Office of the
TOWN MANAGER

TELEPHONE: (508) 841-8508
FAX: (508) 842-0587
dmorgado@shrewsburyma.gov

TOWN OF SHREWSBURY

Richard D. Carney Municipal Office Building
100 Maple Avenue
Shrewsbury, Massachusetts 01545-5398

September 25, 2015

To: Insurance Advisory Committee
Interested Parties

From: Daniel J. Morgado

Re: Health Insurance Program (HIP) Fiscal Year 2016 and Fiscal Year 2017

Reference is made to my memo to you dated September 15, 2015.

I have attached several exhibits which I have gleaned from materials provided at yesterday's Board meeting of the West Suburban Health Group (WSHG) and from other sources, which I wish to review with you:

Enrollment and Comparison to the Group Insurance Commission (GIC)

As of the last census on June 26, 2015, a total of 1,231 subscribers were participating in the Town's HIP. In June of 2014, enrollment was 1,215. Fallon remains the largest provider for the active plans at 87% of that business.

Harvard Pilgrim has 45% of the Medicare eligible subscribers. The Fallon Senior Plan now covers only 23% of the Medicare eligible population. Tufts combined is the second largest insurer in the Medicare area at 27% a major departure of just two years earlier when they had only 9%.

For Fiscal Year 2016, membership in the WSHG is still positive in relation to the costs of membership in the GIC as follows:

Plan	Employer Cost	Employee/ Retiree Cost	Total Cost
WSHG	$8,736,106	$3,885,114	$12,621,220
GIC	$8,711,806	$4,107,269	$12,819,075
Difference to WSHG	($24,300)	$222,155	$197,855

I have attached detailed comparisons to the impact upon subscribers of membership in the WSHG versus the GIC that are worth reviewing, concentrating on the Fallon Select and Harvard Pilgrim plan offerings. Membership in these two plans involve 58% of all subscribers.

Financial Indicators

As outlined in my September 15, 2015 memo, the WSHG ended the fiscal year with a fund balance of $5,951,989. It began the year with a fund balance of $9,558,500, so the loss of fund balance was $3,606,511. By way of comparison, the fund balance on June 30, 2013, was $18,023,940. So in two years' time, the fund balance has dropped about $12 Million. The primary reasons for this fund balance reduction were 1) use of fund balance to moderate premium rate increases; 2) expenses paid out that were not made part of rate setting process; and 3) higher than expected claims in some of the plans.

Through August 31, 2015, the fund balance has dropped another $1.9 Million primarily due to the run out of claims for the Towns of Walpole, Ashland and Westwood that left the WSHG on June 30, 2015. WSHG is responsible to pay claims incurred prior to June 30, 2015, by subscribers of these communities but were not paid out until after July 1, 2015. If we end the fiscal year with a fund balance of $3 Million or more, I will consider the fiscal year to be a success from a financial standpoint.

Large claims continue to be a draw on the fund balance and you will note one claim for Fiscal Year 2015 of $899,515. In total in Fiscal Year 2015, large claims cost the WSHG $10.2 Million for a total of 38 claimants or $267,690 per claimant.

Membership in the WSHG

The Town of Natick adopted G. L. c. 32B, s. 21-23 (21-23). The Town of Wayland did not adopt these sections on Monday, but have this question under review. The Town of Sherborn is scheduled to act on sections 21-23 later this fall. The Towns of Natick, Dedham and Needham are examining options that may include MIIA. I suspect that several of the communities are also considering going it alone and reaching an agreement with a single carrier.

The only communities that seem solid for the WSHG are Wellesley, Dover and Wrentham, however; all communities present yesterday expressed a desire to stay with the WSHG.

Senior Plan Renewal

The WSHG Board yesterday set the following rates for calendar 2016:

Plan	2015 Rate	2016 Rate	Percent Increase	Basis
Managed Blue for Seniors	$295.63	$313.20	5.9%	Fully Insured
Fallon Senior Plan	$299.00	$310.00	3.7%	Fully Insured
Tufts Medi Pref. PDP Plus	$330.00	$321.00	-2.7%	Fully Insured
Tufts Medi Pref HMO	$262.00	$267.00	1.9%	Fully Insured
BC/BS Medex	$340.00	$360.00	5.9%	Self-Insured
HPHC Medicare Enhanced	$328.33	$342.00	4.2%	Self-Insured

The Fallon Senior Plan has the following plan design changes:

Required by Fallon	ER co-pay from $50 to $75 Retail Rx $10/25/50 to $10/30/65 Mail order Rx $20/50/100 to $20/60/$162.50
Action taken by Board to reduce rate of increase	Inpatient co-pay from $0 to $125 Skilled Nursing Facility co-pay from $0 to $25/day for the first (5) days

Note that where required by Federal law, Medicare Part D Catastrophic Coverage limits are adjusted among the various Senior Plans.

I will ask the IAC on Tuesday, to adopt a favorable recommendation on these renewal proposals.

"Cadillac Tax"

Pending for all employers, that is part of the Affordable Care Act (ACA) regulations, is a 40% tax dubbed the "Cadillac Tax" that is to be paid to the Federal government if health plans cross over pre-set premium thresholds of $10,200 for individual plans and $27,500 for family plans.

This tax is to take effect in Fiscal Year 2018. Current projections put five of the WSHG plans into the "tax zone". While not an immediate concern, action will need to be taken to resolve this matter in upcoming years. I am hoping that as the deadline for this tax draws near, there will be relief from Congress due to the absurdity of the concept. There will be much more to follow on this matter in future months.

Actions taken by the Board

The WSHG Board took two actions yesterday:

1. Voted to increase deductible and co-pays for the Benchmark Plans to meet the current GIC amounts effective July 1, 2015.

2. Voted to phase out the Rate Saver plans as of July 1, 2018.

Both of these actions were taken to keep the WSHG plan offerings competitive from a premium standpoint with those offered by the GIC which remains our biggest competitor. These changes will also reduce the amount of premium increase when renewal rates are set for the Benchmark Plans.

We can also expect to see the out of pocket maximum limits for the Fallon Rate Saver plans to increase to match the other Rate Saver plans.

I have inquired about the Fallon dental benefit being retained in Fiscal Year 2017.

I will advise of other plan design changes as they are reviewed and acted upon.

Options for the Fiscal Year 2017 HIP

I see the following options for Fiscal Year 2017:

1. Extend current WSHG program by one year with the following changes:
    a. Premium changes per normal rate setting process with current contribution percentages remaining. Plan design changes as mandated by carriers/law.
    b. Benchmark plan design changed to GIC limits regarding deductibles, co-pays, etc. This affects 80± subscribers.
    c. Dental benefit for Fallon (if available)
    d. Out of pocket maximums are modified for Fallon Select & Direct Rate Saver (assume change to match other Rate Saver offerings)

2. Eliminate Rate Saver plans effective June 30, 2016 and move all existing active plans to the Benchmark plans with plan designs changed to GIC limits regarding deductibles, co-pays, etc. There will be a change in premium per normal rate setting process with current contribution percentages remaining at Benchmark levels. Fallon dental benefit to remain if available. This will require the adoption of G. L. c. 32B s. 21-23 as necessary.

3. Leave WSHG and move to the Group Insurance Commission (GIC) effective July 1, 2016. Contribution rates for matching plans are retained at Benchmark levels. Contribution rates for non-matched plans will be established. This will require the adoption of G. L. c. 32B s. 21-23 as necessary. Further, notice to the GIC is required by December 1, 2015.

4. Leave WSHG after solicitation of a Fallon only option to become effective on July 1, 2016.

5. Leave WSHG after solicitation of a MIIA only (Blue Cross) option to become effective on July 1, 2016.

I will review all of these matters in greater detail at your next meeting on Tuesday, September 29, 2015, at 3:00 PM.

Please advise with any questions.

