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 MUNCIPAL 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

ADJOURNMENT of Acton Board of Selectmen

Joint School Committee continues at 8:00.

SEGAL

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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

Plan Provisions	GIC Non-Medicare Plan with largest subscriber enrollment Tufts Health Plan Navigator		Current The Harvard Pilgrim HMO		
	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

	GIC Non-Medicare Plan with Largest subscriber enrollment Tufts Health Plan Navigator		Current BCBS Blue Care Elect Preferred (PPO)			
Plan Provisions	**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	CIC 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:

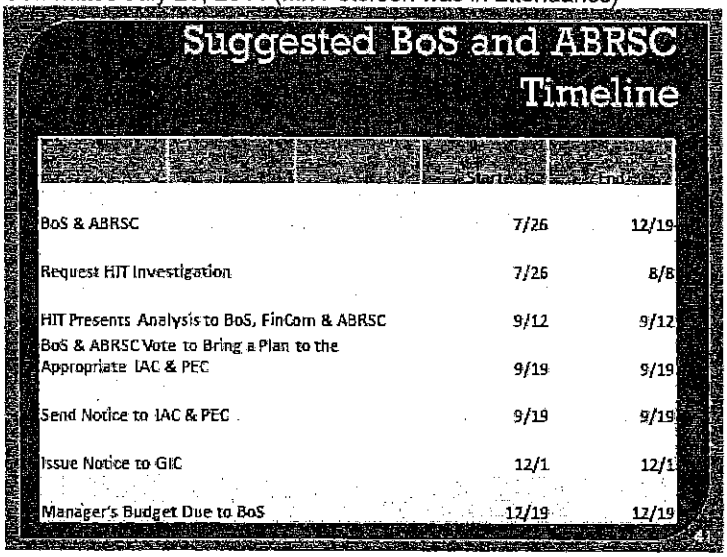
1. Determination whether or not 5% cost savings threshold will be met through plan modification
2. Development of a modified insurance proposal

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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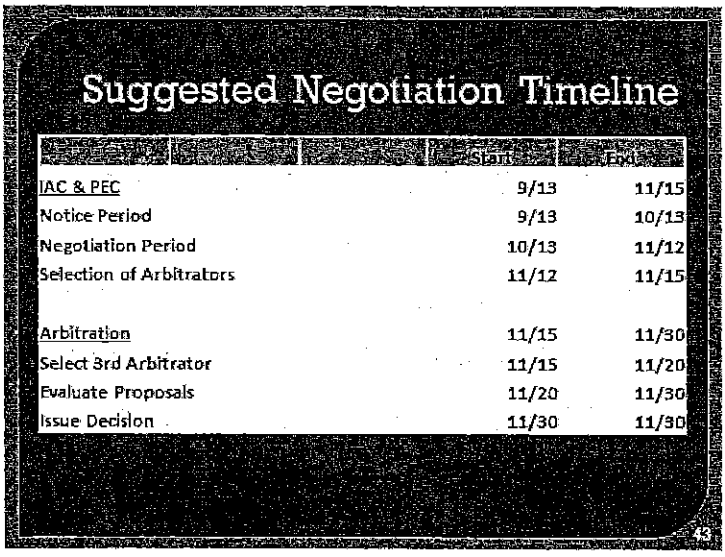

Suggested Negotiation Timeline

	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.

3.1.4

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

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.