rates. Is this based on the statutory language in Section 7(a) that employer shall contribute "remaining 50 percent of such premium" or is there another relevant provision.

2) Section 16 does not require uniformity of HMO contribution rates and is subject to collective bargaining. However, as you mentioned, if the School Dept is successful in negotiating different rates with the different bargaining units, this may create a funding issue with the Town. Since the Town may decide to adjust the School Dept budget, depending on the rates negotiated for the different units. In other words, the Town may decrease the School Dept. budget to compensate for any additional health insurance cost incurred by the Town.

I would appreciate your response (if possible by Monday) and also the bulletin if your able to find it re: collective bargaining.

Thanks again,
Josh

**WATERTOWN FIREFIGHTERS, LOCAL 1347, I.A.F.F., AFL-CIO
vs. TOWN OF WATERTOWN**

376 Mass. 706

September 14, 1978 - November 27, 1978

Middlesex County

Present: HENNESSEY, C.J., QUIRICO, BRAUCHER, KAPLAN, & LIACOS,
JJ.

A provision in a "last and best offer" arbitral award, requiring a town to continue to pay 50% of a group insurance premium for firefighters, for which it had previously obligated itself under G. L. c. 32B, Section 7, and, in addition, to make a lump sum payment during the ensuing year equal to 25% of the premium due for that year, was invalid, since the statutory scheme provided for equal treatment of employee groups and since the town had not accepted G. L. c. 32B, Section 7A, which authorizes municipalities to supplement the 50% contribution. [710-716]

Where an invalid provision in a "last and best offer" arbitral award had been separately considered by the arbitrators, where the arbitrators would surely have approved the offer without the invalid provision, and where there was no practical difficulty of managing the modified award, the invalid provision was severed and the rest of the award enforced. [716-717]

Interest on a "last and best offer" arbitral award ran from the date of the award. [717-719]

CIVIL ACTION commenced in the Superior Court on July 11, 1977.

The case was heard by Arthur Williams, J., a District Court judge sitting under statutory authority.

The Supreme Judicial Court granted a request for direct appellate review.

Brian T. Callahan for the defendant.

Jonathan P. Hiatt for the plaintiff.

KAPLAN, J. On this appeal we return to that form of "interest" arbitration called "last and best offer," a subject discussed recently in *Marlborough Firefighters, Local 1714 v. Marlborough*, 375 Mass. 593 (1978). [Note 1] In the present case the town of Watertown, defendant, appeals from a judgment of the Superior Court directing enforcement of a last and best offer arbitral award. The town claims that the award includes an invalid provision as to group insurance. [Note 2] We agree with the town. We shall also deal with other questions, including the effect of the invalidity on the rest of the award.

The town and the plaintiff, Local 1347, International Association of Firefighters, AFL-CIO (hereafter called the union), were parties to a collective bargaining agreement running to June 30, 1976, and for succeeding years until superseded. As authorized by the contract, the parties

began negotiations for a successor agreement in October, 1975, but that failed of result, as did subsequent mediation. Therefore fact-finding took place under G. L. c. 150E, Section 9, eventuating in a report on November 12, 1976. This, too, failed to move the parties to a settlement, and on the union's petition to the Board of Conciliation and Arbitration, last and best offer arbitration was initiated on April 26, 1977, before a panel of three arbitrators under St. 1973, c. 1078, Section 4. [Note 3]

The panel conducted hearings on six dates from April 27 to May 26, 1977. On some points of a new contract, agreement had been reached previously, and on a few others agreement was attained at the hearings. Notable among the still disputed topics was wages. [Note 4] This was considered in terms of the statutory criteria. [Note 5] Thus there was analysis of the town's economic standing and ability to pay in comparison with

other municipalities; of the firefighters' compensation, also in a comparative sense; and of the need for maintaining employees' purchasing power.

As to group insurance (including medical coverage), the union had proposed during fact-finding that the town increase its contribution to premiums by 25%--to be added to the 50% it had theretofore obligated itself to contribute under G. L. c. 32B, Section 7. [Note 6] The union put its proposal on the ground that the particular employment carried special health hazards, and it noted that some comparable communities were already contributing

Page 709

more than 50%. The fact finder had supported the union's position. At the arbitration hearings the town pointed out, first, that the allowance of any increase of the town's contribution to group insurance would require legislative action by the town under G. L. c. 32B, Section 7A, because it would constitute an additional rate, [Note 7] and, second, that no such increase could be allowed for firefighters alone: by force of a 1973 amendment of that section, the increase would have to be provided for all the town's employees under group insurance. [Note 8] The question whether the town was willing to accept Section 7A and contribute more than 50% across the board was actually put to the annual Watertown town meeting on May 16, 1977, in the form of an article on the agenda for the meeting. The vote was negative ("to postpone indefinitely").

Last and best offers were submitted by the parties on May 26. With respect to wages, the union proposed an increase of 10% in the first year (commencing July 1, 1976) and 5% in the second; the town proposed 8% and 5%. As to any additional contribution by the town to group insurance premiums, the town, as might be expected, made no proposal; the union attempted one, which we paraphrase as follows. There was to be written into the new contract covering the firefighters a provision entitled "insurance," by which the town was to continue to pay 50% of the premium to the insurer. Starting on July 1, 1977, this contribution was to be supplemented by a lump sum payment to the firefighters during the ensuing year equal to 25% of the premiums due for the year. But if the town should increase its across-the-board contribution paid to the insurer above 50% (presumably by reversing the town vote), the lump sum payment would be scaled down accordingly. [Note 9]

Page 710

On June 3, 1977, a majority of the panel approved the union's offer, and on July 3 they filed a statement explaining their choice of the "package." On July 11 the union commenced the Superior Court action to enforce the award. On an agreed record (whose content in material part we have recounted herein), the judge, without opinion, held for the union and directed compliance with the award, with interest from the date of the award. We granted direct appellate review on the application of both parties.