Cc	Union/Association Presidents	Patrick Collins	Barbara Malone
	Michael Hale	Kristen Las	Carolyn Marcotte
	Mary Thompson	Christine Fowler	Paula Brady

Enrollment Information and Comparisons to the Group Insurance Commission (GIC)

Summary of FY 2016 Health Insurance Program
Current Program

Plan	Type	Premium	Town Share	Percent	Employee/ Retiree Share	Percent	# of Participants	% of Plans	Town Share (Annual)	Employee/ Retiree Share (Annual)	Total	Town Share Budget	Employee/ Retiree Share Budget	Total
Harvard Pilgrim PPO	Family	$5,036.00	$2,518.00	50.00%	$2,518.00	50.00%	0	0.00%	$30,216.00	$30,216.00	$60,432.00	$0.00	$0.00	$0.00
	Individual	$2,268.00	$1,134.00	50.00%	$1,134.00	50.00%	4	0.48%	$13,608.00	$13,608.00	$27,216.00	$54,432.00	$54,432.00	$108,864.00
Tufts POS	Family	$5,036.00	$2,518.00	50.00%	$2,518.00	50.00%	0	0.00%	$30,216.00	$30,216.00	$60,432.00	$0.00	$0.00	$0.00
	Individual	$2,268.00	$1,134.00	50.00%	$1,134.00	50.00%	0	0.00%	$13,608.00	$13,608.00	$27,216.00	$0.00	$0.00	$0.00
Blue Choice Rate Saver EPO	Family	$2,261.00	$1,356.60	60.00%	$904.40	40.00%	3	0.36%	$16,279.20	$10,852.80	$27,132.00	$48,837.60	$32,558.40	$81,396.00
	Individual	$843.00	$505.80	60.00%	$337.20	40.00%	3	0.36%	$6,069.60	$4,046.40	$10,116.00	$18,208.80	$12,139.20	$30,348.00
Tufts Navigator Rate Saver EPO	Family	$2,088.00	$1,252.80	60.00%	$835.20	40.00%	4	0.48%	$15,033.60	$10,022.40	$25,056.00	$60,134.40	$40,089.60	$100,224.00
	Individual	$797.00	$478.20	60.00%	$318.80	40.00%	4	0.48%	$5,738.40	$3,825.60	$9,564.00	$22,953.60	$15,302.40	$38,256.00
HPHC Rate Saver EPO	Family	$1,918.00	$1,150.80	60.00%	$767.20	40.00%	25	2.97%	$13,809.60	$9,206.40	$23,016.00	$345,240.00	$230,160.00	$575,400.00
	Individual	$736.00	$441.60	60.00%	$294.40	40.00%	52	6.18%	$5,299.20	$3,532.80	$8,832.00	$275,558.40	$183,705.60	$459,264.00
Fallon Select Rate Saver EPO*	Family	$1,647.00	$1,177.61	71.50%	$469.40	28.50%	356	42.33%	$14,131.26	$5,632.74	$19,764.00	$5,030,728.56	$2,005,255.44	$7,035,984.00
	Individual	$611.00	$436.87	71.50%	$174.14	28.50%	186	22.12%	$5,242.38	$2,089.62	$7,332.00	$975,082.68	$388,669.32	$1,363,752.00
Fallon Direct Rate Saver EPO*	Family	$1,531.00	$1,171.22	76.50%	$359.79	23.50%	70	8.32%	$14,054.58	$4,317.42	$18,372.00	$983,820.60	$302,219.40	$1,286,040.00
	Individual	$570.00	$436.05	76.50%	$133.95	23.50%	49	5.83%	$5,232.60	$1,607.40	$6,840.00	$256,397.40	$78,762.60	$335,160.00
Blue Cross Blue Shield Benchmark	Family	$2,181.00	$1,308.60	60.00%	$872.40	40.00%	2	0.24%	$15,703.20	$10,468.80	$26,172.00	$31,406.40	$20,937.60	$52,344.00
	Individual	$814.00	$488.40	60.00%	$325.60	40.00%	5	0.59%	$5,860.80	$3,907.20	$9,768.00	$29,304.00	$19,536.00	$48,840.00
Tufts Benchmark	Family	$2,015.00	$1,209.00	60.00%	$806.00	40.00%	0	0.00%	$14,508.00	$9,672.00	$24,180.00	$0.00	$0.00	$0.00
	Individual	$769.00	$461.40	60.00%	$307.60	40.00%	1	0.12%	$5,536.80	$3,691.20	$9,228.00	$5,536.80	$3,691.20	$9,228.00
HPHC Benchmark	Family	$1,851.00	$1,110.60	60.00%	$740.40	40.00%	2	0.24%	$13,327.20	$8,884.80	$22,212.00	$26,654.40	$17,769.60	$44,424.00
	Individual	$709.00	$425.40	60.00%	$283.60	40.00%	4	0.48%	$5,104.80	$3,403.20	$8,508.00	$20,419.20	$13,612.80	$34,032.00
Fallon Select Benchmark	Family	$1,591.00	$1,161.43	73.00%	$429.57	27.00%	20	2.38%	$13,937.16	$5,154.84	$19,092.00	$278,743.20	$103,096.80	$381,840.00
	Individual	$591.00	$431.43	73.00%	$159.57	27.00%	30	3.57%	$5,177.16	$1,914.84	$7,092.00	$155,314.80	$57,445.20	$212,760.00
Fallon Direct Benchmark	Family	$1,480.00	$1,154.40	78.00%	$325.60	22.00%	8	0.95%	$13,852.80	$3,907.20	$17,760.00	$110,822.40	$31,257.60	$142,080.00
	Individual	$550.00	$429.00	78.00%	$121.00	22.00%	13	1.55%	$5,148.00	$1,452.00	$6,600.00	$66,924.00	$18,876.00	$85,800.00
							841	100%	Fallon Makes Up		87.04%	$8,071,394.04	$3,343,293.96	$11,414,688.00
									# of Plans		732	70.71%	29.29%	
Harvard Pilgrim Medicare Enhance	Retiree	$328.33	$164.17	50.00%	$164.17	50.00%	176	45.13%	$1,969.98	$1,969.98	$3,939.96	$346,716.48	$346,716.48	$693,432.96
BC/BS Medex II	Retiree	$340.00	$170.00	50.00%	$170.00	50.00%	15	3.85%	$2,040.00	$2,040.00	$4,080.00	$30,600.00	$30,600.00	$61,200.00
Tufts Medicare Prime Suplmt Plus	Retiree	$330.00	$165.00	50.00%	$165.00	50.00%	45	11.54%	$1,980.00	$1,980.00	$3,960.00	$89,100.00	$89,100.00	$178,200.00
BC/BS Managed Blue for Seniors	Retiree	$295.63	$177.38	60.00%	$118.25	40.00%	6	1.54%	$2,128.54	$1,419.02	$3,547.56	$12,771.22	$8,514.14	$21,285.36
Fallon Senior	Retiree	$299.00	$219.77	73.50%	$79.24	26.50%	89	22.82%	$1,318.59	$475.41	$1,794.00	$117,354.51	$42,311.49	$159,666.00
Tufts Medicare Preferred**	Retiree	$262.00	$192.57	73.50%	$69.43	26.50%	59	15.13%	$1,155.42	$416.58	$1,572.00	$68,169.78	$24,578.22	$92,748.00
							390		Fallon Makes Up		22.82%	$664,711.99	$541,820.33	$1,206,532.32
Enrollments shown above include SELCO and Surviving Spouses (22±)									# of Plans (was 158)		89	55.09%	44.91%	
							1,231					$8,736,106.03	$3,885,114.29	$12,621,220.32
												69.22%	30.78%	

