



CITY OF NEW BEDFORD
JONATHAN F. MITCHELL, MAYOR

May 17, 2022

City Council President Ian Abreu, and
Honorable Members of the City Council
133 William Street
New Bedford, MA 02740

Dear Council President Abreu and Honorable Members of the City Council:

I am again submitting to the City Council a proposal to control municipal employee healthcare costs by accepting the provisions of Sections 21-23 of Chapter 32B of the Massachusetts General Laws.

As you know, employee health insurance is a substantial driver of cost increases in the city budget, and as such, is a major contributor to the property tax burden on our residents. Since 2012, employee health insurance costs have risen from \$35.2 million to \$45.7 million, or nearly \$1 million per year every year. And the return of inflation to the broader economy suggest that these trends will not let up anytime soon.

Taxpayers have had to bear this cost increase, and they have had to do it at a time when real household incomes in the City have been stagnant. It didn't have to be this way. As amended by the Legislature in 2011, Sections 21-23 afford municipalities the opportunity to control these costs without compromising the quality of healthcare benefits to their employees.

A municipality's legislative body must first vote to accept the provisions of these Sections, so in January 2018, and again in September 2018, I asked the Council to take the requisite approval vote. The Council's inaction since then has cost taxpayers millions in potential savings and further inaction by the Council will cost taxpayers millions more in the years ahead.

As you will recall from the map included in the January 2018 letter to the Council [attached], virtually every city and town in Southeastern Massachusetts, along with the majority of municipalities and school districts statewide, has accepted Sections 21-23, and with very good reason. They have realized measurable cost savings over time, while still meeting the obligation to provide their employees with the health care coverage they deserve.

The purpose of Sections 21-23 is to equalize the negotiating positions of a municipality and its employee unions when healthcare plan redesigns are considered. At present the City cannot make any changes to healthcare benefits without the active cooperation of the employee unions who receive these benefits. Employee unions wield an effective veto over any City proposal, enabling them to fully utilize their lopsided advantage at the negotiating table, often refusing to make changes, prolonging negotiations, and only agreeing, when pressed, to minor revisions that leave major cost drivers untouched.

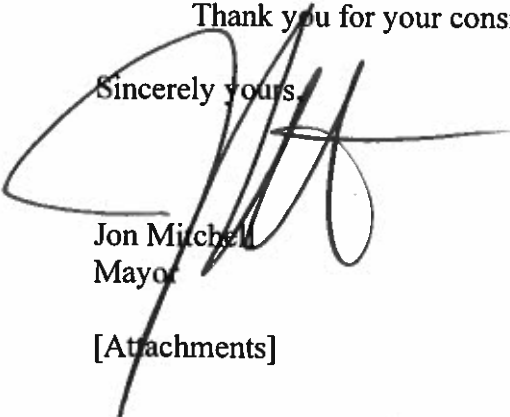
Importantly, adoption of Sections 21-23 will introduce a new, independent arbitration process that will be available to resolve protracted differences between the municipal unions and the City. Simply having the *possibility* of a neutral arbiter ready to step in and resolve impasses in healthcare negotiations will go a long way to making negotiations more collaborative and fruitful.

Minor healthcare plan changes (limited to some copays and deductibles) have been implemented since 2018, but the bottom-line impact on taxpayers has been modest at best, and did not achieve the savings goals the City sought at the time. In the final analysis, it is clear that changes agreed to by employee unions under the current negotiating process will continue to prove negligible from a cost savings standpoint, compared to the long-term cost trajectory of the program. Without a level playing field that a neutral arbiter provides, the City can expect more of the same—occasional, tactical compromises from employee unions that confer no significant benefits to the overall budget or to taxpayers.

It is with these concerns in mind that I encourage the City Council to reconsider its prior refusals to accept Sections 21-23. I am as committed as ever to achieving a sustainable fiscal path for the City and believe that we can respect our hard-working employees while moving toward healthcare coverage that is more reflective of the modern healthcare marketplace. With taxpayers already burdened, essential services at risk, and state mandates growing, we have no good option but to put in place this eminently reasonable reform of our healthcare program.

Thank you for your consideration on this important matter.