1. Invalidity of the insurance provision of the union's offer. In 1955 the Legislature enacted G. L. c. 32B, a comprehensive statute empowering municipalities to provide group insurance (medical and certain other coverages) to their employees and their employees' dependents. Upon its acceptance of the provisions of c. 32B on March 4,

1957, Watertown undertook to provide such insurance and to contribute to the premiums at the required level of 50%, the balance being furnished by employees through deduction from their wages (or, if no wages were forthcoming for the period in question, by direct payment to the employer). In 1968 a new Section 7A was added to c. 32B, authorizing municipalities accepting that section to take action to provide an additional rate supplementing the 50% contribution. Under Section 7A as it read

Page 711

until 1973, the possibility was not expressly foreclosed that the town might undertake to contribute at a higher rate for one employee-group, say firefighters or police officers, than for another, say school teachers. This might occur in fulfillment of differing collective agreements with various employee-groups. See *Brooks v. School Comm. of Gloucester*, 5 Mass. App. Ct. 158 (1977). But that possibility was ruled out through the enactment in 1973 (St. 1973, c. 789, Section 1) of an addendum to Section 7A (first paragraph) as follows: "No governmental unit, however, shall provide different subsidiary or additional rates to any group or class within that unit." See *Broderick v. Mayor of Boston*, 375 Mass. 98 (1978) (Boston ordered to equalize contributions among its employees as required by the 1973 amendment of Section 7A).

The reasons for the 1973 amendment can be readily discerned. A single rate of deduction for all employees of a municipality, joined with a single rate of contribution by the municipality, presents a simpler and hence a less expensive picture for practical management than the fragmented structure that would result from rates varying among the several employee-groups. The more significant consideration, however, is the inexpedience (as a Legislature could view it) of encouraging a competitive scramble in collective bargaining among employee-groups to procure increased municipal contributions to the insurance premiums. This could well lead in the end to a drive for a system to allow bargaining as to the kinds of casualties to be covered. Besides setting up a pressure from contract to contract to escalate the municipal contributions, the process described might result in serious impairment of the basic advantages of the group insurance program which derive from wide distribution of risks and uniform administration. We may note that the foregoing view of the purposes of the 1973 amendment is confirmed by statements of the Group Insurance Commission [Note 10] when that amendment was being offered for

Page 712

enactment, and again in 1974 when there was an abortive effort to repeal the amendment and allow increases of municipal contributions for the benefit particularly of firefighters and police officers or (in another version) for any chosen employee-group. [Note 11]

Thus we see that the insurance provision of the union's offer, embodied in the award, offended against the statutory scheme (rendered exclusive by G. L. c. 32B, Section 15 [Note 12]). The town would be required to make an increased contribution, although it had not legislated the increase, and indeed had expressed itself legislatively against it. Moreover, the town would be put in the position of singling out one employee-group for

special treatment as to premium contributions when the controlling statute required that all town employees under group insurance be dealt with alike.

The arbitration panel sought to defend the insurance provision as a "salary supplement" justified by a special health hazard, [Note 13] analogous to a "night differential" that

Page 713

might be granted to compensate for peculiar characteristics of a job. The panel also suggested that the employees would be subject to tax on the 25% payment they would receive which they might spend for other purposes. [Note 14] However, as indicated in our narrative, in fact salaries were considered on their merits during the hearings; the question of insurance was an issue apart. The proposed contract provision was labeled "Insurance." The 25% added payment was denominated a supplemental contribution to be made by the town, and as such was to be reduced or to cease altogether if the town should later make an increased contribution to the premiums by the prescribed method of voting it across the board. The trouble with the supposed analogy to a "night differential" is that in the present case there is a statutory prohibition on the particular differential involved unless contributed in accordance with the statute. The possibility that the transaction would not be held a mere form for tax purposes hardly avoids a collision with the statutory bar. We are brought to the conclusion that pro tanto the arbitration was here "used as a method of evading a well defined statutory policy." [Note 15]

Page 714

This case exemplifies a well understood principle--that mere characterization of a feature of a collective bargain or an arbitration award as "compensation," or "terms or conditions of employment" or some other subject conventionally or by law within the scope of either process, will not save the provision if in substance it defeats a declared legislative purpose. [Note 16] A case rather close on its facts to the present is the Washington Arbitration Case, 436 Pa. 168 (1969), where an award in ordinary interest arbitration (not confining the arbitrators to the offers of the parties) would have required a city to make premium payments for group insurance covering the families of its police officers in addition to the officers themselves. There was statutory authorization for city contributions to group insurance for its employees. To justify the award the police officers pointed to the law legalizing collective bargaining "concerning the terms and conditions of their employment, including compensation, hours, working conditions, retirement, pensions and other benefits." Id. at 175. Despite this broad language and the fact that the statute on group insurance did not (as does ours) in terms forbid the questioned municipal contribution, [Note 17] the court struck the pertinent part of the award for violation of the perceived policy of the statute, which was not to be circumvented by calling the contribution an addition to salary, or compensation, or benefits: "[A]rbitration panels ... may not mandate that a governing body carry out an illegal act." Id. at 176. This rationale has been followed in a line of cases. [Note 18]

