JOINT ACTON BOARD of SELECTMEN, ACTON PUBLIC and ACTON-BOXBOROUGH REGIONAL SCHOOL COMMITTEE MEETING

Auditorium
R.J. Grey Junior High

November 3, 2011
7:00 pm Joint Board of Selectmen, APS & ABRSC Meeting
8:00 p.m. Joint School Committee Meeting
AB Regional SC Meeting to follow

AGENDA

1.0 JT APS/AB SC CALL TO ORDER (with Acton Board of Selectmen)

2.0 CHAIRMAN'S INTRODUCTION

3.0 MUNICIPAL HEALTH CARE REFORM PRESENTATION

Bob Evans, Chairman of the Health Insurance Trust

3.1 Discussion of Segal Report by Joint School Committee and Acton BOS
- 3.1.1 Final Segal Report
- 3.1.2 Email from Bob Evans to Acton BOS, JT School Committee, and Acton Finance Committee dated 10/27/11
- 3.1.3 Memo from J. Petersen to School Committees dated 10/2/11
- 3.1.4 Chapter 69 Legislation
- 3.1.5 New Regulations 801 CMR 52.00 Municipal Health Insurance
- 3.1.6 Health Insurance Update Presentation to Staff, Marie Altieri, 11/1/11
- 3.1.7 Cook & Co. Report from the Acton Board of Selectmen, 10/31/11
- 3.1.8 Municipal Health Care Reform Presentation slides, Bob Evans, 11/3/11

ADJOURNMENT of Acton Board of Selectmen

Joint School Committee continues at 8:00.

SEGAL

THE SEGAL COMPANY
116 Huntington Avenue 8th Floor Boston, MA 02116-5744
T 617.424.7300 F 617.424.7390 www.segalco.com

MEMORANDUM

To: Robert Evans
Chairman of the Acton/Acton-Boxborough Health Insurance Trust

From: Francesca G. Sciandra
Daniel J. Rhodes

Date: October 25, 2011

Re: Municipal Health Reform Study – Acton/Acton-Boxborough Health Insurance Trust

Introduction

On July 12, 2011, Governor Deval Patrick signed "An Act Relative to Municipal Health Insurance." The new law allows Massachusetts political subdivisions (*i.e.*, cities, towns, counties and districts) to make specific cost-saving health plan design changes, or alternatively, transfer all of their subscribers to the Group Insurance Commission (GIC) provided that prescribed procedures are followed. On August 12, 2011, the Executive Office for Administration and Finance (A&F), responsible for adopting regulations as guidance to communities seeking to implement changes in health insurance plans under the process created by the new law, filed emergency regulations concerning this law. The regulations expire three months from the filing date. A&F's website indicates that it is taking the required steps to transition the regulations from emergency to permanent status, including an additional opportunity for public comment. On August 10, 2011, the GIC also filed emergency regulations concerning these procedures, and its website indicates a scheduled public hearing.

Methodology

The total cost of health care consists of employer and subscriber (employee or retiree) contributions toward the premium (or premium equivalent) cost of the plan, and participant deductibles, copays, and other out-of-pocket expenses, which are determined by plan design. This report analyzes the effect of changing the plan design on both the employer and subscriber share of premiums. The "savings" reported are premium savings per the definition of the municipal health insurance act. For purposes of these savings projections, we used APEX, a third party software application designed to calculate manual medical premium rates and to estimate relative values of plan design changes.

The Acton Health Insurance Trust (HIT) consists of two political subdivisions, the Town of Acton and the Acton-Boxborough Regional School District. Employees of the Town of Acton include all municipal employees as well as employees of the Acton Public School System. The

only employees covered by the Acton-Boxborough Regional School District are employees of the School District. We have reviewed the medical plans currently offered to employees and retirees of the Town of Acton and the Acton-Boxborough Regional School District and prepared an analysis of estimated savings from various changes allowed by the municipal health insurance reform law, with an effective date of July 1, 2012. We have also provided plan design comparisons in Exhibit III.

Key Financial Findings

For the first projected year, FY 2013, the HIT has projected non-Medicare expenses of $14.23 million. More than 90% of the non-Medicare costs of the HIT arise from the two HMO plans, Network Blue New England and HPHC HMO. In aggregate, approximately 74% of the non-Medicare costs of the Trust are paid by the employers and about 26% by the subscribers. Medicare expenses for the Trust are projected to be $1.96 million and are paid 50% by the employers and 50% by the retirees. (See Exhibit I.A.)

Our analysis estimates that the "maximum possible savings" (as defined in the A&F emergency regulations) from changing to GIC-equivalent designs for the non-Medicare plans is an 8% savings of total annual cost as compared to the current plan designs during the first projection year effective July 1, 2012 through June 30, 2013. (See Exhibit I.B.) The estimated total savings are $1.34 million with an employer share of $1.00 million and an employee/retiree share of $0.34 million.

Transferring all subscribers to the GIC is estimated to result in a "maximum possible savings" of 15% of total annual cost during the same time period. This estimate is based on GIC plan migration assumptions described in the "Assumptions" section of this report. The actual impact of transferring subscribers is a function of subscribers' own plan selections.

These estimates include both the employer and employee/retiree share of the contributions toward the cost of the plans.

Two alternative plans were evaluated to determine their impact on costs. In Alternative #1, no deductible and increased copays result in a savings of 3% in year 1 (Exhibit I.C). In Alternative #2, with still no deductible but higher increases in copays as well as new copays for some services, the savings increase to 6% in year 1 (Exhibit I.D).

The estimated savings are contingent on plan enrollment. For illustrative purposes only, we have estimated a "maximum" range of additional cost or savings from transferring subscribers to the GIC. If all subscribers move to the least expensive GIC plans, total health costs could be as much as 32% lower than under the HIT's current plans. Conversely, if all subscribers move to the most expensive GIC plans, total health costs could increase by as much as 26%. However, we believe our estimate of 15% savings shown in Exhibit I.E, which is based on our best judgment, to be a reasonable estimate of the effect of moving to the GIC.

We note that the benefit design changes would result in additional out-of-pocket expenses, e.g. deductibles and copays, for the HIT subscribers. These additional subscriber expenses are not reflected in our analysis of savings projections.

Exhibits

The results of our review and analysis are outlined in the attached exhibits and are summarized below:

Exhibit I – Financials - One-Year Analysis

A. Current HIT Plans
B. Largest Subscriber Enrollment GIC-Equivalent Plans
C. Alternative Plans #1
D. Alternative Plans #2
E. GIC Plans

Exhibit II – Financials - Five-Year Analysis

A. Current HIT Plans
B. Largest Subscriber Enrollment GIC-Equivalent Plans
C. Alternative Plans #1
D. Alternative Plans #2
E. GIC Plans
F. Variations in Annual Medical Trend Assumptions

Exhibit III – Plan Design Comparisons

A. GIC Tufts Health Plan Navigator and Current HIT Non-Medicare Plans
B. GIC UniCare State Indemnity Plan / Medicare Extension OME With CIC (Comprehensive) and Current HIT Medicare Plans
C. GIC Tufts Health Plan Navigator and Alternative Plans #1 and #2
D. Minuteman Nashoba Health Group - Non-Medicare Plans
E. Minuteman Nashoba Health Group - Medicare Plans

Exhibit IV – Enrollment

Currently, the most subscribed GIC non-Medicare plan is Tufts Health Plan Navigator, and the most subscribed GIC Medicare plan is UniCare State Indemnity Plan / Medicare Extension OME with CIC (comprehensive). The HIT cost-sharing plan design features that exceed those of the most subscribed GIC plans are indicated in red font in the attached plan design comparison exhibits.

Assumptions

The savings estimates in the attached exhibits are based on the following assumptions:

1. HIT plans enrollment as of September 14, 2011. No changes in total enrollment are assumed beyond this point.

2. HIT and GIC plans individual and family working rates effective July 1, 2011, and HIT and GIC Tufts Medicare Preferred premium rates effective January 1, 2011. The plans' working rates are assumed to represent the projected claims costs of the plans and administrative expenses without any adjustments.

3. GIC plan designs do not change during the term of the analysis.

4. The employer and subscriber contribution methodology does not change during the period of the analysis.

5. The distribution of enrollees' plan selections does not change during the period of the analysis.

6. Annual medical trend of 10% and annual administrative expenses trend of 4%. These assumptions are based on our projections of 2012 trends, as set forth in the 2012 Segal Health Plan Cost Trend Survey, which is an annual survey[1] of health insurers, managed care organizations, and third-party administrators.

7. For illustrative purposes, we have also calculated five-year cost projections using an alternative annual medical trend of 8%. This alternative is presented in Exhibit II.F.

8. Each of the above trend assumptions was applied equally to all plans being compared. Relative savings would vary between the scenarios if different trends were used for different plans. For each 1% difference in trend assumptions between the current HIT plans and the modified plans, the incremental savings or incremental expense change by approximately 1%.

9. The following GIC plans migration assumption:
   - all Master Health Plus HIT enrollees will migrate to the GIC's UniCare State Indemnity Plan/Basic with CIC (comprehensive),
   - one third of Blue Care Elect Preferred HIT enrollees will migrate to the GIC's HPHC Independence Plan, one third to Tufts Health Plan Navigator, and one third to UniCare State Indemnity Plan/PLUS,
   - one half of Network Blue New England HIT enrollees will migrate to the GIC's Tufts Health Plan Spirit and one half to Tufts Health Plan Navigator,
   - all HPHC HMO HIT enrollees will migrate to the GIC's HPHC Primary Choice,
   - all Medex 3 HIT enrollees will migrate to the GIC's HPHC Medicare Enhance, and
   - all Tufts Medicare Preferred HIT enrollees will migrate to the GIC's Tufts Medicare Preferred.

[1] A report of results of the 2012 *Segal Health Plan Cost Trend Survey* is available online: http://www.segalco.com/publications/surveysandstudies/2012trendsurvey.pdf

10. For purposes of the savings projections, we have assumed all plan changes would take effect July 1, 2012, in accordance with the procedures outlined in the regulations. However, some subscribers are covered under a collective bargaining agreement (CBA) that stipulates their current plan designs. It is our understanding that no changes would be allowed for these participants until the initial term of their CBA expires, and thus the first-year savings in our exhibits may not be fully realized.

The Segal Company: Background Information

The Segal Company is an independent actuarial and employee benefits consulting firm that has been in existence for more than 70 years.

The Segal Company has designated professionals who provide consulting services for cities and towns (as well as states, counties and other governmental entities) throughout the country and New England. Segal offers significant health actuarial expertise and capabilities. Our consultants and actuaries have broad experience and extensive knowledge of the employee benefits field gained from analyzing health and welfare benefit programs. Our professional staff includes Fellows and Associates of the Society of Actuaries, Members of the American Academy of Actuaries, Fellows and Members of the Conference of Consulting Actuaries, Enrolled Actuaries, Chartered Financial Analysts and Certified Employee Benefits Specialists.

Segal's health care consultants utilize various analytical tools, including those developed by Segal as well as by third party providers, to measure, monitor, and predict the costs of health and welfare benefit programs.

We note that the savings projections reflected in the attached exhibits are estimates of future costs and are based on information available to The Segal Company at the time the projections were made. The Segal Company has not audited the information provided. Projections are not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. The accuracy and reliability of health projections decrease as the projection period increases.

As with all of our work involving the analysis of a law and its application to specific facts, the Trustees should rely on Trust Counsel for authoritative advice.

We are prepared to discuss this with you further and to respond to any questions you may have.

Enclosures

cc: John Murray
John Petersen
Mike Gowing
Sharon Summers

Acton Health Insurance Trust
Exhibit I.A - Financials
Current Plans - One-Year Analysis

YEAR 1 (7/1/2012-6/30/2013)	Town of Acton		Acton Public Schools (APS)		Acton-Boxborough Regional Schools (ABRS)		TOTAL	
Non-Medicare Actives and Retirees								
Network Blue New England								
Employer Cost	$1,343,000		$1,526,700		$2,440,600		**$5,310,300**	
Employee/Retiree Cost	315,300		583,600		926,600		**1,825,500**	
Total Cost - Network Blue New England	**$1,658,300**		**$2,110,300**		**$3,367,200**		**$7,135,800**	
HPHC HMO								
Employer Cost	$993,800		$1,504,000		$2,020,500		**$4,518,300**	
Employee/Retiree Cost	175,400		501,300		673,500		**1,350,200**	
Total Cost - HPHC HMO	**$1,169,200**		**$2,005,300**		**$2,694,000**		**$5,868,500**	
Master Health Plus								
Employer Cost	$420,100		$99,200		$48,300		**$567,600**	
Employee/Retiree Cost	163,400		99,200		48,300		**310,900**	
Total Cost - Master Health Plus	**$583,500**		**$198,400**		**$96,600**		**$878,500**	
Blue Care Elect Preferred (PPO)								
Employer Cost	$56,400		$0		$138,200		**$194,600**	
Employee/Retiree Cost	10,000		0		138,200		**148,200**	
Total Cost - Blue Care Elect Preferred (PPO)	**$66,400**		**$0**		**$276,400**		**$342,800**	
Total Employer Cost - Non-Medicare	**$2,813,300**	**80.9%**	**$3,129,900**	**72.6%**	**$4,647,600**	**72.2%**	**$10,590,800**	**74.4%**
Total Employee/Retiree Cost - Non-Medicare	**664,100**	**19.1%**	**1,184,100**	**27.4%**	**1,786,600**	**27.8%**	**3,634,800**	**25.6%**
Total Cost - Non-Medicare	**$3,477,400**	**100.0%**	**$4,314,000**	**100.0%**	**$6,434,200**	**100.0%**	**$14,225,600**	**100.0%**
Medicare Retirees								
Medex 3								
Employer Cost	$173,800		$254,400		$430,600		**$858,800**	
Retiree Cost	173,800		254,400		430,600		**858,800**	
Total Cost - Medex 3	**$347,600**		**$508,800**		**$861,200**		**$1,717,600**	
Tufts Medicare Preferred								
Employer Cost	$25,100		$38,500		$55,300		**$118,900**	
Retiree Cost	25,100		38,500		55,300		**118,900**	
Total Cost - Tufts Medicare Preferred	**$50,200**		**$77,000**		**$110,600**		**$237,800**	
Total Employer Cost - Medicare	**$198,900**	**50.0%**	**$292,900**	**50.0%**	**$485,900**	**50.0%**	**$977,700**	**50.0%**
Total Retiree Cost - Medicare	**198,900**	**50.0%**	**292,900**	**50.0%**	**485,900**	**50.0%**	**977,700**	**50.0%**
Total Cost - Medicare	**$397,800**	**100.0%**	**$585,800**	**100.0%**	**$971,800**	**100.0%**	**$1,955,400**	**100.0%**
TOTAL EMPLOYER COST - YEAR 1	**$3,012,200**	**77.7%**	**$3,422,800**	**69.9%**	**$5,133,500**	**69.3%**	**$11,568,500**	**71.5%**
TOTAL EMOLOYEE/RETIREE COST - YEAR 1	**863,000**	**22.3%**	**1,477,000**	**30.1%**	**2,272,500**	**30.7%**	**4,612,500**	**28.5%**
TOTAL COST - YEAR 1	**$3,875,200**	**100.0%**	**$4,899,800**	**100.0%**	**$7,406,000**	**100.0%**	**$16,181,000**	**100.0%**

Acton Health Insurance Trust
Exhibit I.B - Financials
Largest Subscriber Enrollment GIC-Equivalent Plans - One-Year Analysis

YEAR 1 (7/1/2012-6/30/2013)	Town of Acton		Acton Public Schools (APS)		Acton-Boxborough Regional Schools (ABRS)		TOTAL	
Non-Medicare Actives and Retirees								
Network Blue New England								
Employer Cost	$1,231,100		$1,370,100		$2,190,300		**$4,791,500**	
Employee/Retiree Cost	289,600		524,200		831,800		**1,645,600**	
Total Cost - Network Blue New England	**$1,520,700**		**$1,894,300**		**$3,022,100**		**$6,437,100**	
HPHC HMO								
Employer Cost	$907,300		$1,350,000		$1,813,300		**$4,070,600**	
Employee/Retiree Cost	160,100		450,000		604,400		**1,214,500**	
Total Cost - HPHC HMO	**$1,067,400**		**$1,800,000**		**$2,417,700**		**$5,285,100**	
Master Health Plus								
Employer Cost	$397,100		$94,300		$45,800		**$537,200**	
Employee/Retiree Cost	156,100		94,300		45,800		**296,200**	
Total Cost - Master Health Plus	**$553,200**		**$188,600**		**$91,600**		**$833,400**	
Blue Care Elect Preferred (PPO)								
Employer Cost	$54,100		$0		$132,700		**$186,800**	
Employee/Retiree Cost	9,600		0		132,700		**142,300**	
Total Cost - Blue Care Elect Preferred (PPO)	**$63,700**		**$0**		**$265,400**		**$329,100**	
Total Employer Cost - Non-Medicare	**$2,589,600**	**80.8%**	**$2,814,400**	**72.5%**	**$4,182,100**	**72.1%**	**$9,586,100**	**74.4%**
Total Employee/Retiree Cost - Non-Medicare	**615,400**	**19.2%**	**1,068,500**	**27.5%**	**1,614,700**	**27.9%**	**3,298,600**	**25.6%**
Total Cost - Non-Medicare	**$3,205,000**	**100.0%**	**$3,882,900**	**100.0%**	**$5,796,800**	**100.0%**	**$12,884,700**	**100.0%**
Total Employer Cost - Medicare	**$198,900**	**50.0%**	**$292,900**	**50.0%**	**$485,900**	**50.0%**	**$977,700**	**50.0%**
Total Retiree Cost - Medicare	**198,900**	**50.0%**	**292,900**	**50.0%**	**485,900**	**50.0%**	**977,700**	**50.0%**
Total Cost - Medicare	**$397,800**	**100.0%**	**$585,800**	**100.0%**	**$971,800**	**100.0%**	**$1,955,400**	**100.0%**
TOTAL EMPLOYER COST - YEAR 1	**$2,788,500**	**77.4%**	**$3,107,300**	**69.5%**	**$4,668,000**	**69.0%**	**$10,563,800**	**71.2%**
TOTAL EMOLOYEE/RETIREE COST - YEAR 1	**814,300**	**22.6%**	**1,361,400**	**30.5%**	**2,100,600**	**31.0%**	**4,276,300**	**28.8%**
TOTAL COST - YEAR 1	**$3,602,800**	**100.0%**	**$4,468,700**	**100.0%**	**$6,768,600**	**100.0%**	**$14,840,100**	**100.0%**
Difference with Current Plans - $								
Employer Cost	-$223,700		-$315,500		-$465,500		-$1,004,700	
Employee/Retiree Cost	-48,700		-115,600		-171,900		-336,200	
Total Cost	**-$272,400**		**-$431,100**		**-$637,400**		**-$1,340,900**	
Difference with Current Plans - %								
Employer Cost	-7.4%		-9.2%		-9.1%		-8.7%	
Employee/Retiree Cost	-5.6%		-7.8%		-7.6%		-7.3%	
Total Cost	**-7.0%**		**-8.8%**		**-8.6%**		**-8.3%**	
Max Mitigation Expense (25% of Total Savings)	$68,100		$107,800		$159,400		$335,200	
Total Cost Difference Net of Max Mitigation Expense	**-$204,300**		**-$323,300**		**-$478,000**		**-$1,005,700**	

Acton Health Insurance Trust
Exhibit I.C - Financials
Alternative Plans #1 - One-Year Analysis

YEAR 1 (7/1/2012-6/30/2013)	Town of Acton		Acton Public Schools (APS)		Acton-Boxborough Regional Schools (ABRS)		TOTAL	
Non-Medicare Actives and Retirees								
Network Blue New England								
Employer Cost	$1,323,500		$1,473,000		$2,354,800		**$5,151,300**	
Employee/Retiree Cost	311,300		563,200		894,100		**1,768,600**	
Total Cost - Network Blue New England	**$1,634,800**		**$2,036,200**		**$3,248,900**		**$6,919,900**	
HPHC HMO								
Employer Cost	$975,600		$1,452,800		$1,951,600		**$4,380,000**	
Employee/Retiree Cost	172,200		484,200		650,500		**1,306,900**	
Total Cost - HPHC HMO	**$1,147,800**		**$1,937,000**		**$2,602,100**		**$5,686,900**	
Master Health Plus								
Employer Cost	$410,900		$97,500		$47,400		**$555,800**	
Employee/Retiree Cost	161,500		97,500		47,400		**306,400**	
Total Cost - Master Health Plus	**$572,400**		**$195,000**		**$94,800**		**$862,200**	
Blue Care Elect Preferred (PPO)								
Employer Cost	$56,100		$0		$137,000		**$193,100**	
Employee/Retiree Cost	9,900		0		137,000		**146,900**	
Total Cost - Blue Care Elect Preferred (PPO)	**$66,000**		**$0**		**$274,000**		**$340,000**	
Total Employer Cost - Non-Medicare	**$2,766,100**	**80.9%**	**$3,023,300**	**72.5%**	**$4,490,800**	**72.2%**	**$10,280,200**	**74.4%**
Total Employee/Retiree Cost - Non-Medicare	**654,900**	**19.1%**	**1,144,900**	**27.5%**	**1,729,000**	**27.8%**	**3,528,800**	**25.6%**
Total Cost - Non-Medicare	**$3,421,000**	**100.0%**	**$4,168,200**	**100.0%**	**$6,219,800**	**100.0%**	**$13,809,000**	**100.0%**
Total Employer Cost - Medicare	**$198,900**	**50.0%**	**$292,900**	**50.0%**	**$485,900**	**50.0%**	**$977,700**	**50.0%**
Total Retiree Cost - Medicare	**198,900**	**50.0%**	**292,900**	**50.0%**	**485,900**	**50.0%**	**977,700**	**50.0%**
Total Cost - Medicare	**$397,800**	**100.0%**	**$585,800**	**100.0%**	**$971,800**	**100.0%**	**$1,955,400**	**100.0%**
TOTAL EMPLOYER COST - YEAR 1	**$2,965,000**	**77.6%**	**$3,316,200**	**69.8%**	**$4,976,700**	**69.2%**	**$11,257,900**	**71.4%**
TOTAL EMOLOYEE/RETIREE COST - YEAR 1	**853,800**	**22.4%**	**1,437,800**	**30.2%**	**2,214,900**	**30.8%**	**4,506,500**	**28.6%**
TOTAL COST - YEAR 1	**$3,818,800**	**100.0%**	**$4,754,000**	**100.0%**	**$7,191,600**	**100.0%**	**$15,764,400**	**100.0%**
Difference with Current Plans - $								
Employer Cost	-$47,200		-$106,600		-$156,800		-$310,600	
Employee/Retiree Cost	-9,200		-39,200		-57,600		-106,000	
Total Cost	**-$56,400**		**-$145,800**		**-$214,400**		**-$416,600**	
Difference with Current Plans - %								
Employer Cost	-1.6%		-3.1%		-3.1%		-2.7%	
Employee/Retiree Cost	-1.1%		-2.7%		-2.5%		-2.3%	
Total Cost	**-1.5%**		**-3.0%**		**-2.9%**		**-2.6%**	

Acton Health Insurance Trust
Exhibit I.D - Financials
Alternative Plans #2 - One-Year Analysis

YEAR 1 (7/1/2012-6/30/2013)	Town of Acton		Acton Public Schools (APS)		Acton-Boxborough Regional Schools (ABRS)		TOTAL	
Non-Medicare Actives and Retirees								
Network Blue New England								
Employer Cost	$1,269,400		$1,412,900		$2,258,700		**$4,941,000**	
Employee/Retiree Cost	298,600		540,400		857,700		**1,696,700**	
Total Cost - Network Blue New England	**$1,568,000**		**$1,953,300**		**$3,116,400**		**$6,637,700**	
HPHC HMO								
Employer Cost	$935,700		$1,392,900		$1,871,000		**$4,199,600**	
Employee/Retiree Cost	165,200		464,300		623,700		**1,253,200**	
Total Cost - HPHC HMO	**$1,100,900**		**$1,857,200**		**$2,494,700**		**$5,452,800**	
Master Health Plus								
Employer Cost	$402,900		$95,700		$46,500		**$545,100**	
Employee/Retiree Cost	158,400		95,700		46,500		**300,600**	
Total Cost - Master Health Plus	**$561,300**		**$191,400**		**$93,000**		**$845,700**	
Blue Care Elect Preferred (PPO)								
Employer Cost	$54,800		$0		$134,200		**$189,000**	
Employee/Retiree Cost	9,700		0		134,200		**143,900**	
Total Cost - Blue Care Elect Preferred (PPO)	**$64,500**		**$0**		**$268,400**		**$332,900**	
Total Employer Cost - Non-Medicare	**$2,662,800**	**80.8%**	**$2,901,500**	**72.5%**	**$4,310,400**	**72.2%**	**$9,874,700**	**74.4%**
Total Employee/Retiree Cost - Non-Medicare	**631,900**	**19.2%**	**1,100,400**	**27.5%**	**1,662,100**	**27.8%**	**3,394,400**	**25.6%**
Total Cost - Non-Medicare	**$3,294,700**	**100.0%**	**$4,001,900**	**100.0%**	**$5,972,500**	**100.0%**	**$13,269,100**	**100.0%**
Total Employer Cost - Medicare	**$198,900**	**50.0%**	**$292,900**	**50.0%**	**$485,900**	**50.0%**	**$977,700**	**50.0%**
Total Retiree Cost - Medicare	**198,900**	**50.0%**	**292,900**	**50.0%**	**485,900**	**50.0%**	**977,700**	**50.0%**
Total Cost - Medicare	**$397,800**	**100.0%**	**$585,800**	**100.0%**	**$971,800**	**100.0%**	**$1,955,400**	**100.0%**
TOTAL EMPLOYER COST - YEAR 1	**$2,861,700**	**77.5%**	**$3,194,400**	**69.6%**	**$4,796,300**	**69.1%**	**$10,852,400**	**71.3%**
TOTAL EMOLOYEE/RETIREE COST - YEAR 1	**830,800**	**22.5%**	**1,393,300**	**30.4%**	**2,148,000**	**30.9%**	**4,372,100**	**28.7%**
TOTAL COST - YEAR 1	**$3,692,500**	**100.0%**	**$4,587,700**	**100.0%**	**$6,944,300**	**100.0%**	**$15,224,500**	**100.0%**
Difference with Current Plans - $								
Employer Cost	-$150,500		-$228,400		-$337,200		-$716,100	
Employee/Retiree Cost	-32,200		-83,700		-124,500		-240,400	
Total Cost	**-$182,700**		**-$312,100**		**-$461,700**		**-$956,500**	
Difference with Current Plans - %								
Employer Cost	-5.0%		-6.7%		-6.6%		-6.2%	
Employee/Retiree Cost	-3.7%		-5.7%		-5.5%		-5.2%	
Total Cost	**-4.7%**		**-6.4%**		**-6.2%**		**-5.9%**	

Acton Health Insurance Trust
Exhibit I.E - Financials
GIC Plans - One-Year Analysis