Sincerely yours,



Jon Mitchell
Mayor

[Attachments]



CITY OF NEW BEDFORD

CITY COUNCIL

May 24, 2022

Ordered, that the City of New Bedford hereby accepts M.G.L. chapter 32B, sections 21, 22 and 23, pertaining to health insurance benefits.



ATTACHMENT: JANUARY 18 COUNCIL FILING

[FOR BACKGROUND PURPOSES]

CITY OF NEW BEDFORD

JONATHAN F. MITCHELL, MAYOR

January 4, 2018

City Council President Linda M. Morad, and
Honorable Members of the City Council
133 William Street
New Bedford, MA 02740

Dear Council President Morad and Honorable Members of the City Council:

I am hereby submitting to the City Council an Order to accept Massachusetts General Laws Chapter 32B, Sections 21 through 23, to provide the City with the tools to implement necessary changes to City health insurance benefits and to enable more effective collaboration with the public employee unions. Health care costs have become a growing imposition on tax payers over the last several years. Without the authority provided by Sections 21-23, the City will continue to have a limited ability to rein in health care spending. Virtually every community in Greater New Bedford has accepted Sections 21-23 in recent years and has achieved significant savings while meeting the obligation to provide their employees with the health care coverage they deserve. Fiscal realities make it necessary for New Bedford to follow suit.

As you will recall, the City of New Bedford is responsible for funding 75% of the total medical claims costs for employee health insurance. The City's share of the employee health insurance program increased from \$37.4 million in FY 2016 to \$40.3 million in FY 2017, an increase of nearly 8%. It is estimated that the City's share of the health insurance costs for FY 2018 will increase by another 7%; the health insurance budget will comprise approximately 14.2% of the entire General Fund budget, as health insurance expenses have increased by about 49% over the past ten years.

In 2007, the City Council accepted M.G.L Chapter 32B, Section 19, which established the Public Employee Committee (PEC) in order to provide a single body for the negotiation of employee health care benefits. The City Council accepted Section 20 in 2016, which authorized the establishment of the Other Post Employment Benefits (OPEB) Liability Trust Fund, and took initial steps toward addressing the City's long-term liability. However, the increasing burden of health care costs continues to make fiscal sustainability elusive, both in terms of the current budget and the funding of future liabilities.

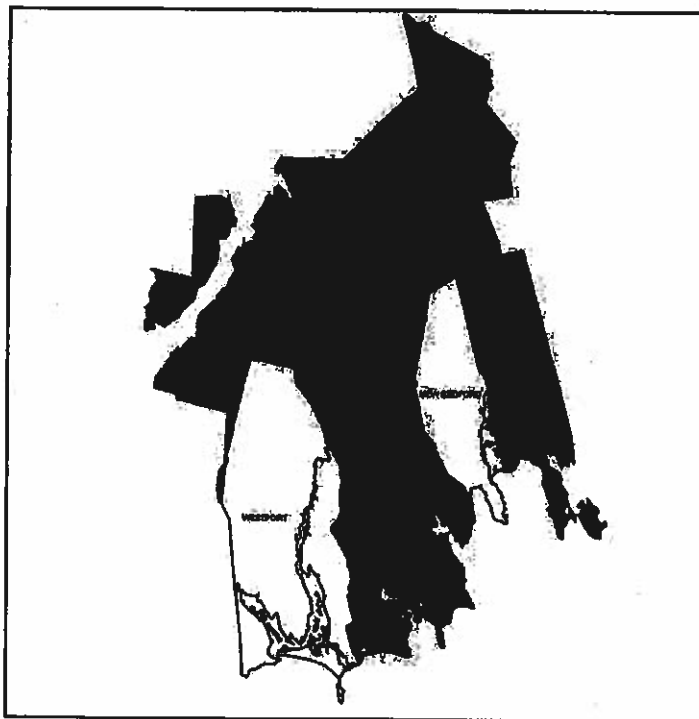
In 2011, the Massachusetts legislature enacted M.G.L. Chapter 32B, Sections 21 through 23, to provide municipalities with additional flexibility in negotiating changes to their health

insurance plans. If adopted, Sections 21 through 23 will provide a process for the City to implement benefit design changes after negotiating with the Public Employee Committee. In accordance with the law, each time the City proposes benefit design changes, the City will be required to offer mitigation to affected employees and retirees, in an amount up to 25% of the total share of first year's savings. In the event the parties are unable to negotiate a mutually acceptable benefit design, a Health Insurance Review Board would determine benefit design changes, as long as the resulting benefit design is no less comprehensive than the benefits offered by the Group Insurance Commission health insurance plan with the most members.

