Folks,

I have gotten one set of comments back from the committee. I wanted to share them with everyone. Below, first, is John Brouder's response to the initial email that I sent out. After I read it, I had some questions. My email with questions is shown below John's first reply, followed by John's follow up.

If anyone else has comments they wished shared, please send them along, and I'll distribute them.

Thanks, and see you all next Thursday.

Peter

Exchange 1

Peter:

I have a few thoughts on the bullet points that you laid out. You have addressed all of the key issues. As a health care consultant, I have worked with employee groups in a number of Cities, Towns and Regional School Districts which have established mitigation programs and I draw on that experience in presenting these responses.

1. **How do we figure out who falls in the category of possible recipients of some of the money.**

    a. Mitigation is a term that gained currency in municipal health insurance negotiations after the passage of the 2011 Municipal Health Care Reform law (I have pasted a summary of the 2011 law into this email). That law, which amended MGL Ch. 32(b), laid out a process by which municipalities could unilaterally make plan design changes if they agreed to create a mitigation fund consisting of up to 25% of the first year savings achieved by the municipality as a result of the changes. Hundreds of municipal mitigation plans have been established and virtually all consisted of 25% of the (estimated or actual) savings. In most cases the municipality contributed for one year; in a relatively small number of cases contributions (albeit at a lower percentage of savings) continued for a second or third year. The mitigation fund under review in Winchester is not specifically tied to the 2011 statute. Some municipalities have provided premium subsidies to all participants, others have reimbursed new copayments or deductibles; very few of the hundreds of mitigation funds statewide have based reimbursement on any type of 'means test', largely because of how difficult it is to calculate "family income".

    b. It is my understanding that Town Meeting specifically desired to provide a benefit, in the form of premium relief, to retirees facing a financial hardship as a result of the increase in their premium contribution. This suggests that the mitigation fund should be accessed only by people who meet a specific 'means test'.

2. **We will need a notification process, that is, how are we going to notify the people who fall into the category of possible recipients of some of the money.**

    a. In my opinion, the Town is the only entity capable of informing retirees of this possible fund.

3. **We will need to decide on what is adequate notification, if we have not heard from a given person.**

    a. I think two first class letters to each retiree plus notices in the Star & the Times, plus outreach to the Jencks would be adequate.

4. **We need to think about what data that will be required so that whoever is making the eligibility decisions will be properly informed.**

    a. This is the heart of the matter. The group needs to decide who can access this Fund. Among the ~500 retirees there are several different groups

        i. Older retirees who will never be eligible for Medicare; this group must participate in the far more expensive Non-Medicare retiree option plans; many of these people will have the smallest pensions and the largest costs;

        ii. Retirees on Medicare who participate in much less expensive Medicare Supplement plans;

        iii. Younger retirees who have not yet reached the Medicare Age (65) and must participate in the more expensive Non-Medicare plans;

    b. Within each of these three (3) groups, incomes vary significantly. The Town must decide what income to calculate.

        i. Is it pension income only (which could be obtained from the local and State Teachers retirement Board) or,

        ii. total income which would require looking at annual IRS tax filings;

        iii. if someone has family coverage do we look at total family income;

5. **Once eligibility is determine, we will need an approach to working out the amount of money that is distributed to each recipient.**

    a. "first come, first serve" seems inappropriate to me;

    b. I think you announce a period for applying (see 3.a), calculate the number of people who qualify, and distribute a pro-rated amount of money to each individual who qualifies.

6. **We will need some guidance on who can look at the collected data. I image that a lot of the information that will be asked for in determining eligibility will be sensitive. We will need to understand who can see it, and what they can see. This will be important after the eligibility decisions are made and some of us will need to explain those decisions.**

    a. Because of the confidentiality issues many municipalities turned the entire Mitigation Fund process over to third parties who publicize the program, collect applications and disburse funds;

        i. Many employees/retirees are reluctant to share income or health information with the municipality;

    b. However, those third party firms can be pricy – and hiring them can eat into the mitigation funds;

c. If the Town is willing to have a designated employee in the Treasurer's Office perform this function it will cost less

7. We will need to think about approaches toward arriving at a recommendation to the Town about future

Summary of the 2011 Municipal Insurance Law, from the Massachusetts Municipal Association

Legislature enacts municipal health insurance reform

July 1, 2011

As part of its fiscal 2012 state budget, enacted today, the Legislature has approved a long-awaited reform to address the skyrocketing costs of municipal employee health insurance. The governor now has 10 days to review the full budget bill. The MMA issued a statement applauding the Legislature's work in creating "meaningful, fair, and effective reform plan that balances the needs of cities and towns, taxpayers, and municipal employees." MMA Executive Director Geoff Beckwith said the legislation "will save taxpayers money, preserve essential local services, protect municipal union jobs, guarantee equity with state employee health benefits, and provide municipal unions with more bargaining power than state unions."

The reform will allow cities and towns to avoid an estimated $100 million in health insurance increases, while guaranteeing a role for municipal unions at every step in the process. Under the plan, the new local-option would be accepted by a vote of the city council in cities and by the board of selectmen in towns. The community would only have to vote once to opt in. After local acceptance, the appropriate municipal authority (generally the executive) could make health insurance plan design changes or transfer communities into the state's Group Insurance Commission following a structured process.

