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The Utility of Trouble

Leveling the Playing Field: Giving Municipal Officials the Tools to Moderate Health Insurance Costs

The First in a Series of Occasional Reports About Bringing Systemic Change to Scale in an Era of Limited Resources

tBf The Boston Foundation
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UMASS BOSTON
THE EDWARD J. COLLINS, JR. CENTER FOR PUBLIC MANAGEMENT
MCCORMACK GRADUATE SCHOOL OF POLICY STUDIES

February 2010

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U N D E R S T A N D I N G   B O S T O N

The Utility of Trouble

Leveling the Playing Field:

Giving Municipal Officials the Tools to Moderate

Health Insurance Costs

The First in a Series of Occasional Reports About

Bringing Systemic Change to Scale in an Era of Limited Resources

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February 2010

TABLE OF CONTENTS

ACKNOWLEDGMENTS………4

PREFACE………5

EXECUTIVE SUMMARY…………………………………………………………………………………………………6

I. INTRODUCTION……………………………………………………………………………………………11

II. KEY FINDINGS……………………………………………………………………………………………16

III. METHODOLOGY…………………………………………………………………………………………19

IV. BACKGROUND INFORMATION ON FOUR MUNICIPAL PLANS……………………………23

V. BACKGROUND INFORMATION ON THE GIC…………………………………………………36

VI. KEY DIFFERENCES BETWEEN THE GIC AND MUNICIPAL COVERAGE…………………44

VII. ANALYSIS…………………………………………………………………………………………………47

VIII. RECOMMENDATIONS……………………………………………………………………………………61

APPENDIX……65

Acknowledgments

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Bob Carey is the principal of RLCarey Consulting, a health and welfare benefits consultancy. Previously, Mr. Carey was director of planning and development for the Commonwealth Health Insurance Connector Authority. In this role, Mr. Carey worked closely with the executive director and the board of the Health Connector to implement new health insurance programs, including designing public and commercial health benefit plans, as well as developing health care financing arrangements. In addition, Mr. Carey served for several years as the director of policy and program management for the Massachusetts Group Insurance Commission, the state agency responsible for providing health and welfare benefits to over 300,000 state and local employees, retirees and their dependents.

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PREFACE

As Greater Boston's community foundation, the Boston Foundation regularly partners with state and local officials to ensure that government operates as efficiently as possible to leverage taxpayer dollars for maximum impact. This is particularly critical during this current period of recession that has led governments to cut many cost-effective services.

In recent years, we have identified the rising cost of health insurance as a serious drain on state and local coffers. In comparing and contrasting the impact of these rising costs, we are struck that cities and towns do not have the same flexibility the state enjoys in designing their health insurance plans. As a result, while the Commonwealth has been able to contain some of the runaway costs of health insurance premiums during this decade through plan design changes approved by the Group Insurance Commission (GIC), most cities and towns do not have that luxury and have paid the price.

Our cities' and towns' inability to determine their own destiny is not unique to health insurance. In 2006, we commissioned a study by Harvard Law School professors Jerry Frug and David Barron in conjunction with the Rappaport Institute for Greater Boston which showed that Boston, compared to six cities nationally, is unduly constrained by the state. That study, *Boston Bound,* identified dozens of powers that most cities across the country take for granted but Boston and other Massachusetts municipalities do not have at their disposal. These include determining health insurance benefits for employees and retirees.

We followed up on that study by joining with state and local officials in calling for greater local options and basic powers that the state enjoys to be conferred upon cities and towns, including the right to set health plans. As a major funder of efforts to recruit cities and towns to join the GIC, our experience is that the greatest barrier to participation is the fact that plan design often is ensnared in collective bargaining. We maintain that not giving cities and towns the right to design their own health insurance plans unduly binds our communities, leading to higher costs and stripping cities and towns of tools other municipalities across the nation routinely enjoy. To test this, we commissioned this report to estimate the savings that would accrue to four communities if they were to participate in the GIC. The findings speak for themselves.

We are quick to point out that one size does not fit all, and that joining the GIC is not necessarily a panacea for all cities and towns. We also underscore that this analysis presupposes that a city or town could join the GIC and realize savings without making any compensatory trade-offs with labor as part of collective bargaining. I hope you find this report by Bob Carey for the Collins Center for Public Management at the McCormack Graduate School of Public Policy Studies at the University of Massachusetts-Boston of interest.

Paul S. Grogan
President & CEO
The Boston Foundation

EXECUTIVE SUMMARY

The drop in state tax revenues and the subsequent reduction in local aid to cities and towns have forced municipal governments across the Commonwealth to reduce services, impose layoffs, and increase taxes and fees to balance their fiscal 2009 and 2010 budgets. The outlook for fiscal 2011 is hardly encouraging. Compounding this problem is the continued escalation in operating and overhead costs, including the enormous cost of providing health insurance benefits to municipal employees and retirees.

Ten years ago, Boston's health insurance costs consumed 8% of the City's budget. Today, more than 11% of the City's budget is spent on health insurance for employees and retirees. Similar rates of growth have occurred across Massachusetts cities and towns, adversely affecting the ability of local governments to provide basic municipal services.

The pressure that employees' and retirees' health insurance costs place on municipal budgets is neither a new problem nor one that has gone unnoticed. However, the current fiscal crisis and the budget demands facing state and local governments heighten the urgency of addressing the spiraling cost of health insurance for Massachusetts cities and towns. It also has led to increased calls for cities and towns to receive greater powers from the state to design health insurance plans.

One option for communities to lower their health insurance costs is to join the state's Group Insurance Commission (GIC), which manages health benefits for state employees, retirees, and their spouses and dependents. The GIC is the largest provider of employer-sponsored health benefits in the Commonwealth, covering over 320,000 individuals. There are other purchasing groups that cities and towns may elect to join, but the GIC is increasingly looked to as a group insurance model for cities and towns in part because the state's health insurance premiums are, on average, lower than municipal health insurance premiums.

Since the law was changed in 2007 to allow local governments to participate in the GIC's health insurance program, nineteen cities and towns have elected to join the GIC after receiving approval to do so from 70% of their local unions, which cities and towns must secure to join the GIC according to state law. Organizations like the Metropolitan Area Planning Council (MAPC) that advocate for economies of scale in government have conducted targeted outreach to cities and towns to promote the benefits of joining the GIC to reduce health insurance costs. But the 70% union approval requirement – and the associated tradeoffs that cities and towns might be expected to make in order to secure that approval – is often too great a hurdle for cities and towns to overcome. Consequently, many cities and towns that could save money by joining the GIC are often discouraged from even trying to do so.

Over the past ten years, the GIC has moderated the growth in its health insurance premiums by increasing members' point-of-service cost sharing and offering health plans that utilize tiered provider networks. During this same period, the municipal health plans reviewed in this report remained largely unchanged, with only minor increases in point-of-service cost sharing and no use of tiered provider network plans.

In fact, the health plans offered to these municipal employees and retirees provide first-dollar coverage for most services, with no – or very low – member costs beyond the monthly premium contribution. These health benefits are among the most generous offered by any employer in the Commonwealth, including the state and federal governments, as well as private employers.

The difference in plan designs – that is, higher point-of-service cost sharing in GIC plans compared to municipal health plans – is the main reason why municipal health insurance premiums are higher than the state's. This analysis highlights the differences in premiums to demonstrate the would-be savings available to municipalities from altering plan designs.

The report provides estimates of the potential savings that four eastern Massachusetts municipalities – Boston, Cambridge, Marshfield, and Melrose – might have achieved by joining the GIC. Boston could have reduced its FY 2010 health insurance premiums by 15.6% to 17.1%, or $41.4 to $45.4 million. Cambridge's FY 2010 premium savings are estimated to be 8.7% to 10.3%, or $3.7 to $4.4 million. Marshfield could have reduced its health insurance premiums by 9.4% to 11.0%, or $450,000 to $530,000.

Melrose – which joined the GIC in July 2009 – will likely save 15.8% to 17.4% off its FY 2009 health insurance premiums, or $1.6 to $1.8 million.

It is important to qualify that these estimated savings presuppose that cities and towns would not be required to make any associated tradeoffs by way of concessions to unions to secure labor approval for joining the GIC. This presupposition is admittedly open to debate.

The irrefutable point, however, is that there could be significant savings for cities and towns – in a time of severe fiscal challenges – if they were allowed to join the GIC apart from collective bargaining. Furthermore, if municipal managers were provided the same authority

Two important caveats regarding the premium savings estimates prepared for this report.

First, this analysis does not evaluate the relative health risk of the individuals covered by these communities' health plans. The health status of each group will have a direct, and potentially material, effect on the cost of coverage. By way of example, despite comparable health benefits among all four communities, the differences in premiums between the two communities that had not adopted Section 18 and the two that had – Cambridge and Marshfield – suggests that Boston and Melrose non-Medicare plans' members were likely to be older and less healthy than the members covered by Cambridge and Marshfield's non-Medicare plans.

Second, because Boston, Cambridge and Marshfield are self-insured, the premiums charged by these municipalities – and used for this report's analysis – may not reflect the actual cost of coverage. That is, in a self-insured arrangement, if the premiums – which are set months before the start of the plan year – are greater than the health care costs incurred by the enrollees, the municipality's actual cost of coverage will be lower than expected, resulting in a budget surplus. Conversely, if the premiums are set too low and do not cover the enrollees' health care costs, the community's actual cost of coverage will be greater than expected, creating a deficit.

that state managers possess to modify plan designs outside the collective bargaining process, it is likely municipalities could attain premium savings comparable to those realized by the GIC.

A prime example of the effect of the differences in management rights occurred earlier this year. A portion of the savings estimates noted above is due to mid-year benefits changes that the GIC made to address a budget deficit in FY 2010 resulting from higher than anticipated health care costs. The benefit changes, approved by the Commission in November 2009 and effective February 2010, increased the amount of cost sharing borne by enrollees and lowered health insurance premiums by an average of 5.5%. These mid-year changes further increased the differences in premiums and point-of-service cost sharing between the health benefits provided municipal employees and those provided state employees.

Furthermore, it is worth noting that the two communities with the greatest savings opportunity – Boston and Melrose[1] – did not require Medicare-eligible retirees to enroll in Medicare Part B as a pre-condition for receiving health coverage from the municipality (i.e., adopting Section 18 of Ch. 32B). Not requiring all Medicare-eligible retirees to enroll in Medicare Part B drives up the total health benefits costs to the community – and to the enrollees who share in these costs – and across the Commonwealth results in the loss of tens of millions of federal dollars each year.

In contrast to the optional Medicare provision that applies to municipalities, retirees and their dependents receiving health benefits through the GIC are required by state law to enroll in Medicare Part B, if eligible, in order to receive health insurance from the state. Communities can choose to require Medicare-eligible retirees to enroll in Medicare by adopting Section 18 of Ch. 32B. And requiring retirees to enroll in Medicare Part B does not need to be collectively bargained.

Many municipalities, including Cambridge and Marshfield, require Medicare-eligible retirees to enroll in Medicare in order to receive supplemental health benefits paid for by the municipality. However, a large number of Massachusetts communities do not take advantage of this federal subsidy.

While the growth in municipal health insurance premiums can be reduced by increasing point-of-service cost sharing, enrollees will incur more out-of-pocket expenses as they utilize the health care system. As this report reveals, the higher cost sharing of the GIC plans compared to municipal health benefits would shift more of the costs to enrollees, although a portion of these expenses would be offset by a reduction in health insurance premiums. As point-of-service cost sharing is increased, employers will need to consider putting in place measures to limit the financial exposure of employees and retirees who may have significant health care needs.

Despite the cost savings available during a time of fiscal stress, reducing premiums by altering health benefits and increasing point-of-service cost sharing has proven particularly difficult for many municipalities. This is due, at least in part, to the statutory requirement that the health benefits provided by a municipality must be negotiated with, and approved by, the municipal unions. In contrast, the GIC's benefits are not subject to negotiation with the state's unions.

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[1] Melrose, since joining the GIC in FY 2010, now requires Medicare-eligible retirees to enroll in Medicare Part B.

Approval of changes to the GIC's health benefits requires a majority vote of the Commission. And, while union and retiree representatives serve on the 15-member Commission, they make up a minority of the membership. Therefore, support from union and retiree representatives is not needed to approve the package of health insurance benefits provided to state employees and retirees. As the mid-year benefits changes recently approved by the GIC demonstrate, the Commission is provided the authority – and the statutory responsibility – to address budget shortfalls and mitigate premium growth by adjusting health plan designs.

If municipalities were granted the same authority as the state to adjust plan designs and reduce the growth in premiums by increasing point-of-service cost sharing and/or offering different types of health plans without having the health benefits subject to collective bargaining, they could likely achieve premium savings comparable to the savings achieved by the GIC. As policymakers consider ways to rein in the cost of municipal health insurance, leveling the health benefits management playing field between state government and local governments deserves serious consideration.

Recommendations

1. **Level the playing field between state and local health benefits management by removing the requirement that municipal officials must collectively bargain plan design changes**

Removing the statutory provision that requires local governments to collectively bargain the health benefits provided to employees and retirees would provide municipalities with the ability to adjust plan designs and better control their health insurance premiums; while still providing employees and retirees with comprehensive health benefits, comparable to those provided to state employees and retirees by the GIC; and comparable to the health benefits provided to millions of federal government workers, as well as private-sector employees.

2. **Bring the health benefits provided to municipal employees into line with the health benefits offered state employees and retirees**

The health benefits offered by these municipalities are among the most generous offered by any employer, public or private, in the Commonwealth. Modest changes in cost sharing can save these cities and towns millions of dollars. Even Commonwealth Care – a publicly subsidized health insurance program for lower-income adults without access to employer-sponsored insurance – has higher member cost sharing than these municipal plans.

3. **Require all municipal retirees who are eligible for Medicare to enroll in Medicare Part B as a precondition for receiving health benefits from the municipality**

The unwillingness of some municipalities to shift their Medicare-eligible retirees into Medicare costs state and local taxpayers tens of millions of dollars every year. Since 1993, the state has required retirees that are eligible for Medicare to enroll in Medicare Part B in order to receive supplemental health benefits from the GIC. This requirement has saved the Commonwealth hundreds of millions of dollars.

4. **Adopt a premium contribution strategy that incents members to select more cost-effective health plans**

Municipalities that offer their employees and retirees a choice of health plans should adopt a premium contribution strategy that encourages members to select more cost-effective plans. For example, the City of Boston pays 85% of the premium for the HMO plans, 80% for the Harvard Pilgrim POS plans, and 75% for all other plans (i.e., POS, PPO and indemnity plans). This strategy helps drive members into the more cost-effective HMO plans.

A more direct contribution strategy that encourages employees and retirees to consider the cost of health insurance – and the difference in premiums across plans – would cap the community's share of the premium at the amount that the community contributes for the lower-cost plans. Employees and retirees who opt for higher-priced plans would then be responsible for paying the full difference in the premium for the higher-priced plan.

5. **As point-of-service cost sharing increases, limit members' financial exposure by putting in place an out-of-pocket maximum or funding a Health Reimbursement Account (HRA)**

As cost sharing is increased, employers will need to consider adopting plan designs that limit a member's out-of-pocket costs. The GIC does this by placing service-specific limits on the collection of co-payments for inpatient hospitalization and outpatient surgery. Another option, and one that some communities have adopted, is to fund a Health Reimbursement Account (HRA), which can be used to offset a member's out-of-pocket costs.

I. Introduction

The drop in state tax revenues and the subsequent reduction in local aid to cities and towns have forced municipal governments across the Commonwealth to reduce services, impose layoffs, and raise fees and taxes to balance their fiscal 2009 and 2010 budgets. Fiscal 2011 is shaping up to be equally challenging.

Compounding this problem is the continued escalation in health insurance costs for local governments. Boston's health insurance costs climbed from 7.9% of the City's budget in fiscal 2002 to 11.2% in fiscal 2010, despite a reduction in the City's share of employees' health insurance premiums.[2] In fiscal 2010, Boston expects to spend more than $280 million on employee and retiree health insurance. Health insurance costs for Cambridge's active employees jumped from $23 million in fiscal 2005 to $38 million in fiscal 2009, an increase of 66 percent in four years.

The pressure that employees' health insurance costs places on municipal budgets is neither a new problem nor one that has gone unnoticed over the past several years.[3] However, the current fiscal crisis heightens the urgency of addressing the spiraling cost of health insurance for Massachusetts municipalities.

One option available to cities and towns to help lower the cost of employees' health insurance is to join the state's Group Insurance Commission (GIC), which manages health benefits for state employees and retirees. As municipal health insurance costs across the Commonwealth climbed 84 percent from fiscal 2001 to fiscal 2006, the GIC's health care costs grew 47 percent.[4] Since FY 2006, the GIC's health insurance premiums have increased 22 percent.[5]

The difference in the rate of growth between the GIC's health insurance premiums and municipal governments' health plans' premiums convinced lawmakers in July 2007 to approve a change in state law that allows local governments to join the GIC's health insurance program.

Since the law was enacted, 19 communities have joined the GIC.[6] Given the current fiscal situation, the bleak outlook for state and local budgets over the next few years, and the continued increase in

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[2] From fiscal 2007 to fiscal 2010, the City's share of the premiums for the Harvard Pilgrim HMO plan dropped from 90% to 85%, and the City's premium share for the Harvard Pilgrim POS plan has dropped from 85% to 80%. Source: City of Boston Fiscal 2010 Budget, **www.cityofboston.gov**, accessed July 23, 2009.

[3] "Municipal Health Reform: Seizing the Moment," Massachusetts Taxpayers Foundation (MTF) and Boston Municipal Research Bureau (BMRB), August 2007; "Soaring Health Insurance Costs Threaten Boston's Competitive Advantage," BMRB, November 2006, and "A Mounting Crisis for Local Budgets: The Crippling Effects of Soaring Municipal Health Costs," MTF, July 2005.

[4] "Special Commission on Municipal Relief," Massachusetts General Court, May 2009.

[5] Author's calculation based on weighted-enrollment in GIC non-Medicare (i.e., active employees and pre-65 retirees) health plans.

[6] A total of 26 local government entities are now covered by the GIC, including 17 municipalities, six regional school districts, and three local planning councils. In July 2010, four more local and regional governmental units will join the GIC: Brookline, Hopedale, Merrimack Valley Planning Commission, and Wachusett Regional School District.

municipal health insurance costs, the GIC "local option" has generated renewed interest among state and local policymakers.