At present, the City cannot redesign benefits if the PEC simply refuses to negotiate. The arbitration authority of the Health Insurance Review Board levels the playing field. This year, both before and after the City Council's rejection of our initial attempt to accept the health plan redesign law, the City made several attempts to establish changes to the benefit plans, but the PEC has not come to terms with the City. The PEC's lack of willingness to engage on this issue shows that the time is now to proceed with Section 21-23 implementation.

Given the rising costs of health care, it is no surprise that the acceptance of Sections 21-23 as a tool for managing health care costs has become common practice for local governments throughout Massachusetts. A 2013 state report indicated that 191 municipalities and school districts had reported savings to the State resulting from benefit redesign. Although we don't have a more up-to-date total, according to the Massachusetts Municipal Association, that number has gone up. We are more informed about the experience of our region. As shown in the accompanying chart, New Bedford and Westport are the only municipalities in Southern Bristol County that have not accepted these provisions.

Health Plan Redesign Acceptance in Southern Bristol County



Because health care redesign is subject to negotiation and arbitration under Sections 21-23, it is difficult to predict precisely how much the City would save by accepting the statute. Nevertheless, the experiences of nearby communities, as indicated in the 2013 report, show that savings will likely be substantial. Jurisdictions in the immediate vicinity that reported annual savings from health plan redesign included:

- Acushnet: \$190,000
- Dartmouth: \$511,000
- Fairhaven: \$540,000
- Fall River: \$3,710,000
- Seekonk: \$427,000
- Somerset: \$900,000

These figures beg the question: why hasn't New Bedford adopted Section 21-23 yet? New Bedford taxpayers, after all, face the same, if not greater, pressure for escalating health care costs.

In order to slow the progression of rate increases, and to implement a program that is more reflective of the modern health care marketplace, the City must be able to implement benefit design changes. For these reasons, I respectfully request that the City Council vote to adopt Massachusetts General Laws, Chapter 32B, Sections 21 through 23.

Thank you for your consideration.

Sincerely yours,



Jon Mitchell, Mayor

Frequently Asked Questions

#1 Why can't the city just switch health insurance providers to save money?

- Switching providers sounds like an easy fix, but is really no solution at all.
 - Some have suggested switching health insurance providers could be a fix. The City, in fact, switched providers in 2015 and costs have continued to climb steadily. ***This is because the choice of a plan provider does not impact any of the direct costs of benefit plans offered to city employees.***
 - ***In any case, a switch of providers wouldn't happen for at least two years. Meanwhile, costs would continue to rise and pressure on the tax levy would increase.*** The City is in the third year of a provider contract with Blue Cross Blue Shield that will last until Dec. 31, 2019.
 - The City always assesses its provider options at the end of a contract period. ***Therefore, it's not accurate and misleading to suggest that the usual assessment of a city's plan provider somehow represents a new, meaningful solution to the problem.***

#2 Will the adoption of Sections 21-23 change the way that city employees share the cost of their health insurance?

- No. Some have suggested that the adoption of Sections 21-23 might allow the city to change the existing "25%/75%" cost-sharing arrangement that requires city employees to pay 25% of the cost of their health insurance plan and the city (as employer) to pay the other 75%.
- There is no basis for this suggestion. It is simply not true. Section 21 does not give any power to the city to unilaterally pursue a change in the existing cost-sharing split. Any change to the "25%/75%" split could only happen as part of a separate agreement between the City and the PEC that is not subject to the provisions of Sections 21-23.
- In fact, bringing overall healthcare costs under control could actually provide relief to employees, since they are responsible for 25% of the cost of their health insurance plan. (If the associated cost of their health insurance premium were to change, then 25% of whatever the change is passed on to them.)

