

# **Town Of Lexington**

## **Report of the Health Benefits Review Committee**



**September 12, 2005**

## **1. Introduction**

The Health Benefits Review Committee (HBRC) was appointed by the Board of Selectmen in October, 2004, to review and analyze health benefits provided by the Town of Lexington. The HBRC was created to explore ways for Lexington to reduce an anticipated 15% growth in health insurance costs this year and in the future<sup>1</sup>. For the charge to the committee and committee membership see Appendix A.

### **1.1. The Background**

The nation recently has experienced double-digit increases in healthcare costs annually.<sup>2</sup> Lexington is projected to spend roughly \$15 million of its \$125 million budget for FY 2005 on health benefits for participants in its plans. One committee member calculated that if health benefit costs continue to grow even at 10%, and assuming the Town's other costs increase at 3% (a common assumption for inflation), within 10 years the portion of the Town budget devoted to health benefits will double. It is this fact, and the inexorable growth in the cost of providing health insurance, that drove the establishment of the HBRC.

### **1.2. Health Benefits in Lexington**

For a brief history of health benefits in Lexington, see Appendix B.

In fall 2004, there were 3616 total subscribers (employees, retirees, dependents and others).<sup>3</sup> Of these 3616 individuals covered by Town Plans, by far the most (1994) are non-retirees covered under the HMO Blue plan. Almost half that many (982) are covered under retiree plans. Of those not under HMO Blue the remaining are mostly split between Harvard (301) and Blue Choice School/Town (285), with a few in TEFRA and Managed Blue. Part time employees who work 20 hours or more are eligible for health benefit coverage and pay the same portion of the premium as full time employees. This is similar to coverage offered by other towns. For Plan Descriptions a complete details of the health benefits offered by the Town, see Appendix C.

With approximately 29% of school employees 55 years old or older, we will continue to see the retiree population growing<sup>4</sup>. Under state law, the Town is responsible for retiree benefits for an individual who retires from a Lexington teaching position even if that person worked for another town for the majority of his or her career. The Town's Early Retirement Initiative in fact added to our health costs disproportionately. When an employee retires, we reap a short-term savings in salary if we replace them with a less experienced, lower salaried employee. However, we also retain the responsibility for retiree health benefits and have likely added the new employee as well, and if the retiree is not eligible for Medicare, costs are high. Other forces also increase Lexington enrollees. When Raytheon closed its local office and Polaroid ended retiree coverage many family members were added to Lexington's coverage.

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<sup>1</sup> Source: Group Benefits Strategies

<sup>2</sup> Boston Globe, Nov. 24, 2004.

<sup>3</sup> Enrollment Breakdown Ind/Family/Total Subscribers covered by plans

<sup>4</sup> Email from Susan Bottan, Nov. 19, 2004

### ***1.2.1. Economic Factors Affecting Health Benefits in Lexington***

There are three additional factors that need to be taken into consideration in looking at the future of health benefits in Lexington. First, benefits offered by the Town are, on the whole, richer and cost less to employees than those offered by other employers. While the Committee was unable to obtain data on benefits offered by private employers, a report by the Worcester Regional Research Bureau documented that private employers spent a much smaller component of their compensation costs on health benefits than did Worcester.<sup>5</sup> In fact, Lexington's share of the health insurance premium, co-insurance and co-pays are among the most generous of the comparable towns we surveyed. The committee believes that because the benefits offered by Lexington are better than those offered by other employers, Town employees whose spouses work elsewhere usually choose to take the Town benefits, thereby increasing costs to the Town. There may be increasing discomfort if citizens find themselves paying for health benefits for Town employees that exceed what they themselves receive, even though the benefits package is part of a larger picture and may be part of what allows Lexington to remain competitive in hiring.

Another issue which the Committee discussed is the probable need to fund future obligations for health insurance. Because the Town is required to insure retirees and their dependents, there is a large, but uncalculated, future obligation. The Government Accounting Standards Board's (GASB) new standards, which are slated to become effective sometime in 2006, will require that funds for retiree health be kept in segregated trust funds available only for that purpose. Wellesley has already begun funding theirs and the bond-rating agencies have begun to use compliance with these standards in their evaluations.

Additionally, Medicare Part D, the pharmaceutical benefit will become operational on January 1, 2006. At this point, in the absence of detailed information about the program, its consequences are not clear. However, the Town should remain alert to the possibility of saving money on retiree pharmaceutical benefits.

## **1.3. Structure of Health Benefits in Lexington**

### ***1.3.1. Administration***

The Town is self-insured and engages a consultant, Group Benefit Strategies (GBS) to help with financial reporting, bids, Requests for Quotations (RFQs), administration and some minor legal issues. Blue Cross/Blue Shield and Harvard Pilgrim Healthcare handle the claims. The Committee thought there was considerable value in the services provided to the Town by GBS.

The Town operates a Flexible Spending Account allowing Town employees to reduce pre-tax income for eligible healthcare and other expenses. In 2004, the Town introduced a pilot "Opt-Out" program, in which one-time payments were made for

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<sup>5</sup> Worcester Regional Research Bureau: "Condition Serious, Prognosis Uncertain: The Impact of Municipal Employee Health Insurance on Massachusetts, Cities, Report No. 05-01, February 28, 2005.

employees who dropped Town coverage and enrolled in a plan maintained by their spouse or partner's employer.

### **1.3.2. Legal Framework**

- Chapter 32B of the Mass General Laws governs the provision of benefits (<http://www.mass.gov/legis/laws/mgl/gl-32b-toc.htm>). People eligible to receive health benefits include: current employees, retirees, surviving spouses of retirees, people who have left the employ of the Town but continued benefits under COBRA; and members of these groups' families.
- Health benefits are subject to negotiations, and the Town cannot change most elements of the plans unilaterally.

### **1.3.3. Fiscal Components**

The Town pays out the following items to cover health benefits:

- Town share of premiums for insured plans (including Dental)
- Claims up to the "stop-loss" limit
- Administration of benefits
- Purchase of "stop-loss" insurance (covering catastrophic claims over the set limit, currently \$90,000)
- Flu vaccine clinics

The Town receives or sets aside money in the Health Insurance Trust Fund to pay for health benefits from:

- Appropriation of money from the Town budget
- Participant premiums
- Reinsurance reimbursements

Lexington operates on the principle that insurance premiums (and re-insurance premiums) are ultimately priced to include a risk premium or profit to the company. Insurers may lose money on an occasional basis because their pricing is based upon statistical averages. Over a period of several years, however, insurance companies will price their products so that they receive their desired risk premium or profit margin.

Historically, Lexington has realized savings through self-insurance as compared to the fully insured rates quoted by the insurance companies in the various Requests for Quotations conducted by the Town. These savings, as a result of other budget pressures, have been passed directly to the operating budget, instead of funding the health insurance trust fund and increasing the reserves. Over the last several years, the level of reserves in the Trust Fund has declined.

The Town purchases "re-insurance" for costs incurred by an individual during a plan year in excess of \$90,000, thereby limiting the Town's exposure to catastrophic claims. Town officials periodically review this level and price out the insurance costs at various levels to make sure the cost is competitive and that the Town is properly protected against undue risk. The reinsurance level has been raised periodically and was recently increased from \$75,000 to \$90,000 in order to save on premiums.

To better understand the costs of Lexington health benefits and the health benefits marketplace for eastern Massachusetts municipalities, the Committee conducted a survey of “comparable” local cities and towns. We selected towns used by unions for comparison purposes in wage agreements and selected other cities and towns with similar demographics and financial status. A survey instrument was developed and modified based upon feedback from town staff and committee members. Twenty-nine towns were contacted by phone, the survey was faxed and phone follow up was conducted as needed. Twenty-four towns responded with most of the requested information. Information included health plans offered, benefit levels, employee premiums, and questions about other benefits offered, including dental benefits, chiropractic coverage and pharmacy benefits. Lexington offered to share the results of the survey with respondents. The results of the survey are spelled out in detail in Appendix E. In general, the Town’s costs, premiums and benefit levels were similar or a little better than average.

## **2. Summary of Recommendations (see table that follows for additional details)**

The committee found that health benefits have been quite well-managed by the Town over the years. As the Committee raised options it found that many had been tried previously, often in partnership with the Coalition of Town Employees, the bargaining unit for health benefits. Claim costs are low relative to other groups insured by Blue Cross/Blue Shield according to their own calculations.<sup>6</sup> Despite these positive aspects, the Town has a problem of costs growing beyond its capacity to pay.

Based upon our review, we would agree with the general feeling that the benefits offered by the Town are better than those provided by local industry; however employees may have foregone pay increases or accepted increases which were below market rates in order to maintain the current benefit levels. The Town and collective bargaining units negotiate wages with each unit separately, but health benefits for all units are collectively bargained. Legislation is under consideration which might allow towns to bargain wages and benefits together, as cities are able to do now. If such legislation is passed, the Town should consider whether it is more cost-effective to continue to provide richer benefits in lieu of salary increases during a period when medical inflation is higher than the general inflation rate.

The Committee offers the following recommendations for changes in health benefits structure and financing by the Town. Even though these benefits are subject to collective bargaining, our goal is to present a comprehensive set of recommendations for the short and long-term. Further explanation of these recommendations and the advantages and disadvantages associated with each are contained in the table that follows. Other options that were considered and rejected by the HBRC are also included in that table.

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<sup>6</sup> Email from Kevin Walsh, Nov. 30, 2004

## **2.1. Short Term Recommendations and the Rationale for Them**

### ***2.1.1. Implement a Carve-Out Pharmacy Benefit Program and Increase Incentives for Generic and Mail Order Drugs.***

The carve-out of pharmacy benefits, recommended by GBS, would establish a separate administrator for all pharmacy benefits with estimated savings of 30% to 50% in cost-growth. Changes in co-pays can be used to increase use of generic drugs and mail-order supply, contributing to the reduction in costs.

### ***2.1.2. Strengthen Claims and Enrollment Audits***

The effectiveness of the membership, claims and other audits currently being performed by the town and its insurers, should be validated by an independent firm. These audits, which can be done at a reasonable cost, help ensure that claims being submitted are legitimate, potentially saving money. The Committee also recommends that the Town review the capabilities of the town's accounting software to support this activity in the future.

### ***2.1.3. Consider Premium Structure and Plan Design Changes***

Options that the Committee recommends be considered are: a change in ratio of premiums so that enrollees pay more and a standard dollar contribution by the Town. Non-pharmaceutical co-pays are relatively low and should be reviewed periodically.

### ***2.1.4. Consider Separate Plan for Out-of state Enrollees***

Because of the need to provide coverage to those who live outside of Massachusetts (e.g. retirees who have moved, children of employees or retirees who are away at college), the Town currently offers Blue Choice, the most expensive option. By creating a separate plan solely for those living out-of-state, the Town could choose a single and most cost-efficient plan for the great majority of enrollees who live within Massachusetts.

### ***2.1.5. Expand Health Promotion Locally***

Among the most likely risks facing Lexington enrollees are smoking, high blood pressure, high cholesterol and being overweight. Reducing risk factors means a reduction or delay in the onset of diseases and a healthier work force would be a more productive work force with reduced absenteeism. Little is known about these risks within the covered group so data needs to be obtained.

### ***2.1.6. Develop a Strategy to Expand Case and Disease Management***

Case management coordinates care and seeks to ensure that it is delivered effectively and in the least costly setting. Although there are indications (e.g. cases reaching the reinsurance cutoff point) that case management could provide savings and better care, data is not currently available to ascertain the number of cases.

**2.1.7. *Continue to Consider Alternative Providers, Stop-loss Levels and Insurance vs. Self-insurance as a Part of Rebidding Process***

The Town has done a good job of this in the past and should continue to review these issues periodically.

**2.1.8. *Ensure that the Health Benefits Trust Fund is at the Recommended Level of Three Months.***

The Town has periodically made decisions not to fund the trust fund, instead using these funds for general operations. This is dangerous and runs the risk of the Town having to appropriate additional funds should expenses be higher than anticipated, as has happened in the past.

**2.1.9. *Review Implementation of This Report on an Ongoing, Perhaps Quarterly Basis.***

In order to provide adequate oversight and progress on these issues, the Board of Selectmen should request the HBRC, or its successor, to review progress at set periods.

**2.2. Long-Term Recommendations**

**2.2.1. *Implement Strategies for Expanded Case Management and Health Promotion***

See 2.1.6 above.

**2.2.2. *Explore Group Purchasing in Tandem with Review of Premium Structure and Plan Design***

Although Lexington has not been successful in finding a satisfactory group in previous attempts, group purchasing would, by increasing the size of the covered group, reduce costs and spread risk. With effective leadership, Lexington may be able to develop its own group.

**2.2.3. *Explore Implementation of Consumer-driven Health Plans.***

Appendix F contains a detailed discussion of consumer-driven health plans.

A first step toward this would be the provision of Explanation of Benefits for all services so that enrollees understand what services actually cost. Currently, Blue Cross does not provide this.

**2.2.4. *Begin Funding Future Obligations for Health Benefits***

The Town will soon be required by GASB standards to account for its health benefits more transparently. To maintain our bond rating and to ensure that we meet our future obligations, it would be wise to fund these trust accounts adequately.

The table that follows provides further information on these recommendations and discusses options which the Committee does not recommend at this time.

### 2.1.1 Implement a Carve-Out Pharmacy Benefit Program (and strengthen recent pharmacy changes)

Option	Comments	Advantages	Disadvantages
Carve out Pharmacy	<ul style="list-style-type: none"> <li>Recommended by GBS.</li> <li>Would establish a separate administrator and plan for all pharmacy benefits.</li> </ul>	<ul style="list-style-type: none"> <li>Unifies administration and benefits across all plans.</li> <li>Estimates of 30% to 50% reduced growth in claims costs (by GBS) with increased generics and mail order</li> <li>Significant improvement in data and reporting.</li> <li>Increases transparency of pricing and uses of rebates.</li> </ul>	<ul style="list-style-type: none"> <li>May impact local pharmacy business, depending on how many employees use the pharmacies to get prescriptions.</li> <li>May increase admin. costs.</li> </ul>
Increase incentives for generics and mail order through changes in pharmacy co-pays	<ul style="list-style-type: none"> <li>More information is needed on current utilization to evaluate.</li> </ul>	<ul style="list-style-type: none"> <li>Decrease pharmacy costs</li> </ul>	<ul style="list-style-type: none"> <li>More use of mail-order and generics requires changes in patient and physician behavior.</li> </ul>
Purchase drugs from Canada or the European Union	<ul style="list-style-type: none"> <li>Not a long-term solution, and not recommended by the HBRC.</li> </ul>	<ul style="list-style-type: none"> <li>Short term savings</li> </ul>	<ul style="list-style-type: none"> <li>Legal issues if not approved by FDA.</li> <li>May have higher administrative costs, particularly for switching.</li> <li>May impact local pharmacy business.</li> </ul>

### 2.1.2 Strengthen claims and enrollment audits

Option	Comments	Advantages	Disadvantages
Claims and Enrollment Audits	<ul style="list-style-type: none"> <li>Use an independent firm to review effectiveness of current audits by town and insurers.</li> <li>Review the capabilities of the town's accounting software to support this activity</li> </ul>	<ul style="list-style-type: none"> <li>Uncover errors.</li> <li>May identify additional savings opportunities</li> <li>Eliminate cost for ineligible participants.</li> </ul>	<ul style="list-style-type: none"> <li>Amount of savings not clear.</li> <li>May increase administrative cost.</li> </ul>
Provide Explanation of Benefits (EOBs) for all services	<ul style="list-style-type: none"> <li>Blue Cross does not currently provide these for Town enrollees.</li> </ul>	<ul style="list-style-type: none"> <li>Enable participants to identify errors in claims.</li> <li>Increase awareness of the cost of services and could therefore impact long-term behavior.</li> </ul>	<ul style="list-style-type: none"> <li>May increase administrative costs.</li> </ul>
Develop incentives for participants to review bills	<ul style="list-style-type: none"> <li>Develop incentives to encourage participants to review bills and EOBs to ensure that billed services were provided. Could be % of \$ recovered.</li> </ul>	<ul style="list-style-type: none"> <li>Uncover billing errors.</li> <li>Make participants aware of cost of services</li> </ul>	