Page 715

On similar or analogous reasoning we have held, by reference to the legislation vesting certain powers in school committees (see G. L. c. 71, Section 37) and the common understanding of that legislation, that collective bargaining cannot reach out to control by agreement subjects "predominantly within the realm of educational management" (Bradley v. School Comm. of Boston, 373 Mass. 53, 56 [1977]), even when those subjects or the purported agreements about them have some relation to wages or employment or working conditions. [Note 19] Thus in School Comm. of Hanover v. Curry, 369 Mass. 683 (1976), we vacated an arbitral award, after grievance procedure, requiring a school committee to undo its unilateral abolition of a supervisory position: "[I]t was beyond the power of the committee to bind itself to that result or to delegate to an arbitrator the power so to bind the committee. The arbitrator therefore exceeded his powers `Public policy, whether derived from, and whether explicit or implicit in statute or decisional law, or in neither, may ... restrict the freedom to arbitrate.... Key to the analysis is that the freedom to contract in exclusively private enterprises or matters does not blanket public school matters because of the governmental interests and public

Page 716

concerns which may be involved, however rarely that may ever be.'" Id. at 685, quoting from *Susquehanna Valley Cent. School Dist. v. Susquehanna Valley Teachers' Ass'n*, 37 N.Y.2d 614, 616-617 (1975). And see *Berkshire Hills Regional School Dist. Comm. v. Berkshire Hills Educ. Ass'n*, 375 Mass. 522 (1978); *School Comm. of W. Springfield v. Korb*, 373 Mass. 788 (1977); *Boston Teachers Local 66 v. School Comm. of Boston*, 370 Mass. 455 (1976); *School Comm. of Braintree v. Raymond*, 369 Mass. 686 (1976). From *School Comm. of Boston v. Boston Teachers Local 66*, 372 Mass. 605 (1977), it appears that like ideas are at work to limit interest arbitration. [Note 20]

We turn to a minor point. Besides the insurance provision of the union's offer, the town objects to a clause about longevity pay. There is no merit in the latter contention. [Note 21]

2. Modification of the award. As the part of the arbitration award corresponding to the insurance provision of the union's offer cannot stand, we have the question whether the rest of the award should be enforced. The town argues that, as part of the union's offer was invalid, the union's entire "package" is disqualified and the town's offer becomes the only one in the field and must be approved. On the other hand, the union has indicated that in case of partial invalidity it would rather start all over again before the arbitrators than secure enforcement

Page 717

of the valid remainder. We dealt with some aspects of this general problem in *Marlborough Firefighters*, supra, also a case of partial invalidity of an award in a last and best offer arbitration. The question has its peculiar aspects because in this form of arbitration an offer is finally approved in solido. Nevertheless in *Marlborough* we severed the invalid part of the award and enforced the rest, having concluded, as had the trial judge, that that would not do an injustice (375 Mass. at 593): the part rejected had been separately considered by the arbitrators; the arbitrators would surely have approved the offer, had it been so reduced in the first place; and no practical difficulty of managing the

modified award could result. These factors exist in our case as well. The discarded part in Marlborough was probably less important, relatively, than it is in the present case, and there the union, which had won the award, was quite willing to accept it as truncated, while here the union is not so willing. But we attach weight to the circumstance that here the union was made aware of the chance that its insurance proposal would be held invalid, and yet persisted in including it in its offer. On the whole we believe severance is justified and advisable.

3. Interest on the award. The question of the running of interest on a last and best offer award was raised in Marlborough Firefighters but, while indicating a leaning toward allowing interest from the date of the award, we did not have to decide the matter. See 375 Mass. at 601 n.7. We now hold that such should be the general rule for arbitrations of this kind, for the award fixes definite or ascertainable dollar amounts and is by the statute declared presumptively "binding upon the parties" when made. [Note 22] The rule commends itself also because it encourages

Page 718

swift obedience by the parties to the award. [Note 23] A possible contention was considered in the Marlborough case that interest should start when the action to enforce is commenced, because the adversary has no means of precipitating a contest and must await an enforcement action and defend against it. [Note 24] We reserve opinion as to whether the adversary is necessarily deprived of initiative, but, for the reasons mentioned, our decision would be the same if the adversary were so deprived. At the same time, we think the general rule may bend in particular cases to equitable considerations. [Note 25] We add that we see no reason why a party's offer could not itself propose

Page 719

a disposition of the question of interest which would control if the offer became the award. [Note 26]

An adjustment of interest will be required because of the falling out of the insurance provision (the general rule will apply to the remainder despite this modification of the award). The town (assuming, as we hold, that the judge applied the correct rule) asserts that there was a lack of evidence to support the particular computation made; the union says the town waived any right to a hearing on the computation. We are unable to resolve this quarrel on the basis of the present record and think it should be reexamined below.

To sum up: The judgment enforcing the arbitration award should be affirmed except as to the insurance provision, and as to that provision should be reversed. The case is remanded to the Superior Court Department (a) for an adjustment of interest to reflect the reversal, and (b) for reconsideration of the computation of the balance of the interest adjudged if the court should find that course justified.

So ordered.

FOOTNOTES

[Note 1] See generally J.L. Stern et al., Final Offer Arbitration (1975); Somers, An Evaluation of Final-Offer Arbitration in Massachusetts, 6 J. Collective Negotiations in the Pub. Sector 193 (1977).

[Note 2] As will be seen, we use the term "invalid" as a shorthand for the proposition that a statutory policy exists concerning the particular subject which may not be frustrated by means of arbitration.

[Note 3] This statute was later amended in certain respects by St. 1977, c. 347, Section 2.