YEAR 1 (7/1/2012-6/30/2013)	Town of Acton		Acton Public Schools (APS)		Acton-Boxborough Regional Schools (ABRS)		TOTAL	
Non-Medicare Actives and Retirees								
Network Blue New England --> GIC / 1/2 Tufts Health Plan Spirit (HMO-type), 1/2 Tufts Health Plan Navigator (PPO)								
Employer Cost	$1,155,900		$1,294,200		$2,068,600		**$4,518,700**	
Employee/Retiree Cost	271,900		493,900		785,000		**1,550,800**	
Total Cost	**$1,427,800**		**$1,788,100**		**$2,853,600**		**$6,069,500**	
HPHC HMO --> GIC / HPHC Primary Choice (HMO)								
Employer Cost	$838,000		$1,257,900		$1,690,400		**$3,786,300**	
Employee/Retiree Cost	147,900		419,300		563,500		**1,130,700**	
Total Cost	**$985,900**		**$1,677,200**		**$2,253,900**		**$4,917,000**	
Master Health Plus --> GIC / UniCare State Indemnity Plan/Basic With CIC (Comprehensive)								
Employer Cost	$278,700		$66,800		$32,400		**$377,900**	
Employee/Retiree Cost	110,500		66,800		32,400		**209,700**	
Total Cost	**$389,200**		**$133,600**		**$64,800**		**$587,600**	
Blue Care Elect Preferred (PPO) --> GIC / 1/3 HPHC Independence Plan (PPO), 1/3 Tufts Health Plan Navigator (PPO), 1/3 UniCare State Indemnity Plan/PLUS								
Employer Cost	$33,100		$0		$79,000		**$112,100**	
Employee/Retiree Cost	5,800		0		79,000		**84,800**	
Total Cost	**$38,900**		**$0**		**$158,000**		**$196,900**	
Total Employer Cost - Non-Medicare	**$2,305,700**	**81.1%**	**$2,618,900**	**72.8%**	**$3,870,400**	**72.6%**	**$8,795,000**	**74.7%**
Total Employee/Retiree Cost - Non-Medicare	**536,100**	**18.9%**	**980,000**	**27.2%**	**1,459,900**	**27.4%**	**2,976,000**	**25.3%**
Total Cost - Non-Medicare	**$2,841,800**	**100.0%**	**$3,598,900**	**100.0%**	**$5,330,300**	**100.0%**	**$11,771,000**	**100.0%**
Medicare Retirees								
Medex 3 --> GIC / HPHC Medicare Enhance								
Employer Cost	$174,700		$255,700		$432,900		**$863,300**	
Retiree Cost	174,700		255,700		432,900		**863,300**	
Total Cost	**$349,400**		**$511,400**		**$865,800**		**$1,726,600**	
Tufts Medicare Preferred --> GIC / Tufts Medicare Preferred								
Employer Cost	$26,900		$41,200		$59,100		**$127,200**	
Retiree Cost	26,900		41,200		59,100		**127,200**	
Total Cost	**$53,800**		**$82,400**		**$118,200**		**$254,400**	
Total Employer Cost - Medicare	**$201,600**	**50.0%**	**$296,900**	**50.0%**	**$492,000**	**50.0%**	**$990,500**	**50.0%**
Total Retiree Cost - Medicare	**201,600**	**50.0%**	**296,900**	**50.0%**	**492,000**	**50.0%**	**990,500**	**50.0%**
Total Cost - Medicare	**$403,200**	**100.0%**	**$593,800**	**100.0%**	**$984,000**	**100.0%**	**$1,981,000**	**100.0%**
TOTAL EMPLOYER COST - YEAR 1	**$2,507,300**	**77.3%**	**$2,915,800**	**69.5%**	**$4,362,400**	**69.1%**	**$9,785,500**	**71.2%**
TOTAL EMOLOYEE/RETIREE COST - YEAR 1	**737,700**	**22.7%**	**1,276,900**	**30.5%**	**1,951,900**	**30.9%**	**3,966,500**	**28.8%**
TOTAL COST - YEAR 1	**$3,245,000**	**100.0%**	**$4,192,700**	**100.0%**	**$6,314,300**	**100.0%**	**$13,752,000**	**100.0%**
Difference with Current Plans - $								
Employer Cost	-$504,900		-$507,000		-$771,100		-$1,783,000	
Employee/Retiree Cost	-125,300		-200,100		-320,600		-646,000	
Total Cost	**-$630,200**		**-$707,100**		**-$1,091,700**		**-$2,429,000**	
Difference with Current Plans - %								
Employer Cost	-16.8%		-14.8%		-15.0%		-15.4%	
Employee/Retiree Cost	-14.5%		-13.5%		-14.1%		-14.0%	
Total Cost	**-16.3%**		**-14.4%**		**-14.7%**		**-15.0%**	

Acton Health Insurance Trust
Exhibit II.A - Financials
Current Plans - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
Non-Medicare Actives and Retirees						
Network Blue New England						
Employer Cost	$5,310,300	$5,823,500	$6,387,300	$7,006,800	$7,687,500	**$32,215,400**
Employee/Retiree Cost	1,825,500	2,001,700	2,195,300	2,407,900	2,641,600	**11,072,000**
Total Cost - Network Blue New England	**$7,135,800**	**$7,825,200**	**$8,582,600**	**$9,414,700**	**$10,329,100**	**$43,287,400**
HPHC HMO						
Employer Cost	$4,518,300	$4,950,800	$5,425,800	$5,947,500	$6,520,500	**$27,362,900**
Employee/Retiree Cost	1,350,200	1,479,500	1,621,400	1,777,300	1,948,600	**8,177,000**
Total Cost - HPHC HMO	**$5,868,500**	**$6,430,300**	**$7,047,200**	**$7,724,800**	**$8,469,100**	**$35,539,900**
Master Health Plus						
Employer Cost	$567,600	$623,200	$684,300	$751,400	$825,200	**$3,451,700**
Employee/Retiree Cost	310,900	341,300	374,700	411,400	451,800	**1,890,100**
Total Cost - Master Health Plus	**$878,500**	**$964,500**	**$1,059,000**	**$1,162,800**	**$1,277,000**	**$5,341,800**
Blue Care Elect Preferred (PPO)						
Employer Cost	$194,600	$195,100	$214,200	$235,200	$258,200	**$1,097,300**
Employee/Retiree Cost	148,200	144,100	158,200	173,600	190,500	**814,600**
Total Cost - Blue Care Elect Preferred (PPO)	**$342,800**	**$339,200**	**$372,400**	**$408,800**	**$448,700**	**$1,911,900**
Total Employer Cost - Non-Medicare	**$10,590,800**	**$11,592,600**	**$12,711,600**	**$13,940,900**	**$15,291,400**	**$64,127,300**
Total Employee/Retiree Cost - Non-Medicare	**3,634,800**	**3,966,600**	**4,349,600**	**4,770,200**	**5,232,500**	**21,953,700**
Total Cost - Non-Medicare	**$14,225,600**	**$15,559,200**	**$17,061,200**	**$18,711,100**	**$20,523,900**	**$86,081,000**
Medicare Retirees						
Medex 3						
Employer Cost	$858,800	$941,700	$1,032,700	$1,132,700	$1,242,600	**$5,208,500**
Retiree Cost	858,800	941,700	1,032,700	1,132,700	1,242,600	**5,208,500**
Total Cost - Medex	**$1,717,600**	**$1,883,400**	**$2,065,400**	**$2,265,400**	**$2,485,200**	**$10,417,000**
Tufts Medicare Preferred						
Employer Cost	$118,900	$130,800	$143,900	$158,300	$174,100	**$726,000**
Retiree Cost	118,900	130,800	143,900	158,300	174,100	**726,000**
Total Cost - Tufts Medicare Preferred	**$237,800**	**$261,600**	**$287,800**	**$316,600**	**$348,200**	**$1,452,000**
Total Employer Cost - Medicare	**$977,700**	**$1,072,500**	**$1,176,600**	**$1,291,000**	**$1,416,700**	**$5,934,500**
Total Retiree Cost - Medicare	**977,700**	**1,072,500**	**1,176,600**	**1,291,000**	**1,416,700**	**5,934,500**
Total Cost - Medicare	**$1,955,400**	**$2,145,000**	**$2,353,200**	**$2,582,000**	**$2,833,400**	**$11,869,000**
TOTAL EMPLOYER COST	**$11,568,500**	**$12,665,100**	**$13,888,200**	**$15,231,900**	**$16,708,100**	**$70,061,800**
TOTAL EMOLOYEE/RETIREE COST	**4,612,500**	**5,039,100**	**5,526,200**	**6,061,200**	**6,649,200**	**27,888,200**
TOTAL COST	**$16,181,000**	**$17,704,200**	**$19,414,400**	**$21,293,100**	**$23,357,300**	**$97,950,000**

Acton Health Insurance Trust
Exhibit II.B - Financials
Largest Subscriber Enrollment GIC-Equivalent Plans - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
Non-Medicare Actives and Retirees						
Network Blue New England						
Employer Cost	$4,791,500	$5,252,800	$5,759,500	$6,316,300	$6,927,900	**$29,048,000**
Employee/Retiree Cost	1,645,600	1,803,800	1,977,600	2,168,500	2,378,200	**9,973,700**
Total Cost - Network Blue New England	**$6,437,100**	**$7,056,600**	**$7,737,100**	**$8,484,800**	**$9,306,100**	**$39,021,700**
HPHC HMO						
Employer Cost	$4,070,600	$4,458,400	$4,884,100	$5,351,600	$5,865,100	**$24,629,800**
Employee/Retiree Cost	1,214,500	1,330,300	1,457,200	1,596,700	1,750,000	**7,348,700**
Total Cost - HPHC HMO	**$5,285,100**	**$5,788,700**	**$6,341,300**	**$6,948,300**	**$7,615,100**	**$31,978,500**
Master Health Plus						
Employer Cost	$537,200	$589,800	$647,500	$711,000	$780,700	**$3,266,200**
Employee/Retiree Cost	296,200	325,100	356,900	391,800	430,300	**1,800,300**
Total Cost - Master Health Plus	**$833,400**	**$914,900**	**$1,004,400**	**$1,102,800**	**$1,211,000**	**$5,066,500**
Blue Care Elect Preferred (PPO)						
Employer Cost	$186,800	$186,600	$204,800	$224,900	$246,800	**$1,049,900**
Employee/Retiree Cost	142,300	137,600	151,000	165,700	181,800	**778,400**
Total Cost - Blue Care Elect Preferred (PPO)	**$329,100**	**$324,200**	**$355,800**	**$390,600**	**$428,600**	**$1,828,300**
Total Employer Cost - Non-Medicare	**$9,586,100**	**$10,487,600**	**$11,495,900**	**$12,603,800**	**$13,820,500**	**$57,993,900**
Total Employee/Retiree Cost - Non-Medicare	**3,298,600**	**3,596,800**	**3,942,700**	**4,322,700**	**4,740,300**	**19,901,100**
Total Cost - Non-Medicare	**$12,884,700**	**$14,084,400**	**$15,438,600**	**$16,926,500**	**$18,560,800**	**$77,895,000**
Total Employer Cost - Medicare	**$977,700**	**$1,072,500**	**$1,176,600**	**$1,291,000**	**$1,416,700**	**$5,934,500**
Total Retiree Cost - Medicare	**977,700**	**1,072,500**	**1,176,600**	**1,291,000**	**1,416,700**	**5,934,500**
Total Cost - Medicare	**$1,955,400**	**$2,145,000**	**$2,353,200**	**$2,582,000**	**$2,833,400**	**$11,869,000**
TOTAL EMPLOYER COST	**$10,563,800**	**$11,560,100**	**$12,672,500**	**$13,894,800**	**$15,237,200**	**$63,928,400**
TOTAL EMOLOYEE/RETIREE COST	**4,276,300**	**4,669,300**	**5,119,300**	**5,613,700**	**6,157,000**	**25,835,600**
TOTAL COST	**$14,840,100**	**$16,229,400**	**$17,791,800**	**$19,508,500**	**$21,394,200**	**$89,764,000**
Difference with Current Plans - $						
Employer Cost	-$1,004,700	-$1,105,000	-$1,215,700	-$1,337,100	-$1,470,900	**-$6,133,400**
Employee/Retiree Cost	-336,200	-369,800	-406,900	-447,500	-492,200	**-2,052,600**
Total Cost	**-$1,340,900**	**-$1,474,800**	**-$1,622,600**	**-$1,784,600**	**-$1,963,100**	**-$8,186,000**
Difference with Current Plans - %						
Employer Cost	-8.7%	-8.7%	-8.8%	-8.8%	-8.8%	**-8.8%**
Employee/Retiree Cost	-7.3%	-7.3%	-7.4%	-7.4%	-7.4%	**-7.4%**
Total Cost	**-8.3%**	**-8.3%**	**-8.4%**	**-8.4%**	**-8.4%**	**-8.4%**

Acton Health Insurance Trust
Exhibit II.C - Financials
Alternative Plans #1 - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
Non-Medicare Actives and Retirees						
Network Blue New England						
Employer Cost	$5,151,300	$5,648,700	$6,195,000	$6,795,200	$7,454,800	**$31,245,000**
Employee/Retiree Cost	1,768,600	1,939,200	2,126,600	2,332,300	2,558,400	**10,725,100**
Total Cost - Network Blue New England	**$6,919,900**	**$7,587,900**	**$8,321,600**	**$9,127,500**	**$10,013,200**	**$41,970,100**
HPHC HMO						
Employer Cost	$4,380,000	$4,798,600	$5,258,400	$5,763,400	$6,318,000	**$26,518,400**
Employee/Retiree Cost	1,306,900	1,431,900	1,569,100	1,719,700	1,885,300	**7,912,900**
Total Cost - HPHC HMO	**$5,686,900**	**$6,230,500**	**$6,827,500**	**$7,483,100**	**$8,203,300**	**$34,431,300**
Master Health Plus						
Employer Cost	$555,800	$610,400	$670,200	$735,900	$808,100	**$3,380,400**
Employee/Retiree Cost	306,400	336,500	369,400	405,500	445,300	**1,863,100**
Total Cost - Master Health Plus	**$862,200**	**$946,900**	**$1,039,600**	**$1,141,400**	**$1,253,400**	**$5,243,500**
Blue Care Elect Preferred (PPO)						
Employer Cost	$193,100	$193,400	$212,400	$233,200	$256,000	**$1,088,100**
Employee/Retiree Cost	146,900	142,700	156,700	172,000	188,700	**807,000**
Total Cost - Blue Care Elect Preferred (PPO)	**$340,000**	**$336,100**	**$369,100**	**$405,200**	**$444,700**	**$1,895,100**
Total Employer Cost - Non-Medicare	**$10,280,200**	**$11,251,100**	**$12,336,000**	**$13,527,700**	**$14,836,900**	**$62,231,900**
Total Employee/Retiree Cost - Non-Medicare	**3,528,800**	**3,850,300**	**4,221,800**	**4,629,500**	**5,077,700**	**21,308,100**
Total Cost - Non-Medicare	**$13,809,000**	**$15,101,400**	**$16,557,800**	**$18,157,200**	**$19,914,600**	**$83,540,000**
Total Employer Cost - Medicare	**$977,700**	**$1,072,500**	**$1,176,600**	**$1,291,000**	**$1,416,700**	**$5,934,500**
Total Retiree Cost - Medicare	**977,700**	**1,072,500**	**1,176,600**	**1,291,000**	**1,416,700**	**5,934,500**
Total Cost - Medicare	**$1,955,400**	**$2,145,000**	**$2,353,200**	**$2,582,000**	**$2,833,400**	**$11,869,000**
TOTAL EMPLOYER COST	**$11,257,900**	**$12,323,600**	**$13,512,600**	**$14,818,700**	**$16,253,600**	**$68,166,400**
TOTAL EMOLOYEE/RETIREE COST	**4,506,500**	**4,922,800**	**5,398,400**	**5,920,500**	**6,494,400**	**27,242,600**
TOTAL COST	**$15,764,400**	**$17,246,400**	**$18,911,000**	**$20,739,200**	**$22,748,000**	**$95,409,000**
Difference with Current Plans - $						
Employer Cost	-$310,600	-$341,500	-$375,600	-$413,200	-$454,500	**-$1,895,400**
Employee/Retiree Cost	-106,000	-116,300	-127,800	-140,700	-154,800	**-645,600**
Total Cost	**-$416,600**	**-$457,800**	**-$503,400**	**-$553,900**	**-$609,300**	**-$2,541,000**
Difference with Current Plans - %						
Employer Cost	-2.7%	-2.7%	-2.7%	-2.7%	-2.7%	**-2.7%**
Employee/Retiree Cost	-2.3%	-2.3%	-2.3%	-2.3%	-2.3%	**-2.3%**
Total Cost	**-2.6%**	**-2.6%**	**-2.6%**	**-2.6%**	**-2.6%**	**-2.6%**

Acton Health Insurance Trust
Exhibit II.D - Financials
Alternative Plans #2 - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
Non-Medicare Actives and Retirees						
Network Blue New England						
Employer Cost	$4,941,000	$5,417,300	$5,940,500	$6,515,300	$7,146,800	**$29,960,900**
Employee/Retiree Cost	1,696,700	1,860,100	2,039,500	2,236,500	2,453,100	**10,285,900**
Total Cost - Network Blue New England	**$6,637,700**	**$7,277,400**	**$7,980,000**	**$8,751,800**	**$9,599,900**	**$40,246,800**
HPHC HMO						
Employer Cost	$4,199,600	$4,600,300	$5,040,200	$5,523,400	$6,054,000	**$25,417,500**
Employee/Retiree Cost	1,253,200	1,372,700	1,503,900	1,648,000	1,806,400	**7,584,200**
Total Cost - HPHC HMO	**$5,452,800**	**$5,973,000**	**$6,544,100**	**$7,171,400**	**$7,860,400**	**$33,001,700**
Master Health Plus						
Employer Cost	$545,100	$598,400	$657,100	$721,400	$792,200	**$3,314,200**
Employee/Retiree Cost	300,600	329,900	362,100	397,600	436,600	**1,826,800**
Total Cost - Master Health Plus	**$845,700**	**$928,300**	**$1,019,200**	**$1,119,000**	**$1,228,800**	**$5,141,000**
Blue Care Elect Preferred (PPO)						
Employer Cost	$189,000	$188,900	$207,400	$227,700	$249,900	**$1,062,900**
Employee/Retiree Cost	143,900	139,300	153,000	167,800	184,200	**788,200**
Total Cost - Blue Care Elect Preferred (PPO)	**$332,900**	**$328,200**	**$360,400**	**$395,500**	**$434,100**	**$1,851,100**
Total Employer Cost - Non-Medicare	**$9,874,700**	**$10,804,900**	**$11,845,200**	**$12,987,800**	**$14,242,900**	**$59,755,500**
Total Employee/Retiree Cost - Non-Medicare	**3,394,400**	**3,702,000**	**4,058,500**	**4,449,900**	**4,880,300**	**20,485,100**
Total Cost - Non-Medicare	**$13,269,100**	**$14,506,900**	**$15,903,700**	**$17,437,700**	**$19,123,200**	**$80,240,600**
Total Employer Cost - Medicare	**$977,700**	**$1,072,500**	**$1,176,600**	**$1,291,000**	**$1,416,700**	**$5,934,500**
Total Retiree Cost - Medicare	**977,700**	**1,072,500**	**1,176,600**	**1,291,000**	**1,416,700**	**5,934,500**
Total Cost - Medicare	**$1,955,400**	**$2,145,000**	**$2,353,200**	**$2,582,000**	**$2,833,400**	**$11,869,000**
TOTAL EMPLOYER COST	**$10,852,400**	**$11,877,400**	**$13,021,800**	**$14,278,800**	**$15,659,600**	**$65,690,000**
TOTAL EMOLOYEE/RETIREE COST	**4,372,100**	**4,774,500**	**5,235,100**	**5,740,900**	**6,297,000**	**26,419,600**
TOTAL COST	**$15,224,500**	**$16,651,900**	**$18,256,900**	**$20,019,700**	**$21,956,600**	**$92,109,600**
Difference with Current Plans - $						
Employer Cost	-$716,100	-$787,700	-$866,400	-$953,100	-$1,048,500	**-$4,371,800**
Employee/Retiree Cost	-240,400	-264,600	-291,100	-320,300	-352,200	**-1,468,600**
Total Cost	**-$956,500**	**-$1,052,300**	**-$1,157,500**	**-$1,273,400**	**-$1,400,700**	**-$5,840,400**
Difference with Current Plans - %						
Employer Cost	-6.2%	-6.2%	-6.2%	-6.3%	-6.3%	**-6.2%**
Employee/Retiree Cost	-5.2%	-5.3%	-5.3%	-5.3%	-5.3%	**-5.3%**
Total Cost	**-5.9%**	**-5.9%**	**-6.0%**	**-6.0%**	**-6.0%**	**-6.0%**

Acton Health Insurance Trust
Exhibit II.E - Financials
GIC Plans - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
Non-Medicare Actives and Retirees						
Network Blue New England --> GIC / 1/2 Tufts Health Plan Spirit (HMO-type), 1/2 Tufts Health Plan Navigator (PPO)						
Employer Cost	$4,518,700	$4,970,600	$5,467,600	$6,014,400	$6,615,800	**$27,587,100**
Employee/Retiree Cost	1,550,800	1,705,900	1,876,500	2,064,100	2,270,500	**9,467,800**
Total Cost	**$6,069,500**	**$6,676,500**	**$7,344,100**	**$8,078,500**	**$8,886,300**	**$37,054,900**
HPHC HMO --> GIC / HPHC Primary Choice (HMO)						
Employer Cost	$3,786,300	$4,164,900	$4,581,400	$5,039,600	$5,543,500	**$23,115,700**
Employee/Retiree Cost	1,130,700	1,243,700	1,368,100	1,504,900	1,655,400	**6,902,800**
Total Cost	**$4,917,000**	**$5,408,600**	**$5,949,500**	**$6,544,500**	**$7,198,900**	**$30,018,500**
Master Health Plus --> GIC / UniCare State Indemnity Plan/Basic With CIC (Comprehensive)						
Employer Cost	$377,900	$415,700	$457,300	$503,000	$553,300	**$2,307,200**
Employee/Retiree Cost	209,700	230,600	253,700	279,100	307,000	**1,280,100**
Total Cost	**$587,600**	**$646,300**	**$711,000**	**$782,100**	**$860,300**	**$3,587,300**
Blue Care Elect Preferred (PPO) --> GIC / 1/3 HPHC Independence Plan (PPO), 1/3 Tufts Health Plan Navigator (PPO), 1/3 UniCare State Indemnity Plan/PLUS						
Employer Cost	$112,100	$123,300	$135,600	$149,200	$164,100	**$684,300**
Employee/Retiree Cost	84,800	93,300	102,700	112,900	124,200	**517,900**
Total Cost	**$196,900**	**$216,600**	**$238,300**	**$262,100**	**$288,300**	**$1,202,200**
Total Employer Cost - Non-Medicare	**$8,795,000**	**$9,674,500**	**$10,641,900**	**$11,706,200**	**$12,876,700**	**$53,694,300**
Total Employee/Retiree Cost - Non-Medicare	**2,976,000**	**3,273,500**	**3,601,000**	**3,961,000**	**4,357,100**	**18,168,600**
Total Cost - Non-Medicare	**$11,771,000**	**$12,948,000**	**$14,242,900**	**$15,667,200**	**$17,233,800**	**$71,862,900**
Medicare Retirees						
Medex 3 --> GIC / HPHC Medicare Enhance						
Employer Cost	$863,300	$949,700	$1,044,600	$1,149,100	$1,264,000	**$5,270,700**
Retiree Cost	863,300	949,700	1,044,600	1,149,100	1,264,000	**5,270,700**
Total Cost	**$1,726,600**	**$1,899,400**	**$2,089,200**	**$2,298,200**	**$2,528,000**	**$10,541,400**
Tufts Medicare Preferred --> GIC / Tufts Medicare Preferred						
Employer Cost	$127,200	$139,900	$153,900	$169,300	$186,200	**$776,500**
Retiree Cost	127,200	139,900	153,900	169,300	186,200	**776,500**
Total Cost	**$254,400**	**$279,800**	**$307,800**	**$338,600**	**$372,400**	**$1,553,000**
Total Employer Cost - Medicare	**$990,500**	**$1,089,600**	**$1,198,500**	**$1,318,400**	**$1,450,200**	**$6,047,200**
Total Retiree Cost - Medicare	**990,500**	**1,089,600**	**1,198,500**	**1,318,400**	**1,450,200**	**6,047,200**
Total Cost - Medicare	**$1,981,000**	**$2,179,200**	**$2,397,000**	**$2,636,800**	**$2,900,400**	**$12,094,400**
TOTAL EMPLOYER COST	**$9,785,500**	**$10,764,100**	**$11,840,400**	**$13,024,600**	**$14,326,900**	**$59,741,500**
TOTAL EMOLOYEE/RETIREE COST	**3,966,500**	**4,363,100**	**4,799,500**	**5,279,400**	**5,807,300**	**24,215,800**
TOTAL COST	**$13,752,000**	**$15,127,200**	**$16,639,900**	**$18,304,000**	**$20,134,200**	**$83,957,300**
Difference with Current Plans - $						
Employer Cost	-$1,783,000	-$1,901,000	-$2,047,800	-$2,207,300	-$2,381,200	**-$10,320,300**
Employee/Retiree Cost	-646,000	-676,000	-726,700	-781,800	-841,900	**-3,672,400**
Total Cost	**-$2,429,000**	**-$2,577,000**	**-$2,774,500**	**-$2,989,100**	**-$3,223,100**	**-$13,992,700**
Difference with Current Plans - %						
Employer Cost	-15.4%	-15.0%	-14.7%	-14.5%	-14.3%	**-14.7%**
Employee/Retiree Cost	-14.0%	-13.4%	-13.2%	-12.9%	-12.7%	**-13.2%**
Total Cost	**-15.0%**	**-14.6%**	**-14.3%**	**-14.0%**	**-13.8%**	**-14.3%**

Acton Health Insurance Trust
Exhibit II.F - Financials
Variations in Annual Medical Trend Assumptions - Five-Year Analysis