### 2.1.3 Consider premium structure and plan design changes (includes 2.1.4 on out-of-state plan considerations)

Option	Comments	Advantages	Disadvantages
<b>Premium Structure</b>			
Change ratio of premium contributions	<ul style="list-style-type: none"> <li>▪ Lexington is near the low end of the middle-range for the employee share of premium for comparable towns. Lexington maintains different employee shares for different plans (e.g. 12% for HMO Blue, 20% for Blue Choice and 15% for HPHC). These could be equalized, or each adjusted toward enrollee paying more.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Save the Town \$. May encourage those with alternative health plans to opt out of the Lexington plan.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Forces participants to bear higher costs. Subject to union negotiations.</li> </ul>
Create a standard dollar contribution by Town	<ul style="list-style-type: none"> <li>▪ Same Town contribution for individual or family coverage regardless of plan chosen.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Can be structured to have no cost increase for HMO Blue enrollees. Provides predictability for Town share of costs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Forces participants to bear higher costs.</li> <li>▪ May result in adverse selection, with those in poorer health paying less for a less expensive plan while using more services.</li> <li>▪ Subject to union negotiations.</li> </ul>
Vary required contributions based on salary (see Globe article)	<ul style="list-style-type: none"> <li>▪ We reviewed this alternative and concluded that it is not viable because there are not enough highly-paid employees.</li> </ul>		
Limit entry to Blue Choice Plan or increase the premium to encourage lower in-state enrollment	<ul style="list-style-type: none"> <li>▪ It is necessary to maintain a Plan which can cover out of state employees and retirees.</li> </ul>	<ul style="list-style-type: none"> <li>▪ May decrease use of out of network providers.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Many who elect Blue Choice do not actually go out-of-network. Their premium contributions will decrease if they go to HMO Blue (Town would pay more).</li> </ul>
<b>Plan Design</b>			
Increase non-pharmaceutical co-pays and/or deductibles	<ul style="list-style-type: none"> <li>▪ Based on our survey, the \$5 co-pay is still common among cities and Towns. Plans in industry often have \$10 or \$15 co-pays. Consider setting the co-pay at a % of the discounted cost of the service.</li> <li>▪ The Town has reviewed the impact of changing co-pays and deductibles on a regular basis and should continue to do so.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Higher co-pays/deductibles might impact utilization and thus reduce costs, but the savings will not be great. The 2003 RFQ showed a slightly greater than 1% change in funding rate by raising BCBS from a \$5 to a \$10 office visit co-pay.</li> <li>▪ Setting the co-pay as a percent of the charge will make people more aware of the real cost of services. See Appendix F for discussion of high deductible plans.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Subject to union negotiations.</li> <li>▪ May make it harder to recruit.</li> <li>▪ Lower paid participants may forego medical services they need. Percent co-pays may increase provider administrative costs.</li> <li>▪ Forces participants to bear higher costs.</li> </ul>
Modify/ Expand Opt-out Program	<p>Lexington is the only town that reported an opt-out program. This is still uncommon in many industries. This program and the amounts paid need to be explored further.</p>	<p>May decrease health plan participation and thus lower costs. May save \$ if the payment is less than the approximately \$10,000 cost of each new enrollee.</p>	<ul style="list-style-type: none"> <li>▪ May increase total costs, if those who opt out would have moved to alternate plans without any incentive payment.</li> <li>▪ Added administrative costs.</li> <li>▪ Subject to union negotiations.</li> <li>▪ The PAB originally voted against this program.</li> </ul>

Option	Comments	Advantages	Disadvantages
<b>Plan Design</b>			
Review the new law re: Medicare Coverage for prescription drugs to determine whether any changes should be made to retiree coverage.	Adequate information is not available at this time.		

#### 2.1.4. Consider separate plan for out-of-state enrollees.

Option	Comments	Advantages	Disadvantages
Create separate plan for out-of-state participants	The majority of participants are located within MA. It may be more efficient to split out those who are out-of-state and use a separate third-party administrator or insurance company for that group and then design for the remaining programs to be most efficient within MA	May achieve lower total administrative costs. Town would have more options for in-state plans because it would not have to provide Blue Choice to accommodate those who are out of state.	<ul style="list-style-type: none"> <li>▪ Possible higher administrative costs for out-of-state group.</li> <li>▪ May not be able to exactly duplicate benefits for out-of-state group.</li> <li>▪ Town would have to find a national company with a network that fits for out-of-state participants.</li> </ul>

#### 2.1.5 Expand health promotion locally

Option	Comments	Advantages	Disadvantages
Increase health promotion and disease prevention activities.	<ul style="list-style-type: none"> <li>▪ Information is needed on the major health risks of the Lexington enrollees in order to institute activities to reduce these risks. Among the most likely risks are smoking, high blood pressure, high cholesterol, and being overweight.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reducing risk factors would mean a reduction or delay in the onset of illnesses such as diabetes, heart disease, or stroke, resulting in healthier enrollees and reduced costs.</li> <li>▪ A healthier work force would mean more productive employees with reduced absenteeism.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cooperation is needed from insurers, providers, and enrollees.</li> <li>▪ There would be some additional costs for savings that would occur later and be hard to measure.</li> </ul>

#### 2.1.6 Develop a clear strategy to expand case management and

##### 2.2.1 Implement strategy for expanded case management and disease promotion

Option	Comments	Advantages	Disadvantages
Ensure that there are effective case management and disease management programs.	<ul style="list-style-type: none"> <li>▪ More data is required about the current costs and the extent to which case and disease management are being applied to Lexington enrollees, particularly on an ambulatory basis.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Effective case management and disease management will result in more effective treatment and reduced costs.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Dependent on cooperation of providers, insurers and enrollees.</li> <li>▪ Data is hard to obtain.</li> <li>▪ Hard to monitor, particularly for conditions for which there is no hospitalization.</li> <li>▪ Responsibility split.</li> </ul>

## 2.1.7 Continue to consider alternative providers, stop-loss levels and insurance vs. self-insurance as a part of rebidding process

Option	Comments	Advantages	Disadvantages
<p><b>Consider alternative health plans and providers</b></p>	<ul style="list-style-type: none"> <li>▪ Lexington has requested competitive quotes at each renewal (two years). We recommend continuing that practice. Consider Tufts, United Healthcare, &amp; CIGNA. In the past, Tufts has been more expensive and United and CIGNA networks have not been as good as BC/BS, Harvard Pilgrim, &amp; Tufts.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Bidding keeps BC/BS administrative pricing competitive. Account may get more attention from BCBS, HPHC, and more active management from GBS.</li> </ul>	<ul style="list-style-type: none"> <li>▪ United and CIGNA networks are not as strong in MA. Some participants may have to change providers.</li> <li>▪ Increases the administrative workload.</li> </ul>
<p><b>Review Reinsurance/Stoploss</b> (Increase retention levels, e.g. the portion of risk retained by the Town.)</p>	<ul style="list-style-type: none"> <li>▪ The reinsurance and stop loss levels are reviewed on a regular basis and we recommend that this practice be continued. Currently individual stop loss is set at \$90,000. Last year 6 cases exceeded the stop-loss level which was set at \$75,000.</li> <li>▪ Compare premium savings from increased levels to expected value of claims being assumed by the Town.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reduced premiums</li> </ul>	<ul style="list-style-type: none"> <li>▪ Increased risk – a report the committee reviewed showed only 25 (de-identified) people responsible for \$2M in claims, so a few extra people having adverse health experiences can increase claims costs significantly in any one year.</li> </ul>
<p><b>Review self-insured versus fully insured plans</b></p> <p><b>a) medical</b></p>	<ul style="list-style-type: none"> <li>▪ This has been done at each renewal, and this practice should be continued. Currently Blue Choice, Network Blue, HPHC &amp; Medex are self-insured and the dental and retiree programs (other than Medex) are insured. Less savings to self-insure dental due to smaller average claims size and high claims volume.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Self-insurance costs less in the long run and gives the Town more control over benefit design. Estimates were that risk premiums may ultimately cost an additional 3%-5%. Self insured plans do not have to offer some mandated benefits for insured plans and avoids premium taxes.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Insured quotes may be low at first to gain the business, but is more expensive in the long run.</li> <li>▪ Need to pay runout claims if switch to insurance.</li> <li>▪ Must keep appropriate reserves. Current reserves are below two months. The recommended level is 3 months.</li> </ul>
<p><b>b) dental</b></p>	<ul style="list-style-type: none"> <li>▪ Dental insurance is not self-insured because self-insurance cost more.</li> <li>▪ Continue to review this on an annual basis.</li> </ul>		

### 2.2.2 Explore group purchasing (in tandem with review of premium structure and plan design)

Option	Comments	Advantages	Disadvantages
<b>Re-explore group purchasing</b>	This has been tried in the past, with negative results.	Possible savings because of larger group size and more negotiating power.	<ul style="list-style-type: none"> <li>▪ Less control over benefits offered.</li> <li>▪ Other Towns may have worse experience than Lexington.</li> <li>▪ Each Town may only have one vote, regardless of size.</li> </ul>
<i>Minuteman Nashoba Health Group</i>	This is a new group.		
<i>MIIA</i>	Tried in the past. Did not obtain stop loss coverage.		<ul style="list-style-type: none"> <li>▪ Lexington may not be allowed to re-enter the group.</li> </ul>
<i>West Suburban</i>	Tried in the past. One vote per Town was a problem for Lexington as a larger Town	HPHC rate is lower than the Lexington rate. More choice of plans available.	<ul style="list-style-type: none"> <li>▪ Lexington may not be allowed to re-enter the group.</li> <li>▪ Lexington rate is currently lower for HMO Blue (our highest enrolled plan)</li> </ul>
<i>Other</i>	Form a new group?	Added advantage in the ability to select members and rules.	<ul style="list-style-type: none"> <li>▪ Long term option only. Will take an investment of time and resources to organize.</li> <li>▪ Illegal to pool with local businesses.</li> </ul>

### 2.2.3 Explore implementation of consumer-drive health plans

Option	Comments	Advantages	Disadvantages
<b>Explore Consumer Driven Health Plans</b>	<ul style="list-style-type: none"> <li>▪ This is a long-term project, requiring additional study and extensive participant education.</li> <li>▪ This type of health plan is only now emerging and has little public sector acceptance.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Plan design may encourage participants to compare prices and use health care more wisely thus decreasing costs.</li> <li>▪ May increase consumer choice.</li> <li>▪ Potential long-term change in behavior by patients and providers.</li> <li>▪ Increased focus on patient education through web based and other content.</li> <li>▪ High visibility of products.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires additional administrative resources to implement and administer the program. Requires extensive participant education.</li> <li>▪ For Health Savings Accounts (HSAs), plan design may encourage lower paid participants to pay penalties and use funds for non-medical purposes and leave them without the resources to pay for health care when they need it.</li> <li>▪ All require high deductible levels.</li> <li>▪ May encourage people to forego needed care.</li> <li>▪ Lexington would be one of the first municipalities to adopt such a plan.</li> </ul>

### 2.2.4 Begin funding future obligations for health benefits

Option	Comment	Advantages	Disadvantages
<p><b>Assess future obligations and begin funding.</b></p>	<p>Lexington’s future obligation for retiree benefits has not been calculated but it is large. It seems likely that there will be legal or regulatory requirements to fund this soon – see GASB standards. Bonding agencies are looking at this.</p>	<ul style="list-style-type: none"> <li>▪ Beginning to fund obligation now will reduce its impact later</li> <li>▪ Will establish the principle that the obligation exists and needs to be funded</li> <li>▪ Would prepare Town for future requirements</li> </ul>	<ul style="list-style-type: none"> <li>▪ Will take money from other requirements</li> </ul>

## **Appendix A**

### **The Health Benefits Review Committee**

Members were suggested by individual Board members and invited by the Chair. The Committee met 9 times on November 3, November 17, December 1, December 15 (2004), January 5, January 19, January 26, February 2 and August 24 (2005).

The charge to the Committee was:

**“Description:** Thoroughly review and analyze current components of health insurance being mindful of employee privacy rights. Compare Lexington’s benefits with other communities and private sector operations. Suggest possible changes to operation which could reduce the cost and/or rate of increases to the Town and subscribers. Consider all options including benefit plan designing, pooling with other Towns and/or local businesses, self-insurance, etc. Report back to a joint meeting of the BOS, School Committee and Appropriation Committee findings and recommendations for additional work to be done in three months.

**Membership criteria:** Criteria for membership shall include Health Care Consultants with experience in health insurance, one subscriber, and citizens with good analytical skills”

**Staff Support:** Rose Ducharme (municipal), Susan Bottan (School)

**Membership:** Bob Beckwitt, Richard Dougherty (Co-Chair), Tom Goodwin, Nancy Meadows, Tom Rand, Linda Roemer, Claudia Sheffield, Deborah Strod (Co-Chair). Maggie Oliva, a subscriber, attended the first meeting but was unable to continue, and Claudia Sheffield was asked to take her place. Update March 2005: Bill Kennedy will continue as a member of the committee. Update August 2005: Tom Rand has moved out of town.

**Liaison:** Paul Hamburger and Rick Eurich (Appropriation Committee), Bill Kennedy (Selectmen), Tom Griffiths (School Committee), Evelyn Silber (Personnel Advisory Board). Update March 2005: Hank Manz was assigned as the Selectmen Liaison.

**Meetings:** Two per month

The Health Benefits Review Committee recognizes that many of its recommendations are subject to collective bargaining. State law provides that the Town cannot unilaterally change the management of health benefits plans, but rather that choices are subject to bargaining.

## **Background of Committee Members and Staff**

**Bob Beckwitt** is Portfolio Manager, Trilogy Advisors; Former Managing Director at Goldman Sachs; Former Portfolio Manager at Fidelity Investments. He holds an SM in Finance from MIT, and a Princeton BA in Economics.

**Susan Bottan** is Director of Budget and Finance, for Lexington Public Schools. Update July 1, 2005: Ms. Bottan has left the position.

**Richard Dougherty** is an organizational psychologist with significant experience in public sector procurement, finance, Medicaid and child welfare policy. He has assisted businesses and government agencies in a range of development and change-oriented projects, involving managed care implementation, quality improvement and organizational and strategic change, often with a focus on consumer and stakeholder input.

**Rose Ducharme** is Revenue Officer/Benefits Manager for the Town of Lexington.

**Rick Eurich** is a member of the Appropriation Committee.

**Thomas W. Goodwin** is a partner in a local CPA firm and former chairman of the Finance Committee in Wakefield Mass. For 6 years earlier in his career, he was responsible for the employee benefits of a 600-person multi-state employee group.

**Tom Griffiths** is past-Chairman of the School Committee. He is also a principal in Evans Griffiths & Hart, Inc. where, annually he reviews the company's health care plans and their costs.

**Paul Hamburger** is a Member of the Appropriation Committee and Town Meeting Member

**Bill Kennedy** is a Selectmen Liaison.

**Nancy Meadows** is a subscriber and has experience in benefits administration.

**Tom Rand** owned an employee benefits consulting firm that was sold to a national firm.

**Linda Roemer** is Professor Emerita of Health Care Administration at Simmons College and a former Chairperson of the Lexington Board of Health.

**Claudia Sheffield** is Administrative Assistant, Town Manager's Office.

**Evelyn Silber** has 20 years of experience in corporate benefits and 7 years of experience in HR consulting. She is co-chair of the Personnel Advisory Board and has served on the Town-wide Compensation Committee, and search committees for a Superintendent and Interim Town Manager.

**Deborah Strod** worked for 10 years at Massachusetts General Hospital in technology transfer and has done some graduate work in public health. She is a Town Meeting member in Lexington.

## **Appendix B**

### **Brief History of Health Benefits in Lexington<sup>7</sup>**

- 1987 – The Town switched from premium-based healthcare to a self-insured plan
- 1993 – Lexington reduced the number of plans and replaced one costly plan with more aggressively managed plan – \$1.3 million dollars saved (had been a projected increase of 15% or \$800,000). A change in Massachusetts law allowed this step to take place.
- 1993 – Dental benefit added with benefit cap
- 1995 – Access was limited to another plan to consolidate the risk pool.
- 1994-1999 – Health insurance appropriation was level during a time when other Towns increased appropriations by double-digit amounts.
- 1997 – Third party administration by Blue Cross/Blue Shield avoided \$500,000 in plan increases; Dental cap eliminated
- 2003 – Co-payments increased, employee cost of plan increased, plan administration changes, avoided \$1.5 M in anticipated cost increases.
- 2004 – One time “opt-out” pilot plan implemented; Express Scripts implemented (prescription by mail)
- 2004/5 – adjusted the Town’s stop-loss insurance levels, increasing to \$90,000

Lexington has participated twice in group-purchasing of health insurance: once with the West Suburban group and; once with the MIIA. In each case, Lexington left the group after an unsatisfactory experience. In West Suburban, Lexington had the largest population but only one non-weighted vote, and the others in the group chose plans too expensive for Lexington. In the case of MIIA, the group failed to provide promised re-insurance, which was only recovered after a great deal of time passed.