Part I

ADMINISTRATION OF THE GOVERNMENT

Title IV

CIVIL SERVICE, RETIREMENTS AND PENSIONS

Chapter 32B

CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 21

MANNER OF CHANGING HEALTH INSURANCE BENEFITS; ESTIMATION OF SAVINGS; APPROVAL OF AGREEMENT; IMMEDIATE IMPLEMENTATION; TIME FOR REVIEW; DISTRIBUTION OF SAVINGS; REGULATIONS

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

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

Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be comprised of 3 members, 1 of whom shall be appointed by the public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

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

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans

offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

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

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

Part I

ADMINISTRATION OF THE GOVERNMENT

Title IV

CIVIL SERVICE, RETIREMENTS AND PENSIONS

Chapter 32B

CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 22

COPAYMENTS, DEDUCTIBLES, TIERED PROVIDER NETWORK COPAYMENTS AND OTHER COST-SHARING PLAN DESIGN FEATURES; INCREASES

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

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

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network

copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

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

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

[Subsection (e) effective until July 1, 2016. For text effective July 1, 2016, see below.]

(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, 2016, 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 May 1, 2014; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before May 1, 2014, but to take effect on a date after May 1, 2014, 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 May 1, 2014.

[Subsection (e) as amended by 2016, 133, Sec. 45 effective July 1, 2016. See 2016, 133, Sec. 203. For text effective until July 1, 2016, see above.]

(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, 2018, 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 May 1, 2014; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before May 1, 2014, but to take effect on a date after May 1, 2014, 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 May 1, 2014.

Part I

ADMINISTRATION OF THE GOVERNMENT

Title IV

CIVIL SERVICE, RETIREMENTS AND PENSIONS

Chapter 32B

CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS

Section 23

TRANSFER OF SUBSCRIBERS TO COMMISSION; NOTICE; TRANSFER TO MEDICARE OF ELIGIBLE SUBSCRIBERS; WITHDRAWAL FROM COMMISSION COVERAGE; GROUP COVERAGE PROVIDED BY COMMISSION; DEFICIT IN CLAIMS TRUST FUND BY SELF-INSURED POLITICAL SUBDIVISION; ADMINISTRATION OF COVERAGE FOR TRANSFERRED SUBSCRIBERS BY COMMISSION; REIMBURSEMENT OF COMMISSION FOR COVERAGE COSTS; WITHDRAWAL FROM COMMISSION

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

[Second paragraph of subsection (a) effective until July 1, 2015. For text effective July 1, 2015, see below.]

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.

[Second paragraph of subsection (a) as amended by 2015, 46, Sec. 59 effective July 1, 2015. See 2015, 46, Sec. 216. For text effective until July 1, 2015, see above.]

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 after an initial 3-year period from the date of transfer of subscribers to the commission, at whole-year intervals; provided, however, that such whole-year intervals shall not be less than 2 years in length as determined by the written agreement established in subsection (c) of section 21.

[Third paragraph of subsection (a) effective until July 1, 2015. For text effective July 1, 2015, see below.]

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.

[Third paragraph of subsection (a) as amended by 2015, 46, Sec. 60 effective July 1, 2015. See 2015, 46, Sec. 216. For text effective until July 1, 2015, see above.]

The appropriate public authority shall provide notice of any withdrawal by December 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.

[Subsection (b) effective until July 1, 2015. For text effective July 1, 2015, see below.]

(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.

[Subsection (b) as amended by 2015, 46, Sec. 61 effective July 1, 2015. See 2015, 46, Sec. 216. For text effective until July 1, 2015, see above.]

(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. Upon a written request by the mayor, town manager or the public employee committee of a political subdivision, the commission shall provide the political subdivision with its claims history from the previous year, which shall include, but not be limited to, the following information: (i) subscriber count; (ii) covered lives count; (iii) total paid medical claims; and (iv) total paid prescription drug claims. The commission may charge a fee for providing the data in an amount determined by the executive director, which shall not be greater than \$1,000. The commission shall provide a detailed data response to such request within 60 days.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150E, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

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

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

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

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

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

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

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