Enrollment As Of 6/26/2015

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2015-2016

JUNE PAYROLL CHANGES FOR JULY 1, 2015 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY	TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY*	TOWN 21 P/R BI-WEEKLY**	TOWN WEEKLY*	EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY*	EMP. 21P/R BI-WEEKLY**	EMPLOYEE WEEKLY*	COBRA
INDEMNITY PLANS											
Harvard Pilgrim PPO											
50/50	**FAMILY**	***$5,036.00***	$2,518.00	$1,162.15	$1,438.86	$581.08	**$2,518.00**	**$1,162.15**	**$1,438.86**	**$581.08**	$5,136.72
50/50	FAMILY (SS)	***$5,036.00***	$2,518.00	$1,162.15	$1,438.86	$581.08	$2,518.00	$1,162.15	$1,438.86	$581.08	
50/50	**INDIVIDUAL**	***$2,268.00***	$1,134.00	$523.38	$648.00	$261.69	**$1,134.00**	**$523.38**	**$648.00**	**$261.69**	$2,313.36
50/50	INDIVIDUAL (SS)	***$2,268.00***	$1,134.00	$523.38	$648.00	$261.69	$1,134.00	$523.38	$648.00	$261.69	
RATE SAVER HMO PLANS											
Effective 7/1/2014 Rate Saver plans are not available to new Active Employees and Non-Medicare Eligible Retirees											
BLUE OPTIONS RATE SAVER EPO											
60/40	**FAMILY**	***$2,261.00***	$1,356.60	$626.12	$775.20	$313.06	**$904.40**	**$417.42**	**$516.80**	**$208.71**	$2,306.22
50/50	FAMILY (SS)	***$2,261.00***	$1,130.50	$521.77	$646.00	$260.88	$1,130.50	$521.77	$646.00	$260.88	
60/40	**INDIVIDUAL**	***$843.00***	$505.80	$233.45	$289.03	$116.72	**$337.20**	**$155.63**	**$192.69**	**$77.82**	$859.86
50/50	INDIVIDUAL (SS)	***$843.00***	$421.50	$194.54	$240.86	$97.27	$421.50	$194.54	$240.86	$97.27	
TUFTS NAVIGATOR RATE SAVER EPO											
60/40	**FAMILY**	***$2,088.00***	$1,252.80	$578.22	$715.89	$289.11	**$835.20**	**$385.48**	**$477.26**	**$192.74**	$2,129.76
50/50	FAMILY (SS)	***$2,088.00***	$1,044.00	$481.85	$596.57	$240.92	$1,044.00	$481.85	$596.57	$240.92	
60/40	**INDIVIDUAL**	***$797.00***	$478.20	$220.71	$273.26	$110.35	**$318.80**	**$147.14**	**$182.17**	**$73.57**	$812.94
50/50	INDIVIDUAL (SS)	***$797.00***	$398.50	$183.92	$227.71	$91.96	$398.50	$183.92	$227.71	$91.96	
HPHC RATE SAVER EPO											
60/40	**FAMILY**	***$1,918.00***	$1,150.80	$531.14	$657.60	$265.57	**$767.20**	**$354.09**	**$438.40**	**$177.05**	$1,956.36
50/50	FAMILY (SS)	***$1,918.00***	$959.00	$442.62	$548.00	$221.31	$959.00	$442.62	$548.00	$221.31	
60/40	**INDIVIDUAL**	***$736.00***	$441.60	$203.82	$252.34	$101.91	**$294.40**	**$135.88**	**$168.23**	**$67.94**	$750.72
50/50	INDIVIDUAL (SS)	***$736.00***	$368.00	$169.85	$210.29	$84.92	$368.00	$169.85	$210.29	$84.92	
FALLON SELECT RATE SAVER EPO											
71.5/28.5	**FAMILY**	***$1,647.00***	$1,177.61	$543.51	$672.92	$271.76	**$469.40**	**$216.64**	**$268.23**	**$108.32**	$1,679.94
50/50	FAMILY (SS)	***$1,647.00***	$823.50	$380.08	$470.57	$190.04	$823.50	$380.08	$470.57	$190.04	
71.5/28.5	**INDIVIDUAL**	***$611.00***	$436.87	$201.63	$249.64	$100.82	**$174.14**	**$80.37**	**$99.51**	**$40.19**	$623.22
50/50	INDIVIDUAL (SS)	***$611.00***	$305.50	$141.00	$174.57	$70.50	$305.50	$141.00	$174.57	$70.50	
FALLON DIRECT RATE SAVER EPO											
76.5/23.5	**FAMILY**	***$1,531.00***	$1,171.22	$540.56	$669.27	$270.28	**$359.79**	**$166.05**	**$205.59**	**$83.03**	$1,561.62
50/50	FAMILY (SS)	***$1,531.00***	$765.50	$353.31	$437.43	$176.65	$765.50	$353.31	$437.43	$176.65	
76.5/23.5	**INDIVIDUAL**	***$570.00***	$436.05	$201.25	$249.17	$100.63	**$133.95**	**$61.82**	**$76.54**	**$30.91**	$581.40
50/50	INDIVIDUAL (SS)	***$570.00***	$285.00	$131.54	$162.86	$65.77	$285.00	$131.54	$162.86	$65.77	

(SS) REPRESENTS SURVIVING SPOUSE

**** PLEASE NOTE BI-WEEKLY & WEEKLY DEDUCTIONS ARE BASED ON 26 & 52 WEEK PAYROLLS RESPECTIVELY.***

*****SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)***

TURN OVER FOR ADDITIONAL RATES

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2015-2016

JUNE PAYROLL CHANGES FOR JULY 1, 2015 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY	TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY*	TOWN 21 P/R BI-WEEKLY**	TOWN WEEKLY*	EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY*	EMP. 21P/R BI-WEEKLY**	EMPLOYEE WEEKLY*	COBRA
BENCHMARK HMO PLANS											
BLUE CROSS NETWORK BLUE BENCHMARK											
60/40	**FAMILY**	***$2,181.00***	$1,308.60	$603.97	$747.77	$301.98	**$872.40**	**$402.65**	**$498.51**	**$201.32**	$2,224.62
50/50	FAMILY (SS)	***$2,181.00***	$1,090.50	$503.31	$623.14	$251.65	$1,090.50	$503.31	$623.14	$251.65	
60/40	**INDIVIDUAL**	***$814.00***	$488.40	$225.42	$279.09	$112.71	**$325.60**	**$150.28**	**$186.06**	**$75.14**	$830.28
50/50	INDIVIDUAL (SS)	***$814.00***	$407.00	$187.85	$232.57	$93.92	$407.00	$187.85	$232.57	$93.92	
TUFTS BENCHMARK											
60/40	**FAMILY**	***$2,015.00***	$1,209.00	$558.00	$690.86	$279.00	**$806.00**	**$372.00**	**$460.57**	**$186.00**	$2,055.30
50/50	FAMILY (SS)	***$2,015.00***	$1,007.50	$465.00	$575.71	$232.50	$1,007.50	$465.00	$575.71	$232.50	
60/40	**INDIVIDUAL**	***$769.00***	$461.40	$212.95	$263.66	$106.48	**$307.60**	**$141.97**	**$175.77**	**$70.98**	$784.38
50/50	INDIVIDUAL (SS)	***$769.00***	$384.50	$177.46	$219.71	$88.73	$384.50	$177.46	$219.71	$88.73	
HPHC BENCHMARK											
60/40	**FAMILY**	***$1,851.00***	$1,110.60	$512.58	$634.63	$256.29	**$740.40**	**$341.72**	**$423.09**	**$170.86**	$1,888.02
50/50	FAMILY (SS)	***$1,851.00***	$925.50	$427.15	$528.86	$213.58	$925.50	$427.15	$528.86	$213.58	
60/40	**INDIVIDUAL**	***$709.00***	$425.40	$196.34	$243.09	$98.17	**$283.60**	**$130.89**	**$162.06**	**$65.45**	$723.18
50/50	INDIVIDUAL (SS)	***$709.00***	$354.50	$163.62	$202.57	$81.81	$354.50	$163.62	$202.57	$81.81	
FALLON SELECT BENCHMARK											
73/27	**FAMILY**	***$1,591.00***	$1,161.43	$536.04	$663.67	$268.02	**$429.57**	**$198.26**	**$245.47**	**$99.13**	$1,622.82
50/50	FAMILY (SS)	***$1,591.00***	$795.50	$367.15	$454.57	$183.58	$795.50	$367.15	$454.57	$183.58	
73/27	**INDIVIDUAL**	***$591.00***	$431.43	$199.12	$246.53	$99.56	**$159.57**	**$73.65**	**$91.18**	**$36.82**	$602.82
50/50	INDIVIDUAL (SS)	***$591.00***	$295.50	$136.38	$168.86	$68.19	$295.50	$136.38	$168.86	$68.19	
FALLON DIRECT BENCHMARK											
78/22	**FAMILY**	***$1,480.00***	$1,154.40	$532.80	$659.66	$266.40	**$325.60**	**$150.28**	**$186.06**	**$75.14**	$1,509.60
50/50	FAMILY (SS)	***$1,480.00***	$740.00	$341.54	$422.86	$170.77	$740.00	$341.54	$422.86	$170.77	
78/22	**INDIVIDUAL**	***$550.00***	$429.00	$198.00	$245.14	$99.00	**$121.00**	**$55.85**	**$69.14**	**$27.92**	$561.00
50/50	INDIVIDUAL (SS)	***$550.00***	$275.00	$126.92	$157.14	$63.46	$275.00	$126.92	$157.14	$63.46	