It should be noted that the Coalition of Town Employees has repeatedly bargained with the Town about ways in which to reduce health care costs.

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<sup>7</sup> See *Lexington Minuteman*, May 24, 2004 by former Town Manager Richard White; Coalition of Town Employees: Health Insurance Bargaining History, provided by Vito LaMura, Lexington Education Association President.

## **Appendix C**

### **Plan Descriptions**

The current census and medical premium structures are summarized in Exhibit I. Benefits covered under the various plans are summarized in Exhibit II.

Currently, the Blue Choice, Network Blue, HPHC, and Medex programs are self-insured and the HPHC First Seniority, the Managed Blue Senior Plan, and all the dental programs are insured. The Town purchases stop-loss insurance for protection against claims in excess of \$90,000 for the self-insured programs.

In the corporate environment, the cost of providing retiree health care is reduced somewhat when the employee reaches age 65 and qualifies for Medicare. Some Town employees may never qualify for Medicare unless they or their spouses have had jobs outside of state or local government. The Committee understands that this currently involves only one or two retirees.

**2.3. Exhibit I: November, 2004 Census and Monthly Premium Structure (per Employee/ Retiree)**

<b>Plan</b>	<b>Coverage</b>	<b>Enrollment</b>	<b>Town %</b>	<b>Town Contribution</b>	<b>Employee/ Retiree Contribution</b>	<b>Total Working Rate</b>
<b>Medical</b>						
Blue Choice	Individual	151	80%	\$440.80	\$110.20	\$551.00
Blue Choice	Family	116	80%	\$1,143.20	\$285.80	\$1,429.00
Network Blue	Individual	337	88%	\$337.92	\$46.06	\$384.00
Network Blue	Family	576	88%	\$872.96	\$119.04	\$992.00
HPHC	Individual	43	85%	\$369.75	\$65.25	\$435.00
HPHC	Family	73	85%	\$885.80	\$156.30	\$1,042.00
Medex	Individual	548	80%	\$252.80	\$63.20	\$316.00
Mngd Blue Srs.	Individual	44	80%	\$221.61	\$94.98	\$316.59
HPHC 1 <sup>st</sup> Seniority	Individual	40	80%	\$153.60	\$38.40	\$192.00
<b>COBRA</b>						
Blue Choice	Individual	1		\$0.00	\$551.00	\$551.00
Network Blue	Individual	7		\$0.00	\$384.00	\$384.00
Network Blue	Family	2		\$0.00	\$992.00	\$992.00
HPHC	Individual	2		\$0.00	\$435.00	\$435.00
HPHC	Family	1		\$0.00	\$1,042.00	\$1,042.00
<b>Dental</b>						
Delta Premier	Individual	498	50%	\$21.30	\$21.30	\$42.60
Delta Premier	I + 1	454	50%	\$34.23	\$34.23	\$68.46
Delta Premier	Family	382	50%	\$54.77	\$54.77	\$109.54
DeltaCare	Individual	88	50%	\$11.92	\$11.92	\$23.84
DeltaCare	I + 1	27	50%	\$22.34	\$22.34	\$44.68
DeltaCare	Family	12	50%	\$33.63	\$33.63	\$67.26
<b>COBRA</b>						
Delta Premier	Individual	8		\$43.45	\$0.00	\$43.45
Delta Premier	I+1	1		\$69.83	\$0.00	\$69.83
Delta Premier	Family	3		\$111.73	\$0.00	\$111.73
DeltaCare	Individual	1		\$24.32	\$0.00	\$24.32

## Exhibit II - Benefit Summaries

	<b>Blue Choice In-Network</b>	<b>Blue Choice Out of Network/ Self-Referred</b>	<b>HMO Blue</b>	<b>HPHC HMO</b>
<b>Deductible</b>	Not applicable	\$250 per person/ \$500 family	Not applicable	Not applicable
<b>Co-Pay per Visit</b>	\$5	20% coinsurance after deductible. No routine care.	\$5	\$5
<b>Out of Pocket Maximum</b>	Not applicable	\$1,250 per person/ \$2,500 family	Not applicable	Not applicable
<b>Lifetime Maximum</b>	\$2,000,000	\$2,000,000	None	None
<b>Hospital In-Patient (including maternity)</b>	Covered in Full	20% coinsurance after deductible.	Covered in Full	Covered in Full
<b>Hospital Out- Patient</b>	Covered in Full. \$25 emergency room copay if not admitted.	20% coinsurance after deductible.	Covered in Full. \$25 emergency room copay if not admitted.	Covered in Full. \$30 emergency room copay if not admitted.
<b>Skilled Nursing Facility</b>	Up to 100 days/ year	20% coinsurance (up to 100 days/ year)	Up to 100 days/ year.	Up to 100 days/ year.
<b>Laboratory Tests</b>	Covered in Full	20% coinsurance after deductible.	Covered in Full	Covered in Full
<b>Doctor Visits</b>	\$5 Co-Pay	20% coinsurance after deductible.	\$5 Co-Pay	\$5 Co-Pay
<b>Mental Health</b>				
<b>General Hospital</b>	Covered in Full	20% coinsurance after deductible.	Covered in Full	Covered in Full
<b>Specialty Hospital</b>	Biologically based conditions covered in full Other conditions to 60 days/ year	20% coinsurance after deductible. Up to 60 days / year	Biologically based conditions covered in full Other conditions to 60 days/ year	Up to 60 days / year
<b>Out-Patient</b>	\$5 Co-Pay. Up to 24 visits per year	20% coinsurance after deductible. Up to 24 visits per year	\$5 Co-Pay. Up to 24 visits per year	\$5 Co-Pay. Up to 24 individual visits or 25 group visits per year (to a maximum of 25 total visits)
<b>In-Patient Drug/ Alcohol</b>	Up to 30 days/ year in a substance abuse facility.	20% coinsurance after deductible. Up to 30 days/ year.	Up to 30 days/ year in a substance abuse facility. Unlimited in general hospital.	Up to 30 days/ year.
<b>Out-Patient Drug/ Alcohol</b>	Up to 8 visits per year \$5 copay per visit	20% coinsurance after deductible. Up to 8visits per year	Up to 8 visits per year, \$5 copay per visit	Up to 20 visits or \$500 in benefit value, whichever is greater. \$5 copay for first 8 visits, \$25 thereafter. \$5 copay for group therapy.
<b>Home Health Care</b>	Covered in Full.	20% coinsurance after deductible.	Covered in Full.	Covered in Full.

	<b>Blue Choice In-Network</b>	<b>Blue Choice Out of Network/ Self-Referred</b>	<b>HMO Blue</b>	<b>HPHC HMO</b>
<b>Prescription Drugs</b>	\$5 generic/\$10 preferred brand/\$25 non preferred  Up to a 30 day supply from a pharmacy or 90 day supply mail order	\$5 generic/\$10 preferred brand/\$25 non preferred  Up to a 30 day supply from a pharmacy or 90 day supply mail order	\$5 generic/\$10 preferred brand/\$25 non preferred  Up to a 30 day supply from a pharmacy or 90 day supply mail order	\$5 generic/\$10 preferred brand/\$25 non preferred pharmacy. \$10/\$20/\$75 mail order.  Up to a 30 day supply from a pharmacy or 90 day supply mail order

**Medicare Supplement Plans (Plan coverage plus Medicare)**

	<b>Medex</b>	<b>Managed Blue</b>	<b>HPHC First Seniority</b>
<b>Deductible</b>	Not applicable	Not applicable	Not applicable
<b>Co-Pay per Visit</b>	None (No routine care.)	\$10.	\$15
<b>Out of Pocket Maximum</b>	Not applicable	Not applicable	Not applicable
<b>Lifetime Maximum</b>	Not applicable	Not applicable	Not applicable
<b>Hospital In-Patient (including maternity)</b>	Covered in Full	Covered in Full.	Covered in Full
<b>Hospital Out-Patient</b>	Covered in Full.	Covered in Full. \$50 deductible for emergency room unless admitted.	Covered in Full. \$50 emergency room copay if not admitted.
<b>Skilled Nursing Facility</b>	Full coverage for 100 days. \$10/day for 101-365	Covered in Full	Covered in Full
<b>Laboratory Tests</b>	Covered in Full	Covered in full.	Covered in Full
<b>Doctor Visits</b>	Covered in Full	\$10 per visit.	\$15 per visit
<b>Mental Health</b>			
<b>General Hospital</b>	Covered in Full	20% coinsurance after deductible.	Covered in Full up to 190 days
<b>Specialty Hospital</b>	Biologically based conditions covered in full Other conditions to 60 days/ year	Biologically based conditions covered in full Other conditions to 60 days/ year	Covered in Full up to 190 days.
<b>Out-Patient</b>	Up to 24 visits per year	\$10 per visit. No limit for biologically based. Up to 24 visits per year for other	\$15 Co-Pay visit 1-8, \$25 for 9-20, then 50%. \$15 for group visit 1-20, then 50%.
<b>In-Patient Drug/ Alcohol</b>	Up to 30 days/ year in a substance abuse facility.	20% coinsurance after deductible. Up to 30 days/ year.	Up to 90 days in a Medicare covered hospital. Additional Lifetime reserve of 60 days.
<b>Out-Patient Drug/ Alcohol</b>	Up to 8 visits per year \$5 copay per visit	\$10 per visit. Up to 8 visits or \$500 per year	\$15 Co-Pay visit 1-8, \$25 for 9-20, then 50%. \$15 for group visit 1-20, then 50%.
<b>Home Health Care</b>	Covered in Full.	Covered in Full.	Covered in Full.
<b>Prescription Drugs</b>	\$50 deductible, then full coverage for generics and 80% for brands at pharmacy  Mail order \$2/ \$10 for 90 day supply.	25% copay generic, 50% preferred brand, 75% brand  Mail order \$5/ \$30/ \$50 for 90 day supply	\$10 generic/\$20 preferred brand/\$35 non preferred pharmacy. \$20/ \$40/ \$105 mail order.  Up to a 30 day supply from a pharmacy or 90 day supply mail order

<b>Dental Programs</b>	<b>Delta Premier</b>	<b>DeltaCare in Network</b>	<b>DeltaCare out of network</b>
<b>Deductible for out-of-network services</b>	Not applicable	Not applicable	\$100 per person, no family maximum
<b>Preventative</b>	Full coverage for most diagnostic and preventative services once every 6 months	Full coverage for most diagnostic and preventative services once every 6 months	The Plan will pay 20% less than it would have paid for services in network.
<b>Combined Deductible for Basic &amp; Major Restorative</b>	\$50 Individual/ \$100 Family	Not applicable	
<b>Basic Restorative</b>	Covered at 80% after deductible	Copayment schedule by type of service. \$1,000 maximum per calendar year for oral surgery, endodontics, & periodontics.	The Plan will pay 20% less than it would have paid for services in network.
<b>Major Restorative</b>	Covered at 50% after deductible	Copayment schedule by type of service. \$1,000 maximum per calendar year for oral surgery, endodontics, & periodontics.	The Plan will pay 20% less than it would have paid for services in network.

## **Appendix D**

### **Discussion of Options**

In this section, we detail more of the Committee's discussions about the options we recommend the Town investigate further or begin to implement, and other ideas we rejected after an initial look. For ease of reference, we use the same number as in the initial summary page and chart.

#### **1. Short-Term Recommendations**

##### **1.1. Implement a Carve-Out Pharmacy Benefit Program**

###### ***1.1.1. Pharmacy Benefit Management Carve-out***

Pharmacy Benefit Management (PBM) companies have grown considerably in recent years by offering strategies for clients to lower pharmaceutical costs. One way in which this is done is through management of the drug formulary. A drug formulary lists the pharmaceuticals that will be covered by insurance, often in three-tiers with generic drugs costing the least and drugs not on the formulary the most. PBMs also use retail drug card programs, encourage the use of mail order and provide other clinical management programs. Maintenance drugs dispensed by mail tend to be cheaper because the distributor can negotiate lower prices because of volume.

Express Scripts currently provides some pharmacy benefit management services for Lexington enrollees. The consensus of the Committee and GBS consultants was that significantly more savings could be realized through more aggressive benefit management procedures. For a number of its municipal clients, GBS intends to develop a pharmacy carve-out plan, where pharmacy benefits are separately administered from the health benefits, providing a higher level of attention to benefit management, improved reporting and increased transparency of costs. GBS estimates that pharmaceutical cost growth could be reduced by about one-third if the most aggressive plans are implemented. These savings are obtained by increased incentives for enrollees to order drugs for delivery by mail and by encouraging doctors to prescribe generic drugs where possible.

###### ***1.1.2. Mail-in prescriptions and generic drug use***

Express Scripts, the Blue Cross PBM, was implemented in Lexington in 2004. Express Scripts has over 50 million lives under coverage, representing \$24 billion in pharmaceutical spending each year. In 2003, the company managed 379 million retail prescriptions and 32 million mail prescriptions.

Express Scripts helps its clients select plan design features that balance the need for cost control with member convenience and satisfaction. The most common benefit design options offered to its clients are: financial incentives and reimbursement limitations including formularies, tiered co-payments, deductibles, or annual maximums; incentives for generic drug utilization; incentives or requirements to use only network pharmacies or mandatory mail delivery of maintenance drugs; and reimbursement limitations on the amount of a drug that can be obtained within a specific period.

Lexington currently benefits only from the filling of prescriptions by mail and the substitution of generic drugs for brand name ones. Significant savings can accrue from each of these with the largest savings coming from increased use of generic drugs. There is an almost even split between prescriptions which are filled by generic versus brand name drugs. Therefore, there is considerable room to grow the use of generics, through incentive or other programs. Reports provided to the committee (“Drug Payment Drilldown” from BCBS) indicate that for Network Blue subscribers, only about 10% of the prescriptions are being filled by mail. Thus, there are also large potential savings from increasing mail order prescriptions.

There has been controversy in the field about the transparency of drug pricing and perceptions of conflicts of interest in the use of rebates and other manufacturer incentives. Express Scripts has had some rebates from pharmaceutical manufacturers but has committed to reducing the amount of fees that it receives from manufacturers, which may result in some additional savings.

A familiar feature of pharmacy benefits is tiered co-payments, in which Express Scripts or the client actively seek to educate individuals about formulary drugs, programs that actively promote lower-cost therapeutic and generic interchanges. Whereas clients typically have selected a plan with an open formulary, today an increasing number of clients are selecting formularies that offer financial or other incentives (such as three-tier co-payments) to encourage the selection of preferred drugs. (While Lexington offers a tiered co-payment scheme, it is questionable whether the difference in prices is large enough to save the Town money.)

These approaches help contain the rate of cost increases for clients and encourage greater involvement by beneficiaries in the decision making process. Some clients opt for even more restrictive closed formularies, in which benefits are available only for those drugs included on the formulary. In 2003, 54% of all claims fell into three-tier or closed categories, compared to 42% for 2001, indicating increased efforts to reduce costs.

Express Scripts uses its electronic claims processing system to apply the client’s benefit plan design parameters to submitted claims and to enable monitoring of the financial performance of the plan.

At the end of 2003, Express Scripts operated seven mail pharmacies, located in Missouri, New Mexico, Pennsylvania, New York and Arizona. These pharmacies provide members with convenient access to maintenance and specialty medications, while helping the company manage drug costs through operating efficiencies and economies of scale. Since mail order pharmacies are directly involved with the patient and member, they are generally able to achieve a higher level of generic substitutions and therapeutic interventions than is typically achieved at retail. Within its mail pharmacies, Express Scripts maintains a large inventory of brand name and generic drugs, which it purchases either directly from manufacturers or through wholesalers.

Other services are available from Express Scripts. These include disease management and education programs to plan beneficiaries in an effort to help manage clinical outcomes and the total healthcare costs associated with certain

chronic conditions such as asthma, diabetes, and cardiovascular disease. These programs are based on the premise that better-informed patient and physician behavior can positively influence medical outcomes and reduce overall medical costs. Express Scripts identifies patients who may benefit from these programs through analysis of claims data or through self-enrollment. Express Scripts offers a tiered approach to member education and wellness, ranging from information provided through its Internet site, to educational mailings, to its intensive one-on-one registered nurse or pharmacist counseling. The programs include providing patient profiles directly to their physicians, as well as measurements of the clinical, personal and economic outcomes of the programs. However, Lexington enrollees do not appear to benefit from these additional services.