[Note 4] Besides the wage and insurance questions, the matters remaining in controversy included vacation, bereavement and sick leave, paid holidays, and protective clothing and uniforms.

[Note 5] Arbitrators are adjured by the statute to consider ten matters among others that may be relevant.

[Note 6] Chapter 32B permits municipalities to elect to provide group insurance with certain coverages for their employees and their dependents. "Acceptance" by a municipality takes place under Section 10.

[Note 7] In order to contribute a subsidiary or additional rate, the municipality must separately accept Section 7A as therein stated.

[Note 8] The addendum to the first paragraph of Section 7A, inserted by St. 1973, c. 789, Section 1, is set out in the text below.

[Note 9] The proposal was set out as art. XV of the union's offer (corresponding to art. XV of the contract) and read as follows:

"Insurance

....

"The present Group Insurance Plan, including Master Medical Coverage, shall remain in full force and effect for the term of this Agreement; the Employer shall continue to pay fifty percent (50%) of the premium cost thereof for each employee. Effective July 1, 1977, the Employer's contribution shall be supplemented by an annual lump sum payment (monthly or otherwise as determined by the Town) equal to the difference between fifty percent (50%) and seventy five percent (75%) of said premium during the particular year. In the event that the Town should increase its percentage of premium cost above fifty percent (50%), payments under the preceding sentence shall not duplicate any such increase."

[Note 10] Established in 1955, the Commission has had varying responsibilities regarding group insurance for government employees. For its present status, see G. L. c. 32A, Sections 3, 4; G. L. c. 32B, Sections 3, 11. See also *Brooks v. School Comm. of Gloucester*, 5 Mass. App. Ct. 158 , 161-162 n.5 (1977).

[Note 11] According to the Commission, varying contributions by a municipal unit would be "discriminatory and create unnecessary friction between employees"; group insurance "should not be fragmented into smaller elements of special interests." (Statement of March 20, 1973, on House No. 5656.) Repeal of the 1973 amendment "may be foreseen as a forerunner of an attempt to fragmentize the level of coverage itself," all contrary to the principle that "the broader the spread of risk, ... the lower the total premium cost." (Statements of March 26, 1974, on House Nos. 1421 and 1414.)

These statements are referred to in the *Brooks* case, cited earlier in the text, and are mentioned here not as necessarily proving the legislative intent with respect to the 1973 amendment, but as confirming a common sense interpretation of the amendment.

[Note 12] Section 15 prohibits any governmental unit from appropriating or expending public funds for the group insurance unless the insurance is procured pursuant to the provisions of c. 32B (with an exception not relevant here).

[Note 13] It may be noted that if firefighters are assumed to have more serious health hazards, they are already somewhat favored by being brought into group insurance on an equal basis with others sustaining only ordinary hazards.

[Note 14] Under G. L. c. 32B, Section 11A, employees individually may purchase additional insurance, but it is noteworthy that municipalities are forbidden to contribute to this: "[T]he governmental unit shall make no contribution to said premium."

[Note 15] The words are quoted from *Kerrigan v. Boston*, 361 Mass. 24 , 31 n.3 (1972). In that case, as part of a collective agreement, a trust was set up for the benefit of city teachers, and Boston undertook to pay a certain sum per teacher into the fund in the years 1968 and 1969. A proposal by the trustees to use part of the money to purchase group accidental death insurance additional to that provided in accordance with c. 32B was held by the trial judge to be offensive to Section 15, see note 12, supra. The point was not reached on appeal, but we remarked (*id.*): "Thus we need not consider on this record the problems which may arise if a collective bargaining agreement is used as a method of evading a well defined statutory policy. Such problems may properly be left for a case where the record and arguments adequately present the issue sought to be raised."

[Note 16] Contrast G. L. c. 150E, Section 7, which states that the terms of a collective bargaining agreement may supersede the provisions of certain State statutes there enumerated.

[Note 17] In fact the Pennsylvania court said "the legislative policy precluding the payment of premiums such as those involved in this case may be weak indeed," in light of two recent statutes "demonstrat[ing] the absence of a clear legislative policy favoring the proscription." *Id.* at 178.

[Note 18] See Local 1400, Chester City Fire Fighters Ass'n v. Nacrelli, 30 Pa. Commw. Ct. 242 (1977) (credit for periods of nonemployment); Hartshorn v. Allegheny County, 9 Pa. Commw. Ct. 132 (1973) (control and assignment of detectives); Cheltenham v. Cheltenham Police Dep't, 8 Pa. Commw. Ct. 360 (1973) (eligibility for retirement at age fifty-three); Allegheny County Firefighters, Local 1038 v. Allegheny County, 7 Pa. Commw. Ct. 81 (1973) (union membership requirements). Cf. Fraternal Order of Police v. Scranton, 26 Pa. Commw. Ct. 513 (1976) (upholding additional compensation for educational degrees); Reading v. Reading Lodge Fraternal Order of Police No. 9, 15 Pa. Commw. Ct. 344 (1974) (permitting pension benefits before age of fifty).

[Note 19] The statutory regulation of group insurance for municipal employees does not exclude all collective bargaining by a union on the subject, but any proposal for a municipal contribution over 50% must envisage an increase for all employees, and this would "tend to make bargaining on that issue atypical and more difficult." Brooks v. School Comm. of Gloucester, 5 Mass. App. Ct. 158 , 160-161 n.4.