(SS) REPRESENTS SURVIVING SPOUSE

**** PLEASE NOTE BI-WEEKLY & WEEKLY DEDUCTIONS ARE BASED ON 26 & 52 WEEK PAYROLLS RESPECTIVELY.***

*****SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)***

TURN OVER FOR ADDITIONAL RATES

Town of Shrewsbury West Suburban Health Group Senior Plans Rates as of January 1, 2015				
% Paid Town/Retiree		Total Monthly	Town Monthly	Retiree Monthly
Medicare Supplement Plans				
Freedom Of Choice				
Harvard Pilgrim - Medicare Enhance With First Health Part D				
50/50	**Subscriber**	$328.33	$164.17	***$164.17***
50/50	Surviving Spouse	$328.33	$164.17	***$164.17***
BC/BS - Medex II With Blue Medicare Rx				
50/50	**Subscriber**	$340.00	$170.00	***$170.00***
50/50	Surviving Spouse	$340.00	$170.00	***$170.00***
Tufts - Medicare Prime Supplement With PDP Plus				
50/50	**Subscriber**	$330.00	$165.00	***$165.00***
50/50	Surviving Spouse	$330.00	$165.00	***$165.00***
HMO Medi-Wrap Plans				
BC/BS - Managed Blue For Seniors				
60/40	**Subscriber**	$295.63	$177.38	***$118.25***
50/50	Surviving Spouse	$295.63	$147.82	***$147.82***
Medicare Advantage HMO Plans				
Fallon - Senior Plan				
73.5/26.5	**Subscriber**	$299.00	$219.77	***$79.24***
50/50	Surviving Spouse	$299.00	$149.50	***$149.50***
Tufts - Medicare Preferred HMO				
73.5/26.5	**Subscriber**	$262.00	$192.57	***$69.43***
50/50	Surviving Spouse	$262.00	$131.00	***$131.00***

Summary of FY 2016 Health Insurance Program
GIC Option

Plan	Type	Premium	Town Share	Percent	Employee/ Retiree Share	Percent	# of Participants	% of Plans	Town Share (Annual)	Employee/ Retiree Share (Annual)	Total	Town Share Budget	Employee/ Retiree Share Budget	Total
Unicare (Comprehensive)	Family	$2,281.72	$1,140.86	50.00%	$1,140.86	50.00%	0	0.00%	$13,690.32	$13,690.32	$27,380.64	$0.00	$0.00	$0.00
	Individual	$974.65	$487.33	50.00%	$487.33	50.00%	4	0.48%	$5,847.90	$5,847.90	$11,695.80	$23,391.60	$23,391.60	$46,783.20
Tufts Health Plan Spirit	Family	$1,207.85	$724.71	60.00%	$483.14	40.00%	4	0.48%	$8,696.52	$5,797.68	$14,494.20	$34,786.08	$23,190.72	$57,976.80
	Individual	$501.40	$300.84	60.00%	$200.56	40.00%	5	0.59%	$3,610.08	$2,406.72	$6,016.80	$18,050.40	$12,033.60	$30,084.00
HPHC Pilgrim Primary Choice Plan	Family	$1,462.80	$877.68	60.00%	$585.12	40.00%	32	3.80%	$10,532.16	$7,021.44	$17,553.60	$337,029.12	$224,686.08	$561,715.20
	Individual	$599.51	$359.71	60.00%	$239.80	40.00%	64	7.61%	$4,316.47	$2,877.65	$7,194.12	$276,254.21	$184,169.47	$460,423.68
Fallon Select Rate Saver EPO*	Family	$1,571.91	$1,100.34	70.00%	$471.57	30.00%	376	44.71%	$13,204.04	$5,658.88	$18,862.92	$4,964,720.54	$2,127,737.38	$7,092,457.92
	Individual	$654.98	$458.49	70.00%	$196.49	30.00%	216	25.68%	$5,501.83	$2,357.93	$7,859.76	$1,188,395.71	$509,312.45	$1,697,708.16
Fallon Direct Rate Saver EPO*	Family	$1,182.96	$887.22	75.00%	$295.74	25.00%	78	9.27%	$10,646.64	$3,548.88	$14,195.52	$830,437.92	$276,812.64	$1,107,250.56
	Individual	$492.89	$369.67	75.00%	$123.22	25.00%	62	7.37%	$4,436.01	$1,478.67	$5,914.68	$275,032.62	$91,677.54	$366,710.16
							841	100%	Fallon Makes Up		87.04%	$7,948,098.20	$3,473,011.48	$11,421,109.68
									# of Plans		732	69.59%	30.41%	
Harvard Pilgrim Medicare Enhance	Retiree	$392.24	$196.12	50.00%	$196.12	50.00%	242	62.05%	$2,353.44	$2,353.44	$4,706.88	$569,532.48	$569,532.48	$1,139,064.96
Fallon Senior	Retiree	$302.13	$226.60	75.00%	$75.53	25.00%	89	22.82%	$1,359.59	$453.20	$1,812.78	$121,003.07	$40,334.36	$161,337.42
Tufts Medicare Preferred**	Retiree	$275.60	$206.70	75.00%	$68.90	25.00%	59	15.13%	$1,240.20	$413.40	$1,653.60	$73,171.80	$24,390.60	$97,562.40
							390		Fallon Makes Up		22.82%	$763,707.35	$634,257.44	$1,397,964.78
Enrollments shown above include SELCO and Surviving Spouses (22±)									# of Plans (was 158)		89	54.63%	45.37%	
							1,231					$8,711,805.55	$4,107,268.91	$12,819,074.46
												67.96%	32.04%	

Enrollment As Of 6/25/2015

The Official Website of the Executive Office for Administration and Finance

Administration and Finance

Home > Employee Insurance & Retirement Benefits > Municipality Information > Monthly Full Cost Rates

Monthly Full Cost Rates

Effective July 1, 2015

Full Cost Rates Including the 0.4% Administrative Fee

For the rate you will pay as a municipal employee or retiree/survivor, see separate rate chart from your municipality

Employee and Non-Medicare Retiree/Survivor Health Plans

HEALTH PLAN	PLAN TYPE	INDIVIDUAL	FAMILY
Fallon Health Direct Care	HMO	$492.89	$1,182.96
Fallon Health Select Care	HMO	654.98	1,571.91
Harvard Pilgrim Independence Plan	POS	749.39	1,828.49
Harvard Pilgrim Primary Choice Plan	HMO	599.51	1,462.80
Health New England	HMO	494.17	1,225.14
NHP Care *(Neighborhood Health Plan)*	HMO	470.71	1,247.36
Tufts Health Plan Navigator	POS	659.25	1,609.60
Tufts Health Plan Spirit	HMO-type	501.40	1,207.85
UniCare State Indemnity Plan/Basic with CIC (Comprehensive)	Indemnity	974.65	2,281.72
UniCare State Indemnity Plan/Basic without CIC (Non-Comprehensive)	Indemnity	932.32	2,183.55
UniCare State Indemnity Plan/Community Choice	PPO-type	472.29	1,136.29
UniCare State Indemnity Plan/PLUS	PPO-type	655.64	1,566.91

Medicare Plans

Health Plan	PLAN TYPE	PER PERSON
Fallon Senior Plan	Medicare *(HMO)*	$302.13
Harvard Pilgrim Medicare Enhance	Medicare *(Indemnity)*	392.24
Health New England MedPlus	Medicare *(HMO)*	360.95
Tufts Health Plan Medicare Complement	Medicare *(HMO)*	353.91

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Lower Your Out-of-Pocket Health Care Costs

Tufts Scholarship for Allied Health Students

UniCare OME New Drug Plan Starts January 1

Beacon Health Strategies Merges with Value Options

Harvard Independence & Tufts Navigator Become POS Plans

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Tufts Health Plan Medicare Preferred*	Medicare *(HMO)*	275.60
UniCare State Indemnity Plan/Medicare Extension (OME) with CIC *(Comprehensive)*	Medicare *(Indemnity)*	403.98
UniCare State Indemnity Plan/Medicare Extension (OME) without CIC *(Non-Comprehensive)*	Medicare *(Indemnity)*	393.47

**Benefits and rates of Fallon Senior Plan and Tufts Health Plan Medicare Preferred are subject to federal approval and may change January 1, 2016.*

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- Yes
- No

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Health Insurance Network Types

Network Type: A general label for the "level of restriction" of plan, and the level of coverage provided in-network and out-of-network. Common types include PPO, HMO, EPO, POS, and Indemnity.