	7/1/2012-6/30/2013	7/1/2013-6/30/2014	7/1/2014-6/30/2015	7/1/2015-6/30/2016	7/1/2016-6/30/2017	FIVE-YEAR TOTAL
10% Annual Medical Trend Assumption						
Current Plans (Exhibit II.A)						
Total Cost	**$16,181,000**	**$17,704,200**	**$19,414,400**	**$21,293,100**	**$23,357,300**	**$97,950,000**
Largest Subscriber Enrollment GIC-Equivalent Plans (Exhibit II.B)						
Total Cost	**$14,840,100**	**$16,229,400**	**$17,791,800**	**$19,508,500**	**$21,394,200**	**$89,764,000**
Difference with Current Plans - $	-$1,340,900	-$1,474,800	-$1,622,600	-$1,784,600	-$1,963,100	**-$8,186,000**
Difference with Current Plans - %	-8.3%	-8.3%	-8.4%	-8.4%	-8.4%	**-8.4%**
Alternative Plans #1 (Exhibit II.C)						
Total Cost	**$15,764,400**	**$17,246,400**	**$18,911,000**	**$20,739,200**	**$22,748,000**	**$95,409,000**
Difference with Current Plans - $	-$416,600	-$457,800	-$503,400	-$553,900	-$609,300	**-$2,541,000**
Difference with Current Plans - %	-2.6%	-2.6%	-2.6%	-2.6%	-2.6%	**-2.6%**
Alternative Plans #2 (Exhibit II.D)						
Total Cost	**$15,224,500**	**$16,651,900**	**$18,256,900**	**$20,019,700**	**$21,956,600**	**$92,109,600**
Difference with Current Plans - $	-$956,500	-$1,052,300	-$1,157,500	-$1,273,400	-$1,400,700	**-$5,840,400**
Difference with Current Plans - %	-5.9%	-5.9%	-6.0%	-6.0%	-6.0%	**-6.0%**
GIC Plans (Exhibit II.E)						
Total Cost	**$13,752,000**	**$15,127,200**	**$16,639,900**	**$18,304,000**	**$20,134,200**	**$83,957,300**
Difference with Current Plans - $	-$2,429,000	-$2,577,000	-$2,774,500	-$2,989,100	-$3,223,100	**-$13,992,700**
Difference with Current Plans - %	-15.0%	-14.6%	-14.3%	-14.0%	-13.8%	**-14.3%**
8% Annual Medical Trend Assumption						
Current Plans						
Total Cost	**$15,902,100**	**$17,100,100**	**$18,428,000**	**$19,860,500**	**$21,405,900**	**$92,696,600**
Largest Subscriber Enrollment GIC-Equivalent Plans						
Total Cost	**$14,561,200**	**$15,652,000**	**$16,864,100**	**$18,171,500**	**$19,581,800**	**$84,830,600**
Difference with Current Plans - $	-$1,340,900	-$1,448,100	-$1,563,900	-$1,689,000	-$1,824,100	**-$7,866,000**
Difference with Current Plans - %	-8.4%	-8.5%	-8.5%	-8.5%	-8.5%	**-8.5%**
Alternative Plans #1						
Total Cost	**$15,485,500**	**$16,650,600**	**$17,942,600**	**$19,336,200**	**$20,839,700**	**$90,254,600**
Difference with Current Plans - $	-$416,600	-$449,500	-$485,400	-$524,300	-$566,200	**-$2,442,000**
Difference with Current Plans - %	-2.6%	-2.6%	-2.6%	-2.6%	-2.6%	**-2.6%**
Alternative Plans #2						
Total Cost	**$14,945,600**	**$16,066,900**	**$17,312,100**	**$18,655,400**	**$20,104,300**	**$87,084,300**
Difference with Current Plans - $	-$956,500	-$1,033,200	-$1,115,900	-$1,205,100	-$1,301,600	**-$5,612,300**
Difference with Current Plans - %	-6.0%	-6.0%	-6.1%	-6.1%	-6.1%	**-6.1%**
GIC Plans						
Total Cost	**$13,499,700**	**$14,579,600**	**$15,746,000**	**$17,005,700**	**$18,366,200**	**$79,197,200**
Difference with Current Plans - $	-$2,402,400	-$2,520,500	-$2,682,000	-$2,854,800	-$3,039,700	**-$13,499,400**
Difference with Current Plans - %	-15.1%	-14.7%	-14.6%	-14.4%	-14.2%	**-14.6%**

Acton Health Insurance Trust
Exhibit III.A - Plan Design Comparisons
Tufts Health Plan Navigator and Current Non-Medicare Plans

Plan Provisions	GIC Non-Medicare Plan with largest subscriber enrollment: Tufts Health Plan Navigator		Current: BCBS Network Blue New England		
	In-Network	Out-of-Network	"$5"	"$15"	"$20"
7/1/2011 Working Rates (Individual / Family)	**$590.34 / $1,439.59**		**$664.14 / $1,569.31**	**$644.80 / $1,523.60**	**$629.20 / $1,492.40**
Coinsurance	100%	80%	100%	100%	100%
Annual Deductibles (Individual / Family)	$250 / $750	$150 / Individual	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	$3,150 / Individual	N/A	N/A	N/A
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	Deductible and coinsurance	N/A	N/A	N/A
Preventive Services	100% coverage	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
PCP Office Visits	$20 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Specialist Office Visits	Tier 1: $25 per visit Tier 2: $35 per visit Tier 3: $45 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Emergency Room	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted), then deductible	$30 per visit (waived if admitted)	$30 per visit (waived if admitted)	$75 per visit (waived if admitted)
Hospital Inpatient	Tier 1: $300, then deductible Tier 2: $700, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Day Surgery Not performed at physician office	$150, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Diagnostic Imaging, Lab Tests	100% coverage after deductible	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
High-Tech Imaging (MRIs, CT/CAT/PET scans)	$100, then deductible (max 1 copay per day)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Durable Medical Equipment	100% coverage after deductible	20% coinsurance after deductible	100% coverage ($1,500 annual max*)	100% coverage ($1,500 annual max*)	100% coverage ($1,500 annual max*)
Skilled Nursing Facility	20% coinsurance after deductible (max 45 days per year)		100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3		Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $5 Tier 1 $10 Tier 2 $25 Tier 3	Retail (30 days): $10 Tier 1 $15 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $15 Tier 2 $25 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $40 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $120 Tier 3
Annual Benefit Maximum	Unlimited		Unlimited	Unlimited	Unlimited
Fitness Benefit (membership reimbursement)	$150 per year, per individual / family		$150 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family

* Benefit maximum does not apply to durable medical equipment furnished as part of covered home dialysis, home health care, or hospice services.

Acton Health Insurance Trust
Exhibit III.A - Plan Design Comparisons
Tufts Health Plan Navigator and Current Non-Medicare Plans

	GIC Non-Medicare Plan with largest subscriber enrollment Tufts Health Plan Navigator		Current The Harvard Pilgrim HMO		
Plan Provisions	**In-Network**	**Out-of-Network**	**"$5"**	**"$15"**	**"$20"**
7/1/2011 Working Rates (Individual / Family)	**$590.34 / $1,439.59**		**$664.14 / $1,569.31**	**$644.80 / $1,523.60**	**$629.20 / $1,492.40**
Coinsurance	100%	80%	100%	100%	100%
Annual Deductibles (Individual / Family)	$250 / $750	$150 / Individual	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	$3,150 / Individual	N/A	N/A	N/A
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	Deductible and coinsurance	N/A	N/A	N/A
Preventive Services	100% coverage	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
PCP Office Visits	$20 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Specialist Office Visits	Tier 1: $25 per visit Tier 2: $35 per visit Tier 3: $45 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Emergency Room	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted), then deductible	$30 per visit (waived if admitted)	$30 per visit (waived if admitted)	$75 per visit (waived if admitted)
Hospital Inpatient	Tier 1: $300, then deductible Tier 2: $700, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Day Surgery Not performed at physician office	$150, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Diagnostic Imaging, Lab Tests	100% coverage after deductible	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
High-Tech Imaging (MRIs, CT/CAT/PET scans)	$100, then deductible (max 1 copay per day)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Durable Medical Equipment	100% coverage after deductible	20% coinsurance after deductible	20% coinsurance ($5,000 annual max)	20% coinsurance ($5,000 annual max)	20% coinsurance ($1,000 out-of pocket annual maximum)
Skilled Nursing Facility	20% coinsurance after deductible (max 45 days per year)		100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3		Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $75 Tier 3	Retail (30 days): $10 Tier 1 $15 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $75 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $40 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $120 Tier 3
Annual Benefit Maximum	Unlimited		Unlimited	Unlimited	Unlimited
Fitness Benefit (membership reimbursement)	$150 per year, per individual / family		$150 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family

Acton Health Insurance Trust
Exhibit III.A - Plan Design Comparisons
Tufts Health Plan Navigator and Current Non-Medicare Plans

Plan Provisions	GIC Non-Medicare Plan with largest subscriber enrollment Tufts Health Plan Navigator		Current BCBS Master Health Plus		
	In-Network	Out-of-Network	"$5"	"$15"	"$20"
7/1/2011 Working Rates (Individual / Family)	**$590.34 / $1,439.59**		**$1,328.29 / $3,111.84**	**$1,289.60 / $3,021.20**	**$1,263.60 / $2,958.80**
Coinsurance	100%	80%	100%	100%	100%
Annual Deductibles (Individual / Family)	$250 / $750	$150 / Individual	N/A	N/A	N/A
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	$3,150 / Individual	N/A	N/A	N/A
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	Deductible and coinsurance	N/A	N/A	N/A
Preventive Services	100% coverage	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
PCP Office Visits	$20 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Specialist Office Visits	Tier 1: $25 per visit Tier 2: $35 per visit Tier 3: $45 per visit	20% coinsurance after deductible	$5 per visit	$15 per visit	$20 per visit
Emergency Room	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted), then deductible	$25 per visit (waived if admitted)	$25 per visit (waived if admitted)	$75 per visit (waived if admitted)
Hospital Inpatient	Tier 1: $300, then deductible Tier 2: $700, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Day Surgery Not performed at physician office	$150, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Diagnostic Imaging, Lab Tests	100% coverage after deductible	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
High-Tech Imaging (MRIs, CT/CAT/PET scans)	$100, then deductible (max 1 copay per day)	20% coinsurance after deductible	100% coverage	100% coverage	100% coverage
Durable Medical Equipment	100% coverage after deductible	20% coinsurance after deductible	20% coinsurance	20% coinsurance	20% coinsurance
Skilled Nursing Facility	20% coinsurance after deductible (max 45 days per year)		100% coverage (no day limit)	100% coverage (no day limit)	100% coverage (no day limit)
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3		Retail (34 days): $5 generic $10 brand Mail Order (90 days): $5 generic $5 brand	Retail (30 days): $10 Tier 1 $15 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $15 Tier 2 $25 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $40 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $120 Tier 3
Annual Benefit Maximum	Unlimited		Unlimited	Unlimited	Unlimited
Fitness Benefit (membership reimbursement)	$150 per year, per individual/family		No benefit	No benefit	No benefit

Acton Health Insurance Trust
Exhibit III.A - Plan Design Comparisons
Tufts Health Plan Navigator and Current Non-Medicare Plans

Plan Provisions	GIC Non-Medicare Plan with largest subscriber enrollment: Tufts Health Plan Navigator		Current: BCBS Blue Care Elect Preferred (PPO)			
	In-Network	Out-of-Network	"$15" - In-Network	"15" - Out-of-Network	"$20" - In-Network	"$20" - Out-of-Network
7/1/2011 Working Rates (Individual / Family)	**$590.34 / $1,439.59**		**$1,081.60 / $2,542.80**		**$1,060.28 / $2,491.84**	
Coinsurance	100%	80%	100%	80%	100%	80%
Annual Deductibles (Individual / Family)	$250 / $750	$150 / Individual	N/A	$250 / $500	N/A	$250 / $500
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	$3,150 / Individual	N/A	$1,250 / $2,500	N/A	$1,250 / $2,500
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	Deductible and coinsurance	N/A	Deductible and coinsurance	N/A	Deductible and coinsurance
Preventive Services	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
PCP Office Visits	$20 per visit	20% coinsurance after deductible	$15 per visit	20% coinsurance after deductible	$20 per visit	20% coinsurance after deductible
Specialist Office Visits	Tier 1: $25 per visit Tier 2: $35 per visit Tier 3: $45 per visit	20% coinsurance after deductible	$15 per visit	20% coinsurance after deductible	$20 per visit	20% coinsurance after deductible
Emergency Room	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted), then deductible	$50 per visit (waived if admitted)	$50 per visit (waived if admitted), no deductible	$75 per visit (waived if admitted)	$75 per visit (waived if admitted), no deductible
Hospital Inpatient	Tier 1: $300, then deductible Tier 2: $700, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
Day Surgery Not performed at physician office	$150, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
Diagnostic Imaging, Lab Tests	100% coverage after deductible	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
High-Tech Imaging (MRIs, CT/CAT/PET scans)	$100, then deductible (max 1 copay per day)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
Durable Medical Equipment	100% coverage after deductible	20% coinsurance after deductible	100% coverage ($1,500 annual max*)	20% coinsurance after deductible ($1,500 annual max*)	100% coverage ($1,500 annual max*)	20% coinsurance after deductible ($1,500 annual max*)
Skilled Nursing Facility	20% coinsurance after deductible (max 45 days per year)		100% coverage (max 100 days per year)	20% coinsurance after deductible (max 100 days per year)	100% coverage (max 100 days per year)	20% coinsurance after deductible (max 100 days per year)
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3		Retail (30 days): $10 Tier 1 $25 Tier 2 $45 Tier 3 Mail Order (90 days): $10 Tier 1 $25 Tier 2 $45 Tier 3		Retail (30 days): $10 Tier 1 $25 Tier 2 $40 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $120 Tier 3	
Annual Benefit Maximum	Unlimited		Unlimited		Unlimited	
Fitness Benefit (membership reimbursement)	$150 per year, per individual / family		$150 per year, per individual / family		$150 per year, per individual / family	

* Benefit maximum does not apply to durable medical equipment furnished as part of covered home dialysis, home health care, or hospice services.

Acton Health Insurance Trust
Exhibit III.B - Plan Design Comparisons
UniCare State Indemnity Plan / Medicare Extension OME and Current Medicare Plans

Plan Provisions	GIC Medicare Plan with largest subscriber enrollment: UniCare State Indemnity Plan / Medicare Extension OME With CIC (comprehensive)	Current BCBS Medex 3	Current Tufts Medicare Preferred
Premium/Working Rates	**7/1/2011** **$357.64**	**7/1/2011** **$382.86**	**1/1/2011** **$242.00**
Preventive Services	100% coverage	100% coverage	100% coverage
PCP Office Visits	100% coverage after $35 calendar year deductible	100% coverage of Medicare deductible and coinsurance	$10 per visit
Specialist Office Visits	100% coverage after $35 calendar year deductible	100% coverage of Medicare deductible and coinsurance	$15 per visit
Routine Eye Exams	$10 per visit every 24 months	100% coverage of Medicare deductible and coinsurance	$15 per visit and up to $150 per year toward the purchase of glasses
Emergency Room	$25 per visit (waived if admitted)	100% coverage of Medicare deductible and coinsurance	$50 per visit (waived if admitted)
Hearing Aids	100% coverage of the first $500 after $35 calendar year deductible; then 80% of the next $1,500, up to a maximum benefit of $1,700 every two years	100% coverage of Medicare deductible and coinsurance	$500 purchase or repair allowance every 36 months
Hospital Inpatient	$50 per admission (max 1 copay per calendar quarter; waived if readmitted within 30 days in the same calendar year)	100% coverage of Medicare deductible and coinsurance	100% coverage after $300 annual deductible
Skilled Nursing Facility	$50 per admission (max 1 copay per calendar quarter; waived if readmitted within 30 days in the same calendar year)	100% coverage of Medicare daily coinsurance for days 21-100; $16 daily for days 101-365	100% coverage (max 100 days per year)
Day Surgery Not performed at physician office	100% coverage	100% coverage of Medicare deductible and coinsurance	$50 per day
Diagnostic Imaging, Lab Tests	100% coverage	100% coverage of Medicare deductible and coinsurance	100% coverage
Out-of-Pocket Maximum	$500	N/A	N/A
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3	Retail (30 days): $10 Tier 1 $20 Tier 2 $35 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $35 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $100 Tier 3 After reaching $4,550 in annual out-of-pocket drug costs : $2.50 generic / $6.30 brand or 5% coinsurance, whichever is greater

Acton Health Insurance Trust
Exhibit III.C - Plan Design Comparisons
Tufts Health Plan Navigator and Two Alternative Non-Medicare Plans

Plan Provisions	GIC Non-Medicare Plan with largest subscriber enrollment: Tufts Health Plan Navigator		Alternative 1		Alternative 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network (if applicable)	In-Network	Out-of-Network (if applicable)
Coinsurance	100%	80%	100%	80%	100%	80%
Annual Deductibles (Individual / Family)	$250 / $750	$150 / Individual	N/A	$250 / $500	N/A	$250 / $500
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	$3,150 / Individual	N/A	$1,250 / $2,500	N/A	$1,250 / $2,500
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	Deductible and coinsurance	N/A	Deductible and coinsurance	N/A	Deductible and coinsurance
Preventive Services	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
PCP Office Visits	$20 per visit	20% coinsurance after deductible	$20 per visit	20% coinsurance after deductible	$20 per visit	20% coinsurance after deductible
Specialist Office Visits	Tier 1: $25 per visit Tier 2: $35 per visit Tier 3: $45 per visit	20% coinsurance after deductible	$20 per visit	20% coinsurance after deductible	$35 per visit	20% coinsurance after deductible
Emergency Room	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted), then deductible	$100 per visit (waived if admitted)	$100 per visit (waived if admitted), no deductible	$100 per visit (waived if admitted)	$100 per visit (waived if admitted), no deductible
Hospital Inpatient	Tier 1: $300, then deductible Tier 2: $700, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	$200 copay	20% coinsurance after deductible
Day Surgery Not performed at physician office	$150, then deductible (max 4 copays per year)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	$100 copay	20% coinsurance after deductible
Diagnostic Imaging, Lab Tests	100% coverage after deductible	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible
High-Tech Imaging (MRIs, CT/CAT/PET scans)	$100, then deductible (max 1 copay per day)	20% coinsurance after deductible	100% coverage	20% coinsurance after deductible	$100 copay	20% coinsurance after deductible
Durable Medical Equipment	100% coverage after deductible	20% coinsurance after deductible	Same as current	Same as current	Same as current	Same as current
Skilled Nursing Facility	20% coinsurance after deductible (max 45 days per year)		100% coverage (max days per year - same as current)	20% coinsurance after deductible (max 100 days per year)	100% coverage (max days per year - same as current)	20% coinsurance after deductible (max 100 days per year)
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3		Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3 (or current if higher)		Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $110 Tier 3 (or current if higher)	
Annual Benefit Maximum	Unlimited		Unlimited		Unlimited	
Fitness Benefit (membership reimbursement)	$150 per year, per individual / family		Same as current		Same as current	

Acton Health Insurance Trust
Exhibit III.D - Plan Design Comparisons
Minuteman Nashoba Health Group - Non-Medicare Plans

Plan Provisions	FCHP Selectcare & Directcare EPO	FCHP Selectcare & Directcare EPO Rate Saver	Harvard Pilgrim Health Care EPO	Harvard Pilgrim Health Care EPO Rate Saver	Tufts EPO	Tufts EPO Rate Saver	Tufts POS
6/1/2011 Working Rates (Individual / Family)	**$628.00 / $1,675.00 - Select $593.00 / $1,589.00 - Direct**	**$533.00 / $1,424.00 - Select $504.00 / $1,351.00 - Direct**	**$721.00 / $1,874.00**	**$613.00 / $1,594.00**	**$711.00 / $1,933.00**	**$603.00 / $1,643.00**	**$1,596.00 / $4,210.00**
Coinsurance	100%	100%	100%	100%	100%	100%	80%
Annual Deductibles (Individual / Family)	N/A	N/A	N/A	N/A	N/A	N/A	$200 / $400
Annual Out-of-Pocket Maximum (Individual / Family)	N/A	N/A	N/A	N/A	N/A	N/A	$2,200 / $4,400
Expenses that Apply Towards Out-of-Pocket Maximum	N/A	N/A	N/A	N/A	N/A	N/A	Deductible and coinsurance
Preventive Services	$5 per visit	100% coverage	$10 per visit	100% coverage	$10 per visit	100% coverage	Authorized: $10 per visit Unauthorized: 20% coinsurance after deductible
PCP Office Visits	$5 per visit	$20 per visit	$10 per visit	$20 per visit	$10 per visit	$20 per visit	Authorized: $10 per visit Unauthorized: 20% coinsurance after deductible
Specialist Office Visits	$5 per visit	$40 per visit	$10 per visit	$40 per visit	$10 per visit	$40 per visit	Authorized: $10 per visit Unauthorized: 20% coinsurance after deductible
Emergency Room	$25 per visit (waived if admitted)	$100 per visit (waived if admitted)	$50 per visit (waived if admitted)	$100 per visit (waived if admitted)	$50 per visit (waived if admitted)	$100 per visit (waived if admitted)	$50 per visit (waived if admitted)
Hospital Inpatient	100% coverage	$250 per admission	100% coverage	$250 per admission	100% coverage	$250 per admission (max 4 copays per year)	Authorized: 100% coverage Unauthorized: 20% coinsurance after deductible
Day Surgery Not performed at physician office	100% coverage	$125 per occurrence	100% coverage	$125 per occurrence	100% coverage	$250 per occurrence (max 4 copays per year)	Authorized: 100% coverage Unauthorized: 20% coinsurance after deductible
Diagnostic Imaging, Lab Tests	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	Authorized: 100% coverage Unauthorized: 20% coinsurance after deductible
High-Tech Imaging (MRIs, CT/CAT/PET scans)	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	Authorized: 100% coverage Unauthorized: 20% coinsurance after deductible
Durable Medical Equipment	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	100% coverage	Authorized & Unauthorized: 100% coverage
Skilled Nursing Facility	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	Authorized: 100% coverage Unauthorized: 20% coinsurance after deductible (max 100 days per year)
Prescription Drug Copays	Retail (30 days): $5 Tier 1 $15 Tier 2 $35 Tier 3 Mail Order (90 days): $10 Tier 1 $30 Tier 2 $105 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $45 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $135 Tier 3	Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $75 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $45 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $135 Tier 3	Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $50 Tier 3	Retail (30 days): $10 Tier 1 $25 Tier 2 $45 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $90 Tier 3	Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $50 Tier 3
Annual Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	
Fitness Benefit (membership reimbursement)	$200 / $400 per year, per individual / family	$200 / $400 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family	$150 per year, per individual / family

Acton Health Insurance Trust
Exhibit III.E - Plan Design Comparisons
Minuteman Nashoba Health Group - Medicare Plans

Plan Provisions	Fallon Senior Plan Premier Medicare Advantage HMO	Tufts Medicare Preferred HMO Medicare Advantage HMO	Tufts Medicare Complement (TMC) Medi-gap HMO	Medicare Compliment Plan (MCP) Freedom-of-Choice Medicare supplement plan
1/1/2011 Premium Rates	**$267.00**	**$242.00**	**$390.00**	**$405.00**
Preventive Services	100% coverage	100% coverage	100% coverage	100% coverage
PCP Office Visits	$10 per visit	$10 per visit	$10 per visit	$10 per visit
Specialist Office Visits	$20 per visit	$15 per visit	$10 per visit	$10 per visit
Routine Eye Exams	$20 per visit and $150 eyewear allowance every 24 months	$15 per visit and up to $150 per year toward the purchase of glasses	$10 per visit	Not covered
Emergency Room	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	$50 per visit (waived if admitted)	100% coverage
Hearing Aids	$500 purchase allowance every 36 months	$500 purchase or repair allowance every 36 months	Not covered	Not covered
Hospital Inpatient	100% coverage	100% coverage after $300 annual deductible	100% coverage	100% coverage
Skilled Nursing Facility	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year)	100% coverage (max 100 days per year; any charges over $16 per day from day 101-365 are not covered)
Day Surgery Not performed at physician office	$75 per occurrence	$50 per day	100% coverage	100% coverage
Diagnostic Imaging, Lab Tests	100% coverage	100% coverage	100% coverage	100% coverage
Out-of-Pocket Maximum	N/A	N/A	N/A	N/A
Prescription Drug Copays	Retail (30 days): $10 Tier 1 $25 Tier 2 $45 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $90 Tier 3 After reaching $4,550 in annual out-of-pocket drug costs: $2.50 generic / $6.30 brand or 5% coinsurance, whichever is greater	Retail (30 days): $10 Tier 1 $25 Tier 2 $50 Tier 3 Mail Order (90 days): $20 Tier 1 $50 Tier 2 $100 Tier 3 After reaching $4,550 in annual out-of-pocket drug costs: $2.50 generic / $6.30 brand or 5% coinsurance, whichever is greater	Retail (30 days): $8 Tier 1 $20 Tier 2 $35 Tier 3 Mail Order (90 days): $16 Tier 1 $40 Tier 2 $70 Tier 3	Retail (30 days): $5 Tier 1 $10 Tier 2 $25 Tier 3 Mail Order (90 days): $10 Tier 1 $20 Tier 2 $50 Tier 3 After reaching $4,550 in annual out-of-pocket drug costs: $2.50 generic / $6.30 brand or 5% coinsurance, whichever is greater

Acton Health Insurance Trust
Exhibit IV - Enrollment
Current Plans - Current Enrollment

Enrollment as of September 14, 2011	Town of Acton			Acton Public Schools (APS)			Acton-Boxborough Regional Schools (ABRS)			TOTAL		
	Individual	Family	Total	Individual	Family	Total	Individual	Family	Total	Individual	Family	Total
Non-Medicare Actives and Retirees												
Network Blue New England												
"$5"	5	10	15	0	0	0	0	0	0	5	10	15
"$15"	0	0	0	55	82	137	85	132	217	140	214	354
"$20"	23	62	85	0	0	0	0	0	0	23	62	85
Total - Network Blue New England	28	72	100	55	82	137	85	132	217	168	286	454
HPHC HMO*												
"$5"	3	13	16	0	0	0	0	0	0	3	13	16
"$15"	0	0	0	31	87	118	39	118	157	70	205	275
"$20"	18	37	55	0	0	0	0	0	0	18	37	55
Total - HPHC HMO	21	50	71	31	87	118	39	118	157	91	255	346
Master Health Plus												
"$5"	5	6	11	0	0	0	0	0	0	5	6	11
"$15"	0	0	0	7	2	9	1	2	3	8	4	12
"$20"	8	3	11	0	0	0	0	0	0	8	3	11
Total - Master Health Plus	13	9	22	7	2	9	1	2	3	21	13	34
Blue Care Elect Preferred (PPO)												
"$15"	0	1	1	0	0	0	10	3	13	10	4	14
"$20"	0	1	1	0	0	0	0	0	0	0	1	1
Total - Blue Care Elect Preferred (PPO)	0	2	2	0	0	0	10	3	13	10	5	15
Medicare Retirees												
Medex 3	69	N/A	69	101	N/A	101	171	N/A	171	341	N/A	341
Tufts Medicare Preferred	15	N/A	15	23	N/A	23	33	N/A	33	71	N/A	71
TOTAL CURRENT ENROLLMENT	146	133	279	217	171	388	339	255	594	702	559	1,261

* HPHC HMO enrollment above does not include one individual covered under COBRA.

From: Robert Evans <revans5557@gmail.com> Thu, Oct 27, 2011 9:47:37 PM

Subject: Comments on Segal Report from the Trustees of the Health Insurance Trust

To: Finance Committee <fincom@acton-ma.gov>
Selectmen <bos@acton-mail.gov>
Acton-Boxborough Regional School Committee <abrsc@acton-ma.gov>

Attachments: Attach0.html 12K

To: Acton Board of Selectmen, Acton-Boxborough Regional School Committee, and Acton Finance Committee

From: Bob Evans, Chair Acton and AB Health Insurance Trust

Subject: Health Insurance and the Segal Report

RECOMENDATIONS

The Trustees meeting on October 20, 2011 reviewed and extensively discussed the Segal Report. They then voted to recommend that the Selectmen and the Regional School Committee exercise their rights under Chapter 69 and engage in negotiations with their employees regarding changes in health insurance Plan Design with the goal of standardizing, to the extent appropriate, the Plan Design for their insurance products. Such standardization would be very helpful to the Trust in administering the health insurance programs and in dealing with the insurance companies who administer our self-insured plans on a daily basis. In addition they voted to recommend that the Selectmen and the Regional School Committee do not attempt to move their employees into the GIC because of the large number of financial uncertainties associated with such a
move.