Express Scripts contracts with retail pharmacies to provide prescription drugs to beneficiaries of the plans Express Scripts manages. In the United States, the company negotiates for discounted prices at the pharmacies which will provide drugs to plan members. More than 57,000 retail pharmacies, representing more than 99% of all US retail pharmacies, participate in one or more of its networks. Express Scripts also manages pharmacy networks that are customized for or under direct contract with specific clients. These networks can alert pharmacists to opportunities for generic substitution and therapeutic intervention as well as formulary compliance issues. It is not clear that this is done for Lexington enrollees.

In conclusion, Express Scripts provides a fairly comprehensive set of strategies to control the cost of prescription drugs. Lexington may need to evaluate each option so it can determine whether it has reached the optimal balance between cost containment and member convenience and satisfaction.

### ***1.1.3. Canadian or European Drug Reimportation***

The Town staff had been poised to try importing drugs from Canada two years ago, but it did not move forward because of Selectmen's concerns. At this point, the consensus of the HBRC is that the possible short-term benefits which might have been (or might even still be) realized are not worth the effort now. Whatever benefits might accrue in the short term will decrease over the long term.

There has been considerable study concerning the potential to reimport drugs from Canada into the US to save money. Currently, it is estimated that the reimportation business from Canada is over \$1 billion because many drugs can be as much as 50% cheaper than in the US. There are many who claim that this will grow considerably in the next few years. While the FDA has not approved the reimportation of drugs from Canada, many states, such as Louisiana, North Dakota, Minnesota, Wisconsin, California, Massachusetts, New Hampshire, Maine, Illinois and Maryland are attempting to structure and implement Canadian drug reimportation. Some political leaders have stated publicly their intention if necessary to defy the FDA which believes that such importation is illegal.

To date the FDA has not approved reimportation primarily due to safety concerns. In recent testimony, officials of the Food and Drug Administration, as well as representatives of other government agencies, have noted the potential dangers associated with reimportation, including individual importation, the purchase of drugs from foreign sources over the Internet, and counterfeit drugs entering the

United States. In testimony on this subject, William Hubbard, Senior Associate Commissioner for Policy, Planning, and Legislation at the U.S. Food and Drug Administration (FDA), stated: “Currently, new drugs marketed in the United States must be approved by FDA based on demonstrated safety and efficacy.... This “closed” regulatory system has been very successful in preventing unapproved, adulterated or misbranded drug products from entering the U.S. stream of commerce. Legislation that would establish other distribution routes for drug products, particularly where those routes routinely transverse a U.S. border, creates a wide inlet for counterfeit drugs and other dangerous products that can be injurious to the public health and a threat to the security of our nation’s drug supply.” Similar concerns have been echoed by former Bush administration Health and Human Services (HHS) Secretary Tommy Thompson and former Clinton Administration HHS Secretary Donna Shalala.

Representatives of the Canadian government have recently clarified their position by stating that they could not guarantee the safety and effectiveness of drugs exported from their country. This is especially troublesome as counterfeit drugs entering the U.S. pose genuine risks both in lack of efficacy and in adulteration with unknown substances. There are also many who claim that the safety issue is just a way to politically protect pharmaceutical profits.

Eventually, mechanisms may be put in place to protect US consumers from the risks stated above. At that point, the remaining question will be whether discounts will remain in Canada should the amount of drugs reimported become much larger.

At some point, it is likely that the discounts available to US consumers will disappear, most likely from a combination of efforts from pharmaceutical companies and the Canadian government itself. Pharmaceutical manufacturers, who sell their products to the Canadian government at lower costs, have a direct economic incentive either to limit any surplus sold to Canada or to stop selling their products to Canada altogether. There does not seem to be any reason why Canada should put its own discounts at risk to supply customers in the US.

The probability of sustaining discounts might increase should Congress look beyond Canada to enable the reimportation of drugs from larger European nations. For a number of reasons this seems unlikely at this time.

Therefore, while there may be some short-term savings available from Canadian drug reimportation, it is likely that reimportation will not lead to intermediate or long term discounts and would always face the possibility of being cut off suddenly by Canada, the drug manufacturers or the FDA.

## **1.2. Strengthen Claims and Enrollment Audits**

A significant cost containment opportunity lies in making sure that the Town pays only for services provided to those who should be covered by the Town and that all claims are legitimate and for services that are covered.

First the Town needs to be extremely timely in reporting changes in status. This includes monitoring dependent coverage, tracking dates of death and birth, requesting substantiation

for students who fall outside of the age limits, and promptly terminating former employees and their dependents.

In addition to the internal monitoring, the Town should consider engaging an independent firm to review the claims on a periodic basis, probably quarterly. They would review the data base of employee and dependent information and carefully monitor cut off information to make sure that any claims paid subsequent to a termination are the result of services performed prior to the end of the coverage period. They would also review all large claims paid to make sure that there were no overcharges and that the services were appropriately covered (i.e. not excluded services). It is also important that covered services be fully understood and monitored carefully.

The auditor would also review significant claims for a dependent spouse to make sure that no other coverage was available from another source to pay for these services.

Note that Express Scripts has support for this kind of work for pharmaceutical costs.

### **1.3. Review Premium Structure and Plan Design**

We need to understand how much flexibility there is in determining plan design. For example, if Lexington requests a different benefit structure than the standard programs offered by Blue Cross or Harvard Pilgrim in order to influence participant behavior, will Blue Cross or Harvard Pilgrim be able to administer that program? Some design decisions are tied to other issues; for example, some vendors may refuse to offer high deductible programs with Health Reimbursement Accounts (HRAs) or Health Savings Accounts (HSAs) if the Blue Choice program is also a plan option.

The current structure, with two Blue Cross alternatives and one Harvard Pilgrim alternative for non-Medicare enrollees, was established in 1994 and participants selected plans at that time. There has not been significant movement between plans since that date because at the time of the changes, enrollment was frozen for 3-4 years and people were required to move off the HPHC plan into the BCBS plan to pool risk; most enrollment changes since that time have been due to new employees selecting plans and eligible employees who had not previously enrolled later choosing to get benefits through the town. It is possible that a different premium or benefit structure would result in significant changes in the distribution between plans.

There is a two-tier structure for medical coverage (individual and family) and three-tier structure for dental coverage (individual, individual plus one, and family). We understand that a three-tier structure was considered for medical coverage and rejected because the family premium would be too high. This should be reviewed each year. The committee was not provided with information as to how the current premium structure was developed. For the medical programs, the ratio of the family premium to the individual premium varies by plan between 2.40 – 2.59. This weighting should be reviewed to determine if it is appropriate. It may be more appropriate to use the same ratio for all three plans.

After reviewing long term cost projections for each Plan, the Town should determine whether there is any reason to provide incentives to employees to select one plan over another and, if so, to develop a premium structure which encourages movement towards that plan.

### ***1.3.1. Increase non-pharmaceutical co-pays***

There may be an opportunity to significantly change behavior by changing plan design. Under the current structure, with \$5 copays for most services, there is limited consumerism. Participants do not have the information to make choices based on cost because the amounts they are paying do not relate to the true cost of the services. The cost to the participant of using a high cost or inefficient provider is the same as the cost of using a more efficient provider. There is no incentive, for example to avoid high cost teaching hospitals for routine tests and services which could be performed more efficiently and with equal quality in a community setting. The optimum plan structure would include rewards for wise behavior as a health care consumer.

### ***1.3.2. Institute Explanation of Benefits forms***

Participants generally do not receive explanation of benefits forms from Blue Cross Blue Shield when claims are paid, so they are totally isolated from the real cost of medical care.

### ***1.3.3. A structure with participants paying a percentage of the discounted cost per visit might encourage more cost-effective behavior.***

### ***1.3.4. The \$5/ \$10/\$25 copay structure for prescription drugs is also somewhat low.***

Once again, there is no incentive to compare prices charged by participating pharmacies or to compare the costs of different generics.

### ***1.3.5. Change the ratio of Premium Contributions***

The Town currently pays 80% of the total cost for Blue Choice, Medex, and HPHC First Seniority, 85% for HPHC, 88% for Network Blue, 80% for Managed Blue Seniors, and 50% for all dental plans.

One option to consider is to have the Town contribute the same dollar amount (one dollar amount for individual coverage and one for family coverage), whichever Plan the employee elects and have the employee pay the remaining percent of premium.

Another way to reduce costs would be to make the Lexington benefits less attractive by reducing benefit levels or increasing employee premiums enough so that those with working spouses will elect to participate in those plans instead of the plans offered by the Town. This could detract from the town's ability to attract new employees.

Employee contributions could also vary based on pay, with those over a certain salary contributing more to their own health care. When the Committee examined the salary structure of the Town, it did not seem that this would result in any significant savings.

The committee discussed the possibility of recommending that part time employees pay a higher pro rata share of the premium, in order to encourage those with working spouses to get their medical coverage from the spouse's plan. If legal, this could save

the Town as much as \$1M annually according to one estimate. It appears that this may not be legal under the laws governing municipal benefit plans. Furthermore, an increase in premiums could make it difficult to fill some part time positions as access to health care is a major hiring incentive.

In addition, the Committee was told that many part time jobs within the schools don't work well as full time positions. There has been some effort to keep as many part time jobs as possible below the 20 hours that qualifies the individuals for benefits, but that often is not feasible. For many, the availability of the Town's health care program is the reason they are willing to take the jobs at relatively low wage levels.

The Committee also discussed whether or not it would be possible to charge higher premiums to smokers or other high-risk groups, as is done with life insurance. The consensus was that this would be too difficult to administer and would not be permissible under Mass. General Law 32B and HIPPA. How would the Town treat a family where the employee did not smoke, but the spouse or dependent child did? How would the Town obtain the information and ensure its confidentiality?

#### **1.4. Consider Separate Plan for Out-of-state Enrollees**

Because the Blue Choice Plan is the only one allowing participants to go out of the network for services, it may be the only one appropriate for retirees not eligible for Medicare who live outside Massachusetts (42 individuals and 18 families) and families with dependents in college out of state. Therefore, the Plan cannot be eliminated unless another plan appropriate for this population is added.

As the cost of coverage for out-of-state retirees is higher, a higher retiree share may be appropriate. It is also possible that the Town can find an insurer that could provide coverage to this group separately from the rest of the enrollees. If this were the case the Town could eliminate the Blue Choice option which is the most expensive. However, there are many other potential problems with eliminating Blue Choice. In addition to the need to collectively bargain over this, there is the fact that Blue Choice enrollees pay more, but may not use more expensive services. This is because few actually do go out of network for services. Thus, if Blue Choice were eliminated, premium contributions would decrease, possibly without an accompanying decrease in costs.

#### **1.5. Expand health promotion and disease prevention locally**

There is little systematic attention currently being paid to health promotion and disease prevention activities within the Lexington employee and dependents population.

Health promotion encourages the adoption of healthy practices in areas such as diet, exercise, and stress reduction. Disease prevention involves the identification of specific risks and the taking of steps to reduce those risks. Treatment of individuals shown to be at risk for osteoporosis aimed at preventing future fractures is an example of disease prevention. Early detection, while often included in disease prevention is not prevention but is important for the future health of the individual and the cost of health care. Mammograms and PSA testing for prostate cancer are examples of early detection. Early detection and disease prevention, because they more clearly fall within the scope of practice of medical practitioners, are more likely to be done than is health promotion.

Neither Blue Cross nor HPHC appear to be offering significant health promotion and disease prevention activities to Lexington enrollees. While such services are available, e.g. Weight Watchers or fitness centers, often at reduced costs, there does not seem to be a concerted effort to involve Lexington's employees, retirees and dependents.

While it is tempting to hope that health promotion activities could provide near-term savings in health costs for the Town, this is unlikely for a number of reasons.

- The Town does not have information about various risks that exist within the covered group
- Obtaining data about risks that could or should be addressed will be costly and require the cooperation of Town employees. This is beyond the current scope and capacity of Town government.
- Within the employee population, there are likely to be individuals at high risk and broad-based programs aimed at the general population may not reach them. High-risk individuals pose a particular threat to health care expenses because of their effect on the community experience and future costs. Methods by which an employer may identify and reach these individuals so as to reduce risk are only just being developed and may be difficult to implement, particularly with HIPAA (the Health Information Portability and Accountability Act) in place.
- Effective health promotion and disease prevention activities will entail costs now for savings that **might** be realized in the future. Savings would come in the medium- and long-term and almost certainly would not be identifiable as deriving from such efforts.

Simply talking about health promotion and making it available to employees at reduced rates is not sufficient to change much behavior. More aggressive action would be required.

One example will suffice. It can be assumed that some Town employees and dependents smoke. Smoking affects not only the health of the individual but of his or her family as well. The effects of second hand smoke on household incidence of lung cancer, upper respiratory infections and asthma, for example, have been documented. However, we do not know how many Town employees smoke. We also do not know whether those who smoke are interested in stopping. And, we do not know how effective a Town-organized program would be in reducing the incidence of smoking.

The Town would benefit also from improved reporting on claims made for particular health conditions for our population (diabetes, smoking-related or obesity-related illnesses in particular) in order to gauge how effective increased health-promotion efforts could be in decreasing claims. However, as noted elsewhere in this report, our claims are actually lower than the rest of Blue Cross/Blue Shield's book of business.

Because the data and participation needed for any health promotion and disease prevention programs can only come from the employees themselves, gains can only be made by a combined effort of the Town and its employees. A health risk assessment of Town employees (and possibly of dependents as well) would provide much needed data and might help to build support within Town government and the employee population for needed programs in these areas. This would require funding from the Town.

## **1.6. Develop a Clear Strategy to Expand Case and Disease Management**

There is little data available to the Committee that would enable it to draw any conclusions about savings that more “aggressive” case management might provide to the Town. Case management activities are generally focused on two sets of individuals.

The first group includes those who are in acute episodes. For these, case management concentrates on getting an individual out of expensive care such as hospitals into less expensive services such as rehabilitation facilities or home care. Although Blue Cross and HPHC have little financial incentive to provide these services to Town employees and dependents who are not insured by them, it is likely that they do because they provide such services for those they insure. There is evidence, however that Town staff provide consumer education and certain case management services when they can.

The number of cases in which the reinsurance floor is reached indicates that there are several cases within the Lexington insured group for whom acute episodes are costly. Aggressive case management might lower costs for these individuals. Generally, however, the most substantial savings are realized for cases where the annual claims level is in the \$10,000 to \$50,000 range.

Disease management is usually focused on those with chronic conditions who are not in a health facility and may still be working. Although these individuals may have acute episodes, their care is generally on an outpatient or ambulatory basis and drugs are usually the most expensive part of such treatment. Conditions included in this group include asthma, diabetes, coronary artery disease, heart failure, hypertension, and high cholesterol. It is likely that some forms of case management for these individuals are done by the practitioners who treat them; however there are no incentives for this.

The evidence on savings from disease management for chronic conditions is not encouraging, although it is clear that case management can result in better quality services and improved patient satisfaction. Few entities providing case management report significant savings. One positive example is Asheville, NC which has a program for city employees that concentrates on diabetes, asthma, hypertension, and high cholesterol. This program, which is currently being tried in a few other places, uses specially trained pharmacists to monitor participants. It was reported that the city has saved four dollars for every one dollar it invested in the program, mostly in reduced hospital costs.

There is, unfortunately, little data to estimate how much case or disease management is being done for those with chronic conditions or whether savings can be attained. What is clear is that the incentives are probably not aligned in ways that encourage aggressive management of the chronic conditions of those Lexington covers.

Express Scripts has some features which would support case management of pharmaceutical use but these are probably not being applied aggressively to Lexington enrollees at this time.

## **1.7. Continue to Consider Alternative Insurance Providers, Stop-loss Levels and Insurance vs. Self-insurance as Part of Rebidding Process**

### ***1.7.1. Alternative Health Plans***

Blue Cross/ Blue Shield, Harvard Pilgrim, and Tufts Health Plans have the most extensive networks in Massachusetts. Rose Ducharme has indicated that the Town has requested competitive quotes from Tufts Health Plan in the past and it was more expensive than the programs currently offered. This cost comparison should probably be repeated every three to five years. Periodically, it may be worthwhile to compare the networks offered by United Health Care and CIGNA to the list of providers used by plan participants; although neither network is currently as extensive in Massachusetts as Blue Cross, Harvard Pilgrim, or Tufts, they have apparently taken steps to improve their coverage within the state.

### ***1.7.2. Self-Insurance versus Full Insurance***

Rose Ducharme has indicated that the Town requests quotes and compares self-insured and fully insured programs on an annual basis. This practice should continue. Self-insured and insured dental programs should also be evaluated.