Cliff Notes version:

Detailed version:

	Network Type	In Network Restrictions	Out Of Network Restrictions
More Restrictions	**Health Maintenance Organization (HMO)**	• Can visit ONLY specific doctors • Require a Primary Care Physician	• No coverage
	Point of Sale (POS)	• Can visit ONLY specific doctors • Require a Primary Care Physician	• Lower coverage for out-of-network providers
	Exclusive Provider Organization (EPO)	• Large group of accessible doctors	• No coverage
	Preferred Provider Organization (PPO)	• Large group of accessible doctors	• Lower coverage for out-of-network providers
Less Restrictions	**Indemnity**	Can go to ANY provider or health care organization	

Plan Designs: GIC vs. WSHG Rate Saver as of 7/1/15

	GIC	HPHC	Fallon Select	Fallon Direct
Plan Design Features				
Deductible				
Per member	$300	None	None	None
Family of 2	$600	None	None	None
Not-to-exceed per family	$900	None	None	None
Inpatient copay	$250/$500/$1,500 no tiering for Fallon Direct	$250	$250	$250
Outpatient surgery copay	$250	$125	$125	$125
Specialist copays	$30/$60/$90	$35	$35	$35
Rx copays				
Retail (30 day supply)	$10/$30/$65	$10/$25/$45	$10/$25/$45	$10/$25/$45
Mail Order (90 day supply)	$25/75/$165	$20/$50/$90	$20/$50/$90	$20/$50/$90
Out-of-Pocket Maximum				
Individual	$5,000	$2,000	$1,000	$1,000
Family	$10,000	$4,000	$2,000	$2,000

Premium: GIC Plan Design vs. WSHG Plan Designs

	HPHC			Fallon Select			Fallon Direct		
Monthly Employee Rates									
	GIC	**WSHG**	**Difference**	**GIC**	**WSHG**	**Difference**	**GIC**	**WSHG**	**Difference**
Individual	$239.80	$294.40	**$54.60**	$196.49	$174.14	**($22.35)**	$123.22	$133.95	**$10.73**
Family	$585.12	$767.20	**$182.08**	$471.57	$469.40	**($2.17)**	$295.74	$359.79	**$64.05**
Enrollees									
Individual	64			216			62		
Family	32			376			78		

Plan Designs: GIC vs. WSHG Senior as of 7/1/15

	GIC	HP Medicare Enhance	Fallon Senior	Tufts Medicare Preferred
Plan Design Features				
PCP copay	$10	$5	$15	$10
Inpatient Hospital	none	none	none	$300 annual deductible
Outpatient surgery copay	none	none	$75	$50
Emergency Room *waived if admitted*	$50	$30	$50	$50
Rx copays				
Retail (30 day supply)	$10/$30/$65	$5/$10/$25	$10/$25/$50	$10/$25/$50
Mail Order (90 day supply)	$25/75/$165	$10/$20/$75	$20/$50/$100	$20/$50/$100

Premium: GIC Plan Design vs. WSHG Plan Senior Designs

		HP Medicare Enhance			Fallon Senior			Tufts Medicare Preferred		
Monthly Employee Rates										
		GIC	**WSHG**	**Difference**	**GIC**	**WSHG**	**Difference**	**GIC**	**WSHG**	**Difference**
Individual		$196.12	$164.17	**($31.95)**	$75.53	$79.24	**$3.71**	$68.90	$69.43	**$0.53**
Enrollees										
Individual		242			89			59		

WSHG Financial Indicators

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

July, 2015

FUNDING RATE ANALYSIS BY PLAN - Policy Year 7/1/14 - 6/30/15
(Analysis for 12-mos., 7/14-6/15)

FUNDING ANALYSIS SUMMARY FOR SELF-FUNDED HEALTH PLANS

HEALTH PLAN	*Estimated Funding (rates x enrollments)*	*Estimated Plan * NET Costs*		*Estimated Funding Surplus/(Shortfall)*
Harvard Pilgrim Rate Saver/Benchmark	64,762,522	68,288,606	**105.4%**	($3,526,084)
Harvard Pilgrim PPO	1,179,252	1,625,195	**137.8%**	($445,943)
BCBS Network Blue Rate Saver/Benchmark	13,104,366	12,215,087	**93.2%**	$889,279
Fallon EPO Rate Saver	15,625,913	15,469,566	**99.0%**	$156,347
Fallon EPO Benchmark	678,677	315,607	**46.5%**	$363,070
Tufts Rate Saver/Benchmark	22,762,598	22,239,845	**97.7%**	$522,753
Tufts POS	73,044	26,794	**36.7%**	$46,250
HPHC Medicare Enhance	2,715,899	2,777,420	**102.3%**	($61,521)
BCBS Medex	3,353,615	3,077,023	**91.8%**	$276,592
	$ 124,255,886	$ 126,035,142		($1,779,257)
% COSTS/FUNDING:			**101.4%**	

Retiree Drug Subsidy payments to date based on Plan Year Incurred:

FY07-08	**FY09**	**FY10**	**CY11****	**CY12**	**CY13**
$2,709,600.85	**$1,411,545.85**	**$1,375,702.09**	**$2,056,645.42**	**$1,160,328.00**	**$1,218,298.42**
FINAL	**FINAL**	**FINAL**	**FINAL**	**FINAL**	**FINAL**

**Includes 7/1/10-12/31/10
$655,536.02
1/1/11-12/31/11
$1,357,259.41

NOTES: ** NET Costs include paid claims, carrier administration, reinsurance premium, and reinsurance reimbursements.*
Other "Program Costs" such as GBS Management fee, GBS COBRA fee, WSHG Treasurer and Assistant Treasurer fees, Claims Audit fee, and legal and miscellaneous costs are not included in the above analysis.
*** Plan year changed from fiscal year to calendar year on 1/1/2011.*

WEST SUBURBAN HEALTH GROUP
SUMMARY OF ACTIVITY - CUMULATIVE

FY 2016

REVISED 9/21/15

- Added Abacus (Diabetes Pgm) Aug Activity
- Added GBS/COBRA August Activity
- Added Tufts Deposit Int July & August

ACCRUAL

	FY 2013 June 06/30/13	FY 2014 June 06/30/14	Delta FY 13-14	FY 2015 June 06/30/15	Delta FY 14-15	CUMULATIVE FY 2016 July 07/31/15	FY 2016 August 08/31/15
Fund Balance Beginning of year	22,771,078	18,023,940	(4,747,138)	9,558,500	(8,465,440)	5,951,989	5,951,989
Fund Balance end of month	18,023,940	9,558,500	(8,465,440)	5,951,989	(3,606,511)	4,937,302	3,992,386
Increase (decrease) in Fund Balance	(4,747,138)	(8,465,440)	(3,718,302)	(3,606,511)	4,858,929	(1,014,687)	(1,959,603)
REVENUE:			-				
Member Assessment	121,835,836	127,080,569	5,244,733	134,314,479	7,233,910	9,756,946	19,423,579
EXPENSES:							
Self insured claims:			-				
Tufts, HP, Fallon	91,924,021	99,318,317	7,394,296	101,968,135	2,649,818	7,863,347	15,834,185
BCBS	19,865,478	19,287,336	(578,142)	15,189,928	(4,097,408)		
LMD BCBS	-	-	-	-	-	1,202,800	2,405,600
Total Claims	111,789,499	118,605,653	6,816,154	117,158,063	(1,447,590)	9,066,147	18,039,785
			-		-		
COBRA reimbursement (add back)	(375,245)	(257,765)	117,480	(328,370)	(70,605)	(16,989)	(32,541)
Reinsurance Recoveries (add back)	(362,614)	(706,073)	(343,459)	(1,504,419)	(798,346)	-	-
Claims net of Reimbursements	111,051,640	117,641,815	6,590,175	115,325,274	(2,316,541)	9,049,158	18,007,244
Premiums Paid	7,070,860	9,610,577	2,539,717	12,514,531	2,903,954	1,218,177	2,433,317
Total Claims & Premiums net of reimbursements	118,122,500	127,252,392	9,129,892	127,839,805	587,413	10,267,335	20,440,561
Member Assessments over Claims & Premiums	3,713,336	(171,823)	(3,885,159)	6,474,674	6,646,497	(510,389)	(1,016,982)
			-		-		
Other expenses and income:			-		-		
Administrative expenses - Providers & GBS	5,827,406	5,556,640	(270,766)	5,400,006	(156,634)	108,007	217,500
Reinsurance Premiums	697,092	807,483	110,391	2,157,926	1,350,443	158,773	316,450
Retiree Drug Subsidy 2008 Distribution	1,353,785		(1,353,785)		-		
Increase in Unpaid Claims		540,255			(540,255)		
Transitional Reins Contribution				862,097	862,097		
Accounting, Legal, Misc, other*	2,067,166	2,310,638	243,472	1,905,591	(405,047)	164,867	289,515
Total Administrative costs	9,945,449	9,215,016	(1,270,688)	10,325,620	1,110,604	431,647	823,465
	(6,232,113)	(9,386,839)	(2,614,471)	(3,850,946)	5,535,893	(942,036)	(1,840,447)
			-		-		
Retiree Drug Subsidy	1,227,473	626,028	(601,445)	96,092	(529,936)	-	-
Medicare Reimbursement			-		-		
Interest earned on investments & MV adjust	257,502	295,371	37,869	148,343	(147,028)	(72,651)	(119,156)
Net Gain (Loss)YTD	(4,747,138)	(8,465,440)	(3,178,047)	(3,606,511)	4,858,929	(1,014,687)	(1,959,603)
Change in IBNR					-		
Increase (decrease) in Fund Balance	(4,747,138)	(8,465,440)	(3,178,047)	(3,606,511)	4,858,929	(1,014,687)	(1,959,603)