The executive would develop proposed plan design changes – no plan could have co-pays, deductibles, tiered network co-payments or other plan features that exceed the dollar amounts in the most subscribed plan in the GIC – or a proposal to transfer subscribers into the GIC. The proposal would include estimates of the first-year savings that would result. The executive would then notify the Insurance Advisory Board of the estimated one-year savings and provide documentation. After discussion with the Insurance Advisory Board as to the estimated savings, the executive would convene a meeting of a new public employee committee (PEC), composed of a representative of every union (bargaining unit) as well as a retiree representative. Each participant will have an equal vote, except for the retiree representative, who would have a 10 percent vote.

The executive would provide notice to the PEC detailing the proposed changes, the analysis and estimate of anticipated savings, and a proposal to mitigate, moderate or cap the impact of the changes on subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket costs who would otherwise be disproportionately affected. The executive and the PEC would have 30 days from the date of notice to negotiate over the proposed plan design changes and the executive's plan on how to share a portion of the first-year savings with employees, especially with retirees and those most affected by the changes. A majority vote of the PEC would be required to reach an agreement.

If there is a written agreement by the end of the 30-day period, the community would proceed to implement the plan as agreed. If there is no agreement, the matter would be referred to a "municipal health insurance review panel," composed of a municipal and labor representative and an impartial third member chosen from a list of individuals with professional experience in dispute mediation and municipal finance or municipal health benefits provided by the Executive Office for Administration and Finance. If there is no agreement on the third member after three business days, the Administration and Finance secretary would choose the third member. If the proposed plan design changes do not exceed the GIC benchmark, the panel would be required to approve the community's immediate implementation of the changes. If the community is seeking to join the GIC, the panel would be required to approve the transfer.

The panel would have 10 days to do the following:
• Confirm the estimated monetary savings, to be substantiated by documentation provided by the executive
• Review the proposal to mitigate, moderate or cap the impact of the changes on subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket costs who would otherwise be disproportionately affected
• Concur with the community that the proposed mitigation plan is sufficient

The review panel would have the authority to determine if the mitigation proposal is insufficient and would have the authority to require that additional savings be shared with subscribers, but the total cost of any mitigation plan developed by the panel (such as establishing an HRA or other similar steps) could not exceed 25 percent of the first-year savings, even if the mitigation plan is in place for more than one year. The panel would be prohibited from imposing any change to contribution ratios. Once the mitigation funds are expended, all mitigation plan obligations on the part of the community would expire. The decisions of the municipal health insurance review panel would be binding.

Regional and joint purchasing groups would be allowed to establish a common plan design structure, although participating communities would each go through the steps above to notify unions and retirees of the estimated savings, and follow the 30-day negotiation process and 10-day review panel process regarding the plan design changes and structuring the mitigation plan. Under the proposal, the Administration and Finance secretary would promulgate regulations regarding the administrative procedures for the 30-day negotiation period and the municipal health insurance review panel and issue guidelines for evaluating which subscribers would be disproportionately affected by plan design changes or a transfer to the GIC.

After a community completes the process, the plan design changes could be implemented immediately, except in communities where collective bargaining agreements or Section 19 agreements set specific co-pays and deductibles that are different from the new plan. In those cases, communities would have to wait until the initial term of the agreement has expired. For fiscal 2012, the reform plan will give cities and towns three opportunities to transfer subscribers to the GIC – on January 1, April 1 and July 1 – after a four-month notification to the commission. After fiscal 2012, enrollment in the GIC would be allowed to occur each July 1, with notification by the previous Dec. 1. The contribution ratios for employees entering the GIC would remain the same, but any future changes in the contribution ratios would have to be approved through full collective bargaining. As previously announced in both the House and Senate plans, the new law would require all eligible retirees to be enrolled in a Medicare health plan, and governmental units would pay any federal penalties associated with a transfer to Medicare Part B.

Exchange 2:

John,

Before I send this onto the rest of the committee, I wanted to ask a couple of questions.

- First, our committee does not qualify as a "municipal health insurance review panel", right?
- And if it does qualify, would that mean we could override the initial $55K allotted for "mitigation", and push payments up to 25% of the savings?
    - Do you know what 25% of the savings is?
- And finally, the piece you quoted below mentions a 10 day period, but I can't tease out what that is about.
    - Has all that (the 30 days and the 10 days) past, and are no importance the Winchester anymore?

Thanks

Peter

Peter:

Our Committee has no statutory power, under the terms of MGL 32(b), the laws governing the provision of group medical insurance in municipalities.

As such we would have an "advisory" role only and could not "override" decisions previously approved by the Board of Selectmen or by Town Meeting.

I do not know "how much" was saved for FY 15 by the decision to dramatically lower the Town's premium contribution.

Purely from an OPEB perspective, the reduction in the Town's contribution has reduced the long-term OPEB liability by tens of millions.

John Brouder, Partner