BACKGROUND

What follows is brief review of the issues, the main aspects of the Segal Report, and the basis for the Trustees recommendations.

If the Selectmen and the Regional School Committee are to take advantage of the recently passed legislation relative to municipal and school health insurance, they must acquire certain information concerning how their health insurance programs compare to those in the Commonwealth's GIC program. Acton's Health Insurance Trust agreed to obtain such estimates. The Trust contracted with Segal and Company, a national and well respected firm that consults concerning pensions and health insurance. It is the firm which Acton uses to provide estimates of unfunded liabilities for pension and health insurance for its financial statements.

The Health Insurance Trust has received a final report, copies of which have been provided to the Selectmen, Regional School Committee, and the Finance Committee. The Health Insurance Trust has examined the Report and discussed it at its regular meeting on October 20th.

The Report is filled with many numbers, but I believe that only three of them are really relevant. These are 8%, 32% and 26%. (These are found on pages 7 and 2 of the report)

The Health Insurance Trust offers four different insurance products to active employees, Master Health Plus, a Blue Cross PPO (both considered indemnity plans) and two HMOs, one with Blue Cross and one with Harvard Pilgrim. For these plans the Trust is self-insured. That means that all employee health costs are paid by the Trust and not by the insurance companies which administer them for the Trust. The companies are paid a percentage fee for their administrative services. Downside risk to the Trust is covered by the purchase of stop-loss insurance, which the Trust bids and buys on a yearly basis. Thus the premium rates are set by the Trust based upon Acton and the Regional Schools' experience.

In addition for Medicare retirees we offer self-insured Medix and two premium paid Medicare advantage plans. Except for the Medicare advantage plans the Selectmen and the School Committee negotiated with their unions the plan designs for these products. Plan Design refers to the package of deductibles, amounts paid before any insurance payment is made and co-pays for prescription, visits to doctors, emergency room use, hospital costs, etc. Plan designs for our HMO products are on pages 17 and 18 of the Report. These cover the vast majority of the employees. Plans for other of our insurance products are on pages 19-21.

Since these Plan Designs are negotiated with the School and Town unions. This has led to a number of plan designs. This is not efficient for the Trust in its administration of health insurance and in its dealing with the two insurance companies who administer the insurance plans on a day-to-day basis.

The first part of the Segal Report deals with a comparison of the Trust's cost under its various Plan Designs with the cost it would experience were its plan designs to be exactly the same as those of the most popular GIC insurance product, Tufts Navigator, as required under the regulations for the new legislation. The estimate of the savings (actually potential reductions in premiums set by the Trust) is a little over one million dollars for employees and employers, Acton and Acton-Boxborough, or 8%--the most important number in the Report, and one unchanged from Segal's first draft. (p.7)

The estimated premium savings represents higher employee payments for co-pays, and expected changes in usage, for example a visit to a Minute Clinic rather than the emergency room for certain after-hours events. While employees will save with lower premiums, as a group they will pay more with higher co-pays. The Segal Report does not attempt to estimate the extent of higher employee cost or its distribution between those employees who don't see the doctor in a given year and those who might have major procedures, for example a kidney transplant. Nor have the Trustees discussed these issues.

Since the 8% in premium savings exceeds the law's threshold requirement of 5% it allows—but does not require-- the Selectmen and or the Regional School Committee to open negotiations with their unions on Plan Design. The Trustees have voted to recommend to the Selectmen and the Regional School Committee that these bodies engage in Chapter 69 bargaining with their unions. The Trustees did not consider or vote on how much of the potential 8%, if any, should be sought since that is an issue for the Selectmen and the Regional School Committee not the Trustees. Such bargaining does offer the opportunity to move toward more standardized Plan Designs, and the Trustees strongly support achieving this.

Ideally the 8% could be deconstructed into the proportion due to deductibles, co-pays, etc., but because of the inter-relationship between usage and price the Segal analysis does not provide this. In addition there are tables in the Report which compare Trust Plan designs with other alternative Plan Designs which could provide the basis for a negotiating position if either the Selectmen or the School Committee chose to seek less than an 8% savings. Segal did suggest in an e-mail that about 2.9 percentage points of the eight is related to the deductible part of the Tufts Navigator Plan Design. This is consistent with a 3 percentage point estimate which I made based on Harvard Pilgrim HMO premiums.

Plan Design savings were estimated by Segal for the next five years. There they used their standard assumption that health care expenses will rise at 10% per year. This also is the estimate the Trust received for next year from Blue Cross and Blue Shield. The Trusts' own recent experience is much lower, averaging some 8% per year over a longer period and 4-4.5% for the most recent few years. If GIC rates rise at Segal's predicted 10% over the next five years and the Trust's grow more slowly then the dollar savings to Acton and Acton-Boxborough over the next five years will be lower than the five year savings estimated in the Segal Report.

The next section of Segal's Report deals with how much more or less could be saved by providing employees health insurance through the GIC rather than the Trust. Since the GIC provides a number of different insurance products with different premiums, such estimates require an estimate of which GIC products would be chosen by Acton and Acton Boxborough employees once in GIC. Segal has used its "best professional judgment" in making these assumptions and has estimated an additional 7% of first year savings. (Table 1E p. 10) The more relevant numbers are those in the text rather than

in all the tables. Were all employees to pick the least costly plans, savings would be 32% rather than 15%. BUT, if all chose the most expensive plans Acton and Acton Boxborough's health insurance costs would be 26% higher. (p. 2)

Peter Savage of Cook and Company, the Trust's health insurance advisor, believes as do I, that the assumptions underlying the Segal Report's estimated GIC savings of 15% error on the side of assuming that too many employees would select lower cost plans, especially because some of the plans do not allow treatment at major academic hospitals. There is also the question of which GIC plans would be accepted by Acton Medical or Concord Hillside both of which care for many of our employees. In addition to the uncertainty of which plans employees would purchase were they in GIC there is another un-known concerning GIC rates. Currently significant numbers of GIC employees live west of Route 495 where the prices for medical services are lower than those to the east of 495. As Quincy and other 128 to the Ocean towns move into GIC the higher costs of Metropolitan Boston medical procedures will inflate GIC costs in addition to the normal health care inflation. The Trust's rates already reflect these Metropolitan costs

For all of these reasons the Trustees believe that inherent variability of the estimates of saving from going beyond Plan Design savings and into GIC itself are too great to make such a decision a wise one. The Trustees voted to recommend that neither the Selectmen nor the Regional School Committee try to move their employees into GIC.

To re-cap: 1) There are potential savings associated with moving Acton and Acton Boxborough's Plan Designs closer to those of GIC' Tufts Navigator. (up to 8% in the first year) 2) Moving beyond Plan Design and into GIC is fraught with uncertainty. (Remember 32% savings on one hand and 26 percent cost increases on the other, and no-rational way to choose the probability of where in between our actual experience would lie.

Memo

To:	Acton-Boxborough Regional School Committee, Acton Public School Committee
From:	John Petersen
CC:	Acton Board of Selectmen, Acton Finance Committee,
	Acton Health Insurance Trustees, Steve Mills, Steve Ledoux
Date:	October 2, 2011
Subject:	Municipal Health Care Reform – Acton Process, Intergovernmental Coordination

Summary

This document provides background information relative to the history of health insurance offerings in the schools as well as a brief summary of the Municipal Health Care Reform process and work to date. The importance of coordinating the activity of the Acton-Boxborough Regional School Committee and the Acton Board of Selectmen is emphasized.

Recent Changes in Health Insurance Offerings ABRSD/APS

Three years ago the ABRSC and the APSC began a process of shifting health insurance costs from employer to employee to reduce the impact of health insurance costs on the school budget and as part of a larger effort to encourage more cost-effective use of medical services. The process started with the migration of all administrators (the most highly compensated employees in the schools) from a 15% employee contribution to a 25% employee contribution to health care. This change was embedded in the Administrator's Contract for FY10. On the acceptance of his contract in March of 2009, Dr. Stephen Mills requested that the contribution he had been offered (15%) be increased to match that of the administrators. School Administrators are fully responsible for this 25% contribution in our current fiscal year. Beginning in the fall of 2009, the school committees negotiated with our three unions to achieve contracts which required the same 25% employee contribution to health care. Mitigation payments are provided for FY12 and FY13, employees will be fully responsible for the 25% contribution in FY14. These increased employee health insurance payments are regressive, payment is not proportional to compensation so the school committee negotiated other contract elements with sensitivity to this issue. The schools have estimated that at full implementation more than $1 million per year of cost will be shifted from employer to employee, and the employee costs will increase with health care inflation. A critical element of the contracts as well as the agreements with non-union employees was that the same health insurance at the same cost would be offered to all groups.

Municipal Health Care Reform

Ten weeks ago, Governor Deval Patrick signed into law "An Act Relative to Municipal Health Insurance" which provided governmental bodies including town governments and regional school committees a new mechanism to modify the health care insurance provided to employees. As noted in the governor's press release, the objective of this legislation is, "... the reform's primary goal of creating significant savings for cities and towns." Per the text of the act, " 'Savings', for the purposes of sections 21, 22 and 23, shall mean the difference between the total projected premium costs for health insurance benefits provided by that subdivision without such changes for the same 12 month period."

In Acton, two governmental bodies have the opportunity to act under this legislation, the Town of Acton and the Acton-Boxborough Regional School Committee. The schools employ almost 700 individuals eligible for health insurance. Approximately 60% of the employees work for the ABRSD and about 40% work for the APS. School employees eligible for health insurance include non-union employees (1/3 of all employees), members of the Acton Education Association (AEA) including teachers and nurses, members of the Office Support Association (OSA), members of American Federation of State, County and Municipal Employees (ASFCME) as shown in the tables below. The contracts with the AEA, OSA and ASFCME are contracts between both the Regional School District and the Acton Public Schools. The School Committee has negotiated with each union without distinction between employees of the Region and the local schools. In fact employees frequently move from the region to the local or vice versa. As can be seen in the tables 1&2, subscription rates are comparable for the different groups of employees as well as between the APS and ABRSD employees. School employees represent about 2/3 of the enrollees in the Acton Health Insurance Trust.

Table 1. **Acton Public School**
Employees Eligible for Health Insurance and % Subscribing

Employee Groups	Family	Individual	Total	% Subscribing
Non-Union	76	23	99	73%
AEA	128	40	168	79%
OSA	3	4	7	71%
AFSCME	8	0	8	100%
Total	**215**	**67**	**282**	**77%**

Table 2. **Acton- Boxborough Regional School District**
Employees Eligible for Health Insurance and % Subscribing

Employee Groups	Family	Individual	Total	% Subscribing
Non-Union	113	43	156	79%
AEA	144	64	208	82%
OSA	18	5	23	78%
AFSCME	13	12	25	100%
Total	**230**	**124**	**412**	**82%**

An Act to Reform Health Insurance – A Work in Progress

As I write this, administration and finance issued emergency regulations for the Municipal Health Care Reform Act (August 12, 2011) and comments on the emergency regulations will be accepted until Oct 10, 2011. Thus, we are working in a dynamic regulatory environment.

The process of municipal health care reform as outlined in the Act and regulations has several major steps:

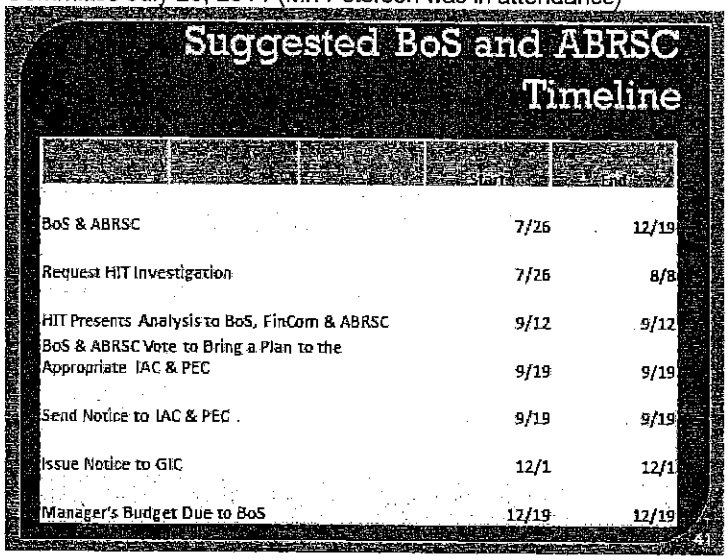
1. Determination whether or not 5% cost savings threshold will be met through plan modification
2. Development of a modified insurance proposal

3. Identification of disproportionately affected subscribers & development of mitigation plan
4. Negotiation with PEC, if successful modified plans implemented
5. If negotiations are not successful, Insurance Advisory Committee (IAC) determination of changes
6. Implement changes as approved by IAC

In July, John Murray outlined a general process by which Acton and the ABRSD might reach a modification of our health insurance offering as described in Table 3 (slides 41 &42, July 20, 2011). At the time of Mr. Murray's presentation, GIC entry was allowed only once per year with notification required by December 1, 2011.

Since then, GIC notification requirements have been relaxed, "For fiscal year 2012, it is our understanding that "An Act Relative to Municipal Health Insurance" (H.3580) allows municipalities to have three opportunities to transfer subscribers to the Group Insurance Commission (GIC): on January 1, April 1 or July 1, after a four-month notification to the GIC." Email from Fran Sciandra 8/5/11.

Table 3. Murray Proposed Process for Health Care Reform in Acton and the ABRSD as presented to the Finance Committee July 20, 2011 (Mr. Petersen was in attendance)



Suggested BoS and ABRSC Timeline

	Start	End
BoS & ABRSC	7/26	12/19
Request HIT Investigation	7/26	8/8
HIT Presents Analysis to BoS, FinCom & ABRSC	9/12	9/12
BoS & ABRSC Vote to Bring a Plan to the Appropriate IAC & PEC	9/19	9/19
Send Notice to IAC & PEC	9/19	9/19
Issue Notice to GIC	12/1	12/1
Manager's Budget Due to BoS	12/19	12/19

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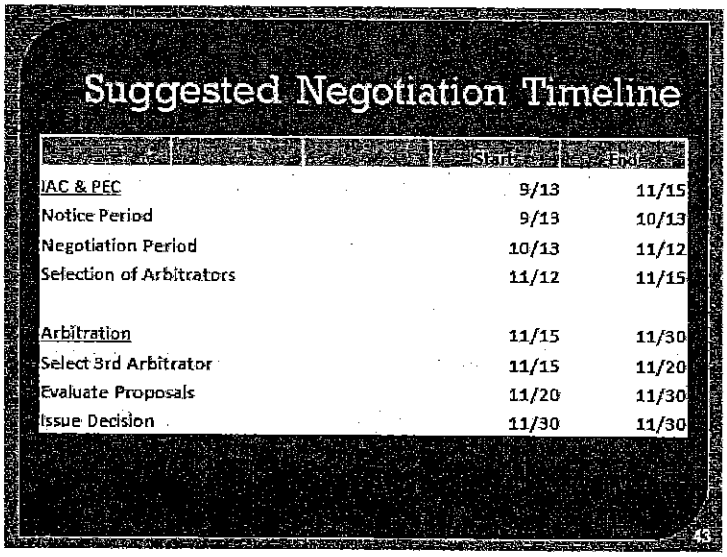

Suggested Negotiation Timeline

	Start	End
IAC & PEC	9/13	11/15
Notice Period	9/13	10/13
Negotiation Period	10/13	11/12
Selection of Arbitrators	11/12	11/15
Arbitration	11/15	11/30
Select 3rd Arbitrator	11/15	11/20
Evaluate Proposals	11/20	11/30
Issue Decision	11/30	11/30

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The first step in the process is to determine whether or not a change in health insurance plans would result in significant savings to the governmental entity. Based on the request of the Acton Board of Selectmen, the Acton-Boxborough Regional School Committee and the Acton Finance Committee, the trustees of the Acton Health Insurance Trust agreed to pay for such a study and contracted with Segal (contract executed on 8/15/11) to perform a study with the following key milestones:

- conference call with HIT representatives to agree on alternate plan designs (held 9/9/11)
- delivery of a draft report to the HIT (9/23/11)
- conference call to discuss revision to draft report (9/29/11)
- revision per instructions of the HIT (in progress)
- acceptance of the final report by the HIT (tbd)

While the final report is not available, the Segal draft analysis (as distributed 9/30/11) provides a useful perspective on the distribution of the costs in the trust between entities as well as between employer and employee (Table 4). The schools represent about 75% of the expense of the Health Insurance Trust (ABRSD 45%, APS 30% and the Town of Acton 25%).

Table 4. Segal DRAFT Report Projected Costs FY13, $ in '000s

Cost	Town		APS		ABRSD		Total
Employer	2813	*81%*	3130	*73%*	4648	*72%*	10591
Employee	664	*19%*	1184	*27%*	1787	*28%*	3635
Total	**3477**		**4314**		**6434**		**14226**
	25%		30%		45%		100%

An Act to Reform Health Insurance – Acton, ABRSD next steps

Within the next two weeks, the Segal report will be finalized. Once the report is complete, the HIT, per Mr. Murray's project plan, can schedule presentations to the Town of Acton, the ABRSC and the Acton Finance Committee so that each of these groups can determine the potential savings associated with modifications to our health care offerings. Each group will need to determine whether or not the 5% savings level which is a requirement for action under H.3580 would be achieved through modifications to our health insurance offering within the constraint of the law.

Given the history of the ABRSC negotiations with its unions (all negotiations conducted jointly with APSC), from a school committee perspective, my view is that it is not tenable for any modification of health care to be conducted separately for SC employees as a function of the whether they are employed by the ABRSD or APS. Such a decoupling would be counter to the principle that the school committee followed during negotiations with the individual unions – the health care offering should be the same for all.

I recommend that the ABRSC work closely with the Acton Board of Selectmen to ensure that however we proceed, we will not advance a course of action which results in different health insurance offerings to employees of the ABRSD and the APS.

H 3580

Chapter 69

THE COMMONWEALTH OF MASSACHUSETTS

In the Year Two Thousand and Eleven

AN ACT RELATIVE TO MUNICIPAL HEALTH INSURANCE.

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

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

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

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

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

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

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

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

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

"Employer", the governmental unit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all

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

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

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

subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

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

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

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

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

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

may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

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

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

(e) The first time a public authority implements plan design changes under this section or section 23, the public authority shall not increase before July 1, 2014,the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums from the percentage that was approved by the public authority prior to and in effect on July 1, 2011; provided however, that if a public authority approved of an increase in said percentage contributed by retirees before July 1, 2011, but to take effect on a date after July 1, 2011, said percentage increase may take effect upon the approval of the secretary of administration and finance based on documented evidence satisfactory to the secretary that the public authority approved the increase prior to July 1, 2011.

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

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the

political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150E and this chapter; provided, however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered

dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

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

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

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may

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

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

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

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

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or

change eligibility standards for health insurance under the definition of "employee" in section 2.

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

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

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

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

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

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

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

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

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

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

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

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

House of Representatives, July 11, 2011.

Preamble adopted, Paul J. Donato, Speaker.

In Senate, July 11, 2011.

Preamble adopted, Kenneth J. Donnelly, President.

House of Representatives, July 11, 2011.

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

In Senate, July 11, 2011.

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

12 July, 2011.

Approved,

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

Governor

COMMONWEALTH OF MASSACHUSETTS
STATE REGULATIONS DIVISION
2011 JUL 12 PM 12:47

NEW REGULATIONS –
801 CMR 52.00 MUNICIPAL HEALTH INSURANCE

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52.01 General provisions

(1) Authority

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

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

(2) Definitions

Unless otherwise provided, terms shall have the meanings assigned to them in M.G.L. c. 32B. The following terms shall have the following meanings:

"Collective bargaining unit" means an employee organization as defined in M.G.L. c. 150E, §1 that is acting as the exclusive bargaining representation of the bargaining unit. Notice to a collective bargaining unit under 801 CMR 52.02 shall be made to the principal officer of each bargaining unit.

"Impartial member" means the member of the review panel selected from a list of 3 potential members provided by the Secretary of Administration and Finance under the process set forth in 801 CMR 52.05(1).

"Implementation notice" means the notice required under M.G.L. c. 32B, §21(b) of the intent to enter into negotiations to implement proposed changes to health insurance benefits.

"Insurance advisory committee" means an advisory committee established by a public authority as specified in M.G.L. c. 32B, §3.

"Limited provider network" means a reduced or selective provider network which is smaller than a carrier's general provider network and from which the carrier may choose to exclude from participation other providers who participate in the carrier's regional provider network or general provider network for the purpose of reducing premium costs but which offers the same benefits to those provided by the carrier's general provider network .

"Maximum possible savings" is used to determine whether a proposal to transfer subscribers to the Commission would achieve at least five percent greater savings than the maximum possible savings that would be attained by plan design changes authorized under M.G.L. c. 32B, § 22 and means the savings that would be realized for the first 12 months if a political subdivision were to provide health insurance coverage to its subscribers by implementing changes to health insurance benefits that equal the dollar amounts of the most-subscribed plan's design features for the same or most similar benefits offered by the commission for a non-Medicare plan under section 4 of M.G.L. c. 32A and for a Medicare-extension plan under section 10C and section 14 of M.G.L. c. 32A. Where the political subdivision currently does not offer a tiered provider network, the maximum possible savings shall be calculated by comparing the savings that would result if the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features in the political subdivision's plan equaled the dollar amounts of the co-pays, deductibles and other cost-sharing plan design features under tier 2 of the commission's most-subscribed plan. Where the political subdivision currently offers a tiered provider network that is tiered differently from the tiering in the commission's most-subscribed plan, the maximum possible savings shall be calculated by assuming the co-pays, deductibles and cost-sharing plan design features in each tier of the political subdivision's plan are equal to those in the same tier of the commission's most-subscribed plan, beginning with a

comparison of the highest tier. If the political subdivision's plan has fewer tiers than the commission's plan, the political subdivision's highest tier shall be compared to the commission's tier 3, and the second highest tier to the commission's tier 2.

"Mitigation proposal" means a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

"Public Employee Committee" means the committee established under M.G.L. c. 32B, §19 or § 21. If a public employee committee has not been established under Section 19, a public employee committee shall be established exclusively to negotiate changes under Sections 21 to 23, and shall be established in the same form and with the same percent votes as prescribed in the fifth paragraph of subsection (a) of Section 19. A public employee committee established under Section 21 exclusively to negotiate changes under M.G.L. c. 32B, §§ 21 to 23 shall be considered dissolved upon completion of the process described in those sections.

"RSCME" means the Retired State, County and Municipal Employees Association, located at 11 Beacon Street, Suite 321, Boston, MA 02108.

"Review panel" means the municipal health insurance review panel comprised of 3 members, 1 of whom shall be appointed by the public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected under the process set forth in 801 CMR 52.05(1).

"Secretary" means the Secretary of Administration and Finance.

"Tiered provider network" means a provider network in which a carrier assigns providers to different benefit tiers based on the carrier's assessment of a provider's cost efficiency and quality, and in which insureds pay the cost-sharing (copayment, coinsurance or deductible) associated with a provider's assigned benefit tiers.

(3) Notices.

(a) All notices provided under 801 CMR 52.00 shall be sent by certified mail, delivery confirmation and return receipt requested, and a copy shall be sent to the Secretary. Either post office evidence of attempted delivery or return receipts shall be prima facie evidence of the time of receipt.

(b) All notices to the Secretary shall be sent electronically to: MunicipalHealth@state.ma.us.

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

(1) Advance notice of intent to vote.

At least two calendar days in advance of any vote electing to change group health insurance under the process authorized by M.G.L. c. 32B, §§ 21-23, the appropriate public authority shall send a notice to each collective bargaining unit to which the authority provides health insurance benefits and to the Retired State, County Municipal Employees Association (RSCME) that the political subdivision intends to vote on whether to implement the process. The vote of the political subdivision under M.G.L. c. 32B, § 21(a) may be in the following form: "The [name of political subdivision] elects to engage in the process to change health insurance benefits under M.G.L. c. 32B, §§ 21-23."

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

(a) A political subdivision which has elected under M.G.L. c. 32B, §21(a) to change health insurance benefits under M.G.L. c. 32B, §§ 22-23, shall, before implementing any changes, evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of cost-sharing plan design changes or upon transfer of its subscribers to the commission. The appropriate public authority shall then notify its insurance advisory committee, or such committee's regional or district equivalent, of its estimated savings. The notice shall include all the information required in section 52.03. In any political subdivision in which an insurance advisory committee has not already been established under M.G.L. c. 32B, §3, the appropriate public authority shall notify the president of each organization of employees affected and shall designate and notify a retiree of a governmental unit as a member of the committee. The insurance advisory committee, within 10 days after receiving this notice, shall meet with the appropriate public authority to discuss its estimated savings and any reports or other documentation requested by the insurance advisory committee before that meeting. If the committee does not meet within 10 days after receiving proper notice, it shall be considered to have discussed the matter with the appropriate public authority.

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

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

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

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

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

collective bargaining units and the RSCME. The notice shall include the following information:

(a) the proposed changes to the political subdivision's health insurance benefits, including:

(i) a description of the political subdivision's current health insurance plans and each plan's co-pays, deductibles and other cost-sharing plan design features, enrollment (broken out by enrollment in individual, individual plus one, and family plans), annual premium total cost, and percentage of premium total cost paid by political subdivision;

(ii) a description of the proposed changes, including:(a) the earliest practical date for implementing the changes under law;(b) each plan to be offered, and the projected enrollment under each plan, including continued projected enrollment for subscribers covered by existing collective bargaining agreements that specify plan design features; retirees enrolled and being transferred for the first time to Medicare under M.G. L. c. 32B, § 18A and Medicare supplemental health insurance plans; and subscribers moved to the new, proposed insurance plans; and (c) the proposed dollar amounts for each plan's co-pays, deductibles and other cost-sharing plan design features. A proposal shall not include a health benefit plan design feature which seeks to achieve premium savings by offering a limited network of providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a limited network of providers.

(b). the co-payments, deductibles, tiered provider network co-payments and other cost-sharing plan design features for the same or most similar benefits of the non-Medicare plan and the co-payments, deductibles, and other cost-sharing plan design features for the same or most similar benefits of the Medicare-extension plan with the largest subscriber enrollment offered by the Commission, as provided by the Commission under M.G.L. c. 32B, §28;

(c). the appropriate public authority's estimate of anticipated savings of such changes and the supporting information and analysis, including but not limited to:

i. the total projected premium costs and enrollment of plans under the existing coverage for the first 12-month period in which the appropriate public authority seeks to make changes as if no such changes were made,

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

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

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

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

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

If the proposed change involves a transfer of health insurance coverage of subscribers to the commission, the savings estimate shall be based on a determination of maximum possible savings.