(944,916)

WEST SUBURBAN HEALTH GROUP

SUMMARY OF ACTIVITY - MONTHLY ACCRUAL

FY 2016

*Using Unaudited June 2015 Fund Balance

	Monthly July	Monthly August
FUND BALANCE-END JULY & monthly change	4,937,302	(944,916)
Increase/(Decrease)from prior month	(1,014,687)	(944,916)
Member Assessment	9,756,946	9,666,633
Invest (Net of MV)	(72,651)	(46,505)
RDS		-
MONTHLY REVENUE	9,684,295	9,620,128
Claims	9,066,147	8,973,638
Premiums	1,218,177	1,215,140
Reimb. (COBRA & Reins Recoveries)	(16,989)	(15,552)
	10,267,335	10,173,226
Admin Costs	431,647	391,818
MONTHLY EXPENSES	10,698,982	10,565,044
Increase(Decrease) Fund Bal (Monthly Impact)	(1,014,687)	(944,916)

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

September, 2015

FUNDING RATE ANALYSIS BY PLAN - Policy Year 7/1/~~14~~ 15 - 6/30/~~15~~ 16
(Analysis for 1-mos., 7/15)

FUNDING ANALYSIS SUMMARY FOR SELF-FUNDED HEALTH PLANS

HEALTH PLAN	*Estimated Funding (rates x enrollments)*	*Estimated Plan * NET Costs*		*Estimated Funding Surplus/(Shortfall)*
Harvard Pilgrim Rate Saver/Benchmark	4,045,530	4,777,393	**118.1%**	($731,863)
Harvard Pilgrim PPO	66,772	132,222	**198.0%**	($65,450)
BCBS Network Blue Rate Saver/Benchmark	844,975	969,239	**114.7%**	($124,264)
Fallon EPO Rate Saver	2,119,019	1,754,404	**82.8%**	$364,615
Fallon EPO Benchmark	84,628	31,474	**37.2%**	$53,154
Tufts Rate Saver/Benchmark	1,376,461	1,438,905	**104.5%**	($62,444)
HPHC Medicare Enhance	175,980	182,086	**103.5%**	($6,106)
BCBS Medex	234,084	281,166	**120.1%**	($47,082)
	$ 8,947,449	$ 9,566,890		($619,441)
% COSTS/FUNDING:			**106.9%**	

Retiree Drug Subsidy payments to date based on Plan Year Incurred:

FY07-08	**FY09**	**FY10**	**CY11****	**CY12**	**CY13**
$2,709,600.85	**$1,411,545.85**	**$1,375,702.09**	**$2,056,645.42**	**$1,160,328.00**	**$1,218,298.42**
FINAL	**FINAL**	**FINAL**	**FINAL**	**FINAL**	**FINAL**

**Includes 7/1/10-12/31/10
$655,536.02
1/1/11-12/31/11
$1,357,259.41

NOTES: ** NET Costs include paid claims, carrier administration, reinsurance premium, and reinsurance reimbursements.*
Other "Program Costs" such as GBS Management fee, GBS COBRA fee, WSHG Treasurer and Assistant Treasurer fees, Claims Audit fee, and legal and miscellaneous costs are not included in the above analysis.
*** Plan year changed from fiscal year to calendar year on 1/1/2011.*

WEST SUBURBAN HEALTH GROUP

Run-out claims to date for governmental units that withdrew from WSHG on 7/1/15

	Run-out Claims		
Govenmental Unit	Jul-15	Aug-15	Total
Ashland	$ 301,715	$ 97,025	$ 398,740
Walpole	$ 434,222	$ 53,424	$ 487,647
Westwood	$ 454,091	$ 45,401	$ 499,492
The Education Coop. (TEC)	$ 26,694	$ 560	$ 27,254
Totals	**$ 1,216,723**	**$ 196,410**	**$1,413,133**
		does not include Tufts	does not include Tufts for August

WEST SUBURBAN HEALTH GROUP
Report of Excess Stop-Loss Claims

ACCOUNT NAME: WEST SUBURBAN HEALTH GROUP
REINSURANCE CARRIER: MMRA / Berkley Life & Health Ins.
POLICY DATES: 07/01/14 - 06/30/15
PAID DATES: 07/01/14 06/30/16
STOP LOSS DEDUCTIBLE: MMRA reimburses claims between $300,000 & $800,000 / above $800,000 Berkley reimburses
Excess Claims

PAID THROUGH JULY 2015

Claims last updated 09/02/15 *reimbursements since 09/14/15*

Carrier	Dep#	Previous Month Total Claims	Additions/ Deletions	Updated Total Paid Claims	Policy Year Deductible	Excess Amt	Previously Reported Reimbursements	New Reimbursements	Total Reimbursements	Outstanding Reimbursements	Notes
THP	0	$ 423,481.00	$ -	$ 423,481.00	$ 300,000.00	$ 123,481.00	$ 121,016.35	$ -	$ 121,016.35	$ 2,464.65	***termed 4/17/15***
HPHC	1	$ 305,181.00	$ -	$ 305,181.00	$ 300,000.00	$ 5,181.00	$ 5,455.04	$ 1,865.35	$ 7,320.39	$ (2,139.39)	***fy14 excess fy14 excess***
FCHP	1	$ 448,558.00	$ -	$ 448,558.00	$ 300,000.00	$ 148,558.00	$ 90,756.16	$ 29,625.10	$ 120,381.26	$ 28,176.74	*fy12 50%,* ***fy13, fy14 excess***
HPHC	3	$ 342,074.92	$ -	$ 342,074.92	$ 300,000.00	$ 42,074.92	$ 40,828.08	$ 1,246.84	$ 42,074.92	$ (0.00)	
HPHC	0	$ 455,557.00	$ -	$ 455,557.00	$ 300,000.00	$ 155,557.00	$ -	$ -	$ -	$ 155,557.00	***deceased 5/31/15***
HPHC	1	$ 899,515.00	$ -	$ 899,515.00	$ 300,000.00	$ 599,515.00	$ -	$ -	$ -	$ 599,515.00	
THP	1	$ 302,735.00	$ -	$ 302,735.00	$ 300,000.00	$ 2,735.00	$ -	$ -	$ -	$ 2,735.00	
BCBS	0	$ 302,060.38	$ -	$ 302,060.38	$ 300,000.00	$ 2,060.38	$ -	$ -	$ -	$ 2,060.38	*fy14 50%*
HPHC	1	$ 340,066.19	$ -	$ 340,066.19	$ 300,000.00	$ 40,066.19	$ -	$ -	$ -	$ 40,066.19	***Term 6/30/15***
HPHC	3	$ 593,103.00	$ -	$ 593,103.00	$ 300,000.00	$ 293,103.00	$ -	$ -	$ -	$ 293,103.00	***Term 6/30/15***
FHP	0	$ 309,757.00	$ -	$ 309,757.00	$ 300,000.00	$ 9,757.00	$ -	$ -	$ -	$ 9,757.00	*fy13, fy14 50%*
		$ 4,722,088.49	$ -	$ 4,722,088.49		$ 1,422,088.49	$ 258,055.63	$ 32,737.29	$ 290,792.92	$ 1,131,295.57	

11 claimants

WEST SUBURBAN HEALTH GROUP
Report of Claims at 50%+

ACCOUNT NAME: WEST SUBURBAN HEALTH GROUP
REINSURANCE CARRIER: MMRA / Berkley Life & Health Ins.
POLICY DATES: 07/01/14 - 06/30/15
PAID DATES: 07/01/14 06/30/16
STOP LOSS DEDUCTIBLE: MMRA reimburses claims between $300,000 & $800,000 / above $800,000 Berkley reimburses