[Note 20] See also Kenai Peninsula Borough School Dist. v. Kenai Peninsula Educ. Ass'n, 572 P.2d 416, 422-423 (Alas. 1977); Biddeford v. Biddeford Teachers Ass'n, 304 A.2d 387 (Me. 1973); West Irondequoit Teachers Ass'n v. Helsby, 35 N.Y.2d 46 (1974); Annot., 68 A.L.R.3d 885, 915-920, 922-926, 932-933 (1976).

[Note 21] The longevity provision rearranged the time for those payments. The town invokes G. L. c. 41, Section 56, which requires that approval of municipal expenditures be given "after an examination to determine that ... services were actually rendered," and claims that it forbids "prepayments." We need not pass on this reading of the statute, as the longevity pay on the revised schedule appears still to relate to services rendered in previous periods. Nor is any "gratuity" involved. See Fitchburg Teachers Ass'n v. School Comm. of Fitchburg, 360 Mass. 105 (1971).

[Note 22] The statute, St. 1973, c. 1078, Section 4, stated: "Any determination or decision of the arbitration panel if supported by material and substantive evidence on the whole record shall be binding upon the parties and may be enforced at the instance of either party or of the arbitration panel in the superior court in equity; ..." Cf. Local 494 IBEW v. Artkraft, Inc., 375 F. Supp. 129, 132 (E.D. Wis. 1974); Meat & Allied Food Workers Local 248 v. Packerland Packing Co., 411 F. Supp. 1280, 1284 (E.D. Wis. 1976); Hackman v. American Mut. Liab. Ins. Co., 110 N.H. 87, 94-95 (1970).

In Glenn Acres, Inc. v. Cliffwood Corp., 353 Mass. 150 , 156 (1967), referred to by the town on this appeal, the court stressed that the "finality" of the commercial arbitration award involved there was "subject to and dependent upon" the entry of a judgment. Prior to such judgment, the award was to be treated as an unliquidated contract claim on which interest would run from the date of the writ (the initiation of the action to confirm). The remarks about lack of finality of the award appear not to fit the situation of a best and last offer award. See also Marlborough Firefighters, Local 1714 v. Marlborough, 375 Mass. 593 , 601 n.7 (1978).

[Note 23] See Lundgren v. Freeman, 307 F.2d 104, 112 (9th Cir. 1962) ("It should be the rule, rather than the exception, that when arbitrators hand down an award the parties will comply with it, without the necessity of court proceedings").

[Note 24] This suggestion was grounded on the statutory text quoted at note 22, supra.

[Note 25] Cf. *Board of County Comm'rs v. United States*, 308 U.S. 343, 352 (1939) (Frankfurter, J.) ("[I]nterest is not recovered according to a rigid theory of compensation for money withheld, but is given in response to considerations of fairness. It is denied when its exaction would be inequitable"); *NF&M Corp. v. United Steelworkers of America*, 390 F. Supp. 266, 270 (W.D. Pa.), aff'd, 524 F.2d 756 (3d Cir. 1975) (interest on arbitrator's back pay award denied in part because of union's repeated requests for delay).

[Note 26] It is now in order to say that the ruling on interest made in *Arlington v. Local 1297, I.A.F.F.*, 6 Mass. App. Ct. 874 (1978), appears not in accord with the general rule we have stated.

Chapter 68 of the Acts of 2011 – State Budget Act for FY2012 – Outside Sections Related to Group Health Insurance Reform

Whereas, The deferred operation of this act would tend to defeat its purpose, which is immediately to make appropriations for the fiscal year beginning July 1, 2011, and to make certain changes in law, 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 55. The fifth paragraph of subsection (a) of section 19 of said chapter 32B, as so appearing, is hereby amended by striking out the fourth sentence and inserting in place thereof the following 2 sentences:- Either the public employee committee or the appropriate public authority may convene the initial meeting of the committee at any time upon 7 days notice. Either the public employee committee or the appropriate public authority may convene any subsequent meeting with notice of not less than 3 business days.

SECTION 56. Said section 19 of said chapter 32B, as so appearing, is hereby amended by striking out, in line 58, the words "70 per cent" and inserting in place thereof the following words:- a majority.

...

SECTION 221. Except as otherwise specified, this act shall take effect on July 1, 2011.

Approved, July 11, 2011.

Specific Legal References for Case Study 3 – OPEB Fund

M.G.L. c. 32B Section 20 (as added by c. 479 of the Acts of 2008)

Section 20. A city, town, district, county or municipal lighting plant that accepts this section, may establish a separate fund, to be known as an Other Post Employment Benefits Liability Trust Fund, and a funding schedule for the fund. The schedule and any future updates shall be designed, consistent with standards issued by the Governmental Accounting Standards Board, to reduce the unfunded actuarial liability of health care and other post-employment benefits to zero as of an actuarially acceptable period of years and to meet the normal cost of all such future benefits for which the governmental unit is obligated. The schedule and any future updates shall be: (i) developed by an actuary retained by a municipal lighting plant or any other governmental unit and triennially reviewed by the board for a municipal lighting plant or by the chief executive officer of a governmental unit; and (ii) reviewed and approved by the actuary in the public employee retirement administration commission.

The board of a municipal lighting plant or the legislative body of any other governmental unit may appropriate amounts recommended by the schedule to be credited to the fund. Any interest or other income generated by the fund shall be added to and become part of the fund. Amounts that a governmental unit receives as a sponsor of a qualified retiree prescription drug plan under 42 U.S.C. 1395w-132 may be added to and become part of the fund.

The custodian of the fund shall be: (i) a designee appointed by the board of a municipal lighting plant; or (ii) the treasurer of any other governmental unit. Funds shall be invested and reinvested by the custodian consistent with the prudent investor rule set forth in chapter 203C.