While joining the GIC is one way to reduce municipal health insurance costs, some have argued that the statutory and regulatory rules pertaining to the manner by which municipal health insurance is provided to local employees and retirees should be changed to provide city and town officials with the same latitude that state officials have to establish and manage health benefits.[7]

In particular, municipalities are required to collectively bargain all aspects of employee health insurance with the employees' unions – including the amount of point-of-service cost sharing and the percentage of premiums paid by employees. Plan designs – and in some instances the actual health insurer – must be agreed to by the unions that receive coverage from the municipality.

The GIC, on the other hand, is allowed to adjust plan designs and change the health plans offered to employees and retirees without negotiating these changes with state employees' unions. In addition, the state legislature sets the annual premium contribution paid by state employees and retirees.

For the past ten years, the GIC has effectively limited the rate of growth in its health insurance premiums by increasing members' point-of-service cost sharing and offering health plans that utilize tiered and select provider networks.[8] Meanwhile, the municipal health plans reviewed in this report have remained largely unchanged, with only slight increases in point-of-service cost sharing and no offering of tiered or select provider network plans.

Most recently, to cover a deficit due to higher than expected health care costs, the GIC approved mid-year benefits changes in November 2009 that took effect on February 1, 2010. These changes, which added an upfront deductible and increased co-payments, allowed the GIC to lower its health plans' premiums, generating additional savings for the state and for the local and regional governmental entities that participate in the GIC's health insurance program.

This report provides estimates of the potential savings that four eastern Massachusetts municipalities might have achieved by joining the GIC. In the case of Melrose, which joined the GIC in FY 2010, the estimates reflect actual premium savings that are likely to be realized. As detailed below, joining the GIC could significantly reduce health insurance premiums for these cities and towns.

However, municipalities could reduce their health insurance premiums without joining the GIC if the cities and towns adjusted their health plan designs so that point-of-service cost sharing was comparable to the cost sharing in the GIC's health plans.

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[7] See, for example, letter from Massachusetts Taxpayers Foundation's President, Michael Widmer, to the Legislature's Special Municipal Relief Commission, December 10, 2008.

[8] Tiered provider network plans offered by the GIC require members to pay higher co-payments for services delivered by more costly/less efficient providers (e.g., physicians, hospitals) while members pay lower co-payments for services delivered by less costly/more efficient providers.

In addition, communities that have not yet adopted Section 18 of Ch. 32B can reduce their health insurance premiums by requiring Medicare-eligible retirees to enroll in Medicare Part B as a precondition for receiving health benefits from the municipality. Unlike plan design changes, adopting Section 18 of Ch. 32B does not need to be collectively bargained.

Removing the statutory provision that requires local governments to collectively bargain the health benefits provided to employees and retirees, just as state government is allowed to do, would provide municipalities with the ability to adjust plan designs and better control their health insurance premiums; while still providing employees and retirees with comprehensive health benefits comparable to those provided to state employees and retirees by the GIC; and comparable to the health benefits provided to millions of federal government workers, as well as private-sector employees.

Background

In 2007, the Commonwealth of Massachusetts made it possible for local governments to join the GIC rather than purchase their own health insurance plans. Chapter 67 of the Acts of 2007 requires municipal officials to employ coalition bargaining to negotiate the conditions for entering the GIC with a local committee of union and retiree representatives.

An affirmative vote of 70 percent of the union/retiree committee, based on the percentage of each union's members that are enrolled in the municipality's health insurance plan, is required to join the GIC. Municipalities wishing to join the GIC must reach agreement with their unions and notify the Commission by December 1 in order to be covered as of July 1 of the succeeding year.

As a precondition for joining the GIC, municipalities must only offer the GIC's health plans (i.e., they cannot offer competing health plans), and they must agree to remain in the GIC for a minimum of three years. Municipal retirees who are eligible for Medicare are required to enroll in Medicare Parts A and B as a precondition for receiving supplemental health insurance from the GIC. Decisions regarding the premium contribution would continue to be collectively bargained by local government managers with the municipal unions.

Since the law was approved, 26 local governmental units have opted for coverage through the GIC, including 17 cities and towns, six school districts, and three local planning councils. In addition, four more local/regional governmental entities recently notified the GIC that they have reached agreement with their employees' unions. These groups – two municipalities, a regional school district, and a regional planning commission – will be covered by the GIC effective July 1, 2010. [The Appendix to this report includes a list of the governmental entities that are covered by the GIC.]

Scope of the Report

To inform state and local officials and other interested parties, this study estimates potential health insurance premium savings that four communities might have realized if they joined the GIC. For Melrose, which joined the GIC effective July 1, 2009, the estimates reflect actual premium savings that are likely to be achieved.

The eastern Massachusetts communities selected for this analysis represent large (Boston and Cambridge) and mid-sized (Melrose) municipalities, as well as a community (Marshfield) that belongs to a group of cities and towns that collectively purchase and provide health benefits to their employees and retirees (i.e., Plymouth County Group Health Plan).

The report focuses primarily on health insurance provided by municipal governments to active employees and non-Medicare retirees,[9] and provides estimates of the potential premium savings that may be achieved by switching to the GIC. The analysis also includes estimates of the impact on enrollees' out-of-pocket expenses due to greater point-of-service cost sharing in the GIC's plans compared to these municipalities' plans.

In addition, an estimate of the difference in premiums from switching each community's Medicare-eligible retirees into the GIC's Medicare plans is provided. However, because the point-of-service cost sharing is quite comparable among GIC Medicare plans and municipal governments' Medicare plans, there is no analysis on the potential impact on enrollees' out-of-pocket expenses associated with the GIC's Medicare plans vis-à-vis municipal governments' Medicare plans.

While the findings of this study are likely applicable to most Massachusetts cities and towns, the savings for other communities will depend upon each community's current health benefits plans, the group's demographics, and the premium contribution paid by employees and retirees. As this report shows, communities

Health insurance premiums for employees and non-Medicare retirees – compared to the premiums for Medicare retirees – constitute the vast majority of health insurance costs for state and local governments. More than 85% of the $1.45 billion in health insurance premiums that the GIC spent in FY 2009 was for health benefits provided to active employees and non-Medicare retirees, compared to 15% that was spent for supplemental health insurance for Medicare-eligible retirees.

Cities and towns reviewed in this report have a similar distribution of premium expenses between their non-Medicare and Medicare plans. Because the federal government picks up the majority of the cost for Medicare enrollees, the cost of the supplementary coverage provided by state and local governments for their Medicare-eligible retirees -- compared to the cost of health benefits provided to employees and non-Medicare retirees -- is relatively modest, although not inconsequential.

[9] The term "non-Medicare retirees" refers to retired workers who have not yet reached age 65 or who are otherwise not eligible for or not enrolled in , Medicare.

in close proximity to one another with virtually identical health benefits would achieve different levels of savings by joining the GIC.

In addition to the *Introduction* and *Key Findings*, this report includes six sections and an *Appendix*. Following the *Key Findings* section is *Methodology*, which provides an overview of the method used to estimate the potential premiums savings for each community as well as a description of the model developed to estimate the impact on members' total costs associated with different levels of point-of-service cost-sharing between municipal health plans and GIC plans. *Background Information on Four Municipal Plans* summarizes the health plans of the four municipalities included in this report. *Background Information on the GIC* discusses the Commission's structure, the health plans offered by the GIC, the premiums and member cost sharing, as well as the financing of health benefits by the GIC.

Section Six of the report, *Key Differences Between the GIC and Municipal Coverage*, highlights the major features that distinguish the GIC plans from the health plans of these communities. Section Seven, *Analysis*, includes estimated premiums and premium savings associated with joining the GIC for each community, as well as the potential impact of co-payment differences on enrollees' out-of-pocket expenses. The report's final section, *Recommendations*, discusses options for policymakers to consider. The *Appendix* to the report includes additional information on the methodology as well as detailed tables on cost sharing estimates for each of the communities reviewed in this report; and a list of the communities that have opted to receive health insurance through the GIC.

II. Key Findings

1. The Group Insurance Commission's ability to adjust the health benefits provided to state employees and retirees without negotiating plan design changes with the state's public sector unions has allowed the Commonwealth to moderate the growth in premiums by increasing point-of-service cost sharing and adopting tiered provider networks. Because municipal managers must negotiate and reach agreement with municipal unions if they wish to make changes to their health benefits, local government officials have less flexibility than the state to manage and control the costs of their health insurance premiums.

2. The four communities profiled in this report – Boston, Cambridge, Marshfield and Melrose – could have lowered their health insurance premiums[10] by $47.2 to $52.2 million in FY 2010, or by approximately 14.6% to 16.1%, if they joined the GIC or offered plans that looked more like the plans offered by the GIC.

   While all four cities and towns would see a reduction in premiums, the estimated savings vary:

   > Boston could have experienced a reduction in its share of health insurance premiums of 15.6% to 17.1%, saving the City $41.4 to $45.4 million;
   >
   > Melrose, which joined the GIC effective July 1, 2009, will see its costs fall between 15.8% to 17.4%, or $1.6 to $1.8 million, compared to its FY 2009 premiums;
   >
   > Marshfield might have reduced its health insurance premiums by 9.4% to 11.0%, or $450,000 to $530,000; and
   >
   > Cambridge could have sliced its FY 2010 health insurance premiums by 8.7% to 10.3%, or $3.7 to $4.4 million.

   These savings estimates were developed based on the GIC's health plans' premiums in effect from July 2009 through January 2010, as well as the mid-year benefits changes that will increase GIC members' point-of-service cost sharing and lower their health plans' premiums. These changes were approved by the Commission in November 2009 and took effect February 1, 2010.

   The estimates reflect a reduction in each community's share of the health insurance premiums that could have been achieved by joining the GIC. Comparable levels of premium savings might also have been realized by adjusting the health benefits offered by the community so that the municipal plans' point-of-service cost sharing was similar to the plans offered by GIC. The net savings to the municipality – and the share of the savings for enrollees – depends on the premium contribution paid by the employees vis-à-vis the amount paid by the municipality.

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[10] Health insurance premiums include only the city's or town's share and do not include the savings that would accrue to the employees and retirees.

3. The two communities that would likely achieve the greatest savings in percentage terms, Boston and Melrose,[11] did not require their Medicare-eligible retirees to enroll in Medicare Parts A and B as a precondition for receiving health coverage from the municipality (i.e., adopting Section 18 of Ch. 32B). In the case of Boston, shifting Medicare-eligible retirees out of non-Medicare plans and into Medicare plans would generate approximately $5 million in immediate and direct premium savings to the City, without necessitating a shift to the GIC and without changing the health benefits offered to retirees.

   By shifting higher-cost Medicare-eligible enrollees out of non-Medicare plans, the City would achieve additional savings, above and beyond the $5 million. This is due to the fact that older individuals utilize more medical services and have greater health care needs than younger individuals. By shifting more of its higher-cost enrollees to the federally-subsidized Medicare plans, the City's non-Medicare plans' premiums would be reduced.

4. The magnitude of any premium savings depends on which GIC health plans each municipality's enrollees select. The GIC's original FY 2010 monthly premiums ranged from $406 to $768 for individual coverage and from $974 to $1,792 for family coverage. For the period from February 2010 through June 2010, these premiums were reduced an average of 5.5%.

   Because premiums vary across the GIC's health plans, plan selection will affect each community's potential premium savings. Furthermore, plan selection will be affected by the share of the premium paid by the municipality and the share paid by the employee/retiree.

5. Because Boston provides health insurance to more than 28,000 employees and retirees, as well as thousands of spouses and dependents, adding a group of this size to the GIC could have a material impact on GIC premiums. If Boston enrollees are, on average, older and less healthy than GIC enrollees, the potential savings to the City would be reduced and the Commonwealth's average cost of insurance would increase. Conversely, if the City's enrollees are younger and healthier than the GIC's enrollees, Boston's savings would increase and the GIC's average premiums might be reduced.

6. The higher point-of-service cost sharing in the GIC plans means municipal employees and retirees would face higher out-of-pocket costs under the GIC's plans than they do under their current health plans. However, total employee costs could be lower, depending on the employees' choice of plan, the members' utilization of health care, and the employees' share of the premium.

   The estimates developed for this analysis indicate that for the vast majority of people who are "low and moderate" users of health care services, the combined total costs of premiums and the potential point-of-service out-of-pocket costs could increase by roughly $1,000 per year or

[11] The GIC requires cities and towns to adopt Section 18 if they wish to join the GIC. Effective July 1, 2009, Melrose now requires Medicare-eligible retirees to enroll in Medicare Parts A and B in order to receive supplemental health insurance coverage from the City.

decrease by approximately $500, depending on the plan selected by the enrollee and the amount of the premium paid by the employee/retiree.

However, regardless of plan choice, individuals and families with the greatest health care needs (i.e., "high" utilizers of the health care system) would likely experience an increase in their total costs under GIC coverage than under their current municipal health plan.

III. Methodology

The following section provides an overview of the methodology used to estimate the differences in health insurance premiums between municipal coverage and GIC coverage (i.e., plan choice), as well as a description of the methodology used to estimate the potential impact of the GIC's greater point-of-service cost sharing on members' out-of-pocket expenses (i.e., utilization of services). The *Appendix* includes additional information and detailed tables containing estimates of enrollees' potential out-of-pocket costs.

Modeling the Impact of Members' Plan Choices on Premiums

This report estimates the difference in health insurance premiums under municipal coverage vis-à-vis GIC coverage by comparing the annual premiums for municipal coverage to a range of estimated annual premiums under GIC coverage. The range of estimates is necessary because the GIC plans' premiums vary significantly, as noted in Table 1, and members' enrollment decisions will determine the premiums paid by the municipality to the GIC.

TABLE 1 – GIC MONTHLY PREMIUMS FOR NON-MEDICARE PLANS[12]
FY 2010

Plan Type	Carrier/Plan Name	Monthly Premiums July 2009 – Jan. 2010		Monthly Premiums Feb. 2010 – June 2010	
		Individual	Family	Individual	Family
HMO	Fallon Community Health Plan's Direct Care Plan	$406	$974	$378	$906
PPO/Select Network	UniCare Community Choice	$411	$987	$380	$911
HMO	Neighborhood Health Plan	$417	$1,105	$386	$1,024
HMO	Health New England	$431	$1,069	$403	$998
HMO	Fallon Community Health Plan's Select Care Plan	$492	$1,181	$453	$1,087
Average Premiums -- HMO/Select Network Plans		**$431**	**$1,062**	**$405**	**$986**
PPO	Tufts Navigator Plan	$519	$1,251	$488	$1,176
PPO	Harvard Pilgrim Independence Plan	$526	$1,274	$487	$1,174
PPO	UniCare PLUS	$531	$1,271	$501	$1,195
Average Premiums -- PPO Plans		**$526**	**$1,265**	**$497**	**$1,185**
Indemnity	UniCare Indemnity Basic Plan w/CIC	$768	$1,792	$736	$1,710

[12] Total premiums include employee's share and employer's share, as well as GIC administrative charge of 0.33%.

Because the GIC made mid-year changes to its health benefits and lowered health insurance premiums for all non-Medicare plans between 4.7% and 7.9%, an adjustment in the savings estimate was necessary to account for the five months (February 2010 through June 2010) that the lower premiums will be in effect. The average monthly reduction in premiums used for this analysis is $29 for individual coverage and $80 for family coverage, which results in a five-month reduction in premiums of $145 and $400, respectively.

Due to the differences in premiums across the GIC plans – and the resulting impact that enrollees' plan choices would have on the potential premium savings that might be achieved – the analysis includes two enrollment scenarios that are used to generate premium estimates for each municipality under GIC coverage. The two enrollment scenarios, which are displayed below in Table 2, are used to demonstrate how premium savings are affected by the enrollees' plan choices. As more members enroll in the highest cost Indemnity plan, the premium savings are impacted.

TABLE 2 – ENROLLMENT SCENARIOS
DISTRIBUTION OF MUNICIPAL MEMBERS' ENROLLMENT BY GIC PLAN TYPE
IMPACT ON PREMIUMS
FY 2010

	Scenario 1	Scenario 2
HMO/Select Network Plans	2%	2%
PPO Plans	85%	80%
Indemnity Plan	13%	18%
Average Monthly Premium[13]		
Individual Policy	$556	$568
$ and % Difference from Scenario 1		$12 2.1%
Family Policy	$1,329	$1,356
$ and % Difference from Scenario 1		$27 2.1%

One could certainly develop a wider range of enrollment scenarios. And while an enrollment scenario in which 10% or 15% of members opt for the lower-cost GIC plans is possible, it is unlikely to occur in these eastern Massachusetts communities. For example, only one percent of GIC members are enrolled in Neighborhood Health Plan, the primary HMO offered in Greater Boston.

In addition, given the types of plans currently offered by the communities profiled in this report (i.e., broad network HMO and PPO plans), it is unlikely that a significant percentage of employees and retirees would opt for the less expensive, more limited network HMO and select network plans offered

[13] Average monthly premiums are based on GIC premiums in effect from July 2009 through January 2010. An adjustment is subsequently applied to account for the reduction in premiums that took effect for the period from February 2010 through June 2010. The reduction in premiums from February through June 2010 would generate an average additional savings of $145 for individual coverage and $400 for family coverage.

by the GIC.[14] While approximately 18% of all GIC members are enrolled in HMO plans and the lower-cost select hospital network PPO plan (UniCare Community Choice), the majority of these members live in central and western Massachusetts.

On the other hand, it may be unlikely that 18% of municipal enrollees would opt for the most expensive GIC plan, the Indemnity plan. However, because more than 20% of the GIC's current members are enrolled in the Indemnity plan, this top-end estimate is used for this analysis. If fewer people opt for the Indemnity plan, and instead enroll in one of the PPO or HMO plans, the premium savings would be greater for both the municipality and the enrollees.

For both enrollment scenarios, the total estimated cost of health insurance is determined for each municipality by multiplying the number of municipal members with individual coverage by the average GIC premium for individual coverage, and by multiplying the number of municipal members with family coverage by the average GIC premium for family coverage.

To estimate the potential savings that may be achieved by switching to the GIC, each municipality's total costs under their current health plans are then compared to the total estimated costs under both enrollment scenarios under GIC coverage.

For members covered by Medicare who receive supplemental coverage from the city or town, the analysis assumes that all Medicare members would enroll in the GIC's Indemnity Medicare plan. For this group of enrollees, a premium comparison is made between the cost of coverage under the city or town's Medicare plans and the cost of coverage under the GIC's Indemnity Medicare plan.[15]

An estimate of the savings to the community is then calculated using the approximate premium contribution percentage currently employed by each municipality. For example, on average Boston contributes 82% of the premium, while employees and retirees contribute an average of 18%.[16] In Marshfield, the premium split is 50/50.