PAID THROUGH JULY 2015

Claims last updated 09/02/15

Carrier	Dep#	Previous Month Total Claims	Additions/ Deletions	Updated Total Paid Claims	
HPHC	0	$ 177,093.00	$ -	$ 177,093.00	***deceased 10/13/14***
HPHC	1	$ 284,949.00	$ -	$ 284,949.00	*fy11 50%*
HPHC	2	$ 200,510.00	$ -	$ 200,510.00	
HPHC	0	$ 244,580.00	$ -	$ 244,580.00	
HPHC	0	$ 258,247.00	$ -	$ 258,247.00	***Term 6/30/15***
HPHC	0	$ 199,709.00	$ -	$ 199,709.00	***deceased 12/31/14***
HPHC	1	$ 273,631.00	$ -	$ 273,631.00	***fy06, fy11, fy13, fy14 excess*** *, / fy10, fy11 50%*
HPHC	0	$ 222,112.00	$ -	$ 222,112.00	***deceased 2/27/15***
BCBS	3	$ 183,025.00	$ -	$ 183,025.00	***fy14 excess***
HPHC	1	$ 255,793.00	$ -	$ 255,793.00	***fy14 excess***
HPHC	1	$ 157,401.00	$ -	$ 157,401.00	
FHP	0	$ 171,887.00	$ -	$ 171,887.00	***deceased 3/13/15***
FHP	0	$ 168,622.00	$ -	$ 168,622.00	
HPHC	0	$ 160,791.00	$ -	$ 160,791.00	***deceased 3/15/15***
HPHC	0	$ 263,797.00	$ -	$ 263,797.00	***deceased 2/26/15***
HPHC	0	$ 187,478.95	$ -	$ 187,478.95	***deceased 5/3/16***
THP	0	$ 188,131.74	$ -	$ 188,131.74	***Term 6/30/15***
FHP	0	$ 152,342.00	$ -	$ 152,342.00	
HPHC	1	$ 153,923.00	$ -	$ 153,923.00	
HPHC	0	$ 211,032.00	$ -	$ 211,032.00	*fy12, FY13 50%*
HPHC	0	$ 155,417.00	$ -	$ 155,417.00	*fy14 50%*
HPHC	2	$ 200,165.00	$ -	$ 200,165.00	
HPHC	0	$ 189,545.00	$ -	$ 189,545.00	*fy14 50%*
HPHC	0	$ 216,807.70	$ -	$ 216,807.70	
THP	1	$ 161,070.00	$ -	$ 161,070.00	
FHP	1	$ 167,753.00	$ -	$ 167,753.00	
FHP	2	$ 244,313.00	$ -	$ 244,313.00	
		$ 5,450,125.39	$ -	$ 5,450,125.39	

27 claimants

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

September, 2015

FUNDING RATE ANALYSIS BY PLAN - Policy Year 7/1/14 - 6/30/15
(Analysis for 1-mos., 7/15)

FUNDING ANALYSIS SUMMARY FOR SELF-FUNDED HEALTH PLANS

HEALTH PLAN	*Estimated Funding (rates x enrollments)*	*Estimated Plan * NET Costs*		*Estimated Funding Surplus/(Shortfall)*
Harvard Pilgrim Rate Saver/Benchmark	4,045,530	4,777,393	**118.1%**	($731,863)
Harvard Pilgrim PPO	66,772	132,222	**198.0%**	($65,450)
BCBS Network Blue Rate Saver/Benchmark	844,975	969,239	**114.7%**	($124,264)
Fallon EPO Rate Saver	2,119,019	1,754,404	**82.8%**	$364,615
Fallon EPO Benchmark	84,628	31,474	**37.2%**	$53,154
Tufts Rate Saver/Benchmark	1,376,461	1,438,905	**104.5%**	($62,444)
HPHC Medicare Enhance	175,980	182,086	**103.5%**	($6,106)
BCBS Medex	234,084	281,166	**120.1%**	($47,082)
	$ 8,947,449	$ 9,566,890		($619,441)
% COSTS/FUNDING:			**106.9%**	

Retiree Drug Subsidy payments to date based on Plan Year Incurred:

FY07-08	**FY09**	**FY10**	**CY11****	**CY12**	**CY13**
$2,709,600.85	**$1,411,545.85**	**$1,375,702.09**	**$2,056,645.42**	**$1,160,328.00**	**$1,218,298.42**
FINAL	**FINAL**	**FINAL**	**FINAL**	**FINAL**	**FINAL**

**Includes 7/1/10-12/31/10
$655,536.02
1/1/11-12/31/11
$1,357,259.41

NOTES: ** NET Costs include paid claims, carrier administration, reinsurance premium, and reinsurance reimbursements.*
Other "Program Costs" such as GBS Management fee, GBS COBRA fee, WSHG Treasurer and Assistant Treasurer fees, Claims Audit fee, and legal and miscellaneous costs are not included in the above analysis.
*** Plan year changed from fiscal year to calendar year on 1/1/2011.*

Senior Plan Renewal Information

WEST SUBURBAN HEALTH GROUP

Fully Insured Senior Plans	*CY15 Rates*	***CY16 Proposed Rates***		*Percent Increase*
Managed Blue for Seniors	$ 295.63	$ ~~313.19~~	* 313.20	5.9%
Fallon Senior Plan *(Medicare Advantage plan)*	$ 299.00	$ **322.00**	**	*7.7%*
Fallon Senior Plan - alternative plan design		$ ***310.00***	***	*3.7%*
Tufts Medicare Pref. Supplement with PDP Plus	$ 330.00	$ **321.00**		*-2.7%*
Tufts Medicare Pref. HMO *(Medicare Advantage Plan)*	$ 262.00	$ **267.00**		*1.9%*

* Managed Blue for Seniors medical rate = $166.54 and PDP rate = $146.65 for a total rate of $313.19.

** *Required plan design changes for Fallon Senior plan*
ER co-pay goes from $50 to $75 for CY16;
Retail Rx co-pays go from $10/25/50 to $10/30/65;
Mail Order Rx co-pays go from $20/50/100 to $20/60/162.50.

*** In addition to plan design changes above, add inpatient co-pay of $125 and Skilled Nursing Facility (SNF) co-pay of $25/day for first 5 days only. Currently there are no co-pays on these services.

	CY15	**CY15 & CY16**
	Fallon Senior	Tufts Medicare HMO
Inpatient member cost-share	$0	$300 Inpt. Deductible
SNF member cost-share	$0	$0

fallonhealth

Fallon Senior Plan™ Premier HMO
2016 group rate & benefits renewal agreement
Plan Sponsor – West Suburban Health Group

Plan Information	Plan Details
Plan Year	January 1, 2016 through December 31, 2016
Monthly Premium PMPM	$322.00
Annual Deductible	$0 deductible
Out of Pocket Max	$3,400
Office visits	$15 Primary Care / $25 Specialty Care
Inpatient hospital care	$0 copay per hospital stay
Skilled nursing facility	$0 per day for days 1 - 100
Worldwide emergency care	$75 copay
Urgently needed care	$15 copay
Outpatient surgery	$75 copay
Lab and imaging services	$0 per service
Vision care	$25 per annual supplemental routine vision exam
Hearing services	$0 per annual supplemental routine hearing exam
Medicare Part D *No deductible/No donut hole*	***Retail copays*** (up to a 30-day supply) $10 / $30 / $65 ***M/O copays*** (90-day supply) $20 / $60 / $162.50
Medicare Part D Catastrophic Coverage: *For drugs covered on the formulary which are not normally covered by Part D, members will pay standard copays throughout the year.*	After total Rx costs reach $4,850 during the benefit year (amount paid by the member and Fallon Health), members pay the greater of: • 5% coinsurance or • $2.95 copays for generic or name brand drugs treated as generic • $7.40 copays for all other drugs.
Plan Highlights	• Free gym membership through SilverSneakers® Fitness program • Free membership in Weight Watchers® for 13-consecutive weeks • $150 toward the purchase of eyewear, every year • $500 toward the purchase of hearing aids, every 36 months • Preventive Dental Care

This agreement is an outline of benefits & services available with this Medicare Advantage HMO benefit plan. Details about specific coverage & service limitations are found in the Plan's Evidence of Coverage. Eligibility and participation are subject to CMS enrollment and termination guidelines. Signature on this agreement, or receipt by Fallon Health of the first new year plan premium payment, acknowledges the following by the Plan Sponsor: agreement to renew the Plan as offered, acceptance of the Plan's Administrative Guidelines; the Plan Sponsor is a valid public or private enterprise recognized by Commonwealth of Massachusetts; follows Medicare Secondary Payer rules related to the use of this plan for Medicare beneficiaries; will allow Fallon Health to share the Sponsor's Federal Employer ID number with appropriate federal and state agencies for audit and other purposes as defined by State or Federal regulations; Benefit designs are subject to change each January 1st. Fallon Health is a health plan with a Medicare contract.