(d) the mitigation proposal, including:
(i) the estimate of the cost to fund the proposal and what percentage that cost is of the savings;
(ii) an explanation and rationale for the proposal;
(iii) the manner in which it affects various subscribers, including those disproportionately affected;
(iv) the manner of distribution or allocation of estimated savings from the proposal.

52.04 The 30-day negotiation period

(1) The 30 (calendar) day negotiation period shall commence when each member of the public employee committee has received the implementation notice, with the information required under Section 52.03, in the manner specified under 801 CMR 52.01(3).

(2) The negotiations between the public employee committee and the appropriate public authority may include all aspects of the public authority's proposal. The parties are encouraged to negotiate in good faith.

(3) The public authority shall not implement any changes in health insurance benefits during negotiations absent mutual agreement of the public employee committee and the appropriate public authority.

(4) Any agreements reached between the public employee committee and the appropriate public authority shall be reduced to writing, and executed by the parties within the 30-day period.

(a) A written agreement shall include the plan design changes or transfer to the Commission, the process to notify subscribers of the changes, the timeframe to implement the changes and the mitigation plan. The same information required for the appropriate public authority's proposal under Section 52.03 shall be included in the agreement or in a separate document accompanying it. The appropriate public authority shall send a copy of the agreement and other documents accompanying it to the Secretary within 3 business days after execution of the agreement, and shall send notice to the health insurance review panel created under 801 CMR 52.05 that there is no need for its services.

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

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

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

52.05 Health insurance review panel

(1) Creation of the panel

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

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

(c) Within 3 business days after receiving the list, the appropriate public authority and the public employee committee shall jointly select the third member for the panel from the list and shall notify the Secretary of their joint selection.

(d) If the appropriate public authority and the public employee committee cannot agree within 3 business days on which person from the list to select as the third member of the review panel, the notice by the public authority to the Secretary shall include notification that the parties have been unable to reach agreement of the selection of a name from the list of potential impartial panel members. If the public authority and the public employee committee cannot agree, the Secretary shall appoint the impartial member from the list and notify the parties not later than the end of the 30-day negotiation period.

(2) If the appropriate public authority and the public employee committee are unable to reach a written agreement on the public authority's proposal within 30 calendar days, the matter shall be submitted to the municipal health insurance review panel. The appropriate public authority shall submit its original proposal to the panel within 3 business days after the end of the 30-day negotiation period, with a copy sent to the Secretary and each member of the public employee committee. The appropriate public authority shall submit to the panel the same proposal that it made to the public employee committee. If the proposal includes the introduction of a limited network plan, the appropriate public authority shall provide an enrollment survey, a determination of which subscribers would enroll in a broad plan and which subscribers would enroll in a limited network plan, and the effect that the addition of a limited network plan would have on total premium costs and on disproportionately affected subscribers. The results of the enrollment survey shall be considered in the savings analysis.

(3) The public employee committee shall also submit any alternate mitigation proposal to the panel and any other information the public employee committee wants the panel to consider with respect to any other matters before them within 3 business days after the end of the 30-day negotiation period, with a copy sent to the Secretary and the other parties.

(4) Any fee or compensation provided to the impartial panel member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority. The impartial members selected from the lists provided by the Secretary will be reimbursed only for reasonable travel expenses.

52.06 The health insurance review panel review process

(1) At any time before the panel has made decisions in accordance with this section, the parties may agree in writing, with copies to the panel and the Secretary, to terminate or suspend the review process for a stated period of time because they have reached an agreement, would like additional time to negotiate an agreement under Section 52.04, have mutually decided to return to collective bargaining pursuant to M.G.L. c. 150E or have mutually decided to resume negotiations under M.G.L. c. 32B, § 19.

(2) If both parties have not mutually agreed to terminate the review process, within 2 business days after receipt of notice of submission to the panel, the impartial member of the review panel shall fix a time, date, and place for the panel to convene and shall give notice to the parties.

(3) Meetings of the panel shall be conducted under the Open Meeting Law. The impartial member shall chair the panel's meetings and shall arrange for suitable records to be kept. The impartial member shall ensure that each member receives advance notice of the time, place and agenda for each meeting. All decisions shall be by recorded vote.

(4)When the panel convenes on the date and time set by the impartial panel member, the panel shall do the following:

(a) Review the public authority's proposed changes

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

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

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

(3) If the panel does not approve implementation because the appropriate public authority's proposal fails to meet the criteria detailed in Section 52.06(4)(a)(1) and (2), above , the appropriate public authority may submit a new proposal to the public employee committee and restart the process from that point pursuant to Section 52.03.

(b) Review the public authority's estimated monetary savings due to proposed changes, after consulting the Commission's actuary:

(1) Within 10 calendar days of receiving proposed changes under M.G.L. c. 32B, §§ 22 or 23, the panel shall confirm, the appropriate public authority's estimated monetary savings due to proposed changes under M.G.L. c. 32B, § 22 or § 23.

(2) If the proposal is to transfer subscribers to the Commission, the panel shall determine if the anticipated savings by doing so would be at least five percent greater than the maximum possible savings amount that would be attained by plan design changes authorized under M.G.L. c.32B, § 22. If the panel confirms these savings, the panel shall approve the appropriate public authority's immediate implementation of the proposed changes under M.G.L. c. 32B, § 23, subject to procedures adopted by the commission for transfer of subscribers.

(3) The appropriate public authority's estimate of savings due to the proposed changes shall be confirmed by the panel after consultation with the actuary selected by the Commission.

(4) If the panel finds that the savings estimate is unsubstantiated, it may require the public authority to provide additional information or submit a new savings estimate for the panel's review and confirmation. It may also require the public employee committee to submit a response to the new estimate.

(5) A certified copy of the vote confirming the savings estimate and, if the proposal is to transfer subscribers to the Commission, approval or rejection of the proposal, and explanation of the basis for any such change or disapproval shall be sent to the parties and the Secretary.

(c) Review the public authority's mitigation proposal:

(1) Within 10 calendar days of receiving proposed changes under M.G.L. c. 32B, § 22 or § 23, the panel shall review the proposal to mitigate, moderate or cap the impact of these changes for

subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(2) The municipal health insurance review panel may approve the mitigation proposal, or it may determine the proposal to be insufficient and may require additional savings to be shared with subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses, as determined by the panel. Premium reductions for subscribers that result from the plan design changes shall not be credited against the total amount determined to be required to fund the mitigation proposal. Any health reimbursement arrangements created under a mitigation proposal shall be administered by the appropriate public authority and shall not be the responsibility of the Commission.

(3) In no case shall the municipal health insurance review panel designate more than 25 percent of the estimated savings to subscribers.

(4) All obligations on behalf of the appropriate public authority related to the mitigation proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to subscribers has been expended.

(5) In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider: (a) any alternative proposal from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers, (b) discrepancies between the percentage contributed by retirees, surviving spouses and their dependent and the percentage contributed by other subscribers, and (c) the impact of the changes on subscribers, including in particular the impact on retirees, low-income subscribers and subscribers with high out-of-pocket costs.

(6) The panel's decision shall incorporate any agreements made by the parties, and shall constitute the written agreement between the public employee committee and the appropriate public authority. The agreement shall be binding on all subscribers and their representatives.

(d) Once the panel has taken the actions required above, the panel shall be considered dissolved.

52.07 Implementation of agreements reached pursuant to M.G.L. c. 32B, §§ 21- 23

(1) Subject to St. 2011, c. 69, § 4, a political subdivision shall implement changes to benefits for all subscribers as soon as practicable upon completing the process provided in M.G.L. c. 32B, § 21 and these regulations, but the public authority shall give subscribers at least 60 days notice before implementing any changes in health insurance benefits under these regulations. Implementation of changes under M.G.L. c. 32B, §22 shall occur not later than 90 days after a written agreement has been signed under 801 CMR 52.04 or 52.06 or, if the appropriate public authority and the public employee committee mutually determine that a mid-year change time would produce an undue burden, at the end of the current health insurance policy year. Implementation of transfer of subscribers to the commission shall be in accordance with the Commission's procedures. If a political subdivision provides notice to the commission by October 1, 2011 that it is transferring its subscribers to the commission and complies with the notice requirements provided by the Commission, the Commission shall allow the political subdivision to transfer its subscribers to the commission on or before January 1, 2012.

(2) Any political subdivision which does not seek to make changes under M.G.L. c. 32B, §§ 21-23, including any political subdivision which votes against adopting G.L. c. 32B, §§ 21-23, shall file with the Executive Office for Administration and Finance a report by June 30, 2012 comparing existing plan design to the maximum possible savings available if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23. To maintain comprehensive records of political subdivisions that make use of this process, savings in health insurance costs that resulted, and potential savings not achieved, and to measure the extent to which political subdivisions took advantage of this process, each political subdivision shall file an annual report by June 30 of each year with the Secretary showing:
(i) the health insurance plans that it offers and the number of subscribers in each;
(ii) whether it made use of M.G.L. c. 32B, § 19 or §§ 21-23;
(iii) if it did not make use of these processes, the maximum possible savings available if health benefit changes were made pursuant to M.G.L. c. 32B, §21-23.

(3) A political subdivision whose subscribers are currently covered by the commission shall not implement changes under this procedure until it has followed the procedure for withdrawal from coverage by the commission under the process set forth in the commission's regulations.

(4) If a political subdivision initiated the process for implementing changes in its group health insurance benefits under M.G.L. c. 32B, §§21 -23 before the effective date of these regulations and has proceeded in a manner inconsistent with any provision of these regulations, the Secretary may waive or modify those inconsistent provisions for that political subdivision provided that the political subdivision comply with all requirements

of M.G.L. c. 32B, §§21-23. An appropriate public authority shall seek such waiver from the Secretary in writing, with a copy to the public employee committee. Any member of the public employee committee may present the Secretary with its position on the waiver request within 3 business days of receipt of the request.

3.1.6
A

From: **Beth Petr** Wed, Nov 02, 2011 3:01:56 PM
"Marie Altieri" <maltieri@mail.ab.mec.edu>

Subject: Fwd: Health Insurance Presentation Attached

To: AB School Committee

Attachments:
Attach0.html 3K
Health Insurance Update.ppt 72K

Hello School Committee members,

This is a presentation that Marie did for our staff yesterday. It will be in the addendum for tomorrow night.

Beth

----- Original Message -----

Hi Everyone,

I am attaching the presentation that was given at the two health insurance presentations this afternoon. There is also more backup information, including the Segal report, in the School Committee packet located at http://ab.mec.edu/about/packets11-12/11-03-11-JT-BOS-JT-SC-packet.pdf .

Marie

Marie Altieri
Director of Personnel and Administrative Services
Acton and Acton-Boxborough Schools
978 264-4700 x 3209

Health Insurance Update for Employees

November 1, 2011

Chapter 69 of the Acts of 2011 "*Municipal Health Insurance Reform*"

- Governor Patrick signed into law July 12, 2011
- Emergency Regulations released August 12, 2011
- Public Comment Period
  August 12 – October 10, 2011
- Final Regulations scheduled for release in November, 2011

Summary of New Law's Methodology

- "After local acceptance, the appropriate **municipal public authority** (generally the executive) may follow a process prescribed by the law in order to make health insurance **plan design** changes or to transfer the community into the state's **Group Insurance Commission**."

Municipal Public Authority

- AB Regional School Employees → *AB Regional School Committee*
- APS and Town of Acton Employees → *Acton Board of Selectmen*

Plan Design

- Office Visit Co-Pays
- Deductibles
- Rx Prescription Drug Co-Pays
- Emergency Room Co-Pays
- In-Network Out-of-Network Co-Insurance
- Hospitalization

Group Insurance Commission (GIC)

- Insurance plans available to state employees
- Since 2007, Municipalities may opt to join the GIC
- Large Purchasing Power
- Lots of plan options
- Current most subscribed to GIC plans:
  Tufts Navigator
  UniCare (Medicare supplemental plan)

GIC Plan Design

• Office Visit Co-Pays $20	• Deductibles $250 ind/$750 family
• Rx Prescription Drug Co-Pays 30 Day: $10/$25/$50 90 Day: $20/$50/$110	• Emergency Room Co-Pays $100
• Out-of-Network Co-Insurance 20% after deductible	• Hospitalization Tier 1: $300 Tier 2: $700

	Premiums	
	Monthly	Annual
GIC:	$590 ind/$1,440 family	$7,080 ind/$17,720 family
Our HMOs:	$644 ind/$1,523 family	$7,740 ind/$18,288 family

Health Insurance Negotiation Paths

Three approaches available:

- Bargaining under MGL Ch. 150E
- Coalition Bargaining under MGL Ch. 32B Section 19
- NEW - Bargaining under MGL Ch. 32B Sections 21-23 (New Chapter 69 regs)
  - Approved July 12, 2011

Public Authority Negotiates

- **Chapter 150E**
  School Committee negotiates all school contracts
  Town Manager negotiates all town contracts

  One issue with 150E: Each union negotiates its own health insurance benefits and they can each end up different, yet the law requires that each municipality have an indemnity plan that is the same across all employees

- **Coalition Bargaining under MGL Ch. 32B Section 19**

- **NEW: Chapter 32B Sections 21-23 (*Chapter 69*)**
  Board of Selectmen have authority to negotiate with town employees and Acton Public School Employees

  Acton-Boxborough Regional School Committee negotiates with Acton-Boxborough Regional School Employees

Insurance Negotiating Committees

- **Insurance Advisory Committee (IAC)**
  A representative of each bargaining unit
  One retiree
  Consultation Only – makes recommendations

- **NEW: Public Employee Committee (PEC)**
  A representative of each bargaining unit
  One retiree (10% vote)
  The remaining 90% is a weighted vote based on members eligible for health insurance

Current School Contract Status

- All three contracts signed last year
- All union and non-union school employees have the same health insurance benefits:
  → Employees pay 25% of costs (HMO) and 50% of indemnity
  → Co-Pays
    $15 Office Visit
    $10, $15, $25 Tiered Prescription Drug
- Contracts expire in 2013
  OSA/AFSCME June 30, 2013
  AEA August 31, 2013

Current Municipal Contract Status

- Two contracts under negotiation
  Currently 15% employee contribution
  One group has $5 office visit co-pays
  The other group has $15 office visit co-pays
- One contract with agreement waiting for Town Meeting April 2012
  25% employee contribution (HMO) and 50% Indemnity
  $20 office visit co-pays
- One contract expires June 2012
  One contract expires June 2013
  Currently 15% employee contribution (HMO)
  and 50% Indemnity
  $20 office visit co-pays

Non-Union Employees

- Half of all employees eligible for health insurance do not belong to a bargaining unit
- Any changes to health insurance will affect all employees
- The IAC and PEC do not have a seat for a non-union representative
- If a school employee works for both school districts, his or her health insurance is in either APS or AB. If the employee looks at his/her paycheck, the paycheck that contains the health insurance deduction is the district that employee belongs to for health insurance

Chapter 69 Requirements

- **Each municipality must compare health insurance costs to the cost of the most highly subscribed GIC plans**
- **This cost comparison must be submitted to the state department of Administration and Finance by June 30, 2012**
- **When compared to the GIC, if there is at least 5% savings, the municipality may consider moving to the GIC or proposing alternate plan design**
- **Chapter 69 only looks at plan design; does not discuss employee contribution rate. Contribution rate is still negotiated under 150E**

Cost comparison study

- In August, the AB Regional School Committee and the Acton Board of Selectmen voted to ask the Health Insurance Trust to engage a study of health insurance costs
- The Segal Company completed the study
- GIC Highest Enrollment Plans:
  Tufts Navigator (Employees under 65)
  UniCare (Medicare supplement indemnity plan)
- Segal showed the GIC plan design would save 8.3% as compared to Town of Acton/ABRSD plan design. This translates to a total of $1.34 million employee/employer shared savings
- Since the report showed more than 5% savings, plan design changes can be considered
- The town is having an additional study done. Report should be available the end of this week

Chapter 69 Process

1. Cost Comparison
2. If they want to pursue options,
   BOS and ABRSC need to vote to accept Chapter 69
3. ABRSC could propose a new plan design to Regional Employee's IAC
   BOS could propose plan design to Town/APS Employee's IAC
   (30 day requirement for initial meeting)
4. Proposal would then go to a newly formed PEC (30 day requirement for initial meeting)
5. Negotiations take place with the PEC. If agreement, BOS and ABRSC shall vote, in open session their approval of the joint proposal

Chapter 69 Process (Continued)

6. If after a negotiation period of 30 days, a written agreement is not reached with the PEC, goes to binding arbitration with a Municipal Health Insurance Review Panel

   Panel Consists of:
   One employee representative of the PEC
   One representative of the public authority
   One person chosen from a list provided by the state department of Administration and Finance

7. Within 10 days the panel shall issue a plan design and mitigation payment plan
   (mitigation of up to 25% of first year savings returned to employees)

8. Implementation depends on language in each collective bargaining agreement. If there is language about co-pays, co-pays will not be changed until the contract expires. Implementation can be immediate for non-union employees and retirees.

Health Insurance Trust

- Town of Acton and Acton-Boxborough Regional Schools are self-insured
- Health Insurance Trust oversees health insurance plans, revenues and expenditures
- HIT Members
  Bob Evans (HIT Chair) Acton Finance Committee
  John Petersen ABRSC
  Mike Gowing Acton Board of Selectmen
  Tess Summers ABRSD Treasurer
  John Murray Town of Acton Treasurer

Recommendations of the HIT

- **The HIT reviewed Segal Report at Sept and Oct meetings**
- **The HIT recommends the BOS and ABRSC accepts chapter 69 and engage in negotiations with employee groups with a goal of standardizing plan design across all town and school employee groups.**
- **The HIT does not recommend moving Town of Acton and ABRSD employees to the GIC.**

Upcoming Meetings

- **Thursday November 3 JH Auditorium 7:00 pm**
  Joint meeting of ABRSC, APSC, and Acton BOS
  → Presentation by Bob Evans Health Insurance Trust
  → Discussion among both boards
  → Public Comment
- **Monday November 7 Acton Town Hall Rm. 204 7:00 pm**
  → Review of second study commissioned by the town
  → Discussion, public comment
  → Possible vote to adopt chapter 69

Town of Acton

And

The Acton Public Schools

Projection

GIC

Versus

New Plan Design
&
Mitigation Plan

Under

Municipal Health Reform Law

Town of Acton/Acton Public Schools
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EXECUTIVE SUMMARY

COOK

- Health Plan Management Group
- Workers' Compension Group
- Claims Recovery Services
- Injured-on-Duty

October 31, 2011

Mr. Steven L. Ledoux
Town Manager
Town of Acton
472 Main Street
Acton, MA 01720

Dear Mr. Ledoux:

The following is the Executive Summary for the report requested by the Town of Acton and the Acton Public Schools:

Cook & Company

The recently passed Municipal Health Reform Law outlines the procedure for Massachusetts municipalities to either modify their plans to resemble the Group Insurance Commission's (GIC) most popular plan design or to join the GIC plans directly. The following is the Town of Acton and the Acton Public School's projected costs for modifying their plans to match as closely as possible the benefit design of the GIC's most popular plan (the Tufts Navigator) and the projected costs should they join the GIC directly.

Since this group is currently part of the Acton Health Insurance Trust and the experience is not collected by sub group, we have projected the total group and extrapolated the Town and APS's costs using their October 1, 2011 enrollment figures.

The following assumptions have been used to develop costs:

1. The projections for the current plans are based on 17 months of claims experience and modifying them using current enrollment figures.
2. The inflation figures are those of the major carriers of 10% indemnity plans (Master Health Plus and Blue Care Elect), 8% for HMOs (Network Blue and HPHC) and 5% for Medex. We have also used 2% for administration and 10% for reinsurance.
3. The rates, however, have all been increased by 6% with the exception of the Medicare extension plans at 5%. These rates should produce revenue quite close to the expected costs in FY2013 and is slightly higher than the increase agreed to at the last Health Insurance Trust meeting.
4. The GIC rates are increased 5% for FY2013, which is about where they have averaged over the last 5 years.
5. When estimating where subscribers would migrate should you elect the GIC, we projected the MHP enrollees would remain in a full indemnity plan (Unicare Indemnity plan with CIC). Of the remaining subscribers, 10% would select one of the limited network HMO's and 90% would split between the Tufts Navigator and the HPHC PPO. All Medex subscribers would move to the Unicare Medicare Extension with CIC and the current Tufts Medicare enrollees would remain with that plan. These assumptions are based on actual migration patterns for municipalities which have moved to the GIC.

1025 Plain Street
P.O. Box 1068
Marshfield, MA
02050-1068

Tel: (781) 837.7300
www.cookandcompany.com

The results indicate that a move to the GIC would save about 6.6% vs. making no change. Modifying your existing plans to GIC look-a-like plans would save slightly more at 6.8% vs. making no change. These are the overall results.

These results are quite similar to the figures we are seeing for municipalities outside Route 128, where subscribers are seeking medical services in their neighborhoods. As you get closer to Boston, we find higher per member costs due to increased use of the higher cost facilities. These municipalities generally see increased savings when moving to the GIC, since GIC rates are statewide averages.

Cook & Company

As you move further away from Boston past Route 495, it is more likely that the current rates are closer to or below the GIC and there is increased savings by modifying the in-force plans rather than join the GIC.

We believe a bit more explanation is required as to why the FY2013 forecast is above the roughly 4% agreed at the Health Insurance Trust meeting in October. Currently we only have experience for three months in FY2012 and your plans have experienced design changes, contribution charges and much larger than normal migrations among plans. With all these variables, we felt the need to be quite conservative in our projections tipping toward higher expenses and the need for higher rates to cover these costs. As the year unfolds and there is more claims experience generated within the current plans and enrollments, forecasting can be a bit more aggressive. To the extent that those forecasts are lower it can only improve the savings resulting from modifying the plan designs or joining the GIC.

Respectfully submitted,

COOK & COMPANY, INC.
HEALTH PLAN MANAGEMENT GROUP

Peter C. Savage, LIA
Senior Executive Vice President

PCS:cl

Encs.

CURRENT
PLAN
YEAR

ACTON TOWN & APS - FISCAL YEAR 2012

For Period 7/1/11 Through 6/30/12

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MHP TOWN $5 co-pay	5	I	12	1328.29	1129.05	67,743	199.24	11,955	79,697	85
	6	F	12	3111.84	2645.06	190,445	466.78	33,608	224,052	85
MHP TOWN $20 co-pay	2	I	12	1263.60	631.80	15,163	631.80	15,163	30,326	50
	0	F	12	2958.80	0.00	-	2958.80	-	-	0
MHP Retiree TOWN	0	I	12	1328.29	664.15	-	664.15	-	-	50
$5 co-pay	0	F	12	3111.84	1555.92	-	1555.92	-	-	50
MHP Retiree TOWN	6	I	12	1263.60	631.80	45,490	631.80	45,490	90,979	50
$20 co-pay	3	F	12	2958.80	1479.40	53,258	1479.40	53,258	106,517	50
		MHP Town TOTALS:				**372,099**		**159,474**	**531,572**	
MHP SCHOOL APS	1	I	12	1289.60	644.80	7,738	644.80	7,738	15,475	50
$15 co-pay	0	F	12	3021.20	1510.60	-	1510.60	-	-	50
MHP Retiree SCHOOL	6	I	12	1289.60	644.80	46,426	644.80	46,426	92,851	50
$15 co-pay APS	2	F	12	3021.20	1510.60	36,254	1510.60	36,254	72,509	50
		MHP School TOTALS:				**90,418**		**90,418**	**180,835**	
Blue Care Elect Town	0	I	12	1081.60	919.36	-	162.24	-	-	85
Active $15 co-pay	1	F	12	2542.80	2161.38	25,937	381.42	4,577	30,514	85
Blue Care Elect Town	0	I	12	1060.28	901.24	-	159.04	-	-	85
Active $20 co-pay	1	F	12	2491.84	2118.06	25,417	373.78	4,485	29,902	85
B' `are Elect Town	0	I	12	1081.60	540.80	-	540.80	-	-	50
Re...ee $15 co-pay	0	F	12	2542.80	1271.40	-	1271.40	-	-	50
Blue Care Elect Town	0	I	12	1060.28	530.14	-	530.14	-	-	50
Retiree $20 co-pay	0	F	12	2491.84	1245.92	-	1245.92	-	-	50
		Blue Care Elect Town TOTALS:				**51,353**		**9,062**	**60,416**	
Blue Care Elect APS	0	I	12	1081.60	540.80	-	540.80	-	-	50
School $15 co-pay	0	F	12	2542.80	1271.40	-	1271.40	-	-	50
Blue Care Elect APS	0	I	12	1081.60	540.80	-	540.80	-	-	50
Retiree $15 co-pay	0	F	12	2542.80	1271.40	-	1271.40	-	-	50
		Blue Care Elect APS TOTALS:				-		-	-	
HMO BLUE TOWN	5	I	12	664.14	564.52	33,871	99.62	5,977	39,848	85
$5 CO-PAY	10	F	12	1569.31	1333.91	160,070	235.40	28,248	188,317	85
HMO BLUE TOWN	19	I	12	629.20	534.82	121,939	94.38	21,519	143,458	85
$20 CO-PAY	54	F	12	1492.40	1268.54	822,014	223.86	145,061	967,075	85
HMO BLUE TOWN	0	I	12	664.14	332.07	-	332.07	-	-	50
Retiree $5 CO-PAY	0	F	12	1569.31	784.66	-	784.66	-	-	50
HMO BLUE TOWN	4	I	12	629.20	314.60	15,101	314.60	15,101	30,202	50
Retiree $20 CO-PAY	8	F	12	1492.40	746.20	71,635	746.20	71,635	143,270	50
		HMO Blue Town TOTALS:				**1,224,630**		**287,541**	**1,512,170**	
HMO BLUE APS	38	I	12	644.80	483.60	220,522	161.20	73,507	294,029	75
$15 CO-PAY	78	F	12	1523.60	1142.70	1,069,567	380.90	356,522	1,426,090	75
H BLUE APS	17	I	12	644.80	322.40	65,770	322.40	65,770	131,539	50
Retiree$15 CO-PAY	4	F	12	1523.60	761.80	36,566	761.80	36,566	73,133	50
		HMO Blue ABS TOTALS:				**1,392,425**		**532,366**	**1,924,790**	