Modeling the Utilization of Services on Members' Potential Out-of-Pocket Expenses

In addition to the differences in premiums based on the distribution of enrollment that may occur across the GIC's health plans, members' point-of-service cost sharing will differ based on the health plan selected and the members' utilization of services (i.e., physician's office visits, hospital admissions, prescription drugs, etc.). To estimate the potential financial impact that the switch to the GIC may have on enrollees -- including point-of-service cost sharing -- an estimate of the health care expenses for six hypothetical members is calculated.

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[14] More than 90% of Melrose members – which joined the GIC effective July 2009 – are enrolled in one of the GIC's broad-network PPO plans.

[15] No mid-year benefits changes were made to the GIC's Medicare plans.

[16] Boston's actual premium contribution percentages are 85% for the HMO plans, 80% for one of the PPO plans, and 75% for all other plans.

The hypothetical members – three individual policy holders and three family policy holders – are assumed to have different levels of medical service utilization (low, moderate and high). These estimates are used to project the potential financial exposure that members with differing health care needs and utilization patterns may face under GIC coverage vis-à-vis their current municipal coverage.[17]

Some members will not utilize any health services and have no out-of-pocket expenses. For these individuals, their only cost is their share of the monthly premium. However, a few individuals and families may experience a series of hospitalizations, outpatient procedures, physicians' office visits, and may need to take a number of prescription drugs. Therefore, for the "high utilizers" in the analysis, very high service utilization is used to present an extreme situation.

For each hypothetical case, the member's cost sharing for medical services is quantified, the member's estimated share of the annual premiums for each plan and rate basis type (i.e., individual or family) is added, and the total member costs are then calculated.

The calculations for the GIC plans are based on the schedule of benefits in effect from February 1, 2010 through June 30, 2010. The GIC added an upfront deductible, increased some co-payments, and lowered monthly premiums, effective February 1, 2010 for the remainder of the fiscal year. The out-of-pocket analysis assumes a full year of coverage.

This part of the analysis is intended to be illustrative and is not designed to demonstrate the financial exposure for all enrollees. It is an attempt to provide an indication of the effect that different premiums and point-of-service cost sharing can have on an individual member's total costs.

[17] For purposes of this analysis, out-of-pocket spending for over-the-counter drugs and other health related costs not covered by health insurance are not included.

IV. Background Information on Four Municipal Plans

Municipal governments in Massachusetts have three basic ways to provide health insurance for their employees and retirees. A city or town can purchase coverage on its own (pursuant to Sec. 3 of Ch. 32B); two or more governmental units can jointly purchase health insurance as part of a collaborative or group (pursuant to Sec. 12 of Ch. 32B); or the municipality can join the Group Insurance Commission and receive coverage through the state employees and retirees health insurance program (pursuant to Sec 19 of Ch. 32B).

Among the four communities included in this report, Boston and Cambridge purchase health insurance on their own; Marshfield participates in a group of governmental entities (i.e., Plymouth County Health Group) who purchase insurance collectively; and Melrose has recently joined the GIC. The following section provides information on the health insurance provided to employees and retirees in these four communities.[18]

Boston

Boston's health insurance benefits cover roughly 28,600 active employees and retirees, as well as thousands of spouses and dependents. In FY 2010, the City expects to spend approximately $280 million on health benefits for its employees and retirees. The FY 2010 average cost per subscriber for Boston's non-Medicare plans is estimated to be $13,840 – $8,096 for individual coverage and $19,368 for family coverage; the average cost per subscriber for its Medicare plans is estimated to be $4,729.[19]

The City contracts with five health carriers for the health benefits offered to its employees and retirees. The City self-insures the health plans offered by Blue Cross Blue Shield of Massachusetts (BCBSMA), and purchases fully insured coverage from Boston Medical Center (BMC), Harvard Pilgrim Health Care (HPHC), Neighborhood Health Plan (NHP) and Tufts Health Plan (THP).[20]

Active Employees and Non-Medicare Retirees

Active employees and retirees who do not choose to enroll in Medicare are offered six health plans – three Health Maintenance Organization (HMO) plans administered by HPHC, NHP and BMC; two Point of Service (POS) plans from HPHC and BCBSMA; and a Preferred Provider Organization (PPO) plan provided

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[18] The information on Melrose's health plans reflects the benefits that were provided to employees and retirees in FY 2009, prior to the City joining the GIC.

[19] Calculation based on Boston's FY 2010 premiums and distribution of enrollment by health plan and rate basis type. Average cost per subscriber is derived by multiplying the annual premiums for each health plan (i.e., individual premium and family premium) by the estimated number of enrollees (i.e., individual subscribers and family subscribers) in each plan, and dividing the total by the number of subscribers.

[20] Self insured means the City pays the health carriers an administrative fee – commonly referred to as an Administrative Services Only (ASO) fee – and the City pays for their enrollees' medical claims as these costs are incurred. The ASO fee covers claims processing and adjudication, access to the carriers' provider network, care management and disease management programs, and customer service. The City bears the risk of covering the cost of medical claims. In a fully insured arrangement, the City pays a monthly premium for each member, which covers all of the services, including medical claims, and the carrier bears the risk of covering these costs.

by BCBSMA. In addition, retirees and members of one union that has yet to come to terms with the City on a new contract are offered an Indemnity plan that is administered by BCBSMA.[21]

As of September 1, 2009, for employees in unions that have a current contract with the City, the employees' share of the premium is 15% for the three HMO plans; 20% for the POS plan administered by HPHC; and 25% for the plans administered by BCBSMA (i.e., POS, PPO and Indemnity plans). Retirees pay 10% for the HMO plans, 15% for the HPHC POS plan, and 25% for the three BCBSMA plans. Table 3 below displays the FY 2010 monthly premiums for individual coverage and family coverage by plan type, along with the City's share and the employee's share of the premium.

TABLE 3 – CITY OF BOSTON HEALTH PLANS AND MONTHLY PREMIUMS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2010

Plan	Individual Coverage			Family Coverage		
	Total Premium	City Share	Employee Share	Total Premium	City Share	Employee Share
BCBSMA Master Medical (Indemnity)	$1,262	$947	$316	$2,927	$2,195	$732
BCBSMA Blue Care Elect (PPO)	$997	$748	$249	$2,312	$1,734	$578
BCBSMA Blue Choice (POS)	$717	$538	$179	$1,849	$1,387	$462
HPHC POS	$610	$488	$122	$1,640	$1,312	$328
HPHC HMO	$572	$486	$86	$1,538	$1,307	$231
BMC HMO	$572	$486	$86	$1,538	$1,307	$231
NHP HMO	$561	$477	$84	$1,486	$1,263	$223

Since FY 2007, the employees' share of the premium for the HPHC POS plan has increased from 15% to 20%, and the employees' percentage contribution for the HMO plans has increased from 10% to 15%. In addition to the savings that have accrued to the City through the increase in the employees' share of the premium, Boston has limited the increase in health insurance premiums to single digits over the past two years. The premiums for the most popular plan, HPHC's HMO plan, increased 7% in FY 2009 and 8% in FY 2010, compared to an overall increase in health insurance costs of 11% in FY 2006 and 12% in FY 2007.[22]

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[21] Indemnity plans allow members to visit any physician or hospital, but members may pay more if the physician or hospital charges more than the carrier is willing to pay (i.e., above the carrier's "allowed amount"); POS and PPO plans provide members with access to a network of physicians and hospitals, but also allow members to use out-of network providers, typically subject to greater member cost-sharing; HMO plans use a network of physicians and hospitals, care is coordinated by a PCP, and members typically must be referred by their PCP to receive care from a specialist. There is no out-of-network coverage provided in an HMO plan.

[22] "Boston Budget Summary, 2010," accessed from the City of Boston's web site on July 18, 2009.

In addition, the City introduced the BCBSMA PPO plan in FY 2008 as an alternative to the costly Indemnity plan. From January 2007 to January 2009, enrollment in the Indemnity plan declined by more than 30%, from 1,824 subscribers to 1,249.

Once negotiations with the last of 43 municipal unions are complete, the City plans to eliminate the Master Medical Indemnity Plan, which is currently restricted to members of the firefighters union and to retirees. Based on information provided by City officials, the elimination of the Master Medical Plan would save Boston more than $5 million in FY 2010.[23]

TABLE 4 – COST SHARING – CITY OF BOSTON HEALTH PLANS ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES FY 2010				
	Neighborhood Health Plan HMO	Boston Medical Center HMO	Harvard Pilgrim HMO	Harvard Pilgrim POS
Deductible	None	None	None	None
Physicians Office Visits				
PCP	$10	$10	$10	$10
Specialists	$10	$10	$10	$10
Hospital Inpatient Admit	None	None	None	None
Outpatient Surgery	None	None	None	None
Radiology	None	None	None	None
ER Visit[24]	$25	$40	$30	$30
Prescription Drugs – Retail (30 days supply)				
Tier 1	$5	$10	$5	$5
Tier 2	$10	$15	$10	$10
Tier 3	$25	$30	$25	$25
Prescription Drugs – Mail (90 days supply)				
Tier 1	$10	$20	$10	$10
Tier 2	$20	$30	$20	$20
Tier 3	$75	$90	$75	$75

Based on January 2009 enrollment, approximately 75% of active employees – or 12,170 of 16,273 employees covered by the City's health plans – were enrolled in the HMO plan administered by HPHC. Among retirees covered by Boston's non-Medicare plans, roughly 57% (or 3,614 of 6,323 retirees) selected the HPHC HMO plan.

All of the health plans provide comparable benefits in terms of point-of-service cost sharing, with no co-payments for most services and relatively modest co-payments for physician offices visits and

[23] For the purposes of this report, individuals enrolled in the Master Medical Plan are shifted to the BCBSMA PPO Plan. This adjustment to the City's health insurance premiums is reflected in the premium savings estimate described in Section VII of this report.

[24] Emergency Room co-payments are waived if the individual is admitted to the hospital.

prescription drug coverage. Tables 4 and 5 summarize the cost sharing provisions for the major health benefits covered by the City's health plans.

The POS and PPO plans include an out-of-network benefit, which allows members to receive care from physicians and at hospitals that are not part of the carrier's network of providers. Using an out-of-network provider requires the member to pay 20% of the cost. The Indemnity plan does not limit members to a network of providers, and enrollees may seek care from virtually any physician and at any hospital at no additional cost to the member.[25]

TABLE 5 – COST SHARING – CITY OF BOSTON HEALTH PLANS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2010

	BCBSMA Blue Choice (POS)	BCBSMA Blue Care Elect (PPO)	BCBSMA Master Medical (Indemnity)
Deductible	None	None	$50 (individual)/ $100 (family)
Physicians Office Visits			
PCP	$10	$15	20%
Specialist	$10	$15	20%
Hospital Inpatient Admit	None	None	None
Outpatient Surgery	None	None	None
Radiology	None	None	None
ER Visits[26]	$25	$50	None
Prescription Drugs – Retail (30 days supply)			
Tier 1	$5	$10	20% -- Full Coverage after reaching coinsurance maximum of $200 per individual or $400 per family
Tier 2	$10	$25	
Tier 3	$10	$45	
Prescription Drugs – Mail (90 days supply)			
Tier 1	$5	$10	$5
Tier 2	$10	$25	$10
Tier 3	$10	$45	$10

<u>Medicare Plans</u>

Boston does not require retirees who are eligible for Medicare to enroll in Part B coverage in order to receive health insurance benefits from the City (i.e., the City has not adopted Section 18 of Ch. 32B). However, legislation was recently enacted that would allow a municipality to require future retirees to

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[25] Because the amount that the health plan pays (i.e., the "allowed amount" or "reasonable and customary charge") could be less than the amount the physician or hospital charges, some members receiving care may be billed for the difference between the amount paid by the plan and the amount charged by the provider.
[26] Emergency Room co-payments are waived if the individual is admitted to the hospital.

enroll in Medicare in order to receive supplemental health coverage from the community.[27] The City Council has not yet acted on this proposal. As a result, Medicare enrollment remains optional for Boston retirees who wish to receive health insurance benefits from the City. According to the Boston Municipal Research Bureau, approximately 1,700 City retirees and spouses of retirees were eligible for Medicare but not enrolled.[28] These retirees are covered by Boston's non-Medicare plans.

Medicare-eligible retirees who voluntarily enroll in Medicare Part B can select from six health plans, as noted in Table 6. For retirees that enroll in Medicare, the City reimburses members for 50% of the cost of their Part B premiums. In FY 2010, the City expects to spend $3.4 million for retirees' Medicare Part B premiums. Part B premiums are paid to the federal government – usually via a deduction from a member's Social Security check. In CY 2009 and 2010, the monthly Medicare Part B premium for most retirees is $96.40, which means Boston retirees enrolled in Medicare Part B pay $48.20 per month for Medicare coverage in addition to their share of the cost of coverage for the Medicare supplement plans offered by the City.[29] Table 6 displays Boston's Medicare plans, the monthly premiums, the retirees' share of the premium, the additional Part B cost to the member, and the total monthly cost for each retiree.[30]

TABLE 6 – CITY OF BOSTON MEDICARE PLANS AND MONTHLY PREMIUMS, PART B MONTHLY PREMIUM, AND TOTAL MONTHLY COST PER MEMBER FY 2010

	Total Premium	City Share	Retiree's Monthly Share		
			Medicare Plan	Part B Premium	Total Cost
BCBSMA Master Medical A&B	$415	$311	$104	$48	$152
BCBSMA Blue Care 65	$224	$202	$22	$48	$71
BCBSMA Managed Blue	$371	$334	$37	$48	$85
HPHC First Seniority	$255	$230	$26	$48	$74
Tufts Medicare Preferred	$164	$148	$16	$48	$65
Tufts Medicare Complement	$326	$293	$33	$48	$81

[27] In contrast to Sec. 18 of Ch. 32B, the new legislation does not require current retirees who are eligible for Medicare to enroll in Medicare Part B in order to receive coverage from the City, but rather would apply only to future retirees.
[28] "Boston Approves Balanced FY20 Budget: City may face more difficult financial challenge in FY11," Boston Municipal Research Bureau, August 6, 2009.
[29] Retirees who have their Part B premiums withheld from their Social Security check will continue to pay $96.40 per month in CY 2010. For all other beneficiaries, the CY 2010 Part B premium will be $110.50 per month. In addition, retirees with adjusted gross income above $85,000 and married couples with AGI above $170,000 are charged higher monthly premiums for Part B coverage.
[30] Medicare coverage is per individual, and there are no family policies. A retiree and spouse covered by Medicare are enrolled as two individual policyholders.

CAMBRIDGE

Approximately 4,800 employees and retirees receive health coverage from the City of Cambridge, in addition to spouses and dependents. In FY 2010, Cambridge will likely spend more than $42 million on employees' and retirees' health insurance premiums. The average cost per subscriber for Cambridge's non-Medicare plans is estimated to be $13,341 – $7,121 for individual coverage and $18,431 for family coverage; the average cost per Medicare subscriber is estimated to be $3,569.

Active Employees and Non-Medicare Retirees

The City offers employees and non-Medicare retirees four health plans from which to choose – two HMO plans, one Exclusive Provider Organization (EPO) plan,[31] and one POS plan. In addition, pre-65 retirees may select Advantage Blue, a network-based plan that is available nationwide. This plan is designed for retirees who live out-of-state. The City self-insures all of these plans. BCBSMA administers the POS plan, the Advantage Blue plan, and one HMO plan; while HPHC administers an HMO plan and THP administers the EPO plan.

Cambridge contributes 82% to 88% of the premium for active employees – depending on the employee's collective bargaining unit – with employees paying 12% to 18% of the premium. For retirees, the city pays 90% or 99% of the premium, depending on the retiree's date of retirement. Table 7 displays the FY 2010 monthly premiums for individual coverage and family coverage by plan type, along with the City's share and the employee's share of the premium.[32]

TABLE 7 – CITY OF CAMBRIDGE HEALTH PLANS AND MONTHLY PREMIUMS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2010

Plan	Individual Coverage			Family Coverage		
	Total Premium	City Share (85%)	Employee Share	Total Premium	City Share (85%)	Employee Share
BCBSMA Blue Choice (POS)	$723	$614	$108	$1,843	$1,567	$276
BCBSMA HMO Blue	$507	$431	$76	$1,299	$1,104	$195
BCBSMA Advantage Blue	$917	$779	$138	$2,295	$1,950	$344
HPHC HMO	$445	$378	$67	$1,202	$1,022	$180
Tufts EPO	$548	$466	$82	$1,489	$1,266	$233

[31] The EPO plan offered by Cambridge operates like an HMO plan, in that members must select a primary care physician who coordinates their care and members must receive referrals to see a specialist. Out-of-network coverage is typically not available, except in instances in which there are no network providers available to treat the member.

[32] Because the percentage contribution varies among employees and retirees, Table 7 assumes the City pays 85% of the premium and the members pays 15%.

Based on January 2009 enrollment, roughly 40% of Cambridge members were enrolled in the Blue Choice POS plan (1,292 of 3,353 subscribers), 25% selected the BCBSMA HMO Blue plan, and 22% were in the HPHC HMO plan.

TABLE 8 –- COST SHARING – CITY OF CAMBRIDGE HEALTH PLANS ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES FY 2010		
	HMO, EPO and POS Plans	BCBSMA Advantage Blue
Deductible	None	None
Physician Office Visits		
PCP	$15	$20
Specialist	$15	$20
Hospital Inpatient Admit	None	None
Outpatient Surgery	None	None
Radiology	None	None
ER Visits	$75	$75
Prescription Drugs (Retail – 30 day supply)		
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$50	$50
Prescription Drugs (Mail – 90 day supply)[33]		
Tier 1	$20	$10
Tier 2	$60	$30
Tier 3	$150	$50

The City's health plans have very similar point-of-service cost sharing, with no co-payments for most services and relatively modest co-payments for physician offices visits and prescription drug coverage. Table 8 summarizes the cost sharing provisions for the major health benefits. The differences among the plans are essentially limited to their respective provider networks and the availability of out-of-network coverage for members of the POS plan.

Medicare Retirees

Retirees who are eligible for Medicare are required to enroll in Medicare Parts A and B as a precondition for receiving supplemental coverage from the City. The City offers six Medicare supplement plans: three from BCBSMA, two from Tufts and one from HPHC. With the exception of the BCBSMA Medex plan – which is closed to new retirees – these plans are fully insured.