In the long run, the cost of coverage for a large group is the total of claims paid, administrative and claims processing costs, the cost of any risk transfer, plus an allowance for profit for the insurer or plan administrator. Insurance may save money over self-insurance in the short run, if the insurer underestimates claims or provides an artificially low quote to “buy” the business, on the assumption that it will recoup its first-year losses in future years. In the long run, self-insurance (perhaps combined with reinsurance or stop loss coverage) is likely to be less costly because the profits or risk premiums assumed by administrators are lower than those assumed by insurers. In addition, state laws mandate certain benefits for insured plans; self-insured plans are not required to offer many state-mandated benefits.

### ***1.7.3. Limit Entry or Reduce Employer Contribution for Blue Choice Plan***

The out-of-state Blue Choice Plan does not require participants to have a primary care physician. Many believe that having a “gate-keeper” can help to keep medical costs down. The in-state Blue Choice Plan requires a primary care physician, but does allow participants to go out of network if they choose; that is when they utilize their out of pocket deductible. If this is true, the premium structure used for the Blue Choice Plan should include an employee contribution reflecting the additional cost of the program. The Town could also consider not allowing new employees to select the Blue Choice Plan.

However, we cannot determine from the information available whether there is adverse selection and whether or not it is costing the Town more when employees elect the Blue Choice Plan. It would be interesting to review the demographics of the employee selecting Blue Choice with those selecting HMO Blue. Rose Ducharme has indicated that in the past in-state employees who selected Blue Choice do not often go out of the HMO network for care. However, they are willing to pay a higher

premium to reserve the right to go out of network. If providing incentives for them to move to the HMO plan does not change their utilization of health care, the cost to the Town might actually increase, since claims would remain the same and employee contributions would decrease. The Town should review the rate structure each year to be sure that relative employee contributions for the Blue Choice and HMO programs reflect the perceived value of the availability of out of network care.

### **1.8. Ensure that the Health Benefits Trust Fund is at the Recommended Level of Three Months**

In recent years the Town has used money designated for the Trust Fund for other government expenses. The Trust Fund has therefore fallen below the recommended three months level.

The Committee believes that the Trust Fund should be allowed to accumulate up to the four-month level. With the lower level, there is a larger possibility that the Town might have to appropriate additional money during a year should unusual expenses occur and the Trust Fund run short.

### **1.9. Review Implementation of this report on an Ongoing, Perhaps Quarterly Basis**

While the HBRC has no desire to indefinitely perpetuate itself, it does believe that there needs to be a specific group, appointed by the Selectmen, to continually monitor health benefits within the Town, and to provide pressure to move forward on recommended and agreed upon changes. The Committee understands that many of its recommendations will be subject to collective bargaining.

However, the cost of health insurance is a very serious problem for the Town, and will become more so. Therefore, there needs to be a mechanism to continue to focus on the problem and to suggest actions that the Town can take.

## **2. Longer-Term Recommendations**

### **2.1. Consumer-Directed Healthcare; Health Savings Accounts, Flexible Spending Accounts, Medical Savings Accounts, Health Reimbursement Arrangements**

The Town should consider various options in the implementation of consumer directed health care strategies, similar to the current trend in many businesses. Please see Appendix F for a more detailed discussion of these options.

### **2.2. Implement strategy for expanded case management and health promotion**

See 2.1.5 above.

### **2.3. Explore group purchasing in tandem with review of premium structure and plan design**

There are currently two major purchasing groups in Massachusetts – MetroWest and MIIA. Lexington has participated in both groups in the past. At the time we were part of the MetroWest Group, we were one of the largest Towns in the group and each entity had one

vote. Lexington dropped out because the group elected to offer benefits that were more generous than the Town thought it could afford. With MIIA, the purchasing group did not purchase the stop-loss insurance expected and the purchasing group was required to fund several claims for Lexington employees which it had not anticipated. It may be worthwhile to review the two groups again to see if the operating rules or the composition of the groups have changed.

Should another group be formed, Lexington should consider whether it would be advantageous to join. Or, the Town could participate in forming a new group. The advantage of belonging to a group is that the wider risk pool would reduce costs and risk, but the disadvantage is the amount of administrative time and effort required. The committee was also asked to explore pooling with local business, but were informed that this was illegal.

#### **2.4. Begin Funding Future Obligation for Health Benefits**

Although this will take considerable fiscal constraint, it seems important to establish the principle that this is a future obligation of the Town. Beginning to fund this obligation soon will help to spread the burden over more years and prepare the Town for future regulatory or legal requirements (such as the GASB standards). Bond-rating agencies have already taken it into account in reviews of other towns, and it would be good to obtain such agencies views of the how soon it is necessary to do this.

## **Appendix E**

### **Review of Comparable Town Benefits Survey**

To better understand the costs of Lexington health benefits and the health benefits marketplace for eastern Massachusetts municipalities, the Committee conducted a survey of “comparable” local cities and towns. We selected towns used by unions for comparison purposes in wage agreements and selected other cities and towns with similar demographics and financial status. A survey instrument was developed and modified based upon feedback from town staff and committee members. Twenty nine towns were contacted by phone, the survey was faxed and phone follow up was conducted as needed. Twenty four towns responded with most of the requested information. Information included health plans offered, benefit levels, employee premiums, and questions about other benefits offered, including dental benefits, chiropractic coverage and pharmacy benefits. We appreciate the respondents' collaboration and will be sending copies of the report to them.

Disclaimer: the data in these charts, although verified by each town, has not been independently verified; misunderstandings and differences in accounting practices among towns may lead to inconsistencies in the responses.

#### **Survey Results**

The detailed findings of the survey are contained in the charts below and the table that follows.

Lexington offers a generally similar set of traditional health plans as most of the towns. Blue Choice, HMO Blue and Harvard Pilgrim were the most frequently offered plans. The Metro Suburban Health Purchasing Collaborative also offers Tufts PPO, Tufts POS and Fallon and a NAA (Out of Area) plan.

For Medicare supplement retiree plans, virtually all towns offered Medex and most also offered HPHC's First Seniority product, a much less costly Medicare HMO product with expanded benefit.

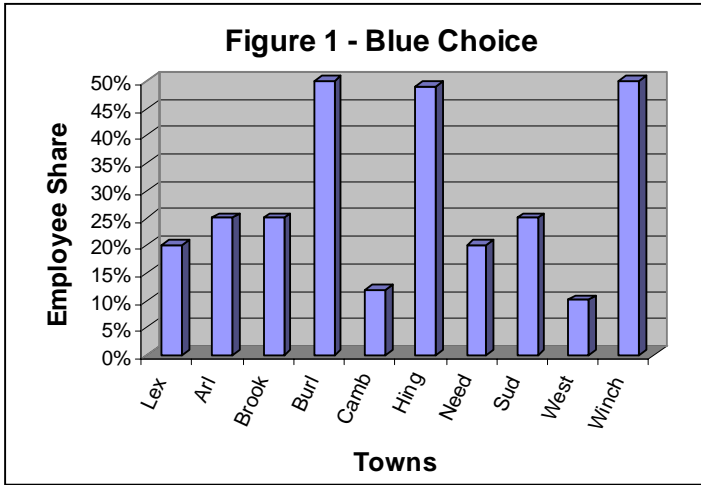
Eighteen towns, including Lexington, offered \$5 co-pays for physician and ambulatory services. Three towns have co-pays of \$10 per visit; one town has an \$8 co-pay and the remainder are mixed in their benefits. Eleven towns have \$25 Emergency Room co-pays. Five towns have \$50 ER co-pays; five have \$25-\$50 co-pays and the remainder are mixed. With the exception of Brookline and Sudbury, Lexington and six other towns had the next lowest levels of pharmacy co-pays - \$5 generic/\$10 brand/ and \$25 formulary. Mail order rates for Lexington were similar but generally for a 90 day supply. Seven towns had similar rates

Of the 24 respondents, seven reported Annual Limits on out of pocket employee expenses. Lexington has a \$1,000/\$2,000 policy; one town (Newton) had a similar benefit. All others were higher – such as \$2,200/\$4,400 in Concord and \$1,600/\$3,200 in Dover.

Lexington offers some coverage and benefits that are not offered by other Towns. Chiropractic services are covered by Lexington with a \$5 co-pay for up to 20 visits. This is similar to Brookline. Fourteen towns reported offering the coverage but most of them only offered it in certain but not all plans. Woburn had a limit of 12 visits per year.

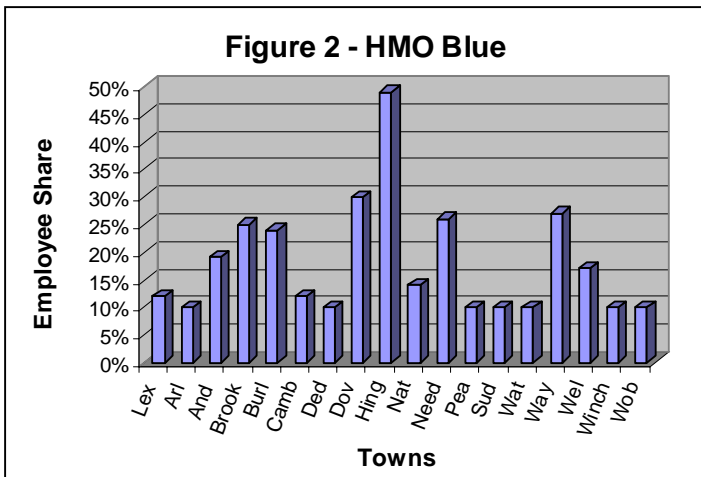
Twenty towns reported offering Dental insurance, but we only received rate sheets for thirteen.

Lexington picks up 50% of the premium for Delta Premier and Delta Care. Ten of the other towns did not contribute to the Dental coverage (100% employee premiums). Sudbury and Wellesley contributed 25% and 47% respectively for DeltaCare coverage, not Delta Premier.

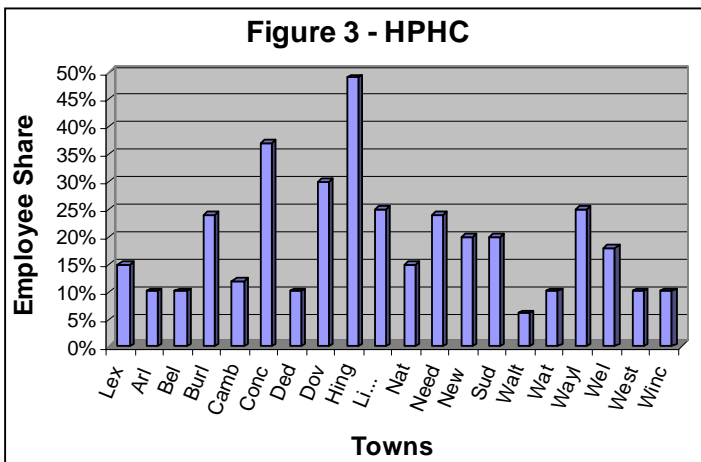


Eighteen towns offer life insurance benefits; two do not. Of those that offer the benefits, Lexington offered what appeared to be the standard benefit of 50% of the premium for \$5,000; employees are responsible for the premium of additional insurance up to \$74K. Three towns offered \$10,000 policies - only one of those reported optional additional coverage (Wellesley).

Lexington was the only Town that reported having used an Opt-Out program, where cash benefits were paid to employees who voluntarily select their spouse's insurance plan. Lexington's plan was one-time only, however.

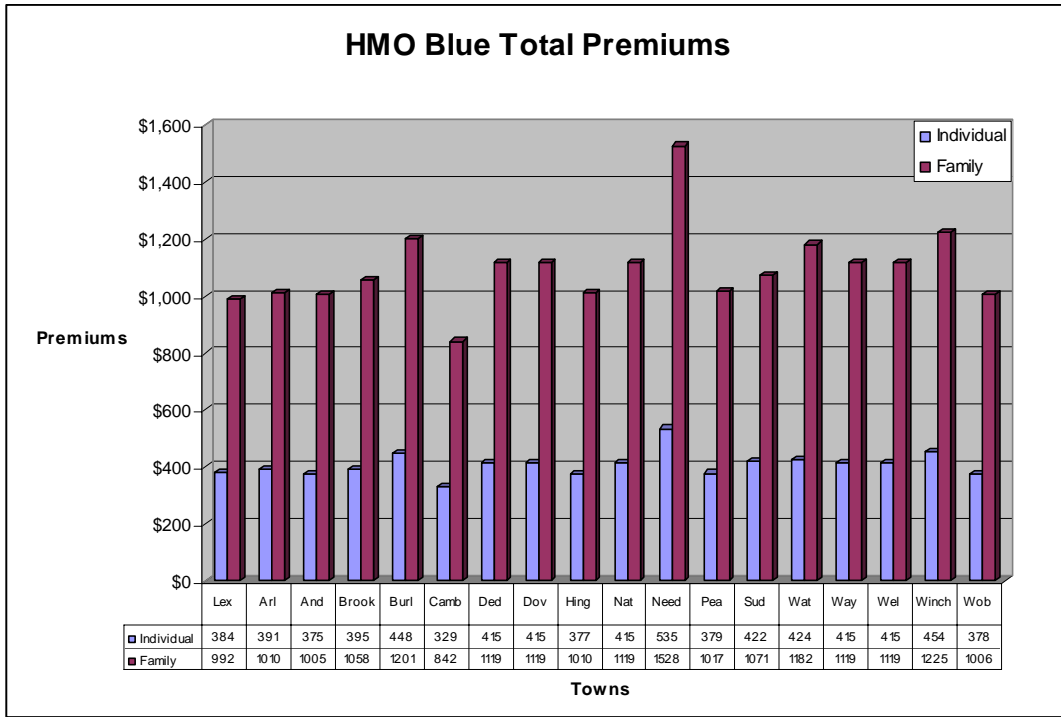


As shown in Figures 1–3, Lexington employees contribute a different percentage of the premium for each of the covered plans: 20% for Blue Choice; 12% for HMO Blue, and; 15% for HPHC. This compares to averages of 29%, 18% and 19% respectively for the towns also offering those plans. The distributions of employee shares for the three plans are shown in the attached charts.

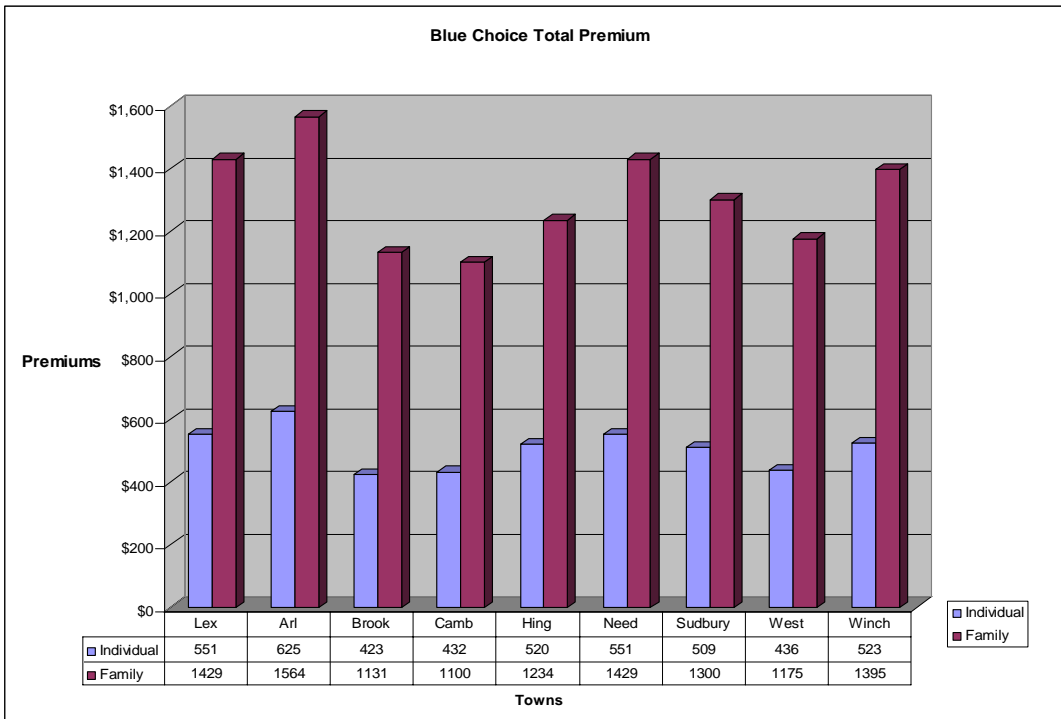


Total premiums for the health plans offered by Lexington were generally comparable to other towns (see Figures 4-6). Premiums were slightly higher than average for Blue Choice and HPHC and lower than average for HMO Blue. While the costs may be somewhat lower, the Town has priced the HMO Blue premiums so as to encourage enrollment in this plan. The premiums vary significantly