This section may be accepted in a city having a Plan D or Plan E charter by vote of the city council; in any other city by vote of the city council and approval of the mayor; in a town by vote of the town at a town meeting; in a district by vote of the governing board; in a municipal lighting plant by vote of the board; and in a county by vote of the county commissioners.

Chapter 68 of the Acts of 2011: OPEB Fund Amendments

SECTION 57. Said chapter 32B is hereby further amended by striking out section 20, as so appearing, and inserting in place thereof the following section:-

Section 20. (a) A city, town, district, county or municipal lighting plant that accepts this section may establish an Other Post-Employment Benefits Liability Trust Fund, and may appropriate amounts to be credited to the fund. Any interest or other income generated by the fund shall be added to and become part of the fund. Amounts that a governmental unit receives as a sponsor of a qualified retiree prescription drug plan under 42 U.S.C. section

1395w-132 may be added to and become part of the fund. All monies held in the fund shall be segregated from other funds and shall not be subject to the claims of any general creditor of the city, town, district, county or municipal lighting plant.

(b) The custodian of the fund shall be (i) a designee appointed by the board of a municipal lighting plant; (ii) the treasurer of any other governmental unit; or (iii) if designated by the city, town, district, county or municipal lighting plant in the same manner as acceptance prescribed in this section, the Health Care Security Trust board of trustees established in section 4 of chapter 29D, provided that the board of trustees accepts the designation. The custodian may employ an outside custodial service to hold the monies in the fund. Monies in the fund shall be invested and reinvested by the custodian consistent with the prudent investor rule established in chapter 203C and may, with the approval of the Health Care Security Trust board of trustees, be invested in the State Retiree Benefits Trust Fund established in section 24 of chapter 32A.

(c) This section may be accepted in a city having a Plan D or Plan E charter, by vote of the city council; in any other city, by vote of the city council and approval of the mayor, in a town, by vote of the town at a town meeting; in a district, by vote of the governing board; in a municipal lighting plant, by vote of the board; and in a county, by vote of the county commissioners.

(d) Every city, town, district, county and municipal lighting plant shall annually submit to the public employee retirement administration commission, on or before December 31, a summary of its other post-employment benefits cost and obligations and all related information required under Government Accounting Standards Board standard 45, in this subsection called "GASB 45", covering the last fiscal or calendar year for which this information is available. On or before June 30 of the following year, the public employee retirement administration commission shall notify any entity submitting this summary of any concerns that the commission may have or any areas in which the summary does not conform to the requirements of GASB 45 or other standards that the commission may establish. The public employee retirement administration commission shall file a summary report of the information received under this subsection with the chairs of the house and senate committees on ways and means, the secretary of administration and finance and the board of trustees of the Health Care Security Trust. ...

SECTION 206. Nothing in section 20 of chapter 32B of the General Laws shall affect the validity of any action taken before July 1, 2011 by a city or town that authorizes the contributory retirement system of which the employees of that city or town are members to be the custodian of an Other Post-Employment Benefits Liability Trust Fund. ...

SECTION 221. Except as otherwise specified, this act shall take effect on July 1, 2011. *Approved, July 11, 2011.*

Email Response 2011-409 – Middleborough OPEB Issue

From: Gorton, Donald E. on behalf of DOR DLS Law
Sent: Tuesday, April 05, 2011 3:13 PM
To: 'Judy MacDonald'
Subject: RE: Middleborough 2011-409

Dear Ms. McDonald:

Many of the questions you raise are not legal issues, and given the newness of the statute, we have no settled guidance to offer. Yes, it makes sense that the transfer be made through the warrant process. Since you will no longer be custodian of the OPEB fund I do not see how you can be responsible for recording activities relating to that fund in your books and records. Investment decisions, within the parameters set by statute, are the responsibility of the custodian of the fund. It makes sense that the fund would use the town's tax ID number since the gas and electric department is not a separate legal entity, but that question is one for the IRS. The statute imposes no requirement that the custodian of the fund be bonded.

I hope this information is helpful.
Donald Gorton, Counsel
Bureau of Municipal Finance Law
Division of Local Services
Massachusetts Department of Revenue
617-626-2400
DLSLAW@dor.state.ma.us

This e-mail response is intended to provide general information about the application of municipal tax and finance laws and Department of Revenue policies and procedures. It is not a public written statement, as defined in 830 CMR 62C.3.1, and does not state the official position of the Department on the interpretation of the laws pertaining to local taxes and finance. Informational responses provided by this e-mail means are akin to ordinary telephone or face-to-face conversations and do not reflect the level of factual or legal inquiry or analysis which would be applied in the case of a formal legal opinion.

From: Judy MacDonald [mailto:jmcdnld@middleborough.com]
Sent: Tuesday, April 05, 2011 12:59 PM
To: DOR DLS Law
Subject:

Hello,

I am Judy Mac Donald Treasurer/Collector of the Town Of Middleborough the reason I am writing to you is because our Gas and Electric Commissioners' are going to vote to appoint a new custodian per Chapter 32B section 20 for the departments Post

Employment Benefits Liability Trust Fund at their meeting on April 12, 2011. The balance in this trust is currently \$2,118,111.19. I have attached a copy of the law, which states they have the ability to do appoint a new custodian. I am currently the custodian of the fund. My question is how I transfer the funds to the new custodian, thru the warrant process? If or when I transfer the funds, how are the funds recorded on the books of the Town if I no longer have custody? Should I require that they show me a bond for the new custodian? I do not believe this law is in the best interest of municipalities. The general manager of the Gas and Electric wants to invest in U.S. Treasuries and I do not agree with him so he has convinced the Gas and Electric Commissioners to appoint him as the custodian.