In addition to paying 90% or 99% of the health insurance premium, the City also covers 90% or 99% of the cost of the retirees' Medicare Part B premiums. In FY 2010, the City expects to spend approximately $1.6 million for retirees' Medicare Part B premiums. Table 9 displays the Medicare plans offered by Cambridge, the retirees' share of the premium, the retiree's Medicare Part B cost, and the total monthly cost for each Medicare-eligible retiree that receives health insurance coverage from Cambridge.[34]

[33] For the BCBSMA HMO and POS plans, the mail order co-payment is the same as the retail co-payment ($10/$30/$50)

[34] The retiree's share of the premium in Table 9 is 10%. Some Cambridge retirees pay only 1% of the monthly premium and 1% of the Part B premium.

TABLE 9 – CITY OF CAMBRIDGE MEDICARE PLANS AND MONTHLY PREMIUMS, PART B MONTHLY PREMIUM, AND TOTAL MONTHLY COST PER MEMBER FY 2010					
	Total Premium	City Share (90%)	Retiree's Monthly Share (10%)		
			Medicare Plan	Part B Premium	Total Cost
BCBSMA Medex	$342	$308	$34	$10	$44
BCBSMA Managed Blue	$321	$289	$32	$10	$42
BCBSMA Medicare PFFS[35]	$174	$157	$17	$10	$27
HPHC First Seniority Freedom	$235	$212	$23	$10	$33
Tufts Medicare HMO	$164	$148	$16	$10	$26
Tufts Medicare PFFS	$182	$164	$18	$10	$28

[35] Medicare PFFS plans, or Private Fee-for-Service plans, allow the Medicare member access to doctors and hospitals that agree to accept the plan's terms, conditions and payment rate.

MARSHFIELD

Marshfield participates in the Plymouth County Health Group, a coalition of 28 governmental entities that includes county government, municipal governments, school districts, and fire districts.[36] These 28 entities jointly purchase health, dental and life insurance, which is provided to roughly 10,000 employees and retirees, as well as thousands of dependents and spouses. The Plymouth County Health Group self-insures its health benefits.[37]

Approximately 1,000 employees and retirees of the Town of Marshfield receive health coverage through the Plymouth County Health Group, in addition to spouses and dependents. In FY 2010, Marshfield expects to spend roughly $4.8 million on employees' and retirees' health benefits. The FY 2010 enrollment-weighted average premium per subscriber for Marshfield's non-Medicare plans is estimated to be $12,243 – $6,947 for individual coverage and $17,997 for family coverage; the average cost per Medicare subscriber is estimated to be $4,645.

Active Employees and Non-Medicare Retirees

In FY 2010 employees and pre-65 retirees are offered five plans from which to choose, four HMO plans and one PPO plan.[38] BCBSMA administers two HMO plans and the PPO plan, while HPHC administers two HMO plans. "Rate Saver" HMO plans were made available for the first time in FY 2010. These plans have higher point-of-service cost sharing, as noted in Table 11, and slightly lower premiums, as shown in Table 10. Marshfield contributes 50% of the premium, with employees and retirees responsible for 50%.

TABLE 10 – TOWN OF MARSHFIELD HEALTH PLANS AND MONTHLY PREMIUMS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2010

Plan	Individual Coverage		Family Coverage	
	Total Premium	Town/Employee Share	Total Premium	Town/Employee Share
BCBSMA Blue Care Elect PPO	$762	$381	$1,806	$903
BCBSMA Network Blue HMO	$539	$270	$1,440	$720
BCBSMA Rate Saver HMO	$512	$256	$1,368	$684
HPHC HMO	$572	$286	$1,527	$764
HPHC Rate Saver HMO	$541	$271	$1,443	$722

[36] Due to a change in state law, effective February 2010, employees and retirees of the Plymouth County Sheriff's Department no longer participates in the Plymouth County Health Group and instead receive their health benefits from the Group Insurance Commission.

[37] The group, collectively, is self-insured. However, member communities are not individually self-insured nor are they individually rated. Premiums from each member community are deposited into a trust fund that is used to pay the claims, administrative fees and other expenses on behalf of the entire group. Any year-end surplus is retained by the group, and any year-end deficit is the responsibility of the group. Individual communities are not responsible for their members' claims, except as their members' claims accumulate toward the total medical claims of the entire group.

[38] In FY 2010, the town also had one individual enrolled in an indemnity plan, BCBSMA Master Medical.

Based on September 2009 enrollment, 375 members (58% of enrollees) were enrolled in the BCBSMA Network Blue HMO plan, while 204 (31%) were enrolled in the HPHC HMO plan, and 72 (11%) members selected the PPO plan. Despite offering enrollees two lower-priced options, no Marshfield members selected either of the "Rate Saver" plans.

As Table 11 shows, the plans selected by Marshfield employees and non-Medicare retirees have no point-of-service cost sharing for hospital admissions, outpatient surgery and radiology, and relatively modest co-payments for office visits and prescription drug coverage.

TABLE 11 – COST SHARING – TOWN OF MARSHFIELD HEALTH PLANS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2010

Carrier	BCBSMA			HPHC	
Plan Type	PPO	HMO	Rate Saver HMO	HMO	Rate Saver HMO
Deductible	None	None	None	None	None
Physician Office Visits					
PCP	$15	$5	$20	$10	$20
Specialist	$15	$5	$20	$10	$20
Hospital Inpatient Admit	None	None	$250	None	$250
Outpatient Surgery	None	None	$150	None	$100
Radiology	None	None	None	None	None
ER Visit	$50	$25	$75	$50	$75
Prescription Drugs – Retail (30 days) and Mail (90 days)					
Tier 1	$10	$10	$10	$5	$10
Tier 2	$20	$20	$25	$15	$25
Tier 3	$35	$35	$45	$35	$40

Members of the PPO plan are able to receive coverage from out-of-network providers. However, PPO members seeking care from a non-network provider must pay an upfront deductible of $250 (individual) or $500 (family), as well as 20% co-insurance up to an annual maximum of $1,000 (individual) or $2,000 (family).

Medicare Retirees

Marshfield retirees who are eligible for Medicare are required to enroll in Medicare Parts A and B as a precondition for receiving supplemental coverage from the Town. The Town does not make any contribution toward the retirees' Medicare Part B premium.

Two Medicare supplement plans are offered to retirees; the BCBSMA Medex plan and HPHC's Medicare Enhance plan. In FY 2010, the BCBSMA Medex plan covered 314 (91%) of the Town's 347 Medicare-eligible retirees. Table 12 displays the Medicare plans offered by Marshfield, the retirees' share of the premium, the Medicare Part B cost, and the total monthly cost for each Medicare-eligible retiree.

TABLE 12 – TOWN OF MARSHFIELD MEDICARE PLANS AND MONTHLY PREMIUMS, PART B MONTHLY PREMIUM, AND TOTAL MONTHLY COST PER MEMBER FY 2010

	Medicare Supplement Plan Premium	Retiree's Monthly Cost		
		Medicare Plan	Part B Premium	Total Member Cost
BCBSMA Medex	$378	$189	$96	$285
HPHC Medicare Enhance	$470	$235	$96	$331

MELROSE

The City of Melrose shifted its employees into the GIC effective July 1, 2009. Unlike the analysis for Boston, Cambridge and Marshfield, which uses the municipalities' FY 2010 health benefits and premiums, Melrose did not have its own health plans in FY 2010. As a result, this analysis uses Melrose's FY 2009 health benefits and health plan premiums.

Approximately 1,050 employees and retirees receive health coverage from the City of Melrose, in addition to spouses and dependents. In FY 2009, Melrose spent more than $10 million on employees' and retirees' health benefits. The FY 2009 enrollment-weighted average premium per subscriber for Melrose's non-Medicare plans was $14,085 – $7,260 for individual coverage and $19,368 for family coverage; the average cost per Medicare subscriber was $5,052.

Active Employees and Non-Medicare Retirees

In FY 2009, employees and non-Medicare retirees were offered two plans, an HMO plan and an Indemnity plan, both of which were administered by BCBSMA on a self-insured basis. For active employees, Melrose contributed 82% of the premium for the HMO plan and 60% of the premium for the Indemnity plan. For retirees, the City contributed 85% of the premium for the HMO plan and 60% for the Indemnity plan. Table 13 displays the FY 2009 monthly premiums for individual and family coverage by plan type for active employees and non-Medicare retirees, along with the City's share and the employees'/retirees' share of the premium.

TABLE 13 – CITY OF MELROSE HEALTH PLANS AND MONTHLY PREMIUMS
ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES
FY 2009

Plan	Individual Coverage			Family Coverage		
	Total Premium	City Share	Employee Share	Total Premium	City Share	Employee Share
Active Employees (18% of HMO premium and 40% of Indemnity premium)						
Network Blue HMO	$605	$496	$109	$1,614	$1,323	$291
Master Medical Indemnity	$983	$590	$393	$2,459	$1,475	$984
Retirees (15% of HMO premium and 40% of Indemnity premium)						
Network Blue HMO	$605	$514	$91	$1,614	$1,372	$242
Master Medical Indemnity	$983	$590	$393	$2,459	$1,475	$984

While Melrose offered two plans to their employees and non-Medicare retirees, virtually all of Melrose's employees and non-Medicare retirees were enrolled in the HMO plan. Of the 811 members receiving health insurance from the City in FY 2009, only 21 (or less than 3%) were enrolled in the Indemnity plan.

The HMO plan had no co-payments for most services and modest co-payments for physician's office visits and prescription drugs. While the Indemnity plan included 20% co-insurance for most services, the plan included an out-of-pocket maximum that capped the members' financial exposure at $1,000 for

individual coverage and $2,000 for family coverage. However, the Indemnity plan also included a lifetime benefit maximum of $1 million, which could leave the member liable for medical costs incurred beyond that amount. Table 14 summarizes the cost sharing provisions for the major health benefits.

TABLE 14 – COST SHARING -- CITY OF MELROSE HEALTH PLANS ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES FY 2009		
	HMO	Indemnity
Deductible	None	$250 (Ind.)/ $500 (Family)[39]
Physician Office Visits		
PCP	$10	20%
Specialist	$10	20%
Hospital Inpatient Admit	None	20%
Outpatient Surgery	None	20%
Radiology	None	20%
ER Visits	$50	20%
Prescription Drugs -- Retail (30 days) and Mail (90 days)		
Tier 1	$10	$10
Tier 2	$20	$20
Tier 3	$35	$35
Co-insurance Out-of-Pocket Maximum	None	$1,000 (Ind.) $2,000 (Family)
Lifetime Maximum	None	$1 Million

Medicare Retirees

Prior to joining the GIC, the City had not adopted Section 18 of Ch. 32B and did not require retirees who were eligible for Medicare to enroll in Medicare Parts A and B as a precondition for receiving health coverage from the City. For those retirees who chose to enroll in Medicare, the City did not make any contribution toward the retirees' Medicare Part B premium.[40]

The City offered one Medicare supplement plan – the BCBSMA Medex plan – and the City paid 50% of the monthly premium. Table 15 displays the retirees' share of the Medex premium, the retirees' Medicare Part B premium, and the total monthly cost for each Medicare retiree. In FY 2009, there were 241 Melrose retirees who were covered by the City's Medex plan.

TABLE 15 – CITY OF MELROSE MEDICARE PLAN AND MONTHLY PREMIUM, PART B MONTHLY PREMIUM, AND TOTAL MONTHLY COST PER MEMBER FY 2009				
	Medicare Supplement Plan Premium	Retiree's Monthly Cost		
		Medicare Plan	Part B Premium	Total Member Cost
BCBSMA Medex	$421	$210	$96	$306

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[39] Deductible does not apply to prescription drug coverage.

[40] Because the GIC requires municipalities that wish to receive coverage through the GIC to adopt Sec. 18 of Ch. 32B (i.e., retirees eligible for Medicare are required to sign up for Parts A and B), Melrose adopted Sec. 18 prior to joining the GIC. As a result of this Medicare requirement, the City reports that 60 retirees who were not previously enrolled in Medicare are now enrolled in Medicare Part B. In FY 2010, the City will reimburse 70% of their Medicare retirees' Part B premiums.

V. Background on the Group Insurance Commission

The Group Insurance Commission (GIC) is a quasi-independent state agency responsible for the administration of health insurance and other benefits[41] to state employees, retirees and their spouses and dependents. In addition to current and former state workers, the GIC provides health insurance to more than 100 local and regional housing and redevelopment agencies, participating municipalities, and retired municipal employees and teachers in certain governmental units.[42]

The Commission is governed by a 15-member board, appointed by the Governor, which is comprised of officials from the executive branch of state government, state and municipal unions, state retirees, the general public and a health economist. The Commission establishes the health benefits and approves contracts with insurers, third-party administrators and other vendors.

The Commonwealth does not negotiate its health insurance benefits or the employees' share of the premium contribution with the state's public sector unions. The Commission has the statutory authority and responsibility to "negotiate with and purchase, on such terms as it deems in the best interest of the commonwealth and its employees"[43] health insurance for state employees and their dependents. The Commission determines the types of health plans offered (e.g., HMO, PPO, Indemnity), the plan designs (e.g., point-of-service cost sharing), and the monthly premiums for each health plan. The legislature, through the annual budget process, establishes the premium contribution percentage for state employees and retirees.

In FY 2010, the state budget includes more than $1.0 billion for health insurance benefits provided by the GIC. During the first seven months of FY 2010, the GIC's enrollment-weighted average annual premium per subscriber[44] for its non-Medicare health plans was estimated to be $11,924 – $6,841 for individual coverage and $15,766 for family coverage. The average premium per subscriber for the GIC's Medicare plans is estimated to be $4,119.

However, benefits changes that took effect on February 1, 2010 reduced premiums for all of the GIC's non-Medicare plans. As a result, the enrollment-weighted average premium for the period from February 2010 through June 2010 is estimated to be $11,273, a reduction of 5.5% or $651 compared to the first seven months of the fiscal year. The average individual premium is estimated to be $6,517; and the average family premium is approximately $14,868. Medicare plans were unaffected.

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[41] The GIC also offers health care spending account and dependent care assistance program, life insurance, long-term disability insurance, dental coverage, and vision coverage. Some of these benefits are only available to a subset of GIC members.
[42] From GIC web site, www.mass.gov/gic "Who is the GIC?"
[43] MGL, Ch. 32A, Sec. 4.
[44] Author's calculation based on FY 2010 premiums and FY 2009 enrollment by health plan and rate basis type (i.e., individual or family coverage). "Enrollment-weighted average annual premium per subscriber" is derived by multiplying the annual premiums for each health plan by the estimated number of enrollees, and dividing the total annual premium amount by the total number of subscribers.

Over 320,000 individuals are covered by the GIC's health plans, and enrollment has grown since a statutory change in 2007 – Chapter 67 of the Acts of 2007 – allowed municipalities to join the GIC's health insurance program.

GIC Health Plans

The GIC offers employees and non-Medicare eligible retirees nine health plans from which to choose: four HMO plans, four PPO plans, and one Indemnity plan. The HMO plans are purchased on a fully insured basis and are provided by three regional health insurers – Neighborhood Health Plan (NHP), Fallon Community Health Plan (FCHP) and Health New England (HNE).

The PPO plans are administered by Harvard Pilgrim Health Care (HPHC) and Tufts Health Plan (THP), while UniCare administers two PPO plans and the Indemnity plan. The PPO plans are available across the state and in a number of regions in neighboring states; while the Indemnity plan is available nationwide, as well as worldwide for individuals residing outside the country. The PPO and Indemnity plans are self-insured.

For some of its health plans, the GIC carves out prescription drug coverage and mental health benefits. The GIC contracts with a pharmacy benefits manager (PBM), Express Scripts, to administer the prescription drug coverage for the health plans offered by UniCare. The Commission contracts with United Behavioral Health to administer the mental health benefits for the health plans offered by Tufts Health Plan and UniCare. The GIC self-insures the PBM and mental health contracts.

Retirees eligible for Medicare are required to enroll in Medicare Parts A and B in order to receive supplemental coverage from the GIC.[45] If a retiree is eligible for Medicare, Part A coverage (i.e., hospital coverage) is free, while there is a monthly premium paid to the federal government for Part B coverage (i.e., physician's services and ancillary care). The State does not contribute toward the Part B premium paid by retirees for Medicare coverage, which costs retirees $96.40 per month in CY 2009 and CY 2010. This monthly cost is in addition to the premiums paid by enrollees for the GIC's Medicare plans.

Medicare-eligible retirees can choose from six health plans, which are provided by five of the six health carriers. The Indemnity Medicare plan covers over 90 percent of GIC Medicare retirees and is self-funded by the GIC. All other GIC Medicare plans are purchased on a fully insured basis.

GIC Health Benefits

With the exception of the Indemnity plan – which has slightly lower point-of-service cost sharing and significantly higher monthly premiums – the health benefits that the GIC offers its members are roughly comparable with regard to point-of-service cost sharing. Most of the health plans offered by the GIC include tiered co-payments for physician office visits and hospital inpatient admissions. This means an individual member's actual co-payment will depend on the tier of the physician and/or hospital

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[45] Because Medicare Parts A and B require enrollees to pay deductibles and co-insurance for many services (e.g., inpatient hospitalization, physician's office visits), retirees enrolled in Medicare are provided additional insurance to reduce their out-of-pocket expenses and to provide coverage for services not covered by Medicare.

providing the service. Tables 16 and 17 display the point-of-service cost sharing for major categories of service for the GIC's non-Medicare health plans in effect February 1, 2010 through June 30, 2010.

TABLE 16 – COST SHARING SUMMARY – GIC PPO and INDEMNITY PLANS FY 2010 (EFFECTIVE FEBRUARY 1, 2010)					
	Tufts PPO	HPHC PPO	PLUS PPO	Community Choice PPO	Indemnity
Deductible[46]	$250	$250	$250	$250	$250
PCP Office Visit					
Tier 1	$20	$20	$15	$15	$15
Tier 2	n/a	n/a	$30	$30	$30
Tier 3	n/a	n/a	$35	$35	$35
Specialist Office Visit					
Tier 1	$25	$20	$25	$25	$20
Tier 2	$35	$35	$30	$30	$30
Tier 3	$45	$45	$45	$45	$40
Hospital Inpatient Admission[47]					
Tier 1	$300	$250	$250	$250	$200
Tier 2	$700	$500	$500	n/a	n/a
Tier 3	n/a	$750	$750	n/a	n/a
Outpatient Surgery[48]	$150	$150	$110[49]	$110	$110
Radiology	$100	$100	$100	$100	$100
ER Visit[50]	$100	$100	$100	$100	$100
Prescription Drugs – Retail (30 days supply)					
Tier 1	$10	$10	$10	$10	$10
Tier 2	$25	$25	$25	$25	$25
Tier 3	$50	$50	$50	$50	$50
Prescription Drugs – Mail (90 days supply)					
Tier 1	$20	$20	$20	$20	$20
Tier 2	$50	$50	$50	$50	$50
Tier 3	$110	$110	$110	$110	$110

A GIC member that visits a primary care physician (PCP) may be charged a co-payment of $15 or $20 if seeing a tier 1 PCP, or as much as $35 if visiting a tier 3 PCP. If a member needs to be seen by a specialist, the lowest co-payment is $20 or $25 (tier 1), and as high as $45 (tier 3). If a member is hospitalized, the lowest co-payments range from $200 to $300, while the highest co-payment is $750.