**Figure 4 HMO Blue Total Premiums**

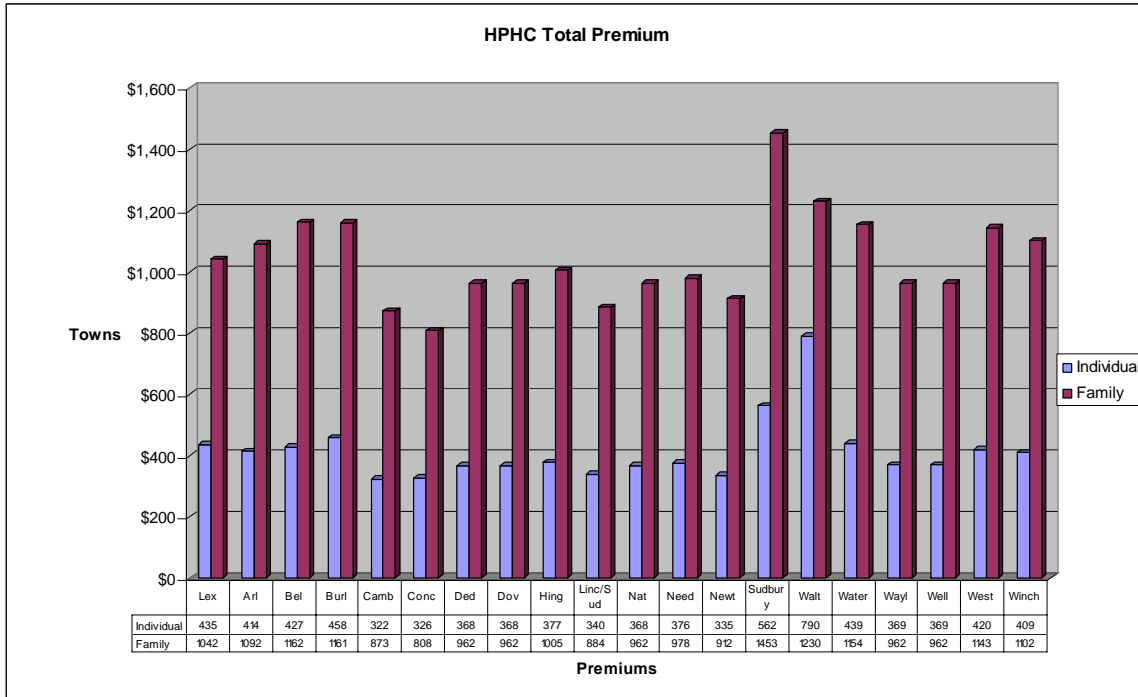


**Figure 5 – Blue Choice Total Premiums**



Of the fourteen towns reporting Medex premiums and contribution rates, Lexington had a very competitive premium rate at \$316 overall. Only Arlington was lower at \$292 per month and Needham was the same as Lexington. Medex premiums were as high as \$423 in Burlington. Most towns, with the exception of Hingham and Needham, offered at least one other plan for seniors. Members of the West Suburban Health Plan offered as many as 8 different options. At 20%, Lexington was one of the lower towns for the employee share of the premium for Medex and Medicare related coverage. Most towns had 25% or more of the premium being picked up by the retiree. Many required the retiree to pick up 100% of the premium.

**Figure 6 – HPHC Total Premiums**



**Other Reviews of Health Benefits**

Of the eleven towns tracked as comparables by the Teachers’ Union for salary and benefit negotiations for FY’05, Lexington ranked fourth in overall health insurance benefits. The total compensation level was ranked lower however. The benefit is calculated based upon family plan premiums for HMO Blue (the most frequently enrolled plan).

Another analysis of comparable towns was conducted by Town staff in the fall of 2004, looking at health benefits as a percentage of total budgets. In that analysis, Lexington ranked second, just behind Arlington, with 10.7% of the budget devoted to health care costs.

Blue Cross compared Lexington’s renewal rate calculations to Blue Cross’ “book of business”. For the HMO Blue plan, Lexington’s projected claims were \$2,717,692 vs. Blue Cross’ claims at \$3,516,076. For the Medex plan, Lexington was \$1,836,932 vs. BCBS at \$2,245,239.

**Figure 7 – Lexington Health Benefits Review Committee – Survey Data**

Town	Lexington	Andover	Arlington	Brookline	Burlington	Concord also Con-Carlisle HS	Dedham	Dover	Hingham
Name	Rose DuCharm	Kathleen Golini	Anne Milici	Kathy McGinnis	Jayne Hyde	Personnel Dept.	Frank Geishecker	Karen Jelloe	Leah Bleicken
Phone	781-861-2768	978-623-8534	781-316-3123	617-730-2117	781-270-1622	978-318-3025	781-751-9171	508-785-0032 x237	781-804-2407
Email	rducharm@ci.lexington.ma.us	kgolini@andoverma.gov	amilici@town.arlington.ma.us	kathy_mcginnis@town.brookline.org	jhyde@burlmass.org	personnel@concordnet.org	fgeishecker@town.dedham.ma.	treasurer@doverma.org	bleickenl@hinghamma.com
Rate Sheet	Y	Y		Y	Y	Y	Y	Y	Y
<b>Average Co-Pays</b>									
Phy/Amb	\$5	\$5	\$5	\$5	\$5	\$5-\$10	\$5	\$5	\$5
ER	\$25	\$25	\$25	\$25	\$25	\$25-\$50	\$25	\$25-\$30	\$25
Prescript - Retail	Generic	\$5	\$10 - 30 day	\$5 - 30 day	\$5	\$10	\$5	\$5	\$5
	Brand	\$10	\$20 - 30 day	\$10 - 30 day	\$10	\$20	\$10-\$15	\$10	\$10-\$15
	Form	\$25	\$35 - 30 day	All charges	\$10	\$35	\$25-\$35	\$25	\$25-\$35
Prescript - Mail Order	Generic	\$5	\$10 - 90 day	\$5 - 90 day	\$5	\$10	\$10	\$10 - 90 day	\$5-\$10
	Brand	\$10	\$20 - 90 day	\$10 - 90 day	\$10	\$20	\$20-\$30	\$40 - 90 day	\$10-\$30
	Form	\$25	\$35 - 90 day	All charges	\$10	\$35	\$50-105	\$50 - 90 day	\$25-\$105
<b>Annual Limits</b>									
Prescription	N/a	None	None		None	n/a	n/a		None
Inpatient	N/a	None	None		None		n/a		None
Out-of-Pocket	\$1000/\$2000	None	None		None	Only w/Tufts POS \$200/\$400 deduct & \$2200/\$4400 max out of pocket	1600 pre member per year POS only	HPHC \$1600/\$3200/yr Tufts \$1500/3000/yr	None
<b>Other Relevant Cvg</b>									
Chiro	Coverage	Y	None	N	Y	Y	Y	Y	N
	Describe	\$5 up to 20 Visits			20 Visits/CY \$5 co-pay		Some plans	Discount only	Only Fallon
Dental	Coverage	Y	Y	Y	N/A	Y	Y	Y	Y
	Describe	Delta Premier	Delta Premier	Dental Blue - paid by employee		BCBS Children under 12 & Delta Premier	Guardian	Voluntary to School Dept only	Delta Dental
Life Ins.	Coverage	Y	Y	Y	Y	Y	Y	Y	Y
	Describe	\$5000 50% Pd-up to \$74K sup employee pd	Boston Mutual Basic Optional Voluntary	Town pays 50%	\$5,000 term life policy	\$5,000 term life town pay 50%	Guardian	\$5K - 50% pd-other ins voluntary	\$10,000
Opt-out Program	Yes	No	N/A	No	No	n/a	N		No

Town	Lexington	Lincoln-Sudbury High School	Medford	Natick	Needham	Newton	Peabody	Sudbury	Waltham	
Name	Rose DuCharm	Kimbrey Goodwin	Ellen Baglio	Linda Clark	Sophie Grintchenko	Paul Deschenes	Elaine Crichton	Deb Greeno	Brenda Capello	
Phone	781-861-2768	978-440-8818 x2382	781-393-2531	508-647-6400 x1439	781-455-7530 x235	617-796-1271	978-532-5721	978-443-8891 x348	781-314-3355	
Email	rducharm@ci.lexington.ma.us	kim_goodwin@lsrhs.net	ebaglio@medford.org	lclark@natickma.org	sgrintchenko@town.needham.ma.us	pdeschenes@newton.ma.gov	elaine.crichton@peabody.ma.us	greenod@town.sudbury.ma.us	bcapello@city.waltham.ma.us	
Rate Sheet	Y	N		Y	Y			Y	Y	
<b>Average Co-Pays</b>										
Phy/Amb	\$5	\$10	\$10	\$5	\$5	\$15	\$5-\$25	\$5	\$5	
ER	\$25	\$50	\$50	\$25-\$30	\$25-\$30	\$50	\$25	\$25	\$25	
Prescript - Retail	Generic	\$5	\$5	\$5	\$5	\$5	\$5-\$10	\$5		
	Brand	\$10	\$10	\$10/\$25	\$10-\$15	\$10-\$15	\$20	\$10-\$15	\$10	
	Form	\$25	\$25		\$10-\$35	\$25-\$35	\$30		\$10	
Prescript - Mail Order	Generic	\$5	\$10	\$5	\$5-\$10 - 90 day	\$5-\$10	\$10	\$5-\$10 - 90 day	\$5	
	Brand	\$10	\$20	\$10/\$25	\$20-\$30 - 90 day	\$10-\$30	\$40	\$10 - 90 day	\$10	
	Form	\$25	\$50		\$25-\$105 -90day	\$10-\$105	\$60		\$10	
<b>Annual Limits</b>										
Prescription	N/a	N/A	0		n/a	N/A	\$1,560 Max on durable med equip	None	None	
Inpatient	N/a	N/A	0		n/a	N/A - POS Plan \$100 yr		None	None	
Out-of-Pocket	\$1000/\$2000	N/A	\$1,200 Ind - \$2,400 Fam		n/a	N/A - POS Plan \$1,000 Ind/\$2,000 Family		None	None	
<b>Other Relevant Cvg</b>										
Chiro	Coverage	Y	Y	N	Y	Y	Y	Y	N	Y
	Describe	\$5 up to 20 Visits	Tufts		Fallon only	Fallon Only	Tufts not HPHC	Blue Care Elect	Only w/Blue Choice Plan	Tufts & BCBS
Dental	Coverage	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Describe	Delta Premier	Fully paid by employee		Children - Adults included w/ Fallon	Children except Fallon: everyone in family-Also Delta Premier dental offered	Delta Dental & Delta Premier Plan	Preventive for children-voluntary plan employee pd	Dental Blue - \$750 max	Delta Dental w/Tufts or Harvard
Life Ins.	Coverage	Y	Y	Y		Y	Y	Y	Y	Y
	Describe	\$5000 50% Pd-up to \$74K sup employee pd	\$10,000 AD&D			\$2K life 50/50	\$5,000 for \$9.45/mo 50/50 split		Basic Life \$56/employee town pays other 1/2-Bstn Mtl	\$15K 50% pd by city-add'l if pd by employee - Bstn Mtl
Opt-out Program	Yes	No			No	No	No	No	No	

Town	Lexington	Watertown	Wayland - EPO/HMO	Wayland - PPO/POS	Wayland - SR	Wellesley	Weston	Winchester	Woburn	
Name	Rose DuCharm	Diane Ryan	Donna Lemoynes	Donna Lemoynes	Donna Lemoynes	Susan Adler	Lisa Yanakakis	Ellen Howard	Elaine Pruyne	
Phone	781-861-2768	617-972-6460	508-358-3612	508-358-3612	508-358-3612	781-431-1019 x240	781-893-7320 x331	781-721-7116	781-932-4478	
Email	rducharm@ci.lexington.ma.us	dryan@ci.watertown.ma.us	mdinapoli@wayland.ma.us			susana@ci.wellesley.ma.us	yanakakis.l@weston.mass.org	ehoward@ci.winchester.ma.us	epruyne@cityofwoburn.com	
Rate Sheet	Y	N	Y	Y	Y	Y	Y	Y	Y	
<b>Average Co-Pays</b>										
Phy/Amb	\$5	\$5	\$5	\$5	\$8	\$5	\$5	\$5	\$10	
ER	\$25	\$25-\$50	\$25	\$35	\$40	\$25-\$30	\$25-\$50	\$25-\$50	\$50	
Prescript - Retail	Generic	\$5	\$5	\$5	\$5	\$9	\$5	\$5	\$5-\$10 & 25%mgd blue	\$10
	Brand	\$10	\$10	\$10	\$10	\$17	10-\$15	\$10-\$15	\$15-\$20 & 50%	\$20
	Form	\$25	\$25	\$25	\$25	\$32	\$25-\$35	\$10-\$35	\$35	\$35
Prescript - Mail Order	Generic	\$5	\$5-\$10	\$10	\$10	\$14	\$5-\$10	\$5-\$10	\$5-\$10	\$10
	Brand	\$10	\$10-\$20	\$20	\$20	\$30	\$10-\$30	\$10-\$30	\$20-\$30	\$20
	Form	\$25	\$25-\$75	\$60	\$65	\$68	\$10-\$105	\$10-\$105	\$35-105	\$35
<b>Annual Limits</b>										
Prescription	N/a		n/a	n/a	n/a-except Medex \$50 ded & Mgd	n/a	None	n/a	None	
Inpatient	N/a		n/a	n/a	n/a-except Blue Care 65 \$900 max/stay HP F.S. - \$600/yr & Tufts SH \$200 one time deductible	n/a	None	n/a	None	
Out-of-Pocket	\$1000/\$2000		n/a	\$1,550/mem - \$3,100/Family	n/a	n/a	None	n/a	None	
<b>Other Relevant Cvg</b>										
Chiro	Coverage	Y	N	Y	Y	N	Y	N	N	Y
	Describe	\$5 up to 20 Visits		Fallon Only			Fallon Only			12 Visit/yr- medically necessary
Dental	Coverage	Y	Y	Y	Y	Y	Y	Y	Y	N
	Describe	Delta Premier	DMS Dental-Warwick, RI	Children except Fallon: everyone in family	Under 14	Blue Care 65-\$50 co/pay - Fallon SR only	Children except Fallon: everyone in family-Also Dental Blue offered	Preventive for children	Preventive for children - also Delta Dental	
Life Ins.	Coverage	Y	Y	Y			Y	Y		N
	Describe	\$5000 50% Pd-up to \$74K sup employee pd	Boston Mutual Life	Active & Retiree			\$10K term life plus optional (employee paid)	\$2k state mandated-Employee optional addtl	\$4k basic life 50/50 & up to \$74K optional employee pd	
Opt-out Program	Yes	No	No	No	No	No	No	No	No	

**Figure 8 – Lexington Health Benefits Review Committee – Review of Other Town’s Rates**

	Lexington			Arlington			Andover			Belmont		
	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee	Employee Share
<b>Blue Choice</b>												
Individual	\$ 440.80	\$ 110.20	20%	\$ 469.13	\$ 156.36	25%						
Family	\$ 1,143.20	\$ 285.80	20%	\$ 1,172.74	\$ 390.88	25%						
<b>Blue Care Elect</b>												
Individual												
Family												
<b>HMO Blue/Network Blue</b>												
Individual	\$ 337.92	\$ 46.08	12%	\$ 352.22	\$ 39.12	10%	\$ 304.23	\$ 70.92	19%			
Family	\$ 872.96	\$ 119.04	12%	\$ 908.97	\$ 101.00	10%	\$ 773.03	\$ 232.36	23%			
<b>HPHC</b>												
Individual	\$ 369.75	\$ 65.25	15%	\$ 372.95	\$ 41.44	10%				\$ 384.55	\$ 42.73	10%
Family	\$ 885.70	\$ 156.30	15%	\$ 985.51	\$ 106.48	10%				\$ 1,045.98	\$ 116.22	10%
<b>HPHC PPO</b>												
Individual										\$ 545.87	\$ 136.47	20%
Family										\$ 1,484.77	\$ 371.19	20%
<b>Tufts PPO or EPO</b>												
Individual												
Family												
<b>Tufts POS</b>												
Individual												
Family												
<b>Fallon SelectCare</b>												
Individual												
Family												
<b>Fallon DirectCare</b>												
Individual												
Family												
<b>BC/BS Master Health Plus</b>												
Individual				\$ 447.53	\$ 149.16		\$ 466.80	\$ 251.40	35%			
Family				\$ 1,160.08	\$ 386.72		\$ 1,056.96	\$ 569.16	35%			
<b>Master Medical</b>												
Individual							\$ 466.80	\$ 251.40	35%			
Family							\$ 1,056.96	\$ 569.16	35%			
<b>NAA (Out-of-area Plan)</b>												
Individual												
Family												
<b>NAA Carveout A</b>												
Individual												
Family												
<b>NAA Carveout A&amp;B</b>												
Individual												
Family												
<b>Retirees</b>												
Medex Individual	\$ 252.80	\$ 63.20	20%	\$ 219.26	\$ 73.09	25%		\$ 121.52	100%			
Mgd Blue for Seniors	\$ 253.27	\$ 63.32		\$ 256.60		0%		\$ 42.96	100%			
Harvard First Seniority	\$ 153.60	\$ 38.40		\$ 172.80		0%				\$ 144.10	\$ 65.90	
Medicare Complement Tufts												
Secure Horizons (Tufts)												
Blue Care 65												
Fallon Senior Plan												
HPHC Medicare Enhances										\$ 235.27	\$ 157.08	
<b>Delta Premier - Ind only</b>	\$ 23.02	\$ 23.02		\$ -	\$ 38.17			\$ 25.00				
<b>Deltacare - Ind only</b>	\$ 13.64	\$ 13.64									\$ 30.00	