Currently I do the all banking and borrowing for the Gas and Electric department. Are the Gas and Electric commissioners (they may appoint themselves) or the appointed custodian now allow the have bank accounts with the Towns tax ID number? If you could give me guidance on how to handle this situation I would greatly appreciate it. Thank you in advance for you help.

Judy M. Mac Donald
Treasurer/Collector
Town of Middleborough
20 Centre St.
Middleborough, MA 02346
(PH) 508-946-2421
Fax 508-947-5447
jmcdnld@middleborough.com

Email Response 2011-589 – Sudbury – OPEB Trust Document

From: Blau, Gary on behalf of DOR DLS Law
Sent: Wednesday, May 18, 2011 2:17 PM
To: 'Chisholm, Barbara'
Subject: 2011-589 - Sudbury - OPEB Trust Document

Barbara:

As we discussed, I do not believe it necessary for the town to draft a "trust document" to place money in an OPEB Trust under M.G.L. c. 32B, §20, if that provision has been accepted by the town. But as we also discussed, it appears that Sudbury did not accept that provision but sought a special act to establish a Post Employment Health Insurance Liability Fund, which was enacted in 2006 as Chapter 72 of that year. That act may be found at <http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter72>. You may wish to consult with town counsel and the town manager about the scope of the fund and how the fund may be used in future years to cover the town's legal responsibility to pay for its share of retiree health insurance. For example, both the Chapter 32B, §20 OPEB trust and Sudbury's special act require an actuarial study, which will provide a reasoned estimate of the amounts needed to be appropriated to the fund over a reasonable period of time in order to meet the town's future retiree health insurance obligations, and

at least in Sudbury's case limit the appropriations that may be made to the amount of the total actuarial liability. Periodic updates to that study will also need to be made to account for actual experience and variances in the factors assumed in conducting the study.

I hope this addresses your concerns.

Gary A. Blau, Tax Counsel
Bureau of Municipal Finance Law
PO Box 9569
Boston, MA 02114-9569
617-626-2400
blau@dor.state.ma.us

This e-mail response is intended to provide general information about the application of municipal tax and finance laws and Department of Revenue policies and procedures. It is not a public written statement, as defined in 830 CMR 62C.3.1, and does not state the official position of the Department on the interpretation of the laws pertaining to local taxes and finance. It should be considered informational only.

From: Chisholm, Barbara [mailto:ChisholmB@sudbury.ma.us]
Sent: Wednesday, May 18, 2011 12:00 PM
To: DOR DLS Law
Subject: RE: OPEB Trust Document

Hello,

At our ATM this year an article was passed to transfer over a million dollars into OPEB Trust. Do we need trust documents or will the language in 32B s.12 satisfy the trust requirement?

Thank you,
Barbara

*Barbara Chisholm
Town Accountant
Town of Sudbury
278 Old Sudbury Road
Sudbury, MA 01776
978-639-3319 phone
978-443-8450 fax
chisholmb@sudbury.ma.us*

Email Response 2009-1278 – Retiree Health Insurance Fund

From: Hinchey, Christopher M on behalf of DOR DLS Law
Sent: Monday, October 05, 2009 8:50 AM
To: 'GiustiHingstonCo@aol.com'
Subject: 2009-1278 RE: Retiree Health Insurance Fund

GL C.32B §20 (a local acceptance provisions added by C.479 of the Acts of 2008) authorizes the creation by municipalities of trust funds for their OPEB liabilities. Once the provision has been accepted by a municipality, the acceptance cannot be rescinded (see the last sentence of C.32B §10). See also the brief note on C.479 in our Bulletin 2009-8B, “2008 Legislation.”

I don't know whether the creation of an OPEB fund under C.32B §20 would satisfy the GASB criteria or not.

Chris Hinchey Tax Counsel
Bureau of Municipal Finance Law
PO Box 9569
Boston, MA 02114-9569
617-626-2400
dlslaw@dor.state.ma.us

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From: GiustiHingstonCo@aol.com [mailto:GiustiHingstonCo@aol.com]
Sent: Friday, October 02, 2009 9:10 AM
To: DOR DLS Law
Subject: Retiree Health Insurance Fund

Hi Chris,

I hope all is well with you. I have a quick question regarding legislation pertaining to an investment vehicle for retiree health insurance funds. Has anything been passed on that (i.e. irrevocable trust). Is anything pending. I have a lot of Towns that want to do some funding. Some are putting it in a separate stabilization fund, but since it is not irrevocable and subject to the Town's creditors it is not considered truly funded by the GASB. Our notes to the financial statements will still show zero funding related to the unfunded liability.

As usual, thanks Chris.
Take care, Dick

CHAPTER 72 of the Acts of 2006

AN ACT ESTABLISHING A POST EMPLOYMENT HEALTH INSURANCE LIABILITY FUND IN THE TOWN OF SUDBURY.