10/31/2011

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
HPHC TOWN	2	I	12	664.14	564.52	13,548	99.62	2,391	15,939	85
$5 ·PAY	13	F	12	1569.31	1333.91	208,091	235.40	36,722	244,812	85
HI TOWN	15	I	12	629.20	534.82	96,268	94.38	16,988	113,256	85
$20 CO-PAY	35	F	12	1492.40	1268.54	532,787	223.86	94,021	626,808	85
HPHC TOWN	1	I	12	664.14	0.00	-	664.14	7,970	7,970	0
COBRA $5 CO-PAY	0	F	12	1569.31	0.00	-	1569.31	-	-	0
HPHC TOWN	0	I	12	664.14	332.07	-	332.07	-	-	50
Retiree $5 CO-PAY	1	F	12	1569.31	784.66	9,416	784.66	9,416	18,832	50
HPHC TOWN	3	I	12	629.20	314.60	11,326	314.60	11,326	22,651	50
Retiree $20 CO-PAY	2	F	12	1492.40	746.20	17,909	746.20	17,909	35,818	50
		HPHC Town TOTALS:				**889,344**		**196,742**	**1,086,086**	
HPHC APS	24	I	12	644.80	483.60	139,277	161.20	46,426	185,702	75
$15 CO-PAY	79	F	12	1523.60	1142.70	1,083,280	380.90	361,093	1,444,373	75
HPHC APS	7	I	12	644.80	322.40	27,082	322.40	27,082	54,163	50
Retiree$15 CO-PAY	8	F	12	1523.60	761.80	73,133	761.80	73,133	146,266	50
		HPHC APS TOTALS:				**1,322,771**		**507,733**	**1,830,504**	
MEDEX TOWN	69	I	12	382.86	191.43	158,504	191.43	158,504	317,008	50
MEDEX APS	101	I	12	382.86	191.43	232,013	191.43	232,013	464,026	50
		MEDEX TOTALS:				**390,517**		**390,517**	**781,034**	
Tufts Medicare Preferre	15	I	6	242.00	121.00	10,890	121.00	10,890	21,780	50
1/1/11 TOWN	15	I	6	226.00	113.00	10,170	113.00	10,170	20,340	50
Tufts Medicare Preferre	23	I	6	242.00	121.00	16,698	121.00	16,698	33,396	50
1/ APS	23	I	6	226.00	113.00	15,594	113.00	15,594	31,188	50
HM		**FIRST SENIORITY 65 TOTALS:**				**53,352**		**53,352**	**106,704**	
				Budget Totals:		**5,786,908**		**2,227,205**	**8,014,112**	
						72.21%		**27.79%**	**100.00%**	

PROJECTED
FY 2013

ACTON TOWN & APS - FISCAL YEAR 2013

For Period 7/1/12 Through 6/30/13

Increase at 6% Average

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MHP TOWN $5 co-pay	5	I	12	1407.99	1196.79	71,807	211.20	12,672	84,479	85
6.0%	6	F	12	3298.55	2803.77	201,871	494.78	35,624	237,496	85
MHP TOWN $20 co-pay	2	I	12	1339.42	669.71	16,073	669.71	16,073	32,146	50
	0	F	12	3136.33	0.00	-	3136.33	-	-	0
MHP Retiree TOWN	0	I	12	1407.99	704.00	-	704.00	-	-	50
$5 co-pay 6%	0	F	12	3298.55	1649.28	-	1649.28	-	-	50
MHP Retiree TOWN	6	I	12	1339.42	669.71	48,219	669.71	48,219	96,438	50
$20 co-pay	3	F	12	3136.33	1568.17	56,454	1568.17	56,454	112,908	50
		MHP Town TOTALS:				**394,425**		**169,042**	**563,467**	
MHP SCHOOL APS	1	I	12	1366.98	683.49	8,202	683.49	8,202	16,404	50
$15 co-pay 6%	0	F	12	3202.47	1601.24	-	1601.24	-	-	50
MHP Retiree SCHOOL	6	I	12	1366.98	683.49	49,211	683.49	49,211	98,423	50
$15 co-pay APS	2	F	12	3202.47	1601.24	38,430	1601.24	38,430	76,859	50
		MHP School TOTALS:				**95,843**		**95,843**	**191,686**	
Blue Care Elect Town	0	I	12	1146.50	974.53	-	171.98	-	-	85
Active $15 co-pay 6%	1	F	12	2695.37	2291.06	27,493	404.31	4,852	32,344	85
Blue Care Elect Town	0	I	12	1123.90	955.32	-	168.59	-	-	85
Active $20 co-pay	1	F	12	2641.35	2245.15	26,942	396.20	4,754	31,696	85
Blue Care Elect Town	0	I	12	1146.50	573.25	-	573.25	-	-	50
Retiree $15 co-pay 6%	0	F	12	2695.37	1347.69	-	1347.69	-	-	50
Blue Care Elect Town	0	I	12	1123.90	561.95	-	561.95	-	-	50
Retiree $20 co-pay	0	F	12	2641.35	1320.68	-	1320.68	-	-	50
		Blue Care Elect Town TOTALS:				**54,435**		**9,606**	**64,041**	
Blue Care Elect APS	0	I	12	1146.50	573.25	-	573.25	-	-	50
School $15 co-pay	0	F	12	2695.37	1347.69	-	1347.69	-	-	50
Blue Care Elect APS	0	I	12	1146.50	573.25	-	573.25	-	-	50
Retiree $15 co-pay	0	F	12	2695.37	1347.69	-	1347.69	-	-	50
		Blue Care Elect APS TOTALS:				-		-	-	
HMO BLUE TOWN	5	I	12	703.99	598.39	35,903	105.60	6,336	42,239	85
$5 CO-PAY 6%	10	F	12	1663.47	1413.95	169,674	249.52	29,942	199,616	85
HMO BLUE TOWN	19	I	12	666.95	566.91	129,255	100.04	22,810	152,065	85
$20 CO-PAY	54	F	12	1581.94	1344.65	871,333	237.29	153,765	1,025,097	85
HMO BLUE TOWN	0	I	12	703.99	352.00	-	352.00	-	-	50
Retiree $5 CO-PAY 6%	0	F	12	1663.47	831.74	-	831.74	-	-	50
HMO BLUE TOWN	4	I	12	666.95	333.48	16,007	333.48	16,007	32,014	50
Retiree $20 CO-PAY	8	F	12	1581.94	790.97	75,933	790.97	75,933	151,866	50
		HMO Blue Town TOTALS:				**1,298,105**		**304,793**	**1,602,897**	
HMO BLUE APS	38	I	12	683.49	512.62	233,754	170.87	77,918	311,671	75
$15 CO-PAY 6%	78	F	12	1615.02	1211.27	1,133,744	403.76	377,915	1,511,659	75
HMO BLUE APS	17	I	12	683.49	341.75	69,716	341.75	69,716	139,432	50
Retiree $15 CO-PAY	4	F	12	1615.02	807.51	38,760	807.51	38,760	77,521	50
		HMO Blue ABS TOTALS:				**1,475,974**		**564,309**	**2,040,283**	

10/31/2011

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
HPHC TOWN	2	I	12	703.99	598.39	14,361	105.60	2,534	16,896	85
$5 CO-PAY 6%	13	F	12	1663.47	1413.95	220,576	249.52	38,925	259,501	85
HI TOWN	15	I	12	666.95	566.91	102,043	100.04	18,008	120,051	85
$20 CO-PAY	35	F	12	1581.94	1344.65	564,753	237.29	99,662	664,415	85
HPHC TOWN	1	I	12	664.14	0.00	-	664.14	7,970	7,970	0
COBRA $5 CO-PAY	0	F	12	1569.31	0.00	-	1569.31	-	-	0
HPHC TOWN	0	I	12	703.99	352.00	-	352.00	-	-	50
Retiree $5 CO-PAY 6%	1	F	12	1663.47	831.74	9,981	831.74	9,981	19,962	50
HPHC TOWN	3	I	12	666.95	333.48	12,005	333.48	12,005	24,010	50
Retiree $20 CO-PAY	2	F	12	1581.94	790.97	18,983	790.97	18,983	37,967	50
		HPHC Town TOTALS:				**942,703**		**208,068**	**1,150,771**	
HPHC APS	24	I	12	683.49	512.62	147,634	170.87	49,211	196,845	75
$15 CO-PAY 6%	79	F	12	1615.02	1211.27	1,148,279	403.76	382,760	1,531,039	75
HPHC APS	7	I	12	683.49	341.75	28,707	341.75	28,707	57,413	50
Retiree$15 CO-PAY	8	F	12	1615.02	807.51	77,521	807.51	77,521	155,042	50
6.0%		**HPHC APS TOTALS:**				**1,402,141**		**538,199**	**1,940,339**	
MEDEX TOWN	69	I	12	405.83	202.92	168,014	202.92	168,014	336,027	50
MEDEX APS	101	I	12	405.83	202.92	245,933	202.92	245,933	491,866	50
6%		**MEDEX TOTALS:**				**413,947**		**413,947**	**827,893**	
Tufts Medicare Preferre	15	I	6	226.00	113.00	10,170	113.00	10,170	20,340	50
1/1/13 TOWN 5%	15	I	6	237.30	118.65	10,679	118.65	10,679	21,357	50
Tufts Medicare Preferre	23	I	6	226.00	113.00	15,594	113.00	15,594	31,188	50
1/ APS 5%	23	I	6	237.30	118.65	16,374	118.65	16,374	32,747	50
HM		**FIRST SENIORITY 65 TOTALS:**				**52,816**		**52,816**	**105,632**	
			Budget Totals:			**6,130,387**		**2,356,622**	**8,487,010**	
						72.23%		**27.77%**	**100.00%**	

PROJECTED
GIC
BUDGETS

ACTON / APS - FISCAL YEAR 2012

For Period 7/1/11 Through 6/30/12

GIC

MHP TO Indemnity; 90%HMOs split Tufts & HPHC ppos; 10% HMOs to Limited Network Plans

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
UNICARE INDEMNITY	5	I	12	866.87	736.84	44,210	130.03	7,802	52,012	85.00
with CIC Town	6	F	12	2023.82	1720.25	123,858	303.57	21,857	145,715	85.00
	2	I	12	866.87	433.44	10,402	433.44	10,402	20,805	50.00
	0	F	12	2023.82	1011.91	-	1011.91	-	-	50.00
7/1/11-6/30/12		**UNICARE INDEMNITY TOTALS:**				**178,471**		**40,062**	**218,532**	
UNICARE INDEMNITY	6	I	12	866.87	433.44	31,207	433.44	31,207	62,415	50.00
with CIC Town Retiree	3	F	12	2023.82	1011.91	36,429	1011.91	36,429	72,858	50.00
7/1/11-6/30/12		**UNICARE INDEMNITY TOTALS:**				**67,636**		**67,636**	**135,272**	
UNICARE INDEMNITY	1	I	12	866.87	433.44	5,201	433.44	5,201	10,402	50.00
with CIC APS	0	F	12	2023.82	1011.91	-	1011.91	-	-	50.00
7/1/11-6/30/12		**UNICARE PLUS TOTALS:**				**5,201**		**5,201**	**10,402**	
UNICARE INDEMNITY	6	I	12	866.87	433.44	31,207	433.44	31,207	62,415	50.00
with CIC APS Retiree	2	F	12	2023.82	1011.91	24,286	1011.91	24,286	48,572	50.00
7/1/11-6/30/12		**UNICARE INDEMNITY TOTALS:**				**55,493**		**55,493**	**110,986**	
HPHC PPO	15	I	12	652.86	554.93	99,888	97.93	17,627	117,515	85.00
7/1/11-6/30/12	47	F	12	1592.99	1354.04	763,679	238.95	134,767	898,446	85.00
HPHC PPO	29	I	12	652.86	489.65	170,396	163.22	56,799	227,195	75.00
7/1/11-6/30/12	75	F	12	1592.99	1194.74	1,075,268	398.25	358,423	1,433,691	75.00
HPHC PPO	16	I	12	652.86	326.43	62,675	326.43	62,675	125,349	50.00
7/1/11-6/30/12	11	F	12	1592.99	796.50	105,137	796.50	105,137	210,275	50.00
HPHC PPO COBRA	1	I	12	652.86	0.00	-	652.86	7,834	7,834	0.00
NDEPENDENCE		**HPHC INDEPENDENCE TOTALS:**				**2,277,044**		**743,262**	**3,020,306**	
HPHC HMO	3	I	12	522.29	443.95	15,982	78.34	2,820	18,802	85.00
Primary Choice	7	F	12	1274.39	1083.23	90,991	191.16	16,057	107,049	85.00
HPHC HMO	4	I	12	522.29	391.72	18,802	130.57	6,267	25,070	75.00
Primary Choice	8	F	12	1274.39	955.79	91,756	318.60	30,585	122,341	75.00
7/1/11-6/30/12		**HPHC Primary Choice TOTALS:**				**217,532**		**55,731**	**273,263**	
TUFTS PPO	15	I	12	590.34	501.79	90,322	88.55	15,939	106,261	85.00
7/1/11-6/30/12	47	F	12	1439.59	1223.65	690,139	215.94	121,789	811,929	85.00
TUFTS PPO	30	I	12	590.34	442.76	159,392	147.59	53,131	212,522	75.00
7/1/11-6/30/12	73	F	12	1439.59	1079.69	945,811	359.90	315,270	1,261,081	75.00
TUFTS PPO	15	I	12	590.34	295.17	53,131	295.17	53,131	106,261	50.00
7/1/11-6/30/12	12	F	12	1439.59	719.80	103,650	719.80	103,650	207,301	50.00
NAVIGATOR		**TUFTS NAVIGATOR TOTALS:**				**2,042,445**		**662,910**	**2,705,355**	
TUFTS Health Plan Spirit	4	I	12	472.28	401.44	19,269	70.84	3,400	22,669	85.00
HMO- Type	7	F	12	1151.67	978.92	82,229	172.75	14,511	96,740	85.00
TUFTS Health Plan Spirit	3	I	12	472.28	354.21	12,752	118.07	4,251	17,002	75.00
HMO- Type	7	F	12	1151.67	863.75	72,555	287.92	24,185	96,740	75.00
7/1/11-6/30/12		**TUFTS NAVIGATOR TOTALS:**				**186,805**		**46,347**	**233,152**	
UNICARE MEDICARE EXTENSION with CIC	170	I	12	357.64	178.82	364,793	178.82	364,793	729,586	50.00
7/1/11-6/30/12		**TUFTS MCP TOTALS:**				**364,793**		**364,793**	**729,586**	
TUFTS HEALTH PLAN	38	I	6	258.79	209.62	47,793	49.17	11,211	59,004	81.00
MED E PREFERRED	38	I	6	258.79	209.62	47,793	49.17	11,211	59,004	81.00
7/1/11-6/30/12		**MEDICARE PREFERRED TOTALS:**				**95,587**		**22,422**	**118,008**	
10/27/2011		**Budget Totals:**				**5,491,006**		**2,063,856**	**7,554,862**	
						72.68%		**27.32%**	**100.00%**	

ACTON / APS - FISCAL YEAR 2013

For Period 7/1/12 Through 6/30/13

GIC

MHP TO Indemnity; 90%HMOs split Tufts & HPHC ppos; 10% HMOs to Limited Network Plans

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
UNICARE INDEMNITY	5	I	12	910.21	773.68	46,421	136.53	8,192	54,613	85.00
with CIC Town	6	F	12	2125.01	1806.26	130,051	318.75	22,950	153,001	85.00
+5%	2	I	12	910.21	455.11	10,923	455.11	10,923	21,845	50.00
	0	F	12	2125.01	1062.51	-	1062.51	-	-	50.00
7/1/12-6/30/13		**UNICARE INDEMNITY TOTALS:**				**187,394**		**42,065**	**229,458**	
JNICARE INDEMNITY	6	I	12	910.21	455.11	32,768	455.11	32,768	65,535	50.00
with CIC Town Retiree	3	F	12	2125.01	1062.51	38,250	1062.51	38,250	76,500	50.00
7/1/12-6/30/13 +5%		**UNICARE INDEMNITY TOTALS:**				**71,018**		**71,018**	**142,035**	
JNICARE INDEMNITY	1	I	12	910.21	455.11	5,461	455.11	5,461	10,923	50.00
with CIC APS	0	F	12	2125.01	1062.51	-	1062.51	-	-	50.00
7/1/12-6/30/13 +5%		**UNICARE PLUS TOTALS:**				**5,461**		**5,461**	**10,923**	
JNICARE INDEMNITY	6	I	12	910.21	455.11	32,768	455.11	32,768	65,535	50.00
with CIC APS Retiree	2	F	12	2125.01	1062.51	25,500	1062.51	25,500	51,000	50.00
7/1/12-6/30/13 +5%		**UNICARE INDEMNITY TOTALS:**				**58,268**		**58,268**	**116,535**	
HPHC PPO	15	I	12	685.50	582.68	104,882	102.83	18,509	123,390	85.00
7/1/12-6/30/13	47	F	12	1672.64	1421.74	801,864	250.90	141,505	943,369	85.00
HPHC PPO	29	I	12	685.50	514.13	178,916	171.38	59,639	238,554	75.00
7/1/12-6/30/13	75	F	12	1672.64	1254.48	1,129,032	418.16	376,344	1,505,376	75.00
HPHC PPO +%5	16	I	12	685.50	342.75	65,808	342.75	65,808	131,616	50.00
7/1/12-6/30/13	11	F	12	1672.64	836.32	110,394	836.32	110,394	220,788	50.00
HPHC PPO COBRA	1	I	12	685.50	0.00	-	685.50	8,226	8,226	0.00
NDEPENDENCE		**HPHC INDEPENDENCE TOTALS:**				**2,390,895**		**780,425**	**3,171,319**	
HPHC HMO	3	I	12	548.41	466.15	16,781	82.26	2,961	19,743	85.00
Primary Choice	7	F	12	1338.11	1137.39	95,541	200.72	16,860	112,401	85.00
HPHC HMO +5%	4	I	12	548.41	411.31	19,743	137.10	6,581	26,324	75.00
Primary Choice	8	F	12	1338.11	1003.58	96,344	334.53	32,115	128,459	75.00
/1/12-6/30/13		**HPHC Primary Choice TOTALS:**				**228,409**		**58,517**	**286,926**	
TUFTS PPO	15	I	12	619.86	526.88	94,839	92.98	16,736	111,575	85.00
/1/12-6/30/13	47	F	12	1511.57	1284.83	724,647	226.74	127,879	852,525	85.00
TUFTS PPO	30	I	12	619.86	464.90	167,362	154.97	55,787	223,150	75.00
/1/12-6/30/13 +5%	73	F	12	1511.57	1133.68	993,101	377.89	331,034	1,324,135	75.00
TUFTS PPO	15	I	12	619.86	309.93	55,787	309.93	55,787	111,575	50.00
/1/12-6/30/13	12	F	12	1511.57	755.79	108,833	755.79	108,833	217,666	50.00
NAVIGATOR		**TUFTS NAVIGATOR TOTALS:**				**2,144,569**		**696,057**	**2,840,626**	
TUFTS Health Plan Spirit	4	I	12	495.89	421.51	20,232	74.38	3,570	23,803	85.00
MO- Type +5%	7	F	12	1209.25	1027.86	86,340	181.39	15,237	101,577	85.00
TUFTS Health Plan Spirit	3	I	12	495.89	371.92	13,389	123.97	4,463	17,852	75.00
MO- Type	7	F	12	1209.25	906.94	76,183	302.31	25,394	101,577	75.00
/1/12-6/30/13		**TUFTS NAVIGATOR TOTALS:**				**196,145**		**48,664**	**244,809**	
NICARE MEDICARE XTENSION with CIC	170	I	12	375.52	187.76	383,030	187.76	383,030	766,061	50.00
/1/12-6/30/13 +5%		**TUFTS MCP TOTALS:**				**383,030**		**383,030**	**766,061**	
TUFTS HEALTH PLAN	38	I	6	258.79	209.62	47,793	49.17	11,211	59,004	81.00
EDI E PREFERRED	38	I	6	258.79	209.62	47,793	49.17	11,211	59,004	81.00
/1/12-6/30/13 +5%		**MEDICARE PREFERRED TOTALS:**				**95,587**		**22,422**	**118,008**	
Budget Totals:						**5,760,775**		**2,165,926**	**7,926,701**	
						72.68%		**27.32%**	**100.00%**	

10/27/2011

PROPOSED
NEW
PLANS

GIC TUFTS NAVIGATOR VERSUS TOWN OF ACTON HEALTH PLANS

		GIC		IN FORCE PLANS**			
		TUFTS NAVIGATOR		HMO HMO BLUE	HPHC	Blue Care Elect Preferred	Master Health Plus
		Calendar Year****	Calendar Year***			Out-of-Network	
Calendar Year Deductible		**In Network**	**Out of Network**				
	Individual	$250	$250	NA	NA	$250	NA
	Family	$750	$750			$500	
Primary Care Office Visit		$20	$20	$5/$15	$5/$15/$20	$15/$20	$5/$15
Preventive Services		Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Specialist Office Visit	Tier 1	$25	$25	$5/$20	$5/$15/$20	$15/$20	$5/$20
	Tier 2	$35	$35				
	Tier 3	$45	$45				
Emergency Room		$100*	$100*	$30/$30/$75	$30/$30/$75	$50/$75	$25/$25
Hospital Admission	Tier 1	$300*	$300*	Covered in Full	Covered in Full	Covered in Full	Covered in Full
	Tier 2	$700*	$700*				
	Tier 3						
Ambulatory Outpatient Surgery		$150*	$150*	Covered in Full	Covered in Full	Covered in Full	Covered in Full
High Tech Imaging (MRI, CT, PET)	Tier 1	$100*	$100*	Covered in Full	Covered in Full	Covered in Full	Covered in Full
	Tier 2	$100*	$100*				
	Tier 3	$100*	$100*				
Prescriptions							
Retail 30-day supply	Tier 1	$10	$10	$10	$5/$10/$10	$10/$10	$5/$10
	Tier 2	$25	$25	$20	$10/$15/$25	$25/$25	$10/$15
	Tier 3	$50	$50	$35	$25/$25/$40	$45/$45	$10/$25
Mail Order 90-day supply	Tier 1	$20	$20	$10	$10/$10/$20	$10/$20	$5/$10
	Tier 2	$50	$50	$20	$20/$20/$50	$25/$50	$5/$15
	Tier 3	$110	$110	$35	$75/$75/$120	$45/$120	$5/$25

* after deductible

** the different co-pays are showing several different in force plan designs

GIC TUFTS NAVIGATOR VERSUS ACTON H[illegible]LTH INSURANCE TRUST PLANS

		GIC	PROPOSED PLANS				
		TUFTS NAVIGATOR	NET BLUE NE/ HPHC Deductible/ Choice Net		Blue Care Elect HCCS		MHP GIC Type
		Calendar year	Plan Year**		Plan Year	Plan Year***	Plan Year**
					In Network	**Out of Network**	
Calendar Year Deductible	Individual	$250	$250	$250	$250	$400	$250
	Family	$750	$750	$750	$750	$800	$750
Primary Care Office Visit		$20	$20	$20	$20	20% Co pay*	$20
Preventive Services		Covered in Full	Covered in Full		Covered in Full	20% Co Pay*	Covered in Full
Specialist Office Visit	Tier 1	$25	$35	$25			
	Tier 2	$35	$35	$35	$35	20% Co pay*	$20
	Tier 3	$45	$35	$45			
Emergency Room		$100	$100	$100	$100*	$100*	$100*
Hospital Admission	Tier 1	$300*	$300*	$300*	$300*	20% Co pay*	OOP Max $1200P/P
	Tier 2	$700*	$300*	$300*	$300*		700*
	Tier 3		$700*	$700*	$700*	20% Co pay*	
Ambulatory Outpatient Surgery		$150*	$150*	$150*	$150*	20% Co pay*	OOP Max $600P/P $150* $150* $150*
High Tech Imaging (MRI, CT, PET)	Tier 1	$100*	$100*	$100*	$100*	20% Co pay*	$100*
	Tier 2	$100*	$100*	$100*	$100*	20% Co pay*	$100*
	Tier 3	$100*	$100*	$100*	$100*	20% Co pay*	$100*
Prescriptions Retail 30-day supply	Tier 1	$10	$10	$10	$10	$10	$10
	Tier 2	$25	$25	$25	$25	$25	$25
	Tier 3	$50	$50	$50	$50	$50	$50
Mail Order 90-day supply	Tier 1	$20	$20	$20	$20	$20	$20
	Tier 2	$50	$50	$50	$50	$50	$50
	Tier 3	$110	$110	$110	$110	$110	$110

* after deductible * after deductible

** Plan Year Out Of Pocket Max $2,500/$5,000

***PPO Out of Network OOP Individlal Max $3,000

GIC UNICARE OME VERSUS ACTON HEALTH INSURANCE TRUST MEDEX

		GIC UNICARE OME	CURRENT Acton Trust MEDEX	PROPOSED Acton Trust MEDEX
Office Visit		$0 after $35 calendar year deductible	Covered in Full	$0 after $35 calendar year deductible
Preventive Services		Covered in Full	Covered in Full	Covered in Full
Emergency Room		$25	Covered in Full	$25
Hospital Admission		$50 per admission (max 1 co-pay per calendar quarter)	Covered in Full	$50 per admission (max 1 co-par percalendar quarter)
Prescriptions				
Retail	Tier 1	$10	$10	$10
30-day supply	Tier 2	$25	$20	$20
	Tier 3	$50	$35	$35
Mail Order	Tier 1	$20	$10	$20
90-day supply	Tier 2	$50	$20	$40
	Tier 3	$110	$35	$70

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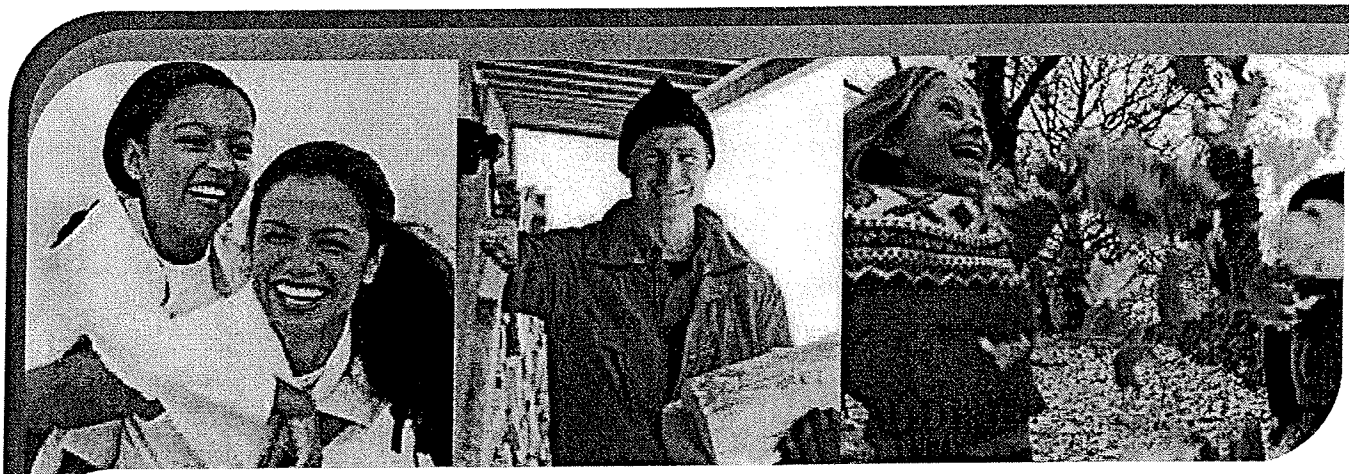
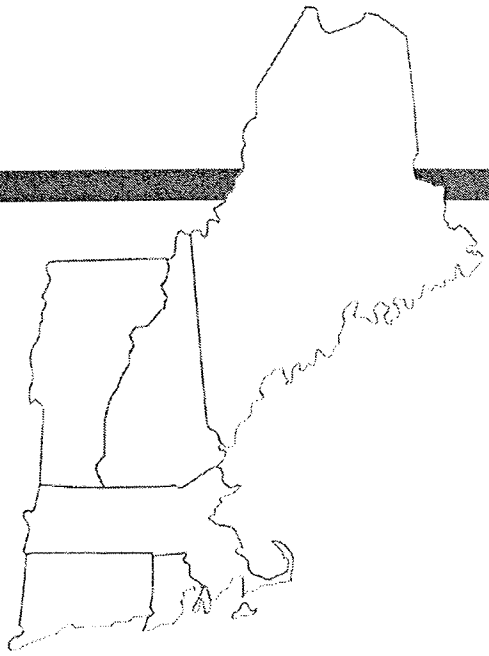


Network Blue New England Deductible

Plan-Year Deductible: $250/$750

Summary of Benefits



✔ This health plan meets Minimum Creditable Coverage Standards for Massachusetts residents effective January 1, 2011, as part of the Massachusetts Health Care Reform Law.