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[46] Deductible does not apply to office visits, mental health and substance abuse services, and prescription drugs. The deductible is applied on an individual basis, up to a maximum of $750 for family coverage.

[47] GIC plans limit the co-payments for inpatient admissions to no more than four per person per year. If a member is admitted to the hospital five or more times in a year, there is no additional member cost sharing.

[48] GIC plans limit the co-payments for outpatient surgery to a maximum of four per person per year. If a member has five or more outpatient surgeries, there is no additional member cost sharing.

[49] Outpatient surgery co-payments are tiered in the PLUS PPO Plan, with members receiving services at a Tier 3 hospital responsible for $250 co-payment.

[50] Emergency Room co-payments are waived if the individual is admitted to the hospital.

TABLE 17 – COST SHARING – GIC HMO PLANS FY 2010 (EFFECTIVE FEBRUARY 1, 2010)				
	Neighborhood HMO	FCHP Direct Care HMO	Fallon Select Care HMO	Health New England HMO
Deductible[51]	$250	$250	$250	$250
PCP Office Visit				
Tier 1	$15	$15	$15	$20
Tier 2	$25	n/a	$20	n/a
Tier 3	$30	n/a	$30	n/a
Specialist Office Visit				
Tier 1	$25	$25	$25	$25
Tier 2	$35	n/a	$35	$35
Tier 3	$45	n/a	$45	$45
Hospital Inpatient Admission[52]				
Tier 1	$250	$200	$250	$250
Tier 2	n/a	n/a	n/a	n/a
Tier 3	n/a	n/a	n/a	n/a
Outpatient Surgery[53]	$110	$110	$125	$110
Radiology	$100	$100	$100	$100
ER Visit[54]	$100	$100	$100	$100
Prescription Drugs – Retail (30 days supply)				
Tier 1	$10	$10	$10	$10
Tier 2	$25	$25	$25	$25
Tier 3	$50	$50	$50	$50
Prescription Drugs – Mail (90 days supply)				
Tier 1	$20	$20	$20	$20
Tier 2	$50	$50	$50	$50
Tier 3	$110	$110	$110	$110

[51] Deductible does not apply to office visits, mental health and substance abuse services, and prescription drugs. The deductible is applied on an individual basis, up to a maximum of $750 for family coverage.
[52] GIC plans limit the co-payments for inpatient admissions to no more than four per person per year. If a member is admitted to the hospital five or more times in a year, there is no additional member cost sharing.
[53] GIC plans limit the co-payments for outpatient surgery to a maximum of four per person per year. If a member has five or more outpatient surgeries, there is no additional member cost sharing.
[54] Emergency Room co-payments are waived if the individual is admitted to the hospital.

Because the HMO plans and the Community Choice PPO plan include a more limited network of hospitals than do the other PPO and Indemnity plans, there is no tiering of hospitals in these plans. In addition, since the Fallon Direct Care HMO plan uses a subset of Fallon's broader network of physicians, there is no additional physician tiering in this plan.

The most significant differences among the GIC plans are the provider networks of each plan (i.e., the physicians and hospitals included in each health carrier's network), the tiering of providers (i.e., which physicians and/or hospitals are included in tier 1 vis-à-vis tier 2, etc.), and whether or not a member can receive care from an out-of-network provider (i.e., HMO plans do not include out-of-network coverage while the PPO plans allow members to receive non-emergency services from providers that are not part of the plans' provider networks; and the Indemnity plan allows members to receive care from virtually any physician and any hospital).

GIC'S HEALTH PLANS' PREMIUMS

Despite relatively comparable benefits among the GIC's health plans, the monthly premiums across the health plans vary significantly. The main reason for the difference in premiums among the GIC plans is the underlying health risk of the enrollees in each plan and the expected medical costs for each plan's members.

TABLE 18 – GIC MONTHLY PREMIUMS FOR NON-MEDICARE PLANS[55]
FY 2010

Plan Type	Carrier/Plan Name	Monthly Premium July 2009 – Jan. 2010		Monthly Premium Feb. 2010 – June 2010	
		Individual	Family	Individual	Family
HMO	Fallon Community Health Plan's (FCHP) Direct Care Plan	$406	$974	$378	$906
PPO	UniCare Community Choice	$411	$987	$380	$911
HMO	Neighborhood Health Plan	$417	$1,105	$386	$1,024
HMO	Health New England	$431	$1,069	$403	$998
HMO	FCHP's Select Care Plan	$492	$1,181	$453	$1,087
PPO	Tufts Navigator Plan	$519	$1,251	$488	$1,176
PPO	Harvard Pilgrim's Independence Plan	$526	$1,274	$487	$1,174
PPO	UniCare PLUS	$532	$1,271	$501	$1,195
Indemnity	UniCare Indemnity Basic Plan w/CIC	$768	$1,792	$732	$1,704

[55] GIC premiums reflect the total cost of the health plan, including the employee's share and the employer's share, and include 0.33% administrative load.

As Table 18 shows, the highest priced GIC plan (Indemnity Basic) is almost twice the cost of the lowest priced plan (Fallon Direct Care HMO). Certainly, a significant part of this premium difference is due to the fact that HMO plans limit members to a network of providers compared to the unlimited provider network of the Indemnity plan, as well as benefits management features of an HMO plan (e.g., referral requirements to see a specialist, prior authorization for certain high-cost procedures).

However, these differences account for approximately 30% to 35% of the premium difference. The majority of the variation in cost is due to differences in the plan's demographics (i.e., age of enrollees), and the health care needs and expected utilization of medical services by the members in each plan.

In FY 2007, the GIC Indemnity plan's members had an average age of almost 47, compared to an average age of 35 for the GIC's HMO plans. In addition to an older population, the Indemnity plan is also the only GIC plan available to members who live outside of New England. This group is predominantly under age 65 and retired, which is the GIC's most expensive group to cover.

GIC ENROLLMENT

Over 80% of GIC policyholders, or approximately 89,000 employees and non-Medicare retirees, are enrolled in the GIC's broad network PPO plans and the Indemnity plan; while roughly 18% are enrolled in regional HMO plans and the GIC's select hospital network PPO plan, Unicare Community Choice. Table 19 shows the FY 2009 distribution of enrollment among the GIC's non-Medicare plans' members.

TABLE 19 – GIC NON-MEDICARE PLANS FY 2009 ENROLLMENT			
Carrier/Plan Name	Plan Type	Subscribers	Percentage of Total
Fallon Direct Care Plan	HMO	1,273	1.2%
Fallon Select Care Plan	HMO	2,845	2.6%
Neighborhood Health Plan	HMO	1,081	1.0%
Health New England	HMO	7,237	6.7%
UniCare Community Choice Plan	PPO/Select Hospital Network	6,555	6.1%
Tufts Navigator	PPO	33,840	31.4%
Harvard Pilgrim Independence Plan	PPO	21,335	19.8%
UniCare PLUS Plan	PPO	10,602	9.8%
UniCare Basic Plan	Indemnity	23,141	21.4%
Total		107,909	

Among Medicare enrollees, more than 90% are members of the Indemnity Medicare plan, which does not restrict members to a network of providers (i.e., physicians and hospitals) the way the Medicare HMO plans do, nor does it require members to coordinate care through a primary care physician. Table 20 displays the FY 2009 distribution of enrollment among the GIC's Medicare plans' members.

TABLE 20 – GIC MEDICARE PLANS FY 2009 ENROLLMENT			
Carrier/Plan Name	Plan Type	Subscribers	Percentage of Total
Fallon Senior Plan	HMO	797	1.6%
Health New England MedPlus	HMO	836	1.7%
Unicare Indemnity Medicare Extension	Supplement	45,065	90.2%
Harvard Pilgrim Medicare Enhance	Supplement	204	0.4%
Tufts Medicare Complement	HMO	1,497	3.0%
Tufts Medicare Preferred	HMO	1,558	3.1%
Total		49,957	

HOW THE GIC FINANCES HEALTH COVERAGE

As noted above, most GIC members are enrolled in plans that are self-insured. This means that the Commonwealth does not buy insurance from the health carriers. Rather, for these self-insured plans, the GIC pays the members' medical claims as they are incurred and processed by the carriers.

Under the terms of the self-insured agreement between the GIC and the health carriers, the carriers process and adjudicate claims. The carriers then request reimbursement from the GIC to pay for the medical claims. As part of the contract between the GIC and the health carriers, the carriers allow access to their physician and hospital networks based on the terms and conditions established by the carriers with their contracted providers; administer disease management and care management programs; and operate a customer service unit.

For these self-insured plans, the GIC establishes a "premium equivalent" rate for individual and family coverage. These rates include an Administrative Services Only (ASO) fee – which is paid on a per member per month basis to the carriers who administer the plan on behalf of the GIC – and a much larger amount that is used to reimburse the carriers for the GIC members' medical claims. The GIC's ASO fees account for approximately 5% of the total premium.

In contrast, for the fully insured HMO plans, the GIC negotiates the rates that the carriers charge to cover GIC members in their respective health plan. The premiums for the HMO plans are paid to the carriers each month and the state assumes no risk with regard to paying members' medical claims. If there is an end-of-year surplus – i.e., the premiums collected by the health plan are greater than the cost of paying the medical claims and the cost of administering the plan – the health insurer retains that revenue. And, if there is a deficit – i.e., the plan's expenses are greater than the premiums collected – the health insurer must cover these costs.

The mid-year benefits changes made by the GIC in FY 2010 were needed to cover a projected deficit of $35 million in its self-funded health plans. These plans' premium equivalent rates – which were set in March 2009 for FY 2010 – were set too low to cover the medical claims that are being incurred by GIC

enrollees. As a result, the Commission increased co-payments, added an upfront deductible of $250 per person, and reduced premiums in order to reduce plan costs and generate sufficient revenues to cover the shortage. When faced with similar circumstances in prior years, the GIC has been able to request a supplemental appropriation from the administration and state legislature. However, with a bleak state revenue picture, the GIC was forced to make rare mid-year benefits change to balance its books.

HEALTH PLANS – NOT THE GIC – CONTRACT WITH PHYSICIANS, HOSPITALS AND OTHER PROVIDERS

While the GIC uses its market position, economies of scale and negotiating ability to its competitive advantage in paying relatively low ASO fees and in negotiations with the fully insured HMO plans, these costs represent a relatively small fraction of the total cost of health insurance for the GIC. The majority of the costs are for the medical care that is provided to GIC members in the self-insured plans.

The health carriers use the reimbursement rates and provider contracts that they negotiate with providers on behalf of their entire book of business. The GIC does not negotiate provider reimbursement rates, nor do the health carriers negotiate different reimbursement rates with providers for GIC members than they do with providers for the rest of their membership (i.e., non-GIC members).

For example, when a GIC member who is enrolled in the Harvard Pilgrim PPO Plan is admitted to Mount Auburn Hospital for a hip replacement, the amount paid by Harvard Pilgrim to Mount Auburn Hospital for the GIC member's hip replacement is the same amount that Harvard Pilgrim pays to Mount Auburn Hospital for a Harvard Pilgrim PPO member who is not a member of the GIC. While the member's share of the cost (e.g., co-payment) may be different, the amount charged by the hospital is the same for all Harvard Pilgrim PPO members.

VI. Key Differences between GIC and Municipal Health Insurance

There are three key differences between the health insurance provided by the GIC and the insurance provided by the municipalities reviewed in this report – point-of-service cost sharing, the use of select and tiered provider network plans, and the likely impact of the collective bargaining requirement on municipal governments' ability to adjust plan designs.

Point-of-Service Cost Sharing

The most significant difference between the health benefits offered by the GIC and the benefits provided by the four municipalities reviewed in this report is the point-of-service cost sharing. Both the amount of the co-payments as well as the range of services to which co-payments apply are more extensive in the GIC plans than they are in these municipalities' plans.

In addition, the benefits changes that took effect in February 2010 – particularly the addition of an upfront deductible across all of the GIC's non-Medicare plans – further increase the disparity in cost sharing between GIC plans and these municipal health plans. These cost sharing differences are the primary reason for the GIC's lower premiums.

As discussed in the preceding sections, almost all of the health plans offered by these four communities do not include any member cost-sharing for outpatient surgery, high-tech imaging, and inpatient hospitalizations. In addition, co-payments for physician's office visits for the municipal plans are generally lower than those charged GIC members, while prescription drug co-payments are lower than or comparable to the GIC's drug co-payments.

The GIC has used co-payments primarily to offset the growth in premiums, but also to incent members to moderate their use of services. As discussed in the next section, the GIC also uses differential co-payments for some services (e.g., physicians' office visits, hospitalizations) to encourage members to utilize more cost-effective providers.

Select and Tiered Network Plans

In addition to cost sharing differences, network design affects the differences in premiums between the GIC and these municipalities' plans. Almost all GIC health plans tier physicians and some plans tier hospitals, as well. Depending on the tier of the physician and/or hospital, the member's co-payment will vary.

While the health plans use cost and quality information derived from a multi-plan[56] data set to inform their approach to the tiering of providers, each of the health plans has developed its own methodology for physician and hospital tiering. Five of the nine GIC plans tier primary care physicians (PCP), and eight plans tier specialists, although not all plans tier the same types of specialists. In addition, three plans

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[56] The six health plans under contract with the GIC provide their book-of-business claims data to a third party vendor, which aggregates the data and generates physician profiles based on episode treatment groups that measure resources used to treat specific conditions.

tier hospitals for inpatient admissions, while one plan extends the hospital tiering to outpatient surgery performed at hospitals.

For example, depending on the tier of the cardiologist, a GIC member enrolled in the Tufts Navigator Plan will face a co-payment of $25 or $35 or $45. For people admitted to an acute care hospital, the co-payments for the Navigator Plan are $300 if admitted to a tier one hospital and $700 if admitted to a tier two hospital.

The Fallon Direct Care Plan, which includes a sub-set of FCHP's broader provider network, does not tier physicians or hospitals. The premiums for the Fallon Direct Care Plan are 17 percent lower than the premiums for the Fallon Select Care Plan, the carrier's broad network plan.

Collective Bargaining

Changes to the health benefits provided by a municipality must be negotiated with, and approved by, the municipal unions,[57] which typically involve separate negotiations and approval from multiple unions within each community. The GIC's benefits are not negotiated with the public sector unions. Approval of changes to the GIC's health benefits (e.g., what's covered, the amounts and types of point-of-service cost sharing, which health plans will be offered, etc.) requires a majority vote of the Commission.

While union and retiree representatives serve on the 15-member Commission, they make up a minority of the membership, and therefore support from union members is not needed to approve benefits changes. This is not to suggest that the unions' concerns are not considered or that union representatives on the Commission always oppose benefits changes.

However, the GIC's ability to modify the benefits and the health plans offered, subject to a majority vote by the Commission but not negotiated with the unions, has allowed the GIC to limit premium growth by increasing co-payments and offering select and tiered network plans. Municipal governments' inability to adjust their health benefits outside of the collective bargaining process limits their options with regard to controlling the growth in health insurance premiums, particularly when circumstances require fast action.

Two recent examples demonstrate the State's ability to offset the growth in premiums by increasing members' point-of-service cost sharing. Faced with plunging state revenues and health insurance premiums projected to climb by more than 7%, in February 2009 the GIC approved approximately $40 million worth of benefits changes (i.e., higher cost sharing). These changes, which took effect on July 1, 2009, lowered the GIC's FY 2010 increase in health insurance premiums to an average of 4%.

Most recently, with the GIC facing a projected $35 million deficit due to higher than expected medical costs and no supplemental funding available from the State, the Commission approved more benefits changes that should enable the Commission to eliminate the looming deficit. These benefits changes took effect on February 1, 2010.

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[57] As established by MGL Chapter 150 and a series of decisions by the Massachusetts Division of Labor Relations.

While plan design (e.g., co-payments, the range of benefits covered, etc.) and the selection of health carriers are determined by the Commission, the premium contribution paid by employees and retirees is established by the legislature as part of the annual budget process. The State's FY 2010 budget increased the employees' share of the premiums by five percentage points.[58] At the municipal level, these decisions are also subject to collective bargaining.

[58] Effective August, 1, 2009, employees hired on or before June 30, 2003 pay 20% of the premium, up from 15%, and employees hired after June 30, 2003 pay 25% of the premium, up from 20%.

VII. ANALYSIS

There are two levels of analysis in this report – the premium savings that may be achieved by joining the GIC, and the potential financial impact on enrollees that may result from higher point-of-service cost sharing in GIC health plans compared to the municipalities' health plans.

ADJUSTMENTS TO BOSTON'S ENROLLMENT AND HEALTH INSURANCE PREMIUMS

Two adjustments to Boston's enrollment and health insurance premiums have been made for the purposes of this analysis; the first to account for the premium savings that may be achieved with the pending elimination of Boston's Master Medical Indemnity Plan; and the second to account for the premium savings that might be achieved if the City required the 1,700-plus Medicare-eligible retirees who are not enrolled in Medicare to sign up for Medicare Part B, as a precondition for receiving coverage from the City. These adjustments could reduce the City's health insurance premiums by approximately $10.7 million.

As Table 21 shows, shifting Indemnity plan enrollees into the City's PPO plan – the second most expensive health plan offered by the City – would generate savings of approximately $5 million. The premium savings would lower the City's average cost of insurance; from $8,096 to $7,737 for individual coverage; and from $19,367 to $19,133 for family coverage.