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. The town of Sudbury may appropriate funds in order to offset the anticipated cost of health insurance contributions for retired employees, their spouses and eligible dependents and the surviving spouses and eligible dependents of deceased retirees. This amount shall be credited to a special fund to be known as the Post Employment Health Insurance Liability Fund. The fund shall be under the supervision and management of the town manager and under the custody of the town treasurer. The town treasurer may deposit the proceeds in national banks or invest the proceeds by deposit in savings banks, cooperative banks, or trust companies organized under the laws of the commonwealth or in federal savings and loan associations situated in the commonwealth or invest the funds in securities that are legal for the investment of funds of savings banks under the laws of the commonwealth. Any interest or other income earned by the fund shall be added to and become part of the fund. Amounts may be appropriated to the fund by any town meeting by a majority vote not to exceed the total liability developed by an actuarial study. Authorized disbursements shall be made from the fund in payment of contributions and premiums for the benefit of retirees and their eligible dependents and surviving spouses and for costs associated with conducting the actuarial study without further appropriation. The town manager may employ any qualified bank, trust company, corporation, firm or person for advice on the investment of the fund and or to prepare an actuarial study and may pay for this advice or service from this fund.

SECTION 2. This act shall take effect upon its passage.

Approved May 4, 2006.

Chapter 88 of the Acts of 2004

AN ACT AUTHORIZING THE TOWN OF WELLESLEY TO ESTABLISH A GROUP INSURANCE LIABILITY FUND

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. As used in this act, the following words shall have the following meanings:-

"Normal cost of post retirement benefits", that portion of the actuarial present value of future premium costs and claim costs payable by the town on behalf of, or direct payments to, retired employees, including school teachers, of the town and the eligible surviving spouses or dependents of deceased employees, including school teachers, of the town, pursuant to this act which is allocable to a particular fiscal year, as determined by an actuary pursuant to section 2.

"Post retirement benefit liability", the present value of the town's obligation for future premium costs and claim costs payable by the town on behalf of, or direct payments to, retired and prospective retired employees of the town and the eligible surviving spouses or dependents of deceased and prospectively deceased employees of the town attributed by the terms of the plan to employee's service rendered to the date of the measurement, pursuant to this act as determined by an actuary, pursuant to section 2.

"Premium costs and claim costs", the amounts payable by the town for the provision of retiree health and life insurance.

"Unfunded post retirement benefit liability", the difference between the post retirement benefit liability on the measurement date and the actuarial value of the assets of the Group Insurance Liability Fund on the same date, as determined by an actuary pursuant to section 2.

"Unfunded post retirement benefit liability amortization payments", the amount which, when paid into the Group Insurance Liability Fund annually over a period of years together with the normal cost of post retirement benefits for each year of said period of years will reduce to zero at the end of said period the unfunded post retirement benefit liability in existence as of the beginning of said period, as determined by an actuary.

SECTION 2. (a) There shall be in the town of Wellesley a Group Insurance Liability Fund, which shall be under the supervision and management of the town's contributory retirement board established under paragraph (b) of subdivision (4) of section 20 of chapter 32 of the General Laws. The town treasurer shall be the custodian of the fund and may employ an outside custodial service.

(b) The fund shall be credited with all amounts appropriated or otherwise made available by the town for the purposes of meeting the current and future premium costs and claim costs payable by the town on behalf of, or direct payments to, retired employees of the town and the eligible surviving spouses or dependents of deceased employees of the town pursuant to this act. Amounts in the fund including any earnings or interest accruing from the investment of such amounts shall be expended only for the payment of such premium costs and claim costs payable by the town on behalf of, or direct payments to, retired employees of the town and the eligible surviving spouses or dependents of deceased employees of the town, except as otherwise provided in this act, and only in accordance

with a schedule of such payments developed by an actuary in consultation with the town's contributory retirement board. Subject in each instance to the approval of the town's contributory retirement board, the town treasurer shall invest and reinvest the amounts in the fund not needed for current disbursement consistent with the prudent person rule, but no funds may be invested directly in mortgages or in collateral loans. The fund shall be subject to the public employee retirement administration commission's triennial audit.

(c) The board may employ any qualified bank, trust company, corporation, firm or person to advise it on the investment of the fund and may pay from the fund for such advice and such other services as determined by the town's contributory retirement board.

SECTION 3. (a) An actuary shall determine, as of January 1, 2003, and no less frequently than every second year thereafter, the normal cost of post retirement benefits, the post retirement benefit liability, and the unfunded post retirement benefit liability. All such determinations shall be made in accordance with generally accepted actuarial standards, and the actuary shall make a report of such determinations. The report shall, without limitation, detail the demographic and economic actuarial assumptions used in making such determinations, and each such report subsequent to the first such report shall also include an explanation of the changes, if any, in the demographic and economic actuarial assumptions employed and the reasons for any such changes, and shall also include a comparison of the actual expenses by the town for premium costs and claim costs constituting the post retirement benefit liability during the period since the last such determination, and the amount of such expenditures which were predicted pursuant to the previous such report for the period.

(b) An actuary, in consultation with the town's contributory retirement board, shall establish a schedule of annual payments to be made to the Group Insurance Liability Fund designed to reduce to zero the unfunded post retirement benefit liability. The schedule shall reduce the initial unfunded post retirement benefit liability over a period of years not to exceed 30. Any additional unfunded liability created subsequent to the last such determination by the provision of any new benefit or by any increase in the premium share payable by the town shall be separately so amortized over the 15 years following the date of the determination in which such additional liability is first recognized. Each such annual payment shall be equal to the sum of the unfunded post retirement benefit liability amortization payment required for such year and the payments required to meet the normal cost of post retirement benefits for such fiscal year.

(c) All payments for the purposes of meeting the town's share of premium costs and claim costs or direct payments to retired employees of the town and the surviving spouses or dependents of deceased employees of the town pursuant to this act shall be made from the Group Insurance Liability Fund in accordance with a schedule of disbursements established by the actuary.

SECTION 4. This act shall take effect upon its passage.

Approved May 6, 2004.