An Association of Independent Blue Cross and Blue Shield Plans

Your Care

Your Primary Care Provider.

When you enroll in Network Blue New England, you must choose a primary care provider (PCP) for you and each member of your family from any New England state. There are several ways to find a PCP: visit the Blue Cross Blue Shield of Massachusetts website at **www.bluecrossma.com**; consult the Provider Directory; or call our Physician Selection Service at **1-800-821-1388**. If you have trouble choosing a doctor, the Physician Selection Service can help. We can tell you whether a doctor is male or female, the medical school(s) he or she attended, and if any languages other than English are spoken in the office.

Referrals You Can Feel Better About.

Your PCP is the first person you call when you need routine or sick care (see *Emergency Care–Wherever You Are* for emergency care services). If you and your PCP decide that you need to see a specialist for covered services, your PCP will refer you to an appropriate network specialist. The specialist will usually be one your PCP knows, probably someone affiliated with your PCP's hospital or medical group. Your provider may also work with Blue Cross Blue Shield concerning the Utilization Review Requirements, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Certain Outpatient Services, and Individual Case Management. Information concerning Utilization Review is detailed in your benefit description.

Your Cost Share.

This plan has two levels of hospital benefits. You will pay a igher cost share when you receive inpatient care in "higher cost share hospital,"

Please note: If your PCP refers you to another hospital it is important to check whether the hospital you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive inpatient services at these hospitals, even if your PCP refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Berkshire Medical Center
- Brigham and Women's Hospital
- Cape Cod Hospital
- Caritas St. Anne's Hospital
- Children's Hospital Medical Center
- Cooley Dickinson Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital

North Shore Medical Center – Salem Campus

North Shore Medical Center – Union Campus

- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

Your Deductible.

You must pay a plan-year deductible for some covered services under this plan. Your deductible is **$250** for each member (or **$750** per family).

Your Out-of-Pocket Maximum.

Your out-of-pocket maximums are as follows:

- $1,200 per member, per plan year for all inpatient admissions
- $600 per member, per plan year for outpatient surgery in facilities other than an office setting

You will still have to pay any costs that are not included in calculating the out-of-pocket maximum.

Emergency Care—Wherever You Are.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call **911** (or the local emergency phone number). After your deductible, you pay a **$100** copayment per visit for emergency room services. The copayment is waived if you're admitted to the hospital or for an observation stay.

Service Area.

The plan's service area includes all cities and towns in the Commonwealth of Massachusetts, State of Rhode Island, State of Vermont, State of Connecticut, State of New Hampshire, and State of Maine.

When Outside the Service Area.

If you're traveling outside the service area and you need urgent or emergency care, go to the nearest appropriate health care facility. You are covered for the urgent or emergency care visit and one follow-up visit while outside the service area. Any additional follow-up care must be arranged by your PCP. Please see your benefit description for more information.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status, unless they are eligible for coverage under a non-parent employer-sponsored plan. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan-Year Deductible	$250 per member/$750 per family
Covered Services	**Your Cost**
ıtpatient Services Well-child care visits	Nothing, no deductible
Routine adult physical exams, including related tests	Nothing, no deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible
Routine hearing exams	Nothing, no deductible
Routine vision exams (one every 24 months)	Nothing, no deductible
Family planning services–office visits	Nothing, no deductible
Emergency room visits	$100 per visit, after deductible (copayment waived if admitted or for observation stay)
Mental health and substance abuse treatment	$15 per visit, no deductible
Office visits • When performed by your PCP, OB/GYN, network nurse practitioner, or nurse midwife • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Chiropractor services	$20 per visit, no deductible
Surgery in an office setting • When performed by your PCP or OB/GYN • When performed by other network providers	 $20 per visit, no deductible $35 per visit, no deductible
Allergy injections only	Nothing, no deductible
Home health care and hospice services	Nothing, no deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible
Diagnostic X-rays, lab tests, and other tests, excluding CT scans, MRIs, PET scans, nuclear cardiac imaging tests	Nothing after deductible
scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 per date of service after deductible
Oxygen and equipment for its administration	Nothing after deductible
Prosthetic devices	Nothing after deductible
Surgery in an ambulatory surgical facility, hospital outpatient department, or surgical day care unit	$150 per admission after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible
Inpatient Care (including maternity care) • General care hospital (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	 $300 per admission after deductible $700 per admission after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible
Mental health or substance abuse care • General hospital (as many days as medically necessary) • Mental hospital or substance abuse facility (as many days as medically necessary)	 $200 per admission after deductible $200 per admission after deductible
Rehabilitation hospital care	Nothing after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

Your Medical Benefits (continued)

Covered Services	Your Cost
Prescription Drug Benefits **(These services are not subject to the plan-year deductible)** At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No Deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No Deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3

Healthy Blue Programs

At Blue Cross Blue Shield of Massachusetts we offer you a group of programs, discounts and savings, resources, and tools to help you get the most you can from your health care plan. Call us at **1-800-782-3675** to receive information that outlines these special programs.

www.livinghealthybabies.com	No additional charge
A Fitness Benefit toward membership at a health club (see your benefit description for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy Vision℠–discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Safe Beginnings–discounts on home safety items	Discount varies
Living Healthy Naturally℠–discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Blue Care Line℠ to answer your health care questions 24 hours a day–call 1-888-247-BLUE (2583)	No additional charge
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com**.

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail?
Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your benefit description and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the benefit description and riders will govern. Some of the services not covered are: cosmetic surgery; custodial care; hearing aids; most dental care; and any services covered by workers' compensation. For a complete list of limitations and exclusions, refer to your benefit description and riders.

Please Note: Blue Cross and Blue Shield of Massachusetts, Inc. administers claims payment only and does not assume financial risk for claims.

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BlueCross® BlueShield®

RAFT **** ChoiceNet Benefit I ns - Illustrative E

Product	HPHC HMO ChoiceNet Option 2 Revised **(Post 12/31/11)**
OV Copay	
Tier 1	$20 / $25
Tier 2	$20 / $35
Tier 3	$20 / $45
ER	$100 then Subject to Deductible
High end Radiology	
Tier 1	$100 then Subject to Deductible
Tier 2	$100 then Subject to Deductible
Tier 3	$100 then Subject to Deductible
Surgical Day Care	
Tier 1	$150 then Subject to Deductible
Tier 2	$150 then Subject to Deductible
Tier 3	$150 then Subject to Deductible
Inpatient	
Tier 1	$300 then Subject to Deductible
Tier 2	$300 then Subject to Deductible
Tier 3	$700 then Subject to Deductible
Deductibles	
Tier 1	$250 / $750
Tier 2	$250 / $750
Tier 3	$250 / $750
OOP Max*	$2,000/$4,000
Out of Network Deductibles	N/A

PCP = All primary care physicians, OB/GYN, certified nurse nurse practioners, chiropractors, PT, ST, OT, mental health care, eye examinations Specialist = Any covered services or provider r under PCP copay.

ER = $100 then subject to the Deductible

Skilled Nursing facilities and rehab hospitals takes Tier 1 across the board

PT/OT/ST takes Tier 1 deductible

Radiology and lab test: physicial and hospital based services deductible of tier of physician or hospital, services at independen (non-hospital) will take Tier 1 deductible

Mental Health providers will take Tier 1

Prescription Drug Coverage

Covered prescription medications are available at participating pharmacies.

Your copayments for up to a 30-day supply are:

- **Tier 1:** **$10**
- **Tier 2:** **$25**
- **Tier 3:** **$50**

These copayment amounts will be shown on your Plan identification (ID) card. Bring your prescription or refill to a participating pharmacy, along with your ID card, and pay the applicable copayment.

Harvard Pilgrim's mail service prescription drug program (Maintenance medications ONLY)

If you have a condition (e.g., high blood pressure) that requires maintenance medications, you can order up to a 90-day supply of these drugs through Harvard Pilgrim's mail service prescription drug program. When you order a 90-day supply, you'll save money on your copayments as well as trips to the pharmacy.

Your copayments for a 90-day supply are:

- **Tier 1:** **$20**
- **Tier 2:** **$50**
- **Tier 3:** **$110**

Harvard Pilgrim Health Care

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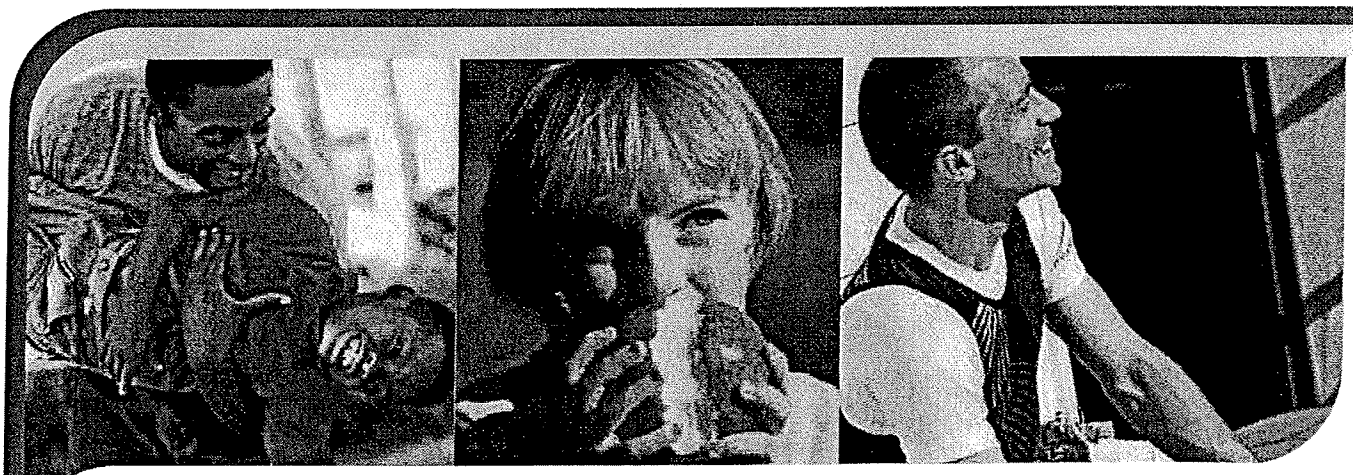
BlueShield®



Blue Care Elect Preferred℠ (PPO)

Summary of Benefits

MIIA
MASSACHUSETTS BASED
MEMBER DRIVEN

An Association of Independent Blue Cross and Blue Shield Plans

Your Choice

When You Choose Preferred Providers.

You must pay a calendar-year deductible for most in-network services. The [illegible]dar-year deductible begins on January 1 and ends on December 31 of [illegible] year. Your deductible is the first $250 of covered charges per member each calendar year (or $750 per family). You must also pay a co-payment for most services. Please refer to the detailed benefit section of this summary for the correct copayment.

When the following copayments equal the amounts shown below for a member in a calendar year, no more copayments will apply to these services for the remainder that calendar year:

- $1,200 per member for inpatient copayments
- $600 per member for day surgical admissions

Please note: If a preferred provider refers you to another provider for covered services (such as a specialist), make sure the provider is a preferred provider in order to receive benefits at the in-network level. If the provider you are referred to is not a preferred provider, you're still covered, but your benefits, in most situations, will be covered at the out-of-network level, even if the preferred provider refers you. It is also important to check whether the provider you are referred to is affiliated with one of the higher cost share hospitals listed below. Your cost will be greater when you receive inpatient services at hospitals, even if your preferred provider refers you.

Higher Cost Share Hospitals.

The Massachusetts hospitals listed below are the hospitals in which your cost share will be higher for inpatient admissions. Blue Cross Blue Shield will let you know if this list changes.

- Baystate Medical Center
- Berkshire Medical Center
- [illegible]gham and Women's Hospital
- [illegible]pe Cod Hospital
- Caritas St. Anne's Hospital
- Children's Hospital Medical Center
- Cooley Dickinson Hospital
- Dana-Farber Cancer Institute
- Fairview Hospital
- Harrington Memorial Hospital
- Massachusetts General Hospital
- North Shore Medical Center – Salem Campus
- North Shore Medical Center – Union Campus
- South Shore Hospital
- Sturdy Memorial Hospital
- UMass Memorial Medical Center – Memorial Campus
- UMass Memorial Medical Center – University Campus

How to Find a Preferred Provider.

There are several ways to find a preferred provider:

- Look up a provider in the Provider Directory. If you need a copy of your directory, call Member Service at the number on your ID card.
- Visit the Blue Cross Blue Shield of Massachusetts website at www.bluecrossma.com for Massachusetts providers.
- [illegible] the BlueCard® Provider Finder website at [illegible]//provider.bcbs.com.
- Call the BlueCard Program at 1-800-810-BLUE (2583), 24 hours a day, seven days a week.

When You Choose Non-Preferred Providers.

You must pay a separate calendar-year deductible for most out-of-network services. The calendar-year deductible begins on January 1 and ends on December 31 of each year. Your deductible is the first $400 of covered charges per member each calendar year (or $800 per family). After the calendar-year deductible has been met, you pay 20 percent co-insurance for most out-of-network covered services. When the money paid for the deductible and co-insurance equals $3,000 for a member in a calendar year, benefits for that member will be provided in full, based on the allowed charge, for the remainder of that calendar year. In Massachusetts, payments to non-preferred providers are based on the allowed charge. Please be aware that this means you may still be responsible for the difference between the allowed charge and the provider's actual charge.

Emergency Room Services.

In an emergency, such as a suspected heart attack, stroke, or poisoning, you should go directly to the nearest medical facility or call 911 (or the local emergency phone number). After your deductible, you pay a $100 copayment per visit for in-network or out-of-network emergency room services. The copayment is waived if you are admitted to the hospital or for an observation stay.

Utilization Review Requirements.

You must follow the requirements of Utilization Review, which are Pre-Admission Review, Concurrent Review and Discharge Planning, Prior Approval for Home Health Care, and Individual Case Management. If you need non-emergency or non-maternity hospitalization, you or someone on your behalf must call the number on your ID card for pre-approval. Information concerning Utilization Review is detailed in your subscriber certificate and riders. If you do not notify Blue Cross Blue Shield and receive pre-approval, your benefits may be reduced or denied.

Dependent Benefits.

This plan covers dependents up to age 26, regardless of the dependent's financial dependency, student status, or employment status. Please see your benefit description (and riders, if any) for exact coverage details.

Your Medical Benefits

Plan Specifics	Your Cost In-Network	Your Cost Out-of-Network
Calendar-year deductible	$250 per member $750 per family	$400 per member $800 per family
Calendar-year out-of-pocket maximum	$1,200 per member for inpatient copayments only $600 per member for day surgical admissions	$3,000 per member (includes deductible)
Covered Services		
Preventive Health Services Well-child care exams, including routine tests, according to age-based schedule as follows: • 10 visits during the first year of life • Three visits during the second year of life • One visit per calendar year from age 2 through age 18	Nothing, no deductible	20% co-insurance after deductible
Routine adult physical exams, including related tests, for members age 19 or older (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine GYN exams, including related lab tests (one per calendar year)	Nothing, no deductible	20% co-insurance after deductible
Routine hearing exams, including routine tests	Nothing, no deductible	20% co-insurance after deductible
Routine vision exams (one every 24 months)	Nothing, no deductible	20% co-insurance after deductible
Family planning services–office visits	Nothing, no deductible	20% co-insurance after deductible
Other Outpatient Care Emergency room visits	$100 per visit after deductible (copayment waived if admitted or for an observation stay)	$100 per visit after deductible (copayment waived if admitted or for an observation stay)
Office visits • Family or general practitioner, geriatric specialist, internist, multi-specialty provider group, nurse midwife, nurse practitioner, OB/GYN physician, or pediatrician • Other covered providers	$20 per visit, no deductible $35 per visit, no deductible	20% co-insurance after deductible 20% co-insurance after deductible
Chiropractors' office visits (up to 20 visits per calendar for members age 16 or older)	$20 per visit, no deductible	20% co-insurance after deductible
Mental health and substance abuse treatment	$15 per visit, no deductible	20% co-insurance after deductible
Short-term rehabilitation therapy–physical and occupational (up to 30 visits per calendar year for each type of therapy*)	$20 per visit, no deductible	20% co-insurance after deductible
Speech, hearing, and language disorder treatment–speech therapy	$20 per visit, no deductible	20% co-insurance after deductible
Diagnostic X-rays tests, lab tests, and other tests, excluding MRIs, CT scans, PET scans and nuclear cardiac imaging tests	Nothing after deductible	20% co-insurance after deductible
CT scans, MRIs, and PET scans and nuclear cardiac imaging tests	$100 per date of service after deductible	20% co-insurance after deductible
Home health care and hospice services	Nothing after deductible	20% co-insurance after deductible
Oxygen and equipment for its administration	Nothing after deductible	20% co-insurance after deductible
Prosthetic devices	Nothing after deductible	20% co-insurance after deductible
Durable medical equipment–such as wheelchairs, crutches, hospital beds	Nothing after deductible	20% co-insurance after deductible
Surgery and related anesthesia in an office or health center setting • Family or general practitioner, geriatric specialist, internist, multi-specialty provider group, nurse midwife, nurse practitioner, OB/GYN physician, or pediatrician • Other covered providers	$20 per visit, no deductible $35 per visit, no deductible	20% co-insurance after deductible 20% co-insurance after deductible
Surgery and related anesthesia in other than an office setting	$150 per admission after deductible	20% co-insurance after deductible

* No visit limit applies when short-term rehabilitation therapy is furnished as part of covered home health care or for the treatment of autism spectrum disorders.

IMPORTANT NOTE about how your copayments will be determined: The copayment amount that you must pay will be determined by Blue Cross and Blue Shield based on the preferred provider's specialty type as shown on Blue Cross and Blue Shield's provider files at the time your claim is processed. A preferred provider may change his or her specialty at any time. However, Blue Cross and Blue Shield's provider files are updated for changes of specialty type only once every three years. Until Blue Cross and Blue Shield's provider files are updated with a new specialty type for a preferred provider, the copayment amount that you pay will be based on the preferred provider's specialty type as shown on Blue Cross and Blue Shield's provider files.

Your Medical Benefits (continued)

Covered Services	Your Cost In-Network	Your Cost Out-of-Network
Inpatient Care (including maternity care) • General hospital care (as many days as medically necessary) • In higher cost share hospitals (as many days as medically necessary)	$300 per admission after deductible $700 per admission after deductible	20% co-insurance after deductible 20% co-insurance after deductible
Mental hospital or substance abuse facility care (as many days as medically necessary)	$200 per admission after deductible	20% co-insurance after deductible
Chronic disease hospital care (as many days as medically necessary)	Nothing after deductible	20% co-insurance after deductible
Rehabilitation hospital care	Nothing after deductible	20% co-insurance after deductible
Skilled nursing facility care (up to 45 days per calendar year)	Nothing after deductible	20% co-insurance after deductible
Prescription Drug Benefits At designated retail pharmacies (up to a 30-day formulary supply for each prescription or refill)	No deductible $10 for Tier 1 $25 for Tier 2 $50 for Tier 3	Not covered
Through the designated mail service pharmacy (up to a 90-day formulary supply for each prescription or refill)	No deductible $20 for Tier 1 $50 for Tier 2 $110 for Tier 3	Not covered

Healthy Blue Programs

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www.livinghealthybabies.com	No additional charge
A Fitness Benefit toward membership at a health club (see your subscriber certificate for details)	$150 per year, per individual/family
Reimbursement for a Blue Cross Blue Shield of Massachusetts designated weight loss program	$150 per year, per individual/family
Living Healthy Vision℠—discounts on eyewear (frames, lenses, supplies, and laser vision correction surgery)	Discount varies
Safe Beginnings—discounts on home safety items	Discount varies
Blue Care Line℠ to answer your health care questions 24 hours a day—call 1-888-247-BLUE (2583)	No additional charge
Living Healthy Naturally℠—discounts on different types of complementary and alternative medicine services such as acupuncture, massage therapy, nutritional counseling, personal training, Pilates, tai chi, and yoga	Up to a 30% discount
Visit www.AHealthyMe.com for an around-the-clock healthy approach to fitness, family, and fun	No additional charge

Questions? Call 1-800-782-3675.

For questions about Blue Cross Blue Shield of Massachusetts, visit the website at **www.bluecrossma.com.**

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BlueCross® BlueShield®

Schedule of Benefits

Master Health Plus

This is the *Schedule of Benefits* that is a part of your Benefit Description. This chart describes the cost share amounts that you must pay for *covered services*. It also shows the *benefit limits* that apply for *covered services*. Do not rely on this chart alone. Be sure to read all parts of your Benefit Description to understand the requirements that you must follow to receive all of your coverage. You should also read the descriptions of *covered services* and the limitations and exclusions that apply for this coverage. These provisions are fully described in your Benefit Description. To receive your health plan coverage, you must be sure to obtain all of your health care services and supplies from *Blue Cross and Blue Shield* participating health care providers. Also, for certain health care services and supplies, you must receive an approval from *Blue Cross and Blue Shield* as outlined in your Benefit Description. (See Part 4 in your Benefit Description.) If an approval is required, you should make sure that you have received the approval from *Blue Cross and Blue Shield* before you receive the *covered services*. Otherwise, you may have to pay all costs.

IMPORTANT NOTE: *Blue Cross and Blue Shield* and/or your *group* may change the provisions described in this *Schedule of Benefits*. If this is the case, the change is described in a *rider*. Be sure to read each *rider* (if there is any) that applies to your coverage in this health plan to see if it changes this *Schedule of Benefits*.

Overall Member Cost Share Provisions	
Deductible Your *deductible* per *Plan Year*:	$250 per *member*; $750 per family
This *deductible* applies to all *covered services* except preventive health services, prescription drugs and supplies, and certain other *covered services* as noted below in this chart.	The family *deductible* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member deductible*.
Out-of-Pocket Maximum Your *out-of-pocket maximum* per *Plan Year*:	$2,500 per *member*; $5,000 per family
This *out-of-pocket maximum* is a total of your *deductible, copayments* that are more than $100, and *coinsurance*, excluding costs for prescription drugs and supplies. You will still have to pay any costs not included in this *out-of-pocket maximum*.	The family *out-of-pocket maximum* can be met by eligible costs incurred by any combination of *members* enrolled under the same family plan. But, no one *member* will have to pay more than the per *member out-of-pocket maximum*.
Overall Benefit Maximum	None

Covered Services		Your Cost is:
Admissions for Inpatient Medical and Surgical Care	• In a General or Chronic Disease Hospital	$700 *copayment* per admission after *deductible*
	• In a Rehabilitation Hospital	Nothing after *deductible*
	• In a Skilled Nursing Facility	Nothing after *deductible*
Ambulance Services (ground or air ambulance transport)	• Air ambulance transport and ground ambulance transport between a hospital and skilled nursing facility while an *inpatient*	Nothing after *deductible*
	• Ground ambulance transport not described above	20% *coinsurance* after *deductible*
Cardiac Rehabilitation	*Outpatient* services	20% *coinsurance* after *deductible*
Chiropractor Services (for *members* of any age)	• *Outpatient* lab tests and x-rays	Nothing after *deductible*
	• *Outpatient* medical care services, including spinal manipulation	$20 *copayment* per visit (*deductible* does not apply)
Dialysis Services	*Outpatient* services and home dialysis	Nothing after *deductible*
Durable Medical Equipment	Purchased or rented for home use	20% *coinsurance* after *deductible*
Early Intervention Services	(for an eligible child through age two)	Nothing (*deductible* does not apply)
Emergency Medical Outpatient Services	• Emergency room services	$100 *copayment* per visit (*deductible* does not apply)
		The emergency room *copayment* is waived if the visit results in your being held for an overnight observation stay.
	• Office, health center, and hospital services	$20 *copayment* per visit (*deductible* does not apply)
Home Health Care	Home care program	Nothing after *deductible*
Hospice Services	*Inpatient* or *outpatient* hospice services for terminally ill	Nothing after *deductible*
Infertility Services	• *Inpatient* services	$700 *copayment* per admission after *deductible*
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* medical care services	$20 *copayment* per visit (*deductible* does not apply)