TABLE 21 – ESTIMATED PREMIUM SAVINGS
ELIMINATION OF MASTER MEDICAL INDEMNITY PLAN AND SWITCH TO PPO PLAN
CITY OF BOSTON
FY 2010

Annual Premiums	Individual	Family
Master Medical Indemnity	$15,144	$35,124
Blue Care Elect PPO	$11,964	$27,744
Difference in Annual Premiums	$3,180	$7,380
Members	1,249	365
Total Premium Savings	$3,971,820	$2,693,700
Premium Savings for Boston @ 75%	$2,978,865	$2,020,275
Total Premium Savings for Boston	$4,999,140	

The enrollment and premium adjustments related to Medicare Part B are necessary to account for the requirement that municipalities wishing to join the GIC must adopt Section 18 (the Medicare Part B requirement). However, Boston has not adopted Section 18, and the City estimates that there are 1,740 retirees and spouses of retirees who are eligible for Medicare but not enrolled. These individuals are covered by one of the City's non-Medicare plans.

The premium savings that would be achieved by requiring these individuals to enroll in Medicare Part B needs to be taken into account before estimating any savings that may be achieved if Boston joined the

GIC. Table 22 shows the approximate premium savings to the City from enrolling these 1,740 Medicare-eligible retirees in Medicare plans.

The number of subscribers (i.e., individual and family policyholders) who would switch from non-Medicare plans into Medicare plans is less than the number of Medicare subscribers who would be added. This is because a Medicare policy is for an individual only (i.e., there are no Medicare "family" policies). Therefore, a retiree and spouse covered by one non-Medicare "family" policy would be covered by two Medicare "individual" policies.

TABLE 22 – ESTIMATED ENROLLMENT SHIFT AND PREMIUM SAVINGS ADOPTION OF SECTION 18 (MEDICARE PART B REQUIREMENT) CITY OF BOSTON FY 2010			
	Average Premium	Subscribers (+/-)	$ Change
Non-Medicare Individual	$7,737	-430	-$3,327,050
Non-Medicare Family	$19,133	-655	-$12,532,028
Medicare (only Individual coverage)	$4,729	+1,740	+$8,229,217
Net $ Change			-$7,629,861
Premium Savings to Boston @ 75%			-$5,722,396

While the City would save approximately $5.7 million in premiums by adopting Section 18, this amount would be partially offset by roughly $1 million in Medicare Part B premiums that the City would pay on behalf of Medicare retirees and an estimated $1.6 million in penalties for Medicare-eligible retirees who sign up late for Medicare Part B. For individuals who are eligible for Medicare Part B but do not enroll when first eligible, Medicare assesses a penalty of 10% of the Medicare Part B premium for each 12-month period that the individual delays enrollment in Part B.

However, the premium savings estimate does not include the additional savings that would accrue by shifting higher-cost retirees out of the non-Medicare plans, thereby further lowering the health insurance costs for the City and its enrollees. The GIC reports that non-Medicare retirees – the vast majority of whom are under age 65 – cost twice as much to cover as active employees. These costs climb even higher for retirees who are over age 65 and not covered by Medicare. While the additional savings to Boston's non-Medicare plans' premiums are not quantified in this report, the savings would likely be significant.

IMPACT ON CITIES AND TOWNS OF SWITCH TO GIC COVERAGE

Much of the discussion over the spiraling cost of municipal health insurance compared to the GIC has centered on the difference in premiums, and in particular the difference in the average cost per subscriber (i.e., cost per employee/retiree). As Table 23 demonstrates, for three of the four communities profiled in this report, their average cost of insurance is significantly higher than the GIC's average cost. This comparison uses the GIC premiums that were in effect from July 2009 through

January 2010. As a result of benefits changes adopted by the GIC effective February 2010, premiums were reduced an average of 5.5%.

TABLE 23 – AVERAGE ANNUAL PREMIUMS PER SUBSCRIBER NON-MEDICARE PLANS FY 2010					
	GIC[59]	Boston	Cambridge	Marshfield	Melrose[60]
Fiscal Year	2010	2010	2010	2010	2009
Cost/Subscriber	$11,924	$13,840	$13,341	$12,243	$14,085
$ Difference		$1,916	$1,417	$319	$2,161
% Difference		16.1%	11.9%	2.7%	18.1%
Average Employee % Share of Premium		18%	15%	50%	13%
Employee's Average $ Share of Premium Difference from GIC		$345	$213	$160	$281
Municipality's Average $ Share of Premium Difference from GIC		$1,571	$1,204	$160	$1,880
# of Subscribers		22,596	3,353	651	825
Municipality's Additional Annual Premiums Compared to GIC Cost/Subscriber		$43.3 M	$4.7 M	$0.2 M	$1.8 M

However, a comparison that uses average premium per subscriber is misleading. First, average premium per subscriber fails to take into account the underlying benefits package (i.e., point-of-service cost sharing). As discussed in the preceding sections of this report, the benefits provided by these communities are richer (i.e., less point-of-service cost sharing) than the benefits provided by the GIC.

Second, even if the benefits are identical, the average premium per subscriber comparison fails to account for demographic differences that may exist between two groups. A group with a disproportionate share of older individuals will have higher average costs than a group of younger individuals.

By way of example, the two communities that did not require Medicare-eligible retirees to enroll in Medicare Part B – Boston and Melrose – have higher average premiums than the two communities that have adopted Section 18 – Cambridge and Marshfield. The differences in premiums exist despite the

[59] The GIC's cost per subscriber is based on premiums in effect from July 2009 through January 2010. Premiums were reduced effective February 1, 2010, which lowered the average cost per subscriber by 5.5% or $54 per month. These lower premiums will generate an average savings of $270 per subscriber over the remaining five months of FY 2010, from February 2010 through June 2010.

[60] Because Melrose joined the GIC effective July 1, 2009 (i.e., FY 2010), the average premium per subscriber shown here is for FY 2009.

fact that all four communities offered similar health benefits, and are likely due in part to the relative health risk of the individuals covered by the non-Medicare plans in these communities.

In addition, a group that has more family contracts than individual contracts will have higher average premiums per subscriber than a group with a greater proportion of individual contracts. The Town of Marshfield provides an illustration of the effect that membership by contract type (i.e., individual or family coverage) can have on a comparison of average premiums per subscriber. While the difference in the average premium per subscriber between Marshfield and the GIC is less than 3% (see Table 23), this is due in part to the distribution of enrollment between individual and family contracts. Individuals comprise 52% of Marshfield's membership, while only 43% of GIC members have individual coverage. This difference drives up the GIC's average premium per subscriber compared to Marshfield's average premium per subscriber.

For a better comparison of the differences in premiums – and the potential premium savings that may be achieved – between municipal coverage and GIC coverage, this report utilizes a migration analysis. A migration analysis uses enrollment information by contract type for each community along with actual premiums by plan and contract type (i.e., individual or family coverage). These data are used to estimate the total premiums for individual coverage and the total premiums for family coverage for each municipality, which are then summed to provide an estimate of the total annual premiums under municipal coverage and under GIC coverage.

A migration analysis eliminates the effect that differences in membership by contract type may have on a comparison between municipal insurance and GIC coverage by using actual individual and family premiums and actual individual and family enrollment for each community. In addition, because the migration analysis uses different enrollment scenarios, the analysis provides a range of cost estimates that would result from plan enrollment decisions by members.

However, a migration analysis cannot account for demographic differences (e.g., age of enrollees) and differences in the relative health status of two groups. As the discussion above regarding Boston and Melrose's average premiums compared to Cambridge and Marshfield shows, the inclusion of older, Medicare-eligible retirees in the Boston and Melrose non-Medicare plans drives up their cost of insurance.

IMPACT OF PLAN SELECTION BY MUNICIPAL ENROLLEES ON SAVINGS ESTIMATES

Since the GIC offers employees a number of plans with different premiums (see Table 18), the potential premium savings that may be achieved by a municipality that joins the GIC will depend on the plan choices of the employees and retirees. These health plan selection decisions will likely be affected by the enrollees' share of the premium, as well as the physicians and hospitals included in the GIC's lower-cost, limited network plans (i.e., HMO plans and Unicare Community Choice plan) vis-à-vis the GIC's broad network plans (i.e., PPO and Indemnity plans).

To account for the uncertainty with regard to members' plan choices, cost savings estimates for each community are provided based on two enrollment scenarios. Table 24 displays the enrollment scenarios and how premium savings are affected by the enrollees' plan choices. The *Methodology* section of this report provides greater detail on the enrollment scenarios.

TABLE 24 – TWO ENROLLMENT SCENARIOS
DISTRIBUTION OF MUNICIPAL MEMBERS' ENROLLMENT BY GIC PLAN TYPE
BASED ON GIC PREMIUMS IN EFFECT FROM JULY 2009 THROUGH JANUARY 2010
FY 2010

	Scenario 1	Scenario 2
HMO/Select Hospital Network Plans	2%	2%
PPO Plans	85%	80%
Indemnity Plan	13%	18%
Average Annual Premium		
Individual Policy	$556	$568
$ and % Difference from Scenario 1		$12 2.1%
Family Policy	$1,329	$1,356
$ and % Difference from Scenario 1		$27 2.1%

The assumption that the vast majority of enrollees would select the PPO plans and very few would opt for the lower-cost HMO plans and the select hospital network PPO plan is based in part on the experience to date of two eastern Massachusetts communities – Saugus and Winthrop – that have joined the GIC. Among Saugus employees and non-Medicare retirees, 75% enrolled in the GIC's PPO plans, 22% in the Indemnity plan, and only 4% in the HMO or Community Choice (select hospital network) PPO plan; whereas 87% of Winthrop employees and non-Medicare retirees opted for the PPO plans, 9% enrolled in the Indemnity plan, and only 2% enrolled in the HMO or Community Choice plan.

In addition, as noted in the *Methodology* section of this report, while approximately 18% of all GIC members are in the HMO/select hospital network plans, the majority of these members live in central and western Massachusetts. Only one percent of GIC members are enrolled in Neighborhood Health Plan, the primary HMO offered in Greater Boston.

Enrollment Scenario 1

Scenario 1 assumes that 85% of municipal enrollees would opt for the broad-network PPO plans offered by the GIC; 2% would select an HMO or select hospital network plan; and 13% would enroll in the Indemnity plan. Table 25 displays savings that range from 15.8% (approximately $37.6 million) for the City of Boston to 9.2% (approximately $366,000) for the Town of Marshfield.

TABLE 25 – SCENARIO 1 PREMIUMS ESTIMATE (NON-MEDICARE PLANS)
85% PPO, 2% HMO/Select Network, 13% Indemnity
FY 2010

	Municipality's Percentage Share of Premium	Estimated Municipal Premiums [61]	Estimated GIC Premiums[62]	Estimated Annual Premium Savings	Savings as Percentage of Estimated Municipal Premiums
Boston	82%	$237.9 M	$200.3 M	$37.6 M	15.8%
Cambridge	85%	$38.0 M	$33.6 M	$4.5 M	11.7%
Marshfield	50%	$4.0 M	$3.6 M	$0.37 M	9.2%
Melrose	87%	$9.4 M	$8.0 M	$1.5 M	15.4%

These projected annual premiums savings are based on the GIC premiums that were in effect from July 2009 through January 2010. Since the GIC made mid-year changes to its health benefits and lowered premiums by an average of 5.5%, additional savings would have accrued to these communities over the final five months of FY 2010. The GIC's premiums were reduced, on average, $29 per month for individual coverage and $80 per month for family coverage. Table 26 provides an estimate of the additional savings from this reduction in premiums, as well as each community's estimated net premiums savings for FY 2010.

TABLE 26 – ADDITIONAL SAVINGS FROM GIC's MID-YEAR REDUCTION IN PREMIUMS
SCENARIO 1
FY 2010

	Estimated Annual Premium Savings (from Table 25)	Estimate of Additional Premium Savings (Feb. – June 2010)	Total Estimated Premium Savings	Savings as Percentage of Estimated Municipal Premiums
Boston	$37.6 M	$4.9 M	$42.5 M	17.9%
Cambridge	$4.5 M	$0.8 M	$5.3 M	13.9%
Marshfield	$0.37 M	$0.08 M	$0.45 M	11.4%
Melrose	$1.5 M	$0.2 M	$1.6 M	17.5%

[61] "Estimated Municipal Premiums" represent the municipality's share of the premiums.
[62] GIC premiums based on rates in effect July 2009 through January 2010.

Enrollment Scenario 2

Scenario 2 assumes fewer members would enroll in the PPO plans and more would opt for the Indemnity plan. Potential savings are reduced as membership shifts to the higher cost plans, but the potential premium savings are still considerable. Savings range from 14.1% (approximately $33.6 million) for the City of Boston to 7.3% (roughly $292,000) for the Town of Marshfield.

TABLE 27 – SCENARIO 2 PREMIUMS ESTIMATE (NON-MEDICARE PLANS)
80% PPO, 2% HMO/Select Network, 18% Indemnity
FY 2010

$ in Millions	Estimated Municipal Premiums	Projected GIC Premiums[63]	Estimated Premium Savings	Savings as Percentage of Estimated Municipal Premiums
Boston	$237.9 M	$204.4 M	$33.6 M	14.1%
Cambridge	$38.0 M	$34.2 M	$3.8 M	9.9%
Marshfield	$4.0 M	$3.7 M	$0.29 M	7.3%
Melrose	$9.4 M	$8.1 M	$1.3 M	13.7%

As is the case in the first scenario, these projected annual premiums savings are based on the GIC premiums that were in effect from July 2009 through January 2010. Making an adjustment for the mid-year reduction in the GIC's premiums results in additional savings. Table 28 provides an estimate of the additional savings from this reduction in premiums, as well as each community's estimated net premiums savings for FY 2010.

TABLE 28 – ADDITIONAL SAVINGS FROM GIC's MID-YEAR REDUCTION IN PREMIUMS
SCENARIO 2
FY 2010

	Estimated Annual Premium Savings (from Table 27)	Estimate of Additional Premium Savings (Feb. – June 2010)	Total Estimated Premium Savings	Savings as Percentage of Estimated Municipal Premiums
Boston	$33.6 M	$4.9 M	$38.4 M	16.1%
Cambridge	$3.8 M	$0.8 M	$4.6 M	12.1%
Marshfield	$0.29 M	$0.08 M	$0.38 M	9.5%
Melrose	$1.3 M	$0.2 M	$1.5 M	15.7%

[63] GIC premiums based on rates in effect July 2009 through January 2010.

MEDICARE PLANS' PREMIUMS

Shifting Medicare-eligible retirees into the GIC's Medicare plans will also impact the estimated premium savings for each community. For this analysis, each community's Medicare-eligible retirees are assumed to switch to the GIC's Indemnity Medicare Plan, which currently covers approximately 90% of the GIC's Medicare retirees. Annual health insurance premiums for Medicare coverage under the municipality's Medicare plans are then compared to the estimated cost of coverage under the GIC's Indemnity Medicare Plan. Table 29 displays these results.

TABLE 29 – MEDICARE PLANS PREMIUMS
MUNICIPAL MEDICARE PLANS AND GIC MEDICARE PLANS
FY 2010

$ in Millions	Estimated Municipal Premiums	Projected GIC Premiums	Premium Savings	Savings as Percentage of Estimated Total Premiums
Boston	$27.5 M	$24.6 M	$3.0 M	10.7%
Cambridge	$4.7 M	$5.6 M	-$0.9 M	-18.3%
Marshfield	$0.8 M	$0.7 M	$0.1 M	9.1%
Melrose	$0.9 M	$0.7 M	$0.1 M	16.4%

One interesting finding from this analysis is the estimate that the annual Medicare plans' premiums for Cambridge would be close to $1 million more under GIC coverage than they are under the City's current Medicare plans. This is likely due to the fact that more than 50% of Cambridge's Medicare retirees are enrolled in a Medicare HMO plan, and the premiums for the Medicare HMO plans are considerably lower than the premiums for Medicare Indemnity plans. As noted above, over 90% of GIC Medicare members are enrolled in a Medicare Indemnity plan.

In contrast, a majority of Medicare retirees in the three other communities are enrolled in Medicare Indemnity plans. Table 30 shows the distribution of Medicare membership by plan type (e.g., Indemnity or HMO) for the four communities and for the GIC, as well as the average annual premiums for each type of Medicare plan.

TABLE 30 – DISTRIBUTION OF ENROLLMENT BY PLAN TYPE FOR MEDICARE RETIREES
(BASED ON FY 2009 ENROLLMENT INFORMATION)

	Indemnity		HMO		Other (e.g., PPO, Medicare Supplement)	
	Percentage of Enrollees	Annual Premium	Percentage of Enrollees	Annual Premium	Percentage of Enrollees	Annual Premium
Boston	86%	$4,980	10%	$2,960	4%	$3,912
Cambridge	45%	$3,970	53%	$3,271	2%	$2,108
Marshfield	100%	$4,641	n/a	n/a	n/a	n/a
Melrose	100%	$5,052	n/a	n/a	n/a	n/a
GIC	90%	$4,222	5%	$2,219	5%	$4,054

TOTAL PREMIUMS – GIC AND MUNICIPAL COVERAGE

Combining the estimated premiums for the non-Medicare plans and the Medicare plans provides an estimate of the differences in premiums between GIC coverage and the health plans provided by these four municipalities. Tables 31 – 34 display the potential premium savings that each community could achieve by joining the GIC. These estimates represent the community's share of the premium, and do not include savings to the enrollees that would result from the reduction in premiums.

CITY OF BOSTON

TABLE 31 – CITY OF BOSTON NON-MEDICARE AND MEDICARE PLANS POTENTIAL PREMIUM SAVINGS UNDER GIC COVERAGE FY 2010			
$ in Millions	Current[64] Municipal Coverage	GIC Enrollment Scenario 1 w/mid-year Premium Adjustment	GIC Enrollment Scenario 2 w/mid-year Premium Adjustment
Non-Medicare Plans	$237.9 M	$195.4 M	$199.5 M
Medicare Plans	$27.5 M	$24.6 M	$24.6 M
Total	$265.5 M	$220.0 M	$224.1 M
$ Savings		**$45.4 M**	**$41.4 M**
% Savings		**17.1%**	**15.6%**

CITY OF CAMBRIDGE

TABLE 32 – CITY OF CAMBRIDGE NON-MEDICARE AND MEDICARE PLANS POTENTIAL PREMIUM SAVINGS UNDER GIC COVERAGE FY 2010			
$ in Millions	Current Municipal Coverage	GIC Enrollment Scenario 1 w/mid-year Premium Adjustment	GIC Enrollment Scenario 2 w/mid-year Premium Adjustment
Non-Medicare Plans	$38.0 M	$32.7 M	$33.4 M
Medicare Plans	$4.7 M	$5.6 M	$5.6 M
Total	$42.7 M	$38.3 M	$39.0 M
$ Savings		**$4.4 M**	**$3.7 M**
% Savings		**10.3%**	**8.7%**

[64] As discussed earlier in this section, the premiums for the City of Boston have been adjusted to account for the pending elimination of the Master Medical Indemnity Plan and the Medicare requirement (Section 18 of Chapter 32B) that is required of all cities and towns that wish to join the GIC.