	Brookline			Burlington			Cambridge			Concord		
	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee 12%	Employee Share	Town	Employee	Employee Share
<b>Blue Choice</b>												
Individual	\$ 317.04	\$ 105.68	25%	\$ 595.11	\$ 595.11	50%	\$ 379.74	\$ 51.78	12%			
Family	\$ 848.27	\$ 282.76	25%	\$ 1,472.14	\$ 1,472.14	50%	\$ 968.27	\$ 132.04	12%			
<b>Blue Care Elect</b>												
Individual												
Family												
<b>HMO Blue/Network Blue</b>												
Individual	\$ 296.25	\$ 98.75	25%	\$ 340.67	\$ 107.58	24%	\$ 289.50	\$ 39.48	12%			
Family	\$ 793.90	\$ 264.63	25%	\$ 901.01	\$ 300.33	25%	\$ 741.06	\$ 101.05	12%			
<b>HPHC</b>												
Individual				\$ 347.78	\$ 109.82	24%	\$ 283.46	\$ 38.65	12%	\$ 214.20	\$ 125.80	37%
Family				\$ 870.48	\$ 290.16	25%	\$ 768.39	\$ 104.78	12%	\$ 486.20	\$ 397.80	45%
<b>HPHC PPO</b>												
Individual										\$ 335.00	\$ 335.00	
Family										\$ 885.50	\$ 885.50	
<b>Tufts PPO or EPO</b>												
Individual							\$ 292.67	\$ 39.91	12%	\$ 225.10	\$ 143.90	39%
Family							\$ 797.30	\$ 108.72	12%	\$ 500.76	\$ 462.24	48%
<b>Tufts POS</b>												
Individual										\$ 327.00	\$ 327.00	50%
Family										\$ 863.00	\$ 863.00	50%
<b>Fallon SelectCare</b>												
Individual										\$ 160.50	\$ 160.50	50%
Family										\$ 424.50	\$ 424.50	50%
<b>Fallon DirectCare</b>												
Individual										\$ 150.50	\$ 150.50	50%
Family										\$ 399.00	\$ 399.00	50%
<b>BC/BS Master Health Plus</b>												
Individual												
Family												
<b>Master Medical</b>												
Individual												
Family												
<b>NAA (Out-of-area Plan)</b>												
Individual												
Family												
<b>NAA Carveout A</b>												
Individual												
Family												
<b>NAA Carveout A&amp;B</b>												
Individual												
Family												
<b>Retirees</b>												
Medex Individual	\$ 266.11	\$ 88.71	25%	\$ 211.51	\$ 211.51	50%	\$ 24.30	\$ 2.70	10%			
Mgd Blue for Seniors	\$ 216.44	\$ 72.15	25%	\$ 33.51	\$ 301.63	90%	\$ 255.78	\$ 28.42	10%			
Harvard First Seniority				\$ 21.00	\$ 189.00	90%	\$ 172.80	\$ 19.20	10%	\$ 105.00	\$ 105.00	
Medicare Complement Tufts							\$ 260.10	\$ 28.90	10%	\$ 144.50	\$ 144.50	
Secure Horizons (Tufts)							\$ 166.50	\$ 18.50	10%	\$ 87.50	\$ 87.50	
Blue Care 65												
Fallon Senior Plan										\$ 99.00	\$ 99.00	
HPHC Medicare Enhances												
<b>Delta Premier - Ind only</b>												
<b>Deltacare - Ind only</b>												

	Dedham			Dover			Hingham			Linc/Sud Reg Sch Dist		
	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee	Employee Share
<b>Blue Choice</b>												
Individual							\$ 265.20	\$ 255.00	49%			
Family							\$ 629.20	\$ 605.00	49%			
<b>Blue Care Elect</b>												
Individual												
Family												
<b>HMO Blue/Network Blue</b>												
Individual	\$ 373.50	\$ 41.50	10%	\$ 290.50	\$ 124.50	30%	\$ 192.40	\$ 185.00	49%			
Family	\$ 1,007.10	\$ 111.90	10%	\$ 783.30	\$ 335.70	30%	\$ 514.80	\$ 495.00	49%			
<b>HPHC</b>												
Individual	\$ 331.20	\$ 36.80	10%	\$ 257.60	\$ 110.40	30%	\$ 192.40	\$ 185.00	49%	\$ 255.00	\$ 85.00	25%
Family	\$ 865.80	\$ 96.20	10%	\$ 673.40	\$ 288.60	30%	\$ 512.20	\$ 492.50	49%	\$ 663.00	\$ 221.00	25%
<b>HPHC PPO</b>												
Individual	\$ 306.00	\$ 306.00	50%									
Family	\$ 673.00	\$ 673.00	50%									
<b>Tufts PPO or EPO</b>												
Individual	\$ 346.50	\$ 38.50	10%	\$ 714.00	\$ 306.00	30%				\$ 276.75	\$ 92.25	25%
Family	\$ 909.90	\$ 101.10	10%	\$ 1,570.33	\$ 673.00	30%				\$ 722.25	\$ 240.75	25%
<b>Tufts POS</b>												
Individual	\$ 306.00	\$ 306.00	50%	\$ 269.50	\$ 115.50	30%				\$ 490.50	\$ 163.50	25%
Family	\$ 673.00	\$ 673.00	50%	\$ 707.70	\$ 303.30	30%				\$ 1,294.50	\$ 431.50	25%
<b>Fallon SelectCare</b>												
Individual	\$ 307.80	\$ 34.20	10%	\$ 239.40	\$ 102.60	30%				\$ 240.75	\$ 80.25	25%
Family	\$ 833.40	\$ 92.60	10%	\$ 648.20	\$ 277.80	30%				\$ 636.75	\$ 212.25	25%
<b>Fallon DirectCare</b>												
Individual	\$ 285.30	\$ 31.70	10%	\$ 221.90	\$ 95.10	30%				\$ 225.75	\$ 75.25	25%
Family	\$ 770.40	\$ 85.60	10%	\$ 599.20	\$ 256.80	30%				\$ 598.50	\$ 199.50	25%
<b>BCBS Master Health Plus</b>												
Individual							\$ 343.12	\$ 326.00	49%			
Family							\$ 813.28	\$ 782.00	49%			
<b>Master Medical</b>												
Individual												
Family												
<b>NAA (Out-of-area Plan)</b>												
Individual	\$ 337.00	\$ 337.00	50%									
Family	\$ 735.00	\$ 735.00	50%									
<b>NAA Carveout A</b>												
Individual												
Family												
<b>NAA Carveout A&amp;B</b>												
Individual												
Family												
<b>Retirees</b>												
Medex Individual				\$ 169.00	\$ 169.00	50%		\$ 165.00	100%	\$ 248.25	\$ 82.75	25%
Mgd Blue for Seniors				\$ 141.36	\$ 141.36	50%						
Harvard First Seniority				\$ 96.00	\$ 96.00	50%				\$ 144.00	\$ 48.00	25%
Medicare Complement Tufts				\$ 144.50	\$ 144.50	50%				\$ 216.75	\$ 72.25	25%
Secure Horizons (Tufts)				\$ 92.50	\$ 92.50	50%				\$ 127.50	\$ 42.50	25%
Blue Care 65				\$ 119.80	\$ 119.80	50%						
Fallon Senior Plan				\$ 118.50	\$ 118.50	50%				\$ 177.75	\$ 59.25	25%
HPHC Medicare Enhances				\$ 185.00	\$ 185.00	50%						
<b>Delta Premier - Ind only</b>								\$ 25.00	100%			
<b>Deltacare - Ind only</b>												

	Natick			Needham			Newton			Peabody		
	Town	Employee	Share	Town	Employee	Share	Town	Employee	Share	Town	Employee	Share
<b>Blue Choice</b>												
Individual				\$ 426.00	\$ 109.06	20%						
Family				\$ 1,140.00	\$ 387.60	25%						
<b>Blue Care Elect</b>												
Individual										\$ 433.92	\$ 48.21	10%
Family										\$ 1,153.45	\$ 128.16	10%
<b>HMO Blue/Network Blue</b>												
Individual	\$ 358.48	\$ 56.52	14%	\$ 316.94	\$ 109.06	26%				\$ 340.74	\$ 37.86	10%
Family	\$ 864.99	\$ 254.01	23%	\$ 752.40	\$ 387.60	34%				\$ 915.66	\$ 101.74	10%
<b>HPHC</b>												
Individual	\$ 312.65	\$ 55.35	15%	\$ 287.64	\$ 88.36	24%	\$ 268.00	\$ 67.00	20%			
Family	\$ 737.95	\$ 224.05	23%	\$ 674.82	\$ 303.18	31%	\$ 729.24	\$ 182.31	20%			
<b>HPHC PPO</b>												
Individual	\$ 306.00	\$ 306.00	50%	\$ 306.00	\$ 306.00	50%						
Family	\$ 673.00	\$ 673.00	50%	\$ 673.00	\$ 673.00	50%						
<b>Tufts PPO or EPO</b>												
Individual	\$ 341.61	\$ 43.39	11%	\$ 294.67	\$ 100.33	25%	\$ 337.52	\$ 84.38	20%			
Family	\$ 786.05	\$ 224.95	22%	\$ 655.23	\$ 371.77	36%	\$ 914.12	\$ 228.53	20%			
<b>Tufts POS</b>												
Individual	\$ 306.00	\$ 306.00	50%	\$ 306.00	\$ 306.00	50%	\$ 485.88	\$ 121.47	20%			
Family	\$ 673.00	\$ 673.00	50%	\$ 673.00	\$ 673.00	50%	\$ 1,166.64	\$ 291.66	20%			
<b>Fallon SelectCare</b>												
Individual	\$ 307.80	\$ 34.20	10%	\$ 261.63	\$ 80.37	24%						
Family	\$ 740.80	\$ 185.20	20%	\$ 638.94	\$ 287.06	31%						
<b>Fallon DirectCare</b>												
Individual	\$ 285.30	\$ 31.70	10%	\$ 242.50	\$ 74.50	24%						
Family	\$ 684.80	\$ 171.20	20%	\$ 590.64	\$ 265.36	31%						
<b>BC/BS Master Health Plus</b>												
Individual												
Family												
<b>Master Medical</b>												
Individual												
Family												
<b>NAA (Out-of-area Plan)</b>												
Individual	\$ 337.00	\$ 337.00	50%									
Family	\$ 735.50	\$ 735.50	50%									
<b>NAA Carveout A</b>												
Individual												
Family												
<b>NAA Carveout A&amp;B</b>												
Individual												
Family												
<b>Retirees</b>												
Medex Individual				\$ 172.00	\$ 172.00	50%				\$ 341.86	\$ -	0%
Mgd Blue for Seniors	\$ 141.36	\$ 141.36	50%	\$ 192.25	\$ 90.47	32%						
Harvard First Seniority	\$ 105.00	\$ 105.00	50%	\$ 113.40	\$ 96.60	46%	\$ 38.40	100%				
Medicare Complement Tufts	\$ 144.50	\$ 144.50	50%	\$ 196.52	\$ 92.48	32%	\$ 63.14	100%				
Secure Horizons (Tufts)	\$ 92.50	\$ 92.50	50%	\$ 92.50	\$ 92.50	50%	\$ 37.00	100%				
Blue Care 65	\$ 133.38	\$ 133.38	50%	\$ 133.38	\$ 133.38	50%	\$ 46.67	100%	\$ 445.98	\$ 36.16	7%	
Fallon Senior Plan	\$ 99.00	\$ 99.00	50%	\$ 99.00	\$ 99.00	50%						
HPHC Medicare Enhances	\$ 185.00	\$ 185.00	50%	\$ 204.00	\$ 204.00	50%						
<b>Delta Premier - Ind only</b>	\$ -	\$ 25.00	100%				\$ 13.33	100%				
<b>Deltacare - Ind only</b>												

	Sudbury			Waltham			Watertown			Wayland		
	Town	Employee	Share	City	Employee	Share	Town	Employee	Share	Town	Employee	Share
<b>Blue Choice</b>												
Individual	\$ 381.75	\$ 127.25	25%									
Family	\$ 975.00	\$ 325.00	25%									
<b>Blue Care Elect</b>												
Individual							\$ 378.07	\$ 378.07	50%			
Family							\$ 874.48	\$ 874.48	50%			
<b>HMO Blue/Network Blue</b>												
Individual	\$ 379.80	\$ 42.10	10%				\$ 381.50	\$ 42.39	10%	\$ 301.29	\$ 113.71	27%
Family	\$ 963.90	\$ 107.10	10%				\$ 1,018.60	\$ 113.18	10%	\$ 744.14	\$ 374.87	34%
<b>HPHC</b>												
Individual	\$ 449.60	\$ 112.40	20%	\$ 743.67	\$ 46.11	6%	\$ 394.79	\$ 43.87	10%	\$ 276.00	\$ 92.00	25%
Family	\$ 1,162.40	\$ 290.60	20%	\$ 1,114.70	\$ 115.31	9%	\$ 1,038.28	\$ 115.36	10%	\$ 668.59	\$ 293.41	31%
<b>HPHC PPO</b>												
Individual										\$ 306.00	\$ 306.00	50%
Family										\$ 673.00	\$ 673.00	50%
<b>Tufts PPO or EPO</b>												
Individual				\$ 409.20	\$ 41.73	9%	\$ 384.80	\$ 42.76	10%	\$ 281.02	\$ 103.98	27%
Family				\$ 1,050.82	\$ 106.60	9%	\$ 1,001.48	\$ 111.28	10%	\$ 655.78	\$ 355.22	35%
<b>Tufts POS</b>												
Individual										\$ 306.00	\$ 306.00	50%
Family										\$ 673.00	\$ 673.00	50%
<b>Fallon SelectCare</b>												
Individual										\$ 248.29	\$ 93.71	27%
Family										\$ 615.79	\$ 310.21	34%
<b>Fallon DirectCare</b>												
Individual										\$ 230.14	\$ 86.86	27%
Family										\$ 569.24	\$ 286.76	34%
<b>BC/BS Master Health Plus</b>												
Individual				\$ 713.88	\$ 57.89	8%						
Family				\$ 1,665.54	\$ 135.07	8%						
<b>Master Medical</b>												
Individual												
Family												
<b>NAA (Out-of-area Plan)</b>												
Individual										\$ 337.00	\$ 337.00	50%
Family										\$ 735.50	\$ 735.50	50%
<b>NAA Carveout A</b>												
Individual										\$ 260.00	\$ 260.00	50%
Family												
<b>NAA Carveout A&amp;B</b>												
Individual										\$ 206.00	\$ 206.00	50%
Family												
<b>Retirees</b>												
Medex Individual	\$ 191.36	\$ 191.36	50%							\$ 169.00	\$ 169.00	50%
Mgd Blue for Seniors										\$ 205.25	\$ 77.47	27%
Harvard First Seniority	\$ 105.00	\$ 105.00	50%							\$ 157.50	\$ 52.50	25%
Medicare Complement Tufts										\$ 210.95	\$ 78.05	27%
Secure Horizons (Tufts)										\$ 135.04	\$ 49.96	27%
Blue Care 65										\$ 193.66	\$ 73.09	27%
Fallon Senior Plan										\$ 143.75	\$ 54.25	27%
HPHC Medicare Enhances										\$ 185.00	\$ 185.00	50%
<b>Delta Premier - Ind only</b>											\$ 25.00	
<b>Deltacare - Ind only</b>	\$ 20.02	\$ 6.68	25%					\$ 18.00			\$ 100.00	