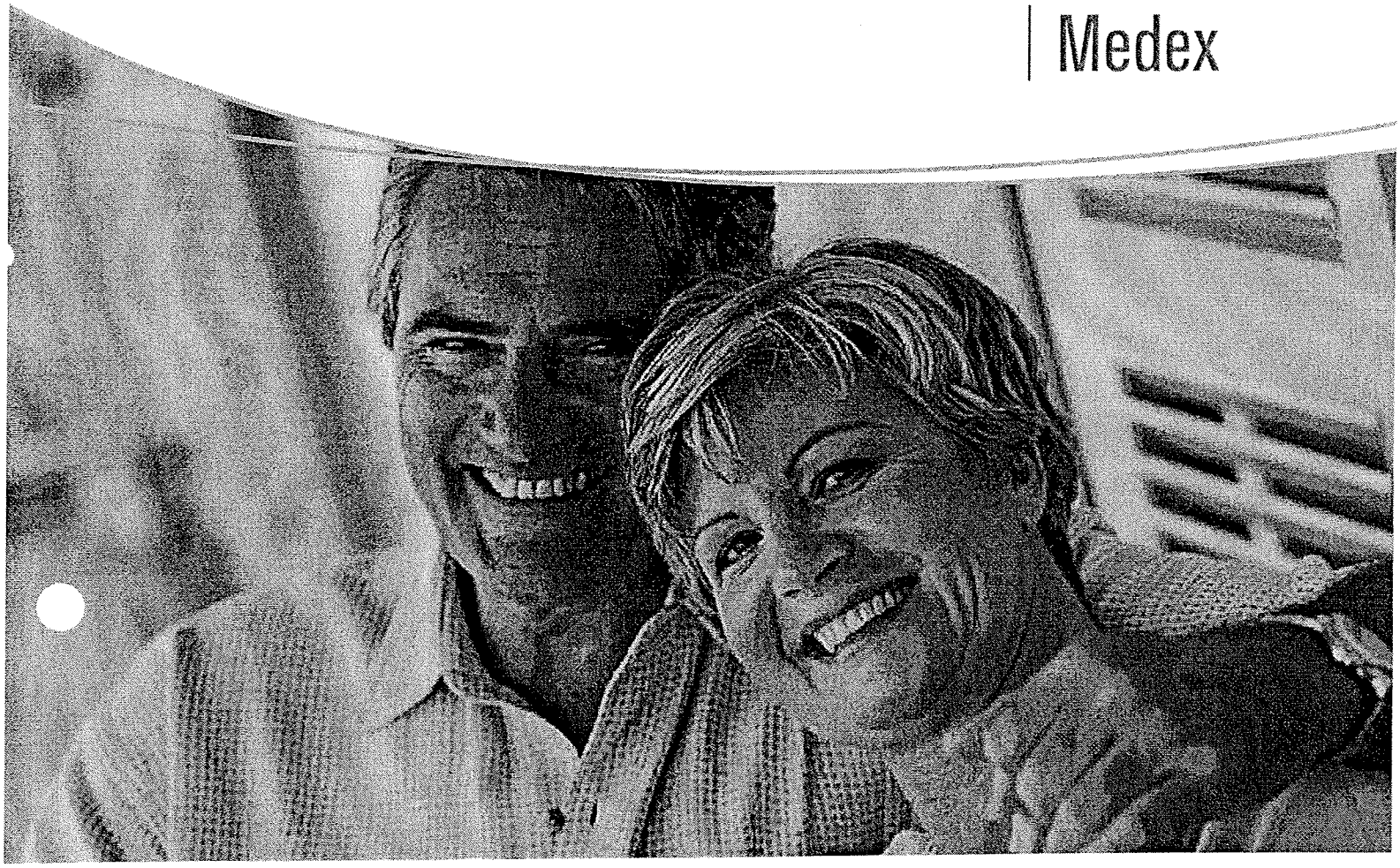
Covered Services		Your Cost Is:
Lab Tests, X-Rays, and Other Tests (diagnostic services)	• *Outpatient* lab tests	Nothing after *deductible*
	• *Outpatient* CT scans, MRIs, PET scans, and nuclear cardiac imaging tests	$100 *copayment* per category of test per service date (*deductible* does not apply)
		The *copayment* does not apply to interpretation costs.
	• Other *outpatient* tests and preoperative tests	Nothing after *deductible*
Maternity Services and Well Newborn Inpatient Care	• Maternity services (includes delivery, prenatal care, and postnatal care except as described below	$700 *copayment* per admission for *inpatient* hospital services after *deductible*; otherwise, you pay nothing
	• *Outpatient* hospital and health center postnatal medical care services	$20 *copayment* per visit (*deductible* does not apply)
	• Well newborn care during enrolled mother's maternity admission	Nothing (*deductible* does not apply)
Medical Care Outpatient Visits (includes syringes and needles dispensed during a visit)	*Outpatient* services	$20 *copayment* per visit (*deductible* does not apply)
Medical Formulas (includes certain medical formulas and low protein foods)	$5,000 *benefit limit* per *member* per calendar year for low protein foods	See Prescription Drugs and Supplies
Mental Health and Substance Abuse Treatment	• *Inpatient* admissions in a General or Mental Hospital or Substance Abuse Facility	$700 *copayment* per admission after *deductible*
	• *Outpatient* services	$20 *copayment* per visit (*deductible* does not apply)
Oxygen and Respiratory Therapy	• Oxygen and equipment for its administration	20% *coinsurance* after *deductible*
	• *Outpatient* respiratory therapy	$20 *copayment* per visit (*deductible* does not apply)
Podiatry Care	• *Outpatient* lab tests and x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* medical care services	$20 *copayment* per visit (*deductible* does not apply)

Covered Services		Your Cost Is:
Prescription Drugs and Supplies Drug Formulary (includes syringes and needles) For insulin infusion pumps, you pay nothing	• Retail Pharmacy (up to 30-day supply) Tier 1: Tier 2: Tier 3:	 $10 *copayment* $25 *copayment* $50 *copayment*
	• Mail Service Pharmacy (up to 90-day supply) Tier 1: Tier 2: Tier 3:	 $20 *copayment* $50 *copayment* $110 *copayment*
Preventive Health Services Refer to your Benefit Description for a complete description of *covered services*.	• Routine pediatric care (10 visits first year of life, 3 visits second year of life, and one exam per calendar year from age 2 through 18)	Nothing for *covered services*; otherwise, you pay all costs These *covered services* include (but are not limited to): routine exams for age-based schedule; immunizations; routine lab tests and x-rays; and blood tests to screen for lead poisoning.
	• Routine adult exams and tests (one exam per calendar year for a *member* age 19 or older)	Nothing for *covered services*; otherwise, you pay all costs These *covered services* include (but are not limited to): one routine exam per *member* per calendar year; immunizations; routine lab tests and x-rays; routine mammograms once between age 35 through 39 and once per calendar year for a *member* age 40 or older; blood tests to screen for lead poisoning; and a routine colonoscopy every ten calendar years for a *member* age 50 or older.
	• Routine GYN exams (once per *member* per calendar year)	Nothing for *covered services*; otherwise, you pay all costs These *covered services* include a routine Pap smear test once per *member* per calendar year.
	• Family planning	Nothing
	• Routine hearing exams and tests (includes newborn hearing screening)	Nothing
	• Routine vision exams (one exam per *member* every 24 months)	Nothing for covered exams; otherwise, you pay all costs
Prosthetic Devices	• Ostomy supplies	20% *coinsurance* after *deductible*
	• Artificial limb devices (includes repairs) and other external prosthetic devices	20% *coinsurance* after *deductible*
Radiation Therapy and Chemotherapy	*Outpatient* services	Nothing after *deductible*
Second Opinions	*Outpatient* second and third surgical opinions	See Medical Care Outpatient Visits
Short-Term Rehabilitation Therapy	*Outpatient* physical and occupational therapy	$20 *copayment* per visit (*deductible* does not apply)

Covered Services		Your Cost Is:
Speech, Hearing, and Language Disorder Treatment	• *Outpatient* diagnostic tests	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* speech therapy	$20 *copayment* per visit (*deductible* does not apply)
	• *Outpatient* medical care services	$20 *copayment* per visit (*deductible* does not apply)
Surgery as an Outpatient (excludes removal of impacted teeth whether or not the teeth are imbedded in the bone)	• Surgical day care unit of hospital, ambulatory surgical facility, and hospital surgery services	$150 *copayment* per admission after *deductible*
	• Office and health center services	$20 *copayment* per visit (*deductible* does not apply)
TMJ Disorder Treatment	• *Outpatient* x-rays	See Lab Tests, X-Rays, and Other Tests
	• *Outpatient* surgical services	See Surgery as an Outpatient
	• *Outpatient* physical therapy	$20 *copayment* per visit (*deductible* does not apply)
	• *Outpatient* medical care services	$20 *copayment* per visit (*deductible* does not apply)

MASSACHUSETTS

Medex



MIIA MASSACHUSETTS BASED MEMBER DRIVEN

Medex® 3
MIIA-U 2011–Summary of Benefits

This Medex plan provides benefits for the:

- Medicare Part A Deductible and Co-insurances
- Medicare Part B Deductible and Co-insurance
- Prescription Drugs
- OBRA Benefits

This health plan, alone, does not meet Minimum Creditable Coverage standards and will not satisfy the individual mandate that you have health insurance; however, the Commonwealth of Massachusetts has stated that enrollment in Original Medicare (Medicare Part A and Medicare Part B) satisfies these standards.

Your Medical Benefits

	Medicare Provides	Medex Provides
Inpatient Care		
Hospital care—including surgical services, X-rays and laboratory tests, anesthesia, drugs and medications, and intensive care services	• Coverage for days 1–60 per benefit period after $1,132 inpatient deductible • Coverage for days 61–90 after $283 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $566 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime when Medicare benefits are used up*
Physician or other professional provider services	80% of approved charges after $162 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Skilled nursing facility—participating with Medicare**	• Full coverage for days 1–20 • Coverage for days 21–100 after daily $141.50 co-insurance	• Full coverage of Medicare daily co-insurance for days 21–100 • $10 daily for days 101–365
Skilled nursing facility—not participating with Medicare**	No benefits	$8 daily for 365 days per benefit period
Outpatient Care		
Office visits	80% of approved charges after $162 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Emergency room visits for accident treatment, sudden and serious medical emergency treatment	80% of approved charges after $162 annual Part B deductible	Full coverage after member pays $25 per visit (waived if admitted or for observation stay)
Outpatient surgery, X-rays and lab tests	80% of approved charges after $162 annual Part B deductible	Full coverage of Medicare deductible and co-insurance
Radiation therapy, durable medical equipment, cardiac rehabilitation services, home health care services, and hospice services	80% of approved charges after $162 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible
Blood glucose monitors and materials to test for the presence of blood sugar	80% of approved charges after $162 annual Part B deductible for all diabetics	Full coverage of Medicare deductible and co-insurance
Urine test strips (Claims must be submitted on a Medex Subscriber Claim form.)	No benefits	Covered to the same extent as brand-name prescription drugs
Chiropractor services	80% of approved charges after $162 annual Part B deductible, for manual manipulation of the spine to correct a subluxation demonstrated by an X-ray	Full coverage after member pays $35 calendar-year deductible
Short-term rehabilitation		
Physical therapy, speech-pathology, and occupational therapy		
Professional provider outpatient services approved by Medicare	80% of approved charges after $162 annual Part B deductible	Full coverage after member pays $35 calendar-year deductible

	Medicare Provides	Medex Provides
Mental Health and Substance Abuse Treatment		
Biologically based mental conditions†		
Inpatient admissions in a general or mental hospital	• Coverage for days 1–60 per benefit period after $1,132 inpatient deductible • Coverage for days 61–90 after $283 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $566 daily co-insurance • Coverage for mental hospital admissions is limited to 190 days per lifetime	After a $50 inpatient calendar-quarter copayment††: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up*
Outpatient visits	Full coverage after $162 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When visits are not covered by Medicare, full coverage with no visit maximum
Non-biologically based mental conditions		
Inpatient admissions in a general hospital	• Coverage for days 1–60 per benefit period after $1,132 inpatient deductible • Coverage for days 61–90 after $283 daily co-insurance • Coverage for an additional 60 lifetime reserve days after $566 daily co-insurance	After a $50 inpatient calendar-quarter copayment: • Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • Full coverage up to 365 additional hospital days in your lifetime, when Medicare benefits are used up*
Inpatient admissions in a mental hospital	Same coverage as a general hospital, but coverage is limited to 190 days per lifetime	• Full coverage of Medicare deductible and co-insurance • Full coverage of lifetime reserve day co-insurance • When Medicare benefits are used up, full coverage up to 120 days per benefit period (at least 60 days per calendar year), less any days in a mental hospital already covered by Medicare or Medex in that benefit period (or calendar year)*
Outpatient visits	Full coverage after $162 annual Part B deductible and the Part B co-insurance	• When covered by Medicare, full coverage of Medicare Part B deductible and co-insurance with no visit maximum • When not covered by Medicare, full coverage up to 24 visits per calendar year

* The additional days are a combination of days in a general or mental hospital.

** A combined maximum of 365 days per benefit period in a Medicare participating and non-participating skilled nursing facility.

† Treatment of rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to rape is covered to the same extent as biologically based conditions.

†† The inpatient calendar-quarter copayment does not apply to admissions in a mental hospital.

Medicare Benefits		Medex Provides
Prescription Drugs		
At a designated retail pharmacy	Medicare does not provide coverage for prescription drugs used outside of the hospital. See your Medicare handbook for certain covered drugs.	Full coverage after a: • ~~$10~~ 10 copayment for Tier 1 • ~~$25~~ 20 copayment for Tier 2 • ~~$50~~ 35 copayment for Tier 3
Through the designated mail-service pharmacy (up to a 90-day supply for each prescription or refill)	No benefits	Full coverage after a: • ~~$20~~ 20 copayment for Tier 1 • ~~$50~~ 40 copayment for Tier 2 • ~~$110~~ 70 copayment for Tier 3

Preventive Services Approved by Medicare and Medex

- One routine fecal-occult blood test every year for members age 50 or older (Full coverage for tests)
- One routine flexible sigmoidoscopy every four years for members age 50 or older (Full coverage for tests)
- One routine colonoscopy every two years for a high-risk member (Full coverage for tests)
- Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare (Full coverage for tests)
- Routine prostate cancer screening for members 50 or older including one (PSA) test and one digital rectal exam, per calendar year (Full coverage for exam if doctor accepts assignment, full coverage for PSA test)
- One routine gynecological exam every two years (Full coverage for exam if doctor accepts assignment)
- One routine gynecological exam per calendar year for a member at high risk for cancer (Full coverage for exam if doctor accepts assignment)
- One baseline mammogram during the five year period a member is age 35-39 and one routine mammogram per calendar year for members age 40 and older (Full coverage for screening)
- One routine Pap smear test per calendar year (Full coverage for test)

Important Information

- Blue Cross Blue Shield and Medicare will pay only for services that are medically necessary.
- The Medicare inpatient deductible and co-insurance amounts are subject to change January 1 of each year. The deductibles and co-insurance amounts listed here are for the year 2011.
- Benefits are available immediately upon your effective date.
- You are encouraged to use an Express Scripts pharmacy outside of Massachusetts. These pharmacies will file claims for you as long as you have your ID card with you.

Questions? Call 1-800-782-3675. (TTY) 1-800-522-1254.

The Member Service staff can assist you Monday through Friday, 8 a.m. to 6 p.m.

Medicare Office Telephone Number in Massachusetts: **1-800-MEDICARE (1-800-633-4227)**

For more information about Blue Cross Blue Shield of Massachusetts, log on to: **www.bluecrossma.com.**

Interested in receiving information from Blue Cross Blue Shield of Massachusetts via e-mail? Go to **www.bluecrossma.com/email** to sign up.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your plan description and riders define the full terms and conditions. Should any questions arise concerning benefits, the plan description and riders will govern. For a complete list of limitations and exclusions, refer to your plan description and riders. **Please note:** Blue Cross and Blue Shield of Massachusetts, Inc., administers claims payment only and does not assume financial risk for claims.

107999B (7/11) 1M CD

MASSACHUSETTS

ACTON TOWN & APS - FISCAL YEAR 2013

For Period 7/1/12 Through 6/30/13

NEW PLANS

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
MHP TOWN $5 co-pay	5	I	12	1253.11	1065.14	63,909	187.97	11,278	75,187	85
	6	F	12	2927.70	2488.55	179,175	439.16	31,619	210,794	85
MHP TOWN $20 co-pay	2	I	12	1253.11	626.56	15,037	626.56	15,037	30,075	50
	0	F	12	2927.70	0.00	-	2927.70	-	-	0
MHP Retiree TOWN	0	I	12	1253.11	626.56	-	626.56	-	-	50
$5 co-pay	0	F	12	2927.70	1463.85	-	1463.85	-	-	50
MHP Retiree TOWN	6	I	12	1253.11	626.56	45,112	626.56	45,112	90,224	50
$20 co-pay	3	F	12	2927.70	1463.85	52,699	1463.85	52,699	105,397	50
		MHP Town TOTALS:				**355,932**		**155,745**	**511,677**	
MHP SCHOOL APS	1	I	12	1253.11	626.56	7,519	626.56	7,519	15,037	50
	0	F	12	2927.70	1463.85	-	1463.85	-	-	50
MHP Retiree SCHOOL	6	I	12	1253.11	626.56	45,112	626.56	45,112	90,224	50
$15 co-pay APS	2	F	12	2927.70	1463.85	35,132	1463.85	35,132	70,265	50
		MHP School TOTALS:				**87,763**		**87,763**	**175,526**	
Blue Care Elect Town	0	I	12	1031.85	877.07	-	154.78	-	-	85
Active $15 co-pay	1	F	12	2425.83	2061.96	24,743	363.87	4,366	29,110	85
Blue Care Elect Town	0	I	12	1031.85	877.07	-	154.78	-	-	85
Active $20 co-pay	1	F	12	2425.83	2061.96	24,743	363.87	4,366	29,110	85
Blue Care Elect Town	0	I	12	1031.85	515.93	-	515.93	-	-	50
Retiree $15 co-pay	0	F	12	2425.83	1212.92	-	1212.92	-	-	50
Blue Care Elect Town	0	I	12	1031.85	515.93	-	515.93	-	-	50
Retiree $20 co-pay	0	F	12	2425.83	1212.92	-	1212.92	-	-	50
		Blue Care Elect Town TOTALS:				**49,487**		**8,733**	**58,220**	
Blue Care Elect APS	0	I	12	1031.85	515.93	-	515.93	-	-	50
School $15 co-pay	0	F	12	2425.83	1212.92	-	1212.92	-	-	50
Blue Care Elect APS	0	I	12	1031.85	515.93	-	515.93	-	-	50
Retiree $15 co-pay	0	F	12	2425.83	1212.92	-	1212.92	-	-	50
		Blue Care Elect APS TOTALS:				-		-	-	
HMO BLUE TOWN	5	I	12	633.59	538.55	32,313	95.04	5,702	38,015	85
$5 CO-PAY	10	F	12	1497.12	1272.55	152,706	224.57	26,948	179,654	85
HMO BLUE TOWN	19	I	12	633.59	538.55	122,790	95.04	21,669	144,459	85
$20 CO-PAY	54	F	12	1497.12	1272.55	824,614	224.57	145,520	970,134	85
HMO BLUE TOWN	0	I	12	633.59	316.80	-	316.80	-	-	50
Retiree $5 CO-PAY	0	F	12	1497.12	748.56	-	748.56	-	-	50
HMO BLUE TOWN	4	I	12	633.59	316.80	15,206	316.80	15,206	30,412	50
Retiree $20 CO-PAY	8	F	12	1497.12	748.56	71,862	748.56	71,862	143,724	50
		HMO Blue Town TOTALS:				**1,219,491**		**286,907**	**1,506,398**	
HMO BLUE APS	38	I	12	633.59	475.19	216,688	158.40	72,229	288,917	75
$15 CO-PAY	78	F	12	1497.12	1122.84	1,050,978	374.28	350,326	1,401,304	75
HMO BLUE APS	17	I	12	633.59	316.80	64,626	316.80	64,626	129,252	50
Retiree$15 CO-PAY	4	F	12	1497.12	748.56	35,931	748.56	35,931	71,862	50
		HMO Blue ABS TOTALS:				**1,368,223**		**523,112**	**1,891,335**	

Plan Name	Enrollment	I/F	# of Months	Rate	EMPLOYER Share	EMPLOYER Cost	EMPLOYEE Share	EMPLOYEE Cost	TOTAL Cost	Employer %
HPHC TOWN	2	I	12	633.59	538.55	12,925	95.04	2,281	15,206	85
$5 CO-PAY	13	F	12	1497.12	1272.55	198,518	224.57	35,033	233,551	85
HPHC TOWN	15	I	12	633.59	538.55	96,939	95.04	17,107	114,046	85
$5 CO-PAY	35	F	12	1497.12	1272.55	534,472	224.57	94,319	628,790	85
HPHC TOWN	1	I	12	633.59	0.00	-	633.59	7,603	7,603	0
COBRA $5 CO-PAY	0	F	12	1497.12	0.00	-	1497.12	-	-	0
HPHC TOWN	0	I	12	633.59	316.80	-	316.80	-	-	50
Retiree $5 CO-PAY	1	F	12	1497.12	748.56	8,983	748.56	8,983	17,965	50
HPHC TOWN	3	I	12	633.59	316.80	11,405	316.80	11,405	22,809	50
Retiree $20 CO-Pay	2	F	12	1497.12	748.56	17,965	748.56	17,965	35,931	50
		HPHC Town TOTALS:				**881,207**		**194,695**	**1,075,902**	
HPHC APS	24	I	12	633.59	475.19	136,855	158.40	45,618	182,474	75
$15 CO-PAY	79	F	12	1497.12	1122.84	1,064,452	374.28	354,817	1,419,270	75
HPHC APS	7	I	12	633.59	316.80	26,611	316.80	26,611	53,222	50
Retiree$15 CO-PAY	8	F	12	1497.12	748.56	71,862	748.56	71,862	143,724	50
		HPHC APS TOTALS:				**1,299,780**		**498,908**	**1,798,689**	
MEDEX TOWN	69	I	12	385.54	192.77	159,614	192.77	159,614	319,227	50
MEDEX APS	101	I	12	385.54	192.77	233,637	192.77	233,637	467,274	50
		MEDEX TOTALS:				**393,251**		**393,251**	**786,502**	
Tufts Medicare Preferre	15	I	6	226.00	113.00	10,170	113.00	10,170	20,340	50
1/1/13 TOWN 5%	15	I	6	237.30	118.65	10,679	118.65	10,679	21,357	50
Tufts Medicare Preferre	23	I	6	226.00	113.00	15,594	113.00	15,594	31,188	50
1/1/13 APS 5%	23	I	6	237.30	118.65	16,374	118.65	16,374	32,747	50
HM		**Tufts Med Preferred TOTALS:**				**52,816**		**52,816**	**105,632**	
				Budget Totals:		**5,707,950**		**2,201,931**	**7,909,881**	
						72.16%		**27.84%**	**100.00%**	

FINANCIAL SUMMARY

Acton / Acton Public Schools
Cost Summary

	Acton Cost	Employee Cost	Total
Current Year FY 2012	5,786,908	2,227,205	8,014,112
Projected FY 2013 No Changes @ 6% Increase	6,130,387	2,356,622	8,487,010
Projected GIC FY 3012	5,491,006	2,063,856	7,554,862
Projected GIC FY 3013 @ 5%	5,760,775	2,165,926	7,926,701

MOVE TO GIC

Projected FY 2013 No Changes	6,130,387	2,356,622	8,487,010
Pr ɔted GIC FY 3013 @ 5%	5,760,775	2,165,926	7,926,701
Projected 2013 Savings To GIC	369,612	190,696	560,309
GIC Mitigation Fund		140,077	

MODIFY CURRENT PLANS

Projected FY 2013 No Changes	6,130,387	2,356,622	8,487,010
Proposed FY 2013 New Plans	5,707,950	2,201,931	7,909,881
Projected Savings	422,437	154,691	577,129
Mitigation Fund		144,282	

PROPOSED MITIGATION PLANS

PROPOSED MITIGATION PLANS

Health Reimbursement Account

Wellness Plans

Trust Fund for Emergency or Inpatient Care

Other Reimbursement for Qualified Medical Expenses

Flex Plans

FORCASTING
EXHIBTS

ACTON HEALTH INSURANCE TRUST - HEALTH PLAN COMBINED RENEWAL WORKSHEET

2013

AT 6%

	MHP	Blue Care Elect	Net Blue	HPHC	Medex RX 10/20/35	Total
PAID CLAIMS	983,322	472,659	6,454,365	4,966,833	1,521,966	14,399,145
ADMIN FEE	31,236	13,088	384,385	410,095	97,088	935,892
REINSURANCE	17,714	7,445	293,106	242,854		561,119
TOTAL	1,032,272	493,192	7,131,856	5,619,782	1,619,054	15,896,156
TRUST CONTRIBUTION	880,427	309,923	6,898,527	5,698,318	1,644,984	15,432,179
SUB. TOTAL	-151,845	-183,269	-233,329	78,536	25,930	-463,977
IBNR$	202,912	97,149	1,367,750	1,075,386	323,811	3,067,007
HEADCOUNTS INDIVIDU/	5/8/8	10/0	5/140/23	3/70/38	341	
FAMILY	6/3/3	0/1	10/224/62	13/205/37		
RATES- INDIVIDUAL T/S	1461.12/1418.56/1389.96	1189.76/1166.31	703.99/683.49/666.95	703.99/683.49/666.95	402.00	
FAMILY T/S	3423.02/3323.32/3254.68	2797.08/2741.02	1663.47/1615.02/1581.94	1663.47/1615.02/1581.94		
co pays$5, $15, $20						
% CHANGE	10.0%	10.0%	6.0%	6.0%	5.0%	

Municipal Health Care Reform

Bob Evans,

Chair Acton Health Insurance Trust

Municipal Health Care Reform

Definitions

Chapter 69: legislation signed in July providing governmental bodies with a new process to change health care plan design

Health Care Plan Design: The health care services and charges associated with a health care insurance policy

Premium: Amount paid for health insurance coverage for a specific period of time

Deductible: Amount that is required to be paid by a subscriber before health plan benefits will begin to reimburse for services

Copay: Amount an insured person is expected to pay for a medical expense

"Savings" re Chapter 69: Reduction in premium expense

Municipal Health Care Reform Chapter 69 Process -Overview

1. Determination whether or not potential cost savings merit plan modification
2. Development of a modified insurance proposal
3. Identification of disproportionately affected subscribers & development of mitigation plan
4. Negotiation with PEC, if successful modified plans implemented
5. If negotiations are not successful, Insurance Advisory Committee (IAC) determination of changes
6. Implement changes as approved by IAC

Municipal Health Care Reform Acton HIT Process

- July Chapter 69 signed into law
- August HIT contracts with Segal
- October Segal reports on projected costs of various plans
- October Acton Health Insurance Trustees make recommendations to the Boards
- Now Review Segal Report
- Next Governmental bodies determine how to proceed

Municipal Health Care Reform Segal – Plan Comparison

What plans did Segal Compare?

- Acton HIT HMOs – NetBlue, HPHC
- Acton HIT indemnity plans – MHP, BCE
- GIC Tufts Navigator (Chapter 69 reference plan)
- MNHG plans (includes "rate saver")
- Retiree plans

Municipal Health Care Reform Segal Report – Plan Design

What plan elements did Segal Compare?

- Premiums
- Deductibles
- Copays for services
  - (doctor, emergency room)
- Copays for drugs,
  - Tiered by drug type, generic vs name brand
  - Tiered by drug supplier, retail vs mail

The "non-cost" element of access to specific physicians is noted but is not part of the cost comparison

Municipal Health Care Reform Segal – Assumptions

What assumptions did Segal make?

- Migration assumptions
- Changes Effective 1 July 2012
- Static environment
  - No enrollment changes
  - No plan changes after day 1
  - Constant inflation
  - Same inflation for all plans

Segal Report Year1 (FY13) Status quo

Health Care Premiums – non-retiree

Town	$3.5 million	(81/19)
APS	$4.3 million	(73/27)
ABRSD	$6.4 million	(72/28)
TOTAL	**$14.2 million**	**(74/26)**

Health Care Premiums – retiree

TOTAL	**$2.0 million**	**(50/50)***

* Employer/Employee split

Segal Report Year1 (FY13)
Plan Modification to GIC equivalent*

- Total Cost Reduction is $1.3 million, 8%
- No change for retirees

Health Care Premiums – non-retiree

Town	$3.2 million	(81/19)
APS	$3.9 million	(73/27)
ABRSD	$5.8 million	(72/28)
TOTAL	**$12.9 million**	**(74/26)**

Health Care Premiums – retiree

TOTAL	**$2.0 million**	**(50/50)**

* Tufts Navigator is the GIC equivalent plan design reference

Segal Report Year1 (FY13) Migration to GIC

- Total Cost Reduction estimated $2.4 M, 15%
- Range of Potential Cost Reduction -32% to +26%
- No significant change for retirees

Savings or expense are strongly dependent on plan selection, low confidence in Segal migration assumption

Municipal Health Care Reform HIT Conclusions

1. The Acton Board of Selectmen and the Acton-Boxborough Regional School Committee should enter into Chapter 69 negotiations with their employees
2. Modified plan designs could significantly reduce employer health insurance costs
3. The Acton BOS and ABRSC should try to achieve common plan designs from multiple vendors
4. The Acton BOS and ABRSC should not pursue entry into the GIC