Town of Marshfield

TABLE 33 – TOWN OF MARSHFIELD NON-MEDICARE AND MEDICARE PLANS POTENTIAL PREMIUM SAVINGS UNDER GIC COVERAGE FY 2010			
$ in Millions	Current Municipal Coverage	GIC Enrollment Scenario 1 w/mid-year Premium Adjustment	GIC Enrollment Scenario 2 w/mid-year Premium Adjustment
Non-Medicare Plans	$3.99 M	$3.53 M	$3.61 M
Medicare Plans	$0.81 M	$0.73 M	$0.73 M
Total	$4.79 M	$4.26 M	$4.34 M
$ Savings		**$0.53 M**	**$0.45 M**
% Savings		**11.0%**	**9.4%**

City of Melrose

TABLE 34 – CITY OF MELROSE NON-MEDICARE AND MEDICARE PLANS POTENTIAL PREMIUM SAVINGS UNDER GIC COVERAGE FY 2010			
$ in Millions	Current Municipal Coverage[65]	GIC Enrollment Scenario 1 w/mid-year Premium Adjustment	GIC Enrollment Scenario 2 w/mid-year Premium Adjustment
Non-Medicare Plans	$9.4 M	$7.8 M	$7.9 M
Medicare Plans	$0.9 M	$0.7 M	$0.7 M
Total	$10.3 M	$8.5 M	$8.7 M
$ Savings		**$1.8 M**	**$1.6 M**
% Savings		**17.4%**	**15.8%**

Impact on Enrollees

With higher point-of-service cost sharing in the health plans offered by the GIC, members that use more medical services would likely pay more out-of-pocket under the GIC's plans than they do under their current municipal health benefits. However, lower premiums for the GIC plans would offset, either in whole or in part, the higher out-of-pocket costs.

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[65] Because Melrose joined the GIC effective July 1, 2010, the premiums included in this table under "Current Municipal Coverage" reflect the City's FY 2009 health insurance costs.

To evaluate the potential differences in members' total costs between municipal coverage and GIC coverage, a quantitative analysis using six hypothetical employees was conducted to estimate the differences in member costs, including members' share of the premiums and their potential out-of-pocket expenses when accessing medical care (e.g., physician's office visits, inpatient admissions, prescription drugs).

Details of these analyses, which were conducted for all four municipalities, can be found in the *Appendix* to this report, and a description of the manner used to develop these estimates can be found in the *Methodology* section.

Members that use fewer medical services (i.e., "low utilizers") are likely to benefit financially from a switch to the GIC health plans because of the lower GIC health plan premiums, which offset the higher point-of-service cost sharing. However, members with greater health care needs would likely pay more under a GIC plan than they pay under their current municipal coverage. This is particularly true for members with significant health care needs.

A member's total costs (i.e., premium and point-of-service cost sharing) depend in part on the percentage of premium paid by the member (i.e., the employee's share of the premium), as well as the health plan selected. For employees of communities that require employees and retirees to pay a greater percentage of the monthly premium, the higher point-of-service cost sharing in the GIC plans is offset, in whole or in part, by lower premiums.

For example, Marshfield employees pay 50% of the monthly premium. As a result, for most Marshfield employees the lower GIC premiums would likely offset any increase in point-of-service cost sharing, and employees would likely see a reduction in their total health care expenses.

**TABLE 35 – TOWN OF MARSHFIELD AND GIC
ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS
INDIVIDUAL COVERAGE
LOW AND MODERATE UTILIZERS OF HEALTH BENEFITS**

	Member's Share of Premium (50%)	Low Utilizer		Moderate Utilizer	
		Cost Sharing Estimate	Total Cost Estimate	Cost Sharing Estimate	Total Cost Estimate
Marshfield Health Plans					
BCBSMA HMO	$3,234	$60	**$3,294**	$200	**$3,434**
HPHC HMO	$3,432	$50	**$3,482**	$210	**$3,642**
BCBSMA PPO	$4,572	$80	**$4,652**	$285	**$4,857**
GIC Health Plans (effective February 2010)					
NHP HMO	$2,352	$465	**$2,817**	$1,060	**$3,412**
UniCare Community Choice PPO	$2,310	$475	**$2,785**	$1,060	**$3,370**
HPHC PPO	$2,954	$495	**$3,449**	$1,335	**$4,289**
UniCare Indemnity	$4,416	$475	**$4,891**	$1,010	**$5,426**

Tables 35 and 36 provide estimates of the Marshfield member's share of the premium, the point-of-service cost sharing for "low and moderate utilizers" of health benefits, and the member's total cost.

TABLE 36 – TOWN OF MARSHFIELD AND GIC ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS FAMILY COVERAGE LOW AND MODERATE UTILIZERS OF HEALTH BENEFITS					
	Member's Share of Premium (50%)	Low Utilizer		Moderate Utilizer	
		Cost Sharing Estimate	Total Cost Estimate	Cost Sharing Estimate	Total Cost Estimate
Marshfield Health Plans					
BCBSMA HMO	$8,640	$185	**$8,825**	$385	**$9,025**
HPHC HMO	$9,162	$195	**$9,357**	$390	**$9,552**
BCBSMA PPO	$10,836	$260	**$11,096**	$525	**$11,361**
GIC Health Plans (effective February 2010)					
NHP HMO	$6,165	$755	**$6,920**	$1,905	**$8,070**
UniCare Community Choice PPO	$5,490	$770	**$6,260**	$1,920	**$7,410**
HPHC PPO	$7,062	$775	**$7,837**	$2,415	**$9,477**
UniCare Indemnity	$10,258	$770	**$11,028**	$1,820	**$12,078**

By comparison, Cambridge and Boston employees – who contribute approximately 15% of the premium – might experience a slight increase in their share of total health care costs (i.e., premiums and point-of-service cost sharing).

TABLE 37 – BOSTON, CAMBRIDGE AND GIC ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS INDIVIDUAL COVERAGE LOW AND MODERATE UTILIZERS OF HEALTH BENEFITS					
	Member's Share of Premium (15%)	Low Utilizer		Moderate Utilizer	
		Cost Sharing Estimate	Total Cost Estimate	Cost Sharing Estimate	Total Cost Estimate
Boston Health Plans					
HPHC HMO	$1,030	$45	**$1,075**	$170	**$1,200**
Cambridge Health Plans					
BCBSMA POS	$1,301	$90	**$1,391**	$345	**$1,646**
BCBSMA HMO	$913	$90	**$1,003**	$345	**$1,258**
GIC Health Plans (effective February 2010)					
NHP HMO	$706	$465	**$1,171**	$1,060	**$1,766**
UniCare Community Choice PPO	$693	$475	**$1,168**	$1,060	**$1,753**
HPHC PPO	$886	$495	**$1,381**	$1,335	**$2,221**
UniCare Indemnity	$1,325	$475	**$1,800**	$1,010	**$2,335**

Tables 37 and 38 provide estimates of the Boston and Cambridge member's share of the premium, the point-of-service cost sharing for "low and moderate utilizers" of health benefits, and the total cost to the member for the most popular plans offered by Boston, Cambridge and for a representative sample of GIC plans.

TABLE 38 – BOSTON, CAMBRIDGE AND GIC
ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS
FAMILY COVERAGE
LOW AND MODERATE UTILIZERS OF HEALTH BENEFITS

	Member's Share of Premium (15%)	Low Utilizer		Moderate Utilizer	
		Cost Sharing Estimate	Total Cost Estimate	Cost Sharing Estimate	Total Cost Estimate
Boston Health Plans					
HPHC HMO	$2,768	$155	**$2,923**	$310	**$3,078**
Cambridge Health Plans					
BCBSMA POS	$3,318	$320	**$3,638**	$645	**$3,963**
BCBSMA HMO	$2,338	$320	**$2,484**	$645	**$2,983**
GIC Health Plans (effective February 2010)					
NHP HMO	$1,849	$755	**$2,604**	$1,905	**$3,754**
UniCare Community Choice PPO	$1,647	$770	**$2,417**	$1,920	**$3,567**
HPHC PPO	$2,119	$775	**$2,894**	$2,415	**$4,534**
UniCare Indemnity	$3,077	$770	**$3,847**	$1,820	**$4,897**

As these tables show, Cambridge and Boston employees and retirees with "moderate" health care needs would experience a slight increase in their health care costs due to higher point-of-service cost sharing in the GIC plans.

Members with significant health care needs could see their out-of-pocket expenses climb by two-to-three thousand dollars, particularly for employees with family coverage that experience multiple inpatient admissions over the course of the year. While the vast majority of members are in the "low and moderate utilizer" category, a minority of individuals and families might need greater levels of care and would pay more out of pocket under GIC coverage than under their current municipal health plans.

Tables 39 and 40 provide estimates of the member's share of the premium, the point-of-service cost sharing for "high utilizers" of health benefits, and the total cost to the member for the most popular plans offered by Boston, Cambridge and for a representative sample of GIC plans.

TABLE 39 – BOSTON, CAMBRIDGE AND GIC ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS INDIVIDUAL COVERAGE HIGH UTILIZERS OF HEALTH BENEFITS			
	Members' Share of Premium (15%)	Cost Sharing Estimate	Total Cost Estimate
Boston Health Plans			
HPHC HMO	$1,030	$660	**$1,690**
Cambridge Health Plans			
BCBSMA POS	$1,301	$1,365	**$2,666**
BCBSMA HMO	$913	$1,365	**$2,278**
GIC Health Plans (effective February 2010)			
NHP HMO	$706	$3,045	**$3,751**
UniCare Community Choice PPO	$693	$3,000	**$3,693**
HPHC PPO	$886	$3,885	**$4,771**
UniCare Indemnity	$1,325	$2,850	**$4,175**

TABLE 40 – BOSTON, CAMBRIDGE AND GIC ANNUAL PREMIUMS AND ESTIMATED OUT-OF-POCKET COSTS FAMILY COVERAGE HIGH UTILIZERS OF HEALTH BENEFITS			
	Members' Share of Premium (15%)	Cost Sharing Estimate	Total Cost Estimate
Boston Health Plans			
HPHC HMO	$2,768	$1,290	**$4,058**
Cambridge Health Plans			
BCBSMA POS	$3,318	$2,655	**$5,973**
BCBSMA HMO	$2,338	$2,655	**$4,993**
GIC Health Plans (effective February 2010)			
NHP HMO	$1,849	$6,020	**$7,869**
UniCare Community Choice PPO	$1,647	$5,930	**$7,577**
HPHC PPO	$2,119	$7,620	**$9,739**
UniCare Indemnity	$3,077	$5,630	**$8,707**

VIII. Recommendations

1. Level the playing field between state and local health benefits management by removing the requirement that municipal officials must collectively bargain plan design changes

Removing the statutory provision that requires local governments to collectively bargain the health benefits provided to employees and retirees would provide municipalities with the ability to adjust plan designs and better control their health insurance premiums; while still providing employees and retirees with comprehensive health benefits, comparable to those provided to state employees and retirees by the GIC; and comparable to the health benefits provided to millions of federal government workers, as well as private-sector employees.

2. Bring the health benefits provided to municipal employees into line with the health benefits offered state employees and retirees

The health benefits offered by these municipalities are among the most generous offered by any employer, public or private, in the Commonwealth. The health benefits provided to these employees and retirees include no point-of-service cost sharing for inpatient care, high-tech imaging and outpatient surgery. Even for the few services that include point-of-service cost sharing, the share of the cost paid by these members is, in most instances, lower than other employers' plans.

This anomaly in benefits design runs counter to the trend toward more point-of-service cost sharing, which is used not only to reduce premiums but also to engage members so that they moderate their use of more expensive services, supplies and pharmaceuticals.

Modest changes in cost sharing can save these cities and towns millions of dollars. Even Commonwealth Care – a publicly subsidized health insurance program for lower-income adults without access to employer-sponsored insurance – has higher member cost sharing than these municipal plans.

Greater savings could be achieved if the health benefits offered to municipal employees were brought into line with benefits offered to over 120,000 Massachusetts workers covered by the federal government's employee health benefits plan (FEHBP). Table 41 compares the typical municipal plans' cost sharing to Commonwealth Care, the GIC's Harvard Pilgrim Health Care PPO plan, and the FEHBP's PPO plan.

TABLE 41 – COST SHARING SUMMARY BOSTON'S HPHC HMO, GIC'S HPHC PPO, COMMONWEALTH CARE and FEHBP PPO FY 2010					
	BOSTON HPHC HMO	GIC HPHC PPO[66]	COMM CARE PLAN TYPE 3[67]	FEHBP Standard PPO Plan	
				Preferred Provider	Participating Providers
Deductible	None	$250[68]	None	$300 (individual)/$600 (family)	
PCP Office Visit	$10	$20	$15	$20	30%
Specialist Office Visit					
Tier 1	$10	$20	$22	n/a	30%
Tier 2	n/a	$35	n/a	n/a	n/a
Tier 3	n/a	$45	n/a	n/a	n/a
Hospital Inpatient Admission[69]					
Tier 1	None	$250	$250	$200 + 15%	$300 + 30%
Tier 2	n/a	$500	n/a	n/a	n/a
Tier 3	n/a	$750	n/a	n/a	n/a
Outpatient Surgery[70]	None	$150	$125	15%	30%
Radiology	None	$100	None	15%	30%
ER Visit[71]	$30	$100	$100	15%	30%
Prescription Drugs – Retail (30 days supply)					
Tier 1	$5	$10	$12.50	$20	20%
Tier 2	$10	$25	$25	30%	30%
Tier 3	$25	$50	$50	30%	30%
Out-of-Pocket Max	None	None	$2,300	$5,000	

[66] Cost sharing for GIC's HPHC PPO Plans is based on plan design changes that took effect February 1, 2010.
[67] Commonwealth Care Plan Type 3 is the health coverage offered by the Commonwealth Health Insurance Connector Authority to adult residents with annual income between $44,100 and $66,150 (200-300% FPL).
[68] Deductible does not apply to office visits, mental health and substance abuse services, and prescription drugs.
[69] GIC plans limit the co-payments for inpatient admissions to no more than four per person per year. If a member is admitted to the hospital five or more times in a year, there is no additional member cost sharing.
[70] GIC plans limit the co-payments for outpatient surgery to a maximum of four per person per year. If a member has five or more outpatient surgeries, there is no additional member cost sharing.
[71] Emergency Room co-payments are waived if the individual is admitted to the hospital.

3. **Require all municipal retirees who are eligible for Medicare to enroll in Medicare Part B as a precondition for receiving health benefits from the municipality**

The unwillingness of some municipalities to shift their Medicare-eligible retirees into Medicare costs state and local taxpayers tens of millions of dollars every year. Since 1993, the state has required retirees to enroll in Medicare in order to receive supplemental coverage from the GIC. However, municipalities are not required to do so, although many communities have adopted this cost-saving measure.

State retirees covered by Medicare – who also received supplemental health coverage from the GIC – are offered a range of plans to choose from, all of which have lower point-of-service cost sharing than the plans offered active employees and non-Medicare retirees.

It is hardly a coincidence that the two communities with the highest health insurance costs – Boston and Melrose – had not adopted Section 18 of Ch. 32B (Medicare Part B requirement) during the period of this study. Not taking advantage of this federally-subsidized health insurance program, which covers millions of retirees across the country, unnecessarily drives up the cost of health insurance for these communities, as well as their employees and retirees.

4. **Adopt a premium contribution strategy that incents members to select more cost-effective health plans**

Municipalities that offer their employees and retirees a choice of health plans should adopt a premium contribution strategy that encourages members to select more cost-effective plans. For example, the City of Boston pays 85% of the premium for the HMO plans, 80% for the Harvard Pilgrim POS plans, and 75% for all other plans (i.e., POS, PPO and indemnity plans). This strategy helps drive members into the more cost-effective HMO plans.

Using a contribution strategy in which the member pays a fixed percentage of the premium across all plan types masks the real cost differences between plans. If the community is picking up 85% of the premium for all plans, there is little incentive for a member to select a lower cost plan, since his or her employer pays for the majority of the difference in premiums.

A more cost-effective and transparent contribution strategy that encourages employees and retirees to consider the cost of health insurance – and the difference in premiums across plans – would cap the community's share of the premium at the amount that the community contributes for the lower-cost plans. Employees and retirees who opt for higher-priced plans would then be responsible for paying the full difference in the premium for the higher-priced plan.

5. As point-of-service cost sharing increases, limit members' financial exposure by putting in place an out-of-pocket maximum or funding a Health Reimbursement Account (HRA)

While increasing point-of-service cost sharing offsets the growth in premiums and can be used effectively to incent members to moderate their use of certain discretionary services, employers should be mindful of the impact of higher point-of-service cost sharing on members with significant health care needs. As noted in the section on the impact of higher cost sharing on "high utilizers," point-of-service cost sharing can become a financial burden for some individuals and families. As cost sharing is increased, employers should consider adopting plan designs that limit a member's out-of-pocket costs.

The GIC does this by placing service specific limits on the collection of co-payments for inpatient hospitalization and outpatient surgery. Co-payments for inpatient admissions and outpatient surgeries are limited to four per year per person, which limits a member's expenses. Other health plans place overall limits on the member's out-of-pocket costs.

Another option, and one that some communities have adopted, is to fund a Health Reimbursement Account (HRA), which can be used to offset a member's out-of-pocket costs. However, because an HRA can undermine the impact that cost sharing can have on members' use of certain "discretionary" services (e.g., brand name drugs when a generic is available, high-tech imaging, etc.), the HRA might be structured to cover only certain higher-cost services (e.g., inpatient hospitalizations).

Appendix

Out-of-Pocket Analysis – Six Hypothetical Employees

To quantify the potential financial impact that switching to the GIC's health plans may have on each community's members – taking into account premiums and point-of-service cost-sharing – an estimate of the total health care expenses for six different employees was calculated for each health plan and for each community. The hypothetical employees – three individual policyholders and three family policyholders – were assumed to have different levels of medical service utilization (low, moderate, and high). These six hypothetical cases were developed in order to estimate the potential financial exposure depending on different medical needs of enrollees.