	Wellesley			Weston			Winchester			Woburn		
	Town	Employee	Employee Share	Town	Employee	Employee Share	Town	Employee	Employee Share	City	Employee	Employee Share
<b>Blue Choice</b>												
Individual				\$ 391.97	\$ 43.55	10%	\$ 261.66	\$ 261.66	50%			
Family				\$ 1,057.13	\$ 117.46	10%	\$ 697.57	\$ 697.57	50%			
<b>Blue Care Elect</b>												
Individual				\$ 504.06	\$ 504.06	50%				\$ 395.77	\$ 131.92	25%
Family				\$ 1,320.11	\$ 1,320.11	50%				\$ 982.64	\$ 327.55	25%
<b>HMO Blue/Network Blue</b>												
Individual	\$ 345.28	\$ 69.72	17%				\$ 408.23	\$ 45.36	10%	\$ 340.36	\$ 37.82	10%
Family	\$ 862.75	\$ 256.25	23%				\$ 869.54	\$ 355.16	29%	\$ 905.35	\$ 100.59	10%
<b>HPHC</b>												
Individual	\$ 302.86	\$ 65.14	18%	\$ 378.15	\$ 42.02	10%	\$ 368.24	\$ 40.92	10%			
Family	\$ 762.87	\$ 199.13	21%	\$ 1,028.57	\$ 114.29	10%	\$ 892.51	\$ 209.35	19%			
<b>HPHC PPO</b>												
Individual	\$ 306.00	\$ 306.00	50%									
Family	\$ 673.00	\$ 673.00	50%									
<b>Tufts PPO or EPO</b>												
Individual	\$ 306.00	\$ 306.00	50%									
Family	\$ 673.00	\$ 673.00	50%									
<b>Tufts POS</b>												
Individual	\$ 307.23	\$ 77.77	20%									
Family	\$ 776.45	\$ 234.55	23%									
<b>Fallon SelectCare</b>												
Individual	\$ 277.70	\$ 64.30	19%									
Family	\$ 716.72	\$ 209.28	23%									
<b>Fallon DirectCare</b>												
Individual	\$ 256.77	\$ 60.23	19%									
Family	\$ 662.54	\$ 193.46	23%									
<b>BC/BS Master Health Plus</b>												
Individual							\$ 983.81	\$ 983.81	50%			
Family							\$ 2,311.97	\$ 2,311.97	50%			
<b>Master Medical</b>												
Individual												
Family												
<b>NAA (Out-of-area Plan)</b>												
Individual							\$ 490.92	\$ 490.92	50%			
Family							\$ 1,217.97	\$ 1,217.97	50%			
<b>NAA Carveout A</b>												
Individual												
Family												
<b>NAA Carveout A&amp;B</b>												
Individual												
Family												
<b>Retirees</b>												
Medex Individual	\$ 169.00	\$ 169.00	50%	\$ 182.65	\$ 182.65	50%	\$ 198.06	\$ 198.06	50%	\$ 241.42	\$ 80.47	25%
Mgd Blue for Seniors	\$ 141.36	\$ 141.36	50%				\$ 266.99	\$ 29.67	10%	\$ 266.90	\$ 29.65	10%
Harvard First Seniority	\$ 96.00	\$ 96.00	50%	\$ 96.00	\$ 96.00	50%	\$ 111.30	\$ 98.70	47%			
Medicare Complement Tufts	\$ 144.50	\$ 144.50	50%									
Secure Horizons (Tufts)	\$ 82.50	\$ 82.50	50%									
Blue Care 65	\$ 119.80	\$ 119.80	50%	\$ 117.17	\$ 117.17	50%						
Fallon Senior Plan	\$ 118.50	\$ 118.50	50%									
HPHC Medicare Enhances	\$ 185.00	\$ 185.00	50%									
<b>Delta Premier - Ind only</b>												
<b>Deltacare - Ind only</b>	\$ 19.38	\$ 19.38	50%				\$ -	\$ 25.00	100%	\$ -	\$ 25.00	100%

## Appendix F Consumer Directed Health Plans HSAs, MSAs, HRAs and FSAs

### *Changing Individuals from Users of Health Care to Consumers of Health Care*

The Town of Lexington is faced with the challenge of determining the appropriate strategies to contain the enormously fast growing costs of health care. While such efforts are still early in their development, many large employers and healthcare experts believe that it necessary to change the mindset of individuals from users of health care to consumers of health care. Although this appears to be fairly far in the future for the Town, it is necessary to begin to think about what this would mean for the Town and its employees.

The first step in this process has been to shift more of the burden of cost from the employer to the employee. The following table, provided by Hewitt Associates, shows the trend in place with employers with more than 5,000 employees.

Categories	1998	1999	2000	2001	2002	2003	2004	1yr%	2yr%	3yr%
HealthCare Costs	\$4100	\$4400	\$4700	\$5000	\$6000	\$7000	\$7800	11%	30%	56%
Employers Pct	74.7%	75.4%	73.8%	74.6%	72.0%	70%	67.7%			
Employees (by payroll ded)	15.7%	15.5%	16.7%	16.8%	17.1%	18.0%	19.5%			
Employees (out of pocket)	9.6%	9.1%	9.5%	8.6%	10.9%	12.0%	12.8%			
Employers Cost	\$3062	\$3318	\$3468	\$3730	\$4320	\$4900	\$5280	8%	22%	41%
Employees Cost	\$1038	\$1082	\$1232	\$1270	\$1680	\$2100	\$2520	20%	50%	98%

While the growth in health care costs for large corporations has been 56% over the last three years (16% per year), the cost to the employer has been 41% (12% per year). This has occurred by shifting some of the burden of health care costs to the employee: from 25.4% in 2001 to 32.3% in 2004. Employees of large corporations currently pay an average of 19.5% of health care costs through payroll deduction, usually in the form of insurance premiums, and 12.8% in out of pocket costs, usually as co-pays and deductibles.

Even with this effort, there has still been little sign of individuals acting as consumers of health care instead of users. As a result, stimulated by government policies, large corporations have started implementing the second step in the process by shifting the perceived cost of health care to individuals in the form of large deductibles rather than monthly premiums and small co-pays. Thus a deductible of perhaps \$3000 would be paid by the employee and everything beyond that by the employer. The goal is to make the employee aware of the cost of services and encourage individuals to weigh their decisions about health care more carefully.

The following analogy summarizes why a high deductible approach seems appealing.

*Imagine if a company provided a food benefit plan to employees. Each month, employees would have to pay \$200 per month to the company and each time they shopped, they would have to pay \$10 to the food store. This would allow a family to purchase all the food they needed throughout the year, with the exception of certain items that were exempt from the plan. In this situation, it is likely that individuals will go to the store and buy whatever they want, doing little to search for bargains because they don't to save anything by buying more carefully. Their costs are fixed. . Manufacturers will notice this buying pattern and do little to offer bargains. The result will be higher prices for food products. Now imagine if the company changes the plan and instead*

*requires a \$2400 deductible before the food plan comes into play. The result will be a more careful shopper who will search for the better deals.*

Some health care experts believe that changing to high deductible plan structures will cause individuals to forego proper care so it is important that any health insurance plan pay for services focused on prevention and early detection such as blood pressure checks and mammograms and behavioral programs to help individuals quit smoking or control weight.

### **Health Savings Accounts**

There are three types of Health Savings accounts (HSAs) that can be used to help fund employee health care expenses: flexible spending accounts, medical savings accounts, and health reimbursement arrangements.

Health Savings Accounts (HSAs) are high deductible plans which were part of the Medicare law, which was approved by Congress in November, 2003, and became effective in January, 2004, well after most employers had settled on their health care arrangements for 2004.

Although the number of people currently enrolled in HSAs is low, many of the largest insurance companies have only recently introduced these products following enactment of the 2003 Medicare law. Millions of people in government and in the private sector will be offered the opportunity to select a high-deductible plan with a health savings account, and the 2005 survey by the American Health Insurance Plans will undoubtedly show that more individuals have chosen to take the HSA option.

In a survey recently conducted jointly by the Kaiser Family Foundation and the Health Research and Educational Trust, 6% of all companies said they were very likely to offer some type of high-deductible plan linked to a savings account in the next two years, while 21 percent said they were "somewhat likely" to do so. Big employers, with 5,000 or more workers, were more likely to offer the option: 22% said very likely and 28 % somewhat likely. If such plans are adopted first by large employers, and then smaller ones, their acceptability will become more widespread.

The table below illustrates the finances of these high deductible health plans.

*Description of HSA/HDHP Policies Individual Market-Best Selling Product*

	<u>Single</u>	<u>Family</u>
Average Annual Deductible	\$2,856	\$5,425
Average Annual Out-Of-Pocket Limit	\$3,068	\$5,781
Average Lifetime Maximum Benefit	\$3.8 million	\$3.8 mi

Of the three types of HSAs only one, Flexible Spending Accounts, is currently appropriate in Lexington.

### ***Flexible Spending Accounts***

Health care flexible spending accounts are employer-established benefit plans. The employee contributes funds to the account through a salary reduction agreement and is able to withdraw the funds set aside for medical bills which are paid by the employer from the fund as they are incurred. The salary reduction agreement means that any funds set aside in a flexible spending

account escape both income tax and Social Security tax. Employers may contribute to these accounts as well.

There is no statutory limit on the amount of money that can be contributed to healthcare flexible spending accounts. Once the amount of contribution has been designated during the open enrollment period that occurs once each year, the employee is not allowed to change the amount or drop out of the plan during the year unless he or she experiences a change of family status. By law, the employee forfeits any unspent funds in the account at the end of the year. There have been proposals introduced in Congress to ease this "use it or lose it" rule by allowing up to \$500 to be carried over to the next year because it is thought that if individuals can save some of this deductible for a future year, they may become more careful consumers.

### ***Medical Savings Accounts (MSAs)***

Medical savings accounts are available only to those who are self-insured or are employed by a firm with 50 or fewer employees. Therefore, Lexington and its employees are not currently eligible for medical savings accounts.

### ***Health Reimbursement Arrangements (HRAs)***

Health reimbursement arrangements, also known as "health reimbursement accounts" or "personal care accounts," are a type of health insurance plan that reimburses employees for qualified medical expenses.

Health reimbursement accounts consist of funds set aside by employers to reimburse employees for qualified medical expenses, just as an insurance plan will reimburse covered individuals for the cost of services incurred. One of the major advantages of HRAs is that employers qualify for preferential tax treatment of funds placed in a health reimbursement account in the same way as funding an insurance plan. This obviously would be of no advantage to the Town but the principles on which they are based may be useful in controlling costs.

Many employers look at an HRA as a vehicle to help them reduce, control and manage the costs associated with their health insurance plan. One of the most common approaches is to combine an HRA implementation with a change to a higher deductible major medical plan. The cost savings result from reduced premiums for the higher deductible program. The HRA is used to give back to employees some portion of the premium savings. Also, the new major medical plan may eliminate co-pays for doctor visits, prescriptions, and other costs, so the employee has no out-of-pocket expense until the HRA balance is gone. At that time, the employee will incur out-of-pocket expense only until the deductible is reached.

The advantage is that many employees will not fully utilize their HRA balance, and will have no out-of-pocket expense at all. For these employees, carryover of unused HRA balances can be used in the future, which means they might have no out-of-pocket expense. For employees who have higher medical expenses, their costs are limited to the corridor between their HRA balance and the established deductible. In general, employers have found that this approach will provide a better health plan (less out-of-pocket costs) for a significant majority of the workforce. Also, many companies have found that the growth in health care costs from year to year is slower when a larger deductible is implemented, as employees get a sense of the cost of health care services and become more careful consumers of medical services.

## **Appendix G**

### **Resources for the Health Benefits Review Committee**

#### **Information from Lexington**

1. “Group Health Insurance Funding Analysis” reports from Group Benefits Strategies - spreadsheets with costs, revenues and projections: Fiscal Years 2002, 2003, 2004, 2005, and projections for 2006.
2. Plan Summaries for Healthcare Plans offered by Town: Blue Choice, Network Blue, Harvard Community Health Plan, Medex
3. RFQ response report from March 2003
4. Enrollment Breakdown by Individual/Family/Total Subscribers
5. High cost claims for Harvard Pilgrim for 2003
6. Top 25 drug prescriptions by dollar cost from HCHP
7. Town of Lexington – ER and Office Visit Utilization
8. Town of Lexington – Large Loss Report
9. Town of Lexington – Retail vs. Mail ordering of drugs
10. Town of Lexington – Top Therapeutic Classes
11. Municipal and School Salary categories
12. Blue Cross/Blue Shield “Disease/Condition Report” for calendar year 2004
13. Blue Cross/Blue Shield “Health Risk Issue Report” for calendar year 2004
14. 7/1/04 Renewal Rate Calculation note of Comparison of Blue Cross/Blue Shield book of business vs. Lexington – email dated 11/30/04 from Kevin Walsh of Group Benefits Strategies to Rose Ducharm, Benefits Manager for Town of Lexington.
15. “Health Insurance Comparables” memo from Kerry Evans, Management Intern, and Michael Young, Budget Officer, to Linda Vine, Acting Town Manager, September 14, 2004.
16. Memorandum of Understanding between the Town of Lexington and the Public Employee Bargaining Coalition of the Town of Lexington July 1, 2003 – June 30, 2005
17. “Coalition of Town Employees: Health Insurance Bargaining History” provided by Vito LaMura, Lexington Education Association President

18. List of comparable Towns and contract language regarding methods of comparison from Teachers contract, email from Vito LaMura 12/1/04.; and list of comparable Towns for other departments in email from Rose Ducharm to Richard Dougherty, 12/1/04
19. Longevity payments, clarification, email from Rose Ducharm to Deborah Strod 12/1/04
20. History of health benefits *Lexington Minuteman*, Sunday, May 02, 2004 by Richard White, Town Manager
21. FY05 Comparable Towns data from Lexington Education Association Website, accessed 1/19/05
22. Spreadsheet showing cost savings by increasing part-time employees' payments for healthcare, from Bill Kennedy
23. Information on School employees' enrollment from Susan Bottan in email 11/19/04.
24. Consultation with Kevin Walsh of Group Benefits Strategies, January 26, 2005.
25. Survey carried out by the Health Benefits Review Committee.

#### **Articles on Health Benefits**

1. "Employers try shifting health costs; Plans ease sting for those at lower end of pay scale" *Boston Globe*, November 25, 2004, by Kimberly Blanton
2. "A Perspective on US Drug Reimportation" Niteesh K. Choudhry, MD, FRCPC; Allan S. Detsky, MD, PhD, FRCPC *JAMA*. 2005;293:358-362.
3. "The rising cost of health care explained," Massachusetts Municipal Association, March 17, 2004 By Mary DeLai, Membership Services Coordinator, MIA summary of speech by Nancy Turnbull of Harvard's School of Public Health, the keynote speaker at an MMA forum on health care held Feb. 26 2004.
4. "Total Benefits: The Kitchen Sink? Managed care-induced 'entitlement mentality' may be money down the drain" Elayne Demby [editors@plansponsor.com](mailto:editors@plansponsor.com), *NewsDash* January 5, 2005 (NewsDash is a daily on-line benefits newsletter sponsored by PlanSponsor.com)
5. "Ruling Could Force Boston to Pay More for Health Care" *Boston Globe*, November 20, 2004 by Andrea Estes
6. "Drugstores Fret as Insurers Demand Pills by Mail" Milt Freudenheim, Published: January 1, 2005, *New York Times*
7. "Employers Unite in Effort to Curb Prescription Costs" *New York Times*, February 3, 2005. By Milt Freudenheim
8. "Your New Health Plan: Health savings accounts, like 401(k)s, will give employees more choices -- but also a greater share of the costs" *Business Week*, November 8, 2004
9. Howard Gleckman with Lorraine Woellert

10. “When Employers Fund Retiree Health Care” by Kathleen Jenks Harm, ICMA Retirement Corporation, Washington, DC ([KHarm@Icmarc.org](mailto:KHarm@Icmarc.org)) as attachment to information received from Brookline by the Lexington 2020 Vision Budget Task Force
11. “Working out at EMC – firm says getting employees to take more responsibility for health, costs paying off,” *Boston Globe*, August 5, 2004 by Diane E. Lewis
12. “Towns Find Insurance Savings by Sharing Plan” *Boston Globe*, September 26, 2004 by Alexander Reid
13. “40 Percent in U.S. Use Prescription Drugs” *Associated Press*, Thursday, December 2, 2004, by Randolph E. Schmid
14. “Pharmacist Oversight Cuts Cost of Chronic Disease“ *Business Insurance*, April 28, 2003 by Michael Prince