To provide some context for the service utilization estimates, in a given year six-to-eight percent (6%-8%) of the population will be admitted to a hospital for inpatient care. For some populations that percentage can be closer to 10% while for other groups it can be less than five percent (5%). Approximately 60% of insured individuals incur less than $1,000 in medical and prescription drug claims. And, fewer than five percent (5%) have medical and prescription drug claims that exceed $5,000. The vast majority of these costs would be covered by health insurance.

Although some members will not utilize any health services and therefore have no out-of-pocket expenses beyond their share of the monthly premium, a small minority of individuals or families may experience a series of hospitalizations, outpatient procedures, physician's office visits, and may need to fill a number of prescription drugs to treat a variety of ailments and chronic conditions. For the "high utilizers" in this analysis, very high service utilization is used to portray an extreme situation. While it certainly would be an anomaly for an individual or family to utilize so many services in a single year (e.g., six inpatient admissions, four outpatient surgical procedures, 42 physicians' office visits, and 80 prescriptions), the model used for this analysis seeks to demonstrate a severe case to account for the rare outlier.

This analysis is designed to illustrate the potential cost differences between each municipality's health plans and the GIC's health plans. It is intended to capture the differences in cost sharing, in an effort to quantify the potential impact on enrollees, depending on their use of medical services. It is illustrative and should not be construed to demonstrate the financial exposure for all enrollees, but rather is an attempt to provide some indication of the impact of cost-sharing on members' total costs. Table 42 shows the service frequencies used for each of the six scenarios.

For example, over the course of a year, the "moderate utilizer" with a family policy (column highlighted in the table below) will experience two inpatient admissions, one outpatient surgery, two ER visits, six office visits to primary care physicians, three office visits to specialists, 14 tier 1 (generic) drugs, four tier 2 (preferred brand-name) drugs, and two tier 3 (non-preferred brand-name) drugs. For each case, the member cost sharing for each service is quantified, the annual premiums for each plan and rate basis type (i.e., individual or family policy) are added, and the total member costs are calculated.

Because the Commission altered plan designs – including the addition of a deductible, increases in some co-payments, and a reduction in premiums – this analysis is based on the plan designs and premiums in effect on February 1, 2010. All of the calculations are based on a full year of coverage.

TABLE 42 – UTILIZATION ANALYSIS FREQUENCY OF SERVICES BY TYPE OF UTILIZER INDIVUDAL AND FAMILY POLICYHOLDERS						
	Individual Policy			Family Policy		
	Frequency of Service Per Year					
Service	Low	Moderate	High	Low	Moderate	High
Deductible	1	1	1	1	2	3
Inpatient Admission	0	1	3	0	2	6
Outpatient Surgery	1	1	3	1	1	4
ER Visit	0	1	2	1	2	3
PCP Office Visit	2	3	6	4	6	12
Specialist Office Visit	0	3	15	1	3	30
Rx – Tier 1	3	7	24	6	14	48
Rx – Tier 2	1	2	12	2	4	24
Rx – Tier 3	0	1	6	1	2	12

TABLE 43 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR INDIVIDUAL POLICYHOLDERS CITY OF BOSTON COMPARED TO THE GIC

	Member's Annual Share of Premium $ (%)	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Boston Health Plans							
BCBSMA Preferred PPO	$2,991 (25%)	$85	$3,076	$305	$3,296	$1,225	$4,216
BCBSMA Blue Choice POS	$2,151 (25%)	$45	$2,196	$170	$2,321	$660	$2,811
HPHC POS	$1,464 (20%)	$45	$1,509	$170	$1,634	$660	$2,124
HPHC HMO	$1,030 (15%)	$45	$1,075	$170	$1,200	$660	$1,690
Neighborhood HMO	$1,010 (15%)	$45	**$1,055**	$165	**$1,175**	$650	**$1,660**
BCBSMA Master Medical	$3,786 (25%)	$132	**$3,918**	$353	**$3,786**	$1,000	**$4,786**
Group Insurance Commission Plans							
Fallon Direct Care HMO	$690 (15%)	$445	**$1,135**	$950	**$1,640**	$2,685	**$3,375**
Fallon Select Care HMO	$825(15%)	$470	$1,295	$1,060	$1,885	$3,060	$3,885
Neighborhood Health Plan HMO	$706 (15%)	$465	$1,171	$1,060	$1,766	$3,045	$3,751
UniCare Community Choice	$693 (15%)	$475	$1,168	$1,060	$1,753	$3,000	$3,693
Tufts Navigator PPO	$1,184 (20%)	$495	$1,679	$1,135	$2,319	$3,285	$4,469
HPHC Independence PPO	$1,182 (20%)	$495	$1,677	$1,335	$2,517	$3,885	**$5,067**
UniCare PLUS PPO	$1,215 (20%)	$475	$1,690	$1,310	$2,525	$3,750	$4,965
UniCare Indemnity Basic w/CIC	$2,208 (25%)	$475	**$2,683**	$1,010	**$3,218**	$2,850	$5,058

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 44 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR FAMILY POLICYHOLDERS CITY OF BOSTON COMPARED TO THE GIC

	Member's Annual Share of Premium $ (%)	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Boston Health Plans							
BCBSMA Preferred PPO	$6,936 (25%)	$280	$7,216	$565	$7,501	$2,400	$9,336
BCBSMA Blue Choice POS	$5,547 (25%)	$155	$5,702	$310	$5,857	$1,290	$6,837
HPHC POS	$3,936 (20%)	$155	$4,091	$310	$4,246	$1,290	$5,226
HPHC HMO	$2,768 (15%)	$155	$2,923	$310	$3,078	$1,290	$4,058
Neighborhood HMO	$2,675 (15%)	$150	**$2,825**	$300	**$2,975**	$1,275	**$3,950**
BCBSMA Master Medical	$8,781 (25%)	$344	**$9,125**	$770	**$9,551**	$2,000	**$10,781**
Group Insurance Commission Plans							
Fallon Direct Care HMO	$1,638 (15%)	$705	**$2,343**	$1,715	**$3,353**	$5,300	**$6,938**
Fallon Select Care HMO	$1,963 (15%)	$750	$2,713	$1,890	$3,853	$6,020	$7,983
Neighborhood Health Plan HMO	$1,849 (15%)	$755	$2,604	$1,905	$3,754	$6,020	$7,896
UniCare Community Choice	$1,647 (15%)	$770	$2,417	$1,920	$3,567	$5,930	$7,577
Tufts Navigator PPO	$2,829 (20%)	$775	$3,604	$2,015	$4,844	$6,420	$9,249
HPHC Independence PPO	$2,825 (20%)	$775	$3,600	$2,415	$5,240	$7,620	$10,445
UniCare PLUS PPO	$2,876 (20%)	$770	$3,646	$2,420	$5,296	$7,430	$10,306
UniCare Indemnity Basic w/CIC	$5,129 (25%)	$770	**$5,899**	$1,820	**$6,949**	$5,630	**$10,759**

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 45 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR INDIVIDUAL POLICYHOLDERS
CITY OF CAMBRIDGE COMPARED TO THE GIC

	Member's Annual Share of Premium 15%	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Cambridge Health Plans							
BCBSMA Blue Choice POS	$1,301	$90	**$1,391**	$345	**$1,646**	$1,365	**$2,666**
BCBSMA HMO Blue	$913	$90	$1,003	$345	$1,258	$1,365	$2,278
HPHC HMO	$801	$90	**$891**	$345	**$1,146**	$1,365	**$2,166**
Tufts Health Plan EPO	$987	$90	$1,077	$345	$1,332	$1,365	$2,352
Group Insurance Commission Plans							
Fallon Direct Care HMO	$690	$445	**$1,135**	$950	**$1,640**	$2,685	**$3,375**
Fallon Select Care HMO	$825	$470	$1,295	$1,060	$1,885	$3,060	$3,885
Neighborhood Health Plan HMO	$706	$465	$1,171	$1,060	$1,766	$3,045	$3,751
UniCare Community Choice PPO (Select Network)	$693	$475	$1,168	$1,060	$1,753	$3,000	$3,693
Tufts Navigator PPO	$888	$495	$1,383	$1,135	$2,023	$3,285	$4,173
HPHC Independence PPO	$886	$495	$1,381	$1,335	$2,221	$3,885	**$4,771**
UniCare PLUS PPO	$911	$475	$1,386	$1,310	$2,221	$3,750	$4,661
UniCare Indemnity Basic w/CIC	$1,325	$475	**$1,800**	$1,010	**$2,335**	$2,850	$4,175

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 46 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR FAMILY POLICYHOLDERS
CITY OF CAMBRIDGE COMPARED TO THE GIC

	Member's Annual Share of Premium 15%	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Cambridge Health Plans							
BCBSMA Blue Choice POS	$3,318	$320	**$3,638**	$645	**$3,963**	$2,655	**$5,973**
BCBSMA HMO Blue	$2,338	$320	$2,658	$645	$2,983	$2,655	$4,993
HPHC HMO	$2,164	$320	**$2,484**	$645	**$2,809**	$2,655	**$4,819**
Tufts Health Plan EPO	$2,680	$320	$3,000	$645	$3,325	$2,655	$5,335
Group Insurance Commission Plans							
Fallon Direct Care HMO	$1,638	$705	**$2,343**	$1,715	**$3,353**	$5,300	**$6,938**
Fallon Select Care HMO	$1,963	$750	$2,713	$1,890	$3,853	$6,020	$7,983
Neighborhood Health Plan HMO	$1,849	$755	$2,604	$1,905	$3,754	$6,020	$7,869
UniCare Community Choice PPO (Select Network)	$1,647	$770	$2,417	$1,920	$3,567	$5,930	$7,577
Tufts Navigator PPO	$2,121	$775	$2,896	$2,015	$4,136	$6,420	$8,541
HPHC Independence PPO	$2,119	$775	$2,894	$2,415	$4,534	$7,620	**$9,739**
UniCare PLUS PPO	$2,157	$770	$2,927	$2,420	$4,577	$7,430	$9,587
UniCare Indemnity Basic w/CIC	$3,077	$770	**$3,847**	$1,820	**$4,897**	$5,630	$8,707

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 47 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR INDIVIDUAL POLICYHOLDERS TOWN OF MARSHFIELD COMPARED TO THE GIC

	Member's Annual Share of Premium 50%	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Marshfield Health Plans							
BCBSMA Network Blue HMO	$3,234	$60	**$3,294**	$200	**$3,434**	$845	**$4,079**
HPHC HMO	$3,432	$50	$3,482	$210	$3,642	$820	$4,252
BCBSMA Blue Care Elect PPO	$4,572	$80	**$4,652**	$285	**$4,857**	$1,105	**$5,677**
BCBSMA Network Blue Rate Saver HMO	$3,072	$245	$3,317	$760	$3,832	$2,580	$5,652
HPHC Rate Saver HMO	$3,246	$195	$3,441	$705	$3,951	$2,400	$5,646
Group Insurance Commission Plans							
Fallon Direct Care HMO	$2,300	$445	**$2,745**	$950	**$3,250**	$2,685	**$4,985**
Fallon Select Care HMO	$2,750	$470	$3,220	$1,060	$3,810	$3,060	$5,810
Neighborhood Health Plan HMO	$2,352	$465	$2,817	$1,060	$3,412	$3,045	$5,397
UniCare Community Choice PPO (Select Network)	$2,310	$475	$2,785	$1,060	$3,370	$3,000	$5,310
Tufts Navigator PPO	$2,959	$495	$3,454	$1,135	$4,094	$3,285	$6,244
HPHC Independence PPO	$2,954	$495	$3,449	$1,335	$4,289	$3,885	$6,839
UniCare PLUS PPO	$3,036	$475	$3,511	$1,310	$4,346	$3,750	$6,786
UniCare Indemnity Basic w/CIC	$4,416	$475	**$4,891**	$1,010	**$5,426**	$2,850	**$7,266**

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 48 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR FAMILY POLICYHOLDERS TOWN OF MARSHFIELD COMPARED TO THE GIC

	Member's Annual Share of Premium 50%	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Marshfield Health Plans							
BCBSMA Network Blue HMO	$8,640	$185	$8,825	$385	**$9,025**	$1,655	**$10,305**
HPHC HMO	$9,162	$195	$9,357	$390	$9,552	$1,590	$10,752
BCBSMA Blue Care Elect PPO	$10,836	$260	**$11,096**	$525	$11,361	$2,160	$12,996
BCBSMA Network Blue Rate Saver HMO	$8,208	$480	**$8,688**	$1,310	$9,518	$4,785	$12,993
HPHC Rate Saver HMO	$8,658	$425	$9,083	$1,250	$9,908	$4,525	**$13,183**
Group Insurance Commission Plans							
Fallon Direct Care HMO	$5,461	$705	**$6,166**	$1,715	**$7,176**	$5,300	**$10,761**
Fallon Select Care HMO	$6,542	$750	$7,292	$1,890	$8,432	$6,020	$12,562
Neighborhood Health Plan HMO	$6,165	$755	$6,920	$1,905	$8,070	$6,020	$12,185
UniCare Community Choice PPO (Select Network)	$5,490	$770	$6,260	$1,920	$7,410	$5,930	$11,420
Tufts Navigator PPO	$7,072	$775	$7,847	$2,015	$9,087	$6,420	$13,492
HPHC Independence PPO	$7,062	$775	$7,837	$2,415	$9,477	$7,620	$14,682
UniCare PLUS PPO	$7,190	$770	$7,960	$2,420	$9,610	$7,430	$14,620
UniCare Indemnity Basic w/CIC	$10,258	$770	**$11,028**	$1,820	**$12,078**	$5,630	**$15,888**

Bolded items are the highest and lowest cost plans under each scenario for GIC and municipal plans.

TABLE 49 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR INDIVIDUAL POLICYHOLDERS
CITY OF MELROSE COMPARED TO THE GIC

	Member's Annual Share of Premium $ (%)	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Melrose Health Plans (FY 2009)							
BCBSMA Network Blue HMO	$1,307 (13%)	$80	$1,387	$265	$1,572	$1,030	$2,337
BCBSMA Master Medical Indemnity	$4,718 (40%)	$650	$5,268	$1,395	$6,113	$1,940	$6,658
Group Insurance Commission Plans (FY 2010)							
Fallon Direct Care HMO	$598 (13%)	$445	**$1,043**	$950	**$1,548**	$2,685	**$3,283**
Fallon Select Care HMO	$715 (13%)	$470	$1,185	$1,060	$1,775	$3,060	$3,775
Neighborhood Health Plan HMO	$612 (13%)	$465	$1,077	$1,060	$1,672	$3,045	$3,657
UniCare Community Choice PPO (Select Network)	$601 (13%)	$475	$1,076	$1,060	$1,661	$3,000	$3,601
Tufts Navigator PPO	$769 (13%)	$495	$1,264	$1,135	$1,904	$3,285	$4,054
HPHC Independence PPO	$768 (13%)	$495	$1,263	$1,335	$2,103	$3,885	$4,653
UniCare PLUS PPO	$789 (13%)	$475	$1,264	$1,310	$2,099	$3,750	$4,539
UniCare Indemnity Basic w/CIC	$3,533 (40%)	$475	**$4,008**	$1,010	**$4,543**	$2,850	**$6,383**

Bolded items are the highest and lowest cost GIC plans under each scenario.

TABLE 50 – ESTIMATED OUT-OF-POCKET AND PREMIUM COSTS FOR FAMILY POLICYHOLDERS
CITY OF MELROSE COMPARED TO THE GIC

	Member's Annual Share of Premium $ (%)	Low Utilizer		Moderate Utilizer		High Utilizer	
		Cost Sharing	Total Cost	Cost Sharing	Total Cost	Cost Sharing	Total Cost
Melrose Health Plans (FY 2009)							
BCBSMA Network Blue HMO	$3,486 (13%)	$245	$3,731	$490	$3,976	$1,990	$5,476
BCBSMA Master Medical Indemnity	$11,803 (40%)	$1,175	$12,978	$2,790	$14,593	$3,880	$15,683
Group Insurance Commission Plans (FY 2010)							
Fallon Direct Care HMO	$1,420 (13%)	$705	**$2,125**	$1,715	**$3,135**	$5,300	**$6,720**
Fallon Select Care HMO	$1,701 (13%)	$750	$2,451	$1,890	$3,591	$6,020	$7,721
Neighborhood Health Plan HMO	$1,603 (13%)	$755	$2,358	$1,905	$3,508	$6,020	$7,623
UniCare Community Choice PPO (Select Network)	$1,427 (13%)	$770	$2,197	$1,920	$3,347	$5,930	$7,357
Tufts Navigator PPO	$1,839 (13%)	$775	$2,614	$2,015	$3,854	$6,420	$8,259
HPHC Independence PPO	$1,836 (13%)	$775	$2,611	$2,415	$4,251	$7,620	$9,456
UniCare PLUS PPO	$1,869 (13%)	$770	$2,639	$2,420	$4,289	$7,430	$9,299
UniCare Indemnity Basic w/CIC	$8,206 (40%)	$770	**$8,976**	$1,820	**$10,026**	$5,630	**$13,836**

Bolded items are the highest and lowest cost GIC plans under each scenario.

Local and Regional Governmental Units Participating in the Group Insurance Commission

Cities
Melrose (effective 7/1/2009)
Quincy (effective 7/1/2009)
Pittsfield (effective 7/1/2009)
Springfield (effective 1/1/2007)

Towns
Brookline (effective 7/1/2010)
Groveland (effective 7/1/2008)
Holbrook (effective 7/1/2008)
Hopedale (effective 7/1/2010)
Millis (effective 7/1/2008)
Norwood (effective 7/1/2009)
Randolph (effective 7/1/2009)
Saugus (effective 1/1/2008)
Stoneham (effective 7/1/2009)
Swampscott (effective 7/1/2009)
Watertown (effective 7/1/2009)
Wenham (effective 7/1/2009)
Weston (effective 7/1/2009)
Weymouth (effective 7/1/2009)
Winthrop (effective 7/1/2008)

School Districts
Athol-Roylston School District (effective 7/1/2008)
Blue Hills Vocational School District (effective 7/1/2009)
Gill-Montague Regional School District (effective 7/1/2008)
Groton-Dunstable Regional School District (effective 7/1/2009)
Hawlemont Regional School District (effective 7/1/2008)
Mohawk Trail Regional School District (effective 7/1/2008)
Wachusett Regional School District (effective 7/1/2010)

Charter Schools and Planning Councils
Merrimack Valley Planning Commission (effective 7/1/2010)
Old Colony Planning Council (effective 7/1/2008)
Pioneer Valley Planning Commission (effective 7/1/2009)
Southeastern Regional Planning and Economic Development District (effective 7/1/2008)