_____
Federal Tax ID

_____ _____ _____
Name (print) **Signature** **Date**

_____ _____
Street address **City, State, ZIP**

Organization type: ☐ DBA ☐ LLP ☐ LLC ☐ Inc ☐ Other _____

Broker / Agency affiliation _____

This document is not intended for distribution to Plan members/Medicare beneficiaries.

alternative plan design

fallonhealth

Fallon Senior Plan™ Premier HMO
2016 group rate & benefits renewal agreement
Sponsor – West Suburban Health Group

Plan Information	Plan Details
Plan Year	January 1, 2016 through December 31, 2016
Monthly Premium PMPM	**$310.00**
Annual Deductible	$0 deductible
Out of Pocket Max	$3,400
Office visits	$15 Primary Care / $25 Specialty Care
Inpatient hospital care	**$125 copay per hospital stay**
Skilled nursing facility	**$25 per day for days 1 – 5. $0 copay for days 6-100**
Worldwide emergency care	**$75 copay**
Urgently needed care	$15 copay
Outpatient surgery	$75 copay
Lab and imaging services	$0 per service
Vision care	$25 per annual supplemental routine vision exam
Hearing services	$0 per annual supplemental routine hearing exam
Medicare Part D *No deductible/No donut hole*	***Retail copays*** (up to a 30-day supply) **$10 / $30 / $65** ***M/O copays*** (90-day supply) **$20 / $60 / $162.50**
Medicare Part D Catastrophic Coverage: *For drugs covered on the formulary which are not normally covered by Part D, members will pay standard copays throughout the year.*	After total Rx costs reach **$4,850** during the benefit year (amount paid by the member and Fallon Health), members pay the greater of: • 5% coinsurance or • **$2.95** copays for generic or name brand drugs treated as generic • **$7.40** copays for all other drugs.
Plan highlights	• Free gym membership through SilverSneakers® Fitness program • Free membership in Weight Watchers® for 13-consecutive weeks • $150 toward the purchase of eyewear, every year • $500 toward the purchase of hearing aids, every 36 months • Preventive Dental Care

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_____
Federal Tax ID

_____ _____ _____
Name (print) **Signature** **Date**

_____ _____
Street address **City, State, ZIP**

Organization type: ☐ DBA ☐ LLP ☐ LLC ☐ Inc ☐ Other _____

Broker / Agency affiliation _____

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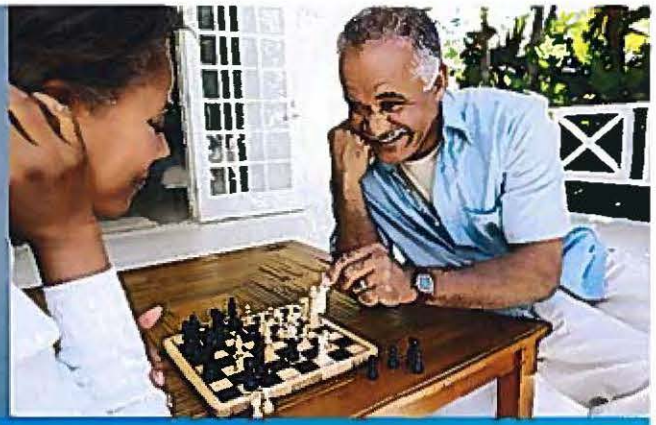

2016 Tufts Health Plan Retiree Plans

West Suburban Health Group

Fall 2015 Fred Winer Account Manager

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TUFTS Health Plan

9/24/2015

Major MP HMO Network Expansion

- New contract signed with Beth Israel Hospital Providers
- Over 500 new PCP's + 2000 Specialists joining Med Pref
- Locations from the Cape to the North Shore
- January 1 2016 Start Date

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TUFTS Health Plan

2016 Tufts Medicare Preferred Final Rate

	2015	2016
HMO Prime Rx	**$262**	**$267**
Medicare Supplement/PDP+	**$330**	**$321**

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TUFTS Health Plan

New for 2016

- Wellness Allowance ($150) now includes reimbursement for acupuncture. (HMO ONLY)
- Weight Management benefit now includes Idiet.
- Discounts on Personal Response System. Local Mass company called Safer At Home
- Meals Discount Program through Independent Living Systems.
- Jenny Craig Discounts on food.

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TUFTS Health Plan

New Web Portal

TUFTS Health Plan
Medicare Preferred

www.tuftsmedicarepreferred.org | Contact Us

ID # S00019350

Home | My Coverage | Claims & Billing | Referrals | Pharmacy

Welcome **MADOX ASPINALL!**

Manage My Account | Forms | Log Out

My Benefits & Coverage | Doctor Search | How My Plan Works | My Plan Documents

Tufts Medicare Preferred HMO Prime Rx Plus

January 1, 2015 - December 31, 2015

Date of Service [ ] Go

BENEFITS FAQ

- What is copay?
- What is co-insurance?
- Forms
- Provider Searches

Benefits Categories

- Chiropractic Services
- Diabetes Services
- Durable Medical Equipment
- Emergency Services
- Hearing
- Imaging Services - Outpatient
- Inpatient Hospital Care and Surgery
- Mental Health and Substance Abuse
- Nutritional Counseling
- Other
- Outpatient Surgery (Day Surgery)

Routine Medical Services

Routine Medical Services include many of the standard medical services and procedures covered by your health plan. Information regarding visits to your primary care physician (PCP) and specialist, as well as coverage information for common tests and screenings are included in this section.

Please see below for a complete description of what your plan covers under Routine Medical Services.

Specific Benefits | View All

Print these Benefits

Bone Mass Measurement	Cardiovascular Disease Testing	Colonoscopy
Colorectal Screening	Doctor's Office Visit - PCP	Doctor's Office Visit - Specialist
HIV Screening	Other Health Care Professional	Podiatry Services
Prostate Cancer Screening	Wellness Visit	

Bone Mass Measurement

Service Type	Member Responsibility
In-Network	No Copayment

5

TUFTS Health Plan

New ID Cards for MP members 2016

- 2016 global ID card release will be implemented beginning with renewal dates of 1/1/16 due to the new Tufts Health Plan Branding

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TUFTS Health Plan

2016 Tufts Health Plan Part D Plans

- CMS has made adjustments to Part D plan coverage effective 1/1/16
- **Initial Coverage Stage** $2,960 to $3,310
- **Catastrophic Coverage** $4,700 to $4850
- Drug copays once retiree reaches catastrophic coverage
  - Generic prescriptions $2.65 to $2.95 per prescription
  - Brand name prescriptions $6.60 to $7.40 per prescription

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TUFTS Health Plan

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

BCBS MEDEX ANTICIPATED CLAIMS AND PROJECTED RATES FOR CALENDAR YEAR 2016

MEDEX 2 RENEWAL - GBS Projections + PDP premium	8/13-7/14	8/14-7/15	
*Medex **Medical** Cost/Contract:*	$ 175.15	$ 193.38	
Trended thru 12/2016 (2.0% annualized for 29/17 mos.)	$ 183.21	$ 198.93	
Weights used:	*30%*	*70%*	Expected Mo. Claims
GBS EXPECTED MEDICAL CLAIMS/mo. CY16:	**$ 194.21**		$ 220,626
BCBS Proposed Administrative Fee, CY16 (0% increase):	23.34		
GBS fee for CY16:	4.25		
CY16 Proposed funding rate for Medical + Fees	$ 221.80		
CY16 Medicare Blue Rx premium:	$ 146.55		
CY16 GBS-Proposed Full funding rate:	**$ 368.35**	*8.3% increase*	

MEDEX 2 *with Medicare PDP premium*			
			Expected Mo. Claims
BCBS EXPECTED MEDICAL CLAIMS/mo. CY16:	**$ 176.62**		$ 200,640
BCBS Proposed Administrative Fee, CY16 (0% increase):	23.34		
GBS fee for CY16:	4.25		
CY16 Proposed funding rate for Medical + Fees	$ 204.21		
CY16 Medicare Blue Rx premium:	$ 146.55		
CY16 BCBS-Proposed full funding rate:	**$ 350.76**	*3.2% increase*	

Current (CY15) rate:	$ 340.00	
		% Increase
Proposed CY16 Level Monthly Deposit for Medex 2 (Medical):	**$ 227,000**	*-14.3%*
Current (CY15) Medex 2 LMD:	$ 265,000	

Blended Rate $360.00

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

HPHC Medicare Enhance ANTICIPATED CLAIMS AND PROJECTED RATES FOR CALENDAR YEAR 2016

Medicare Enhance with PDP - GBS projections	8/13-7/14	8/14-7/15	
Medicare Enhance expected Medical Claims/contract/mo.:	$ 107.40	$ 151.26	
Trended thru 12/2016 (3% annualized trend for 29/17 mos.)	$ 118.69	$ 157.83	
Weights used:	*30%*	*70%*	
GBS Expected Medicare Enhance claims/mo. CY16	$ 146.09		
HPHC Proposed Administrative Fee, CY16 (1.5% increase):	$ 33.47		
Est. GBS fee, CY16:	$ 4.25		
GBS- Proposed funding rate for Medical + Fee, CY16:	$ 183.81		
Medicare Part D/AETNA PDP Premium, CY16 (3.0% increase)	$ 158.00		
GBS's proposed full funding rate, CY16:	**$ 341.81**		*4.1% increase over CY15 rate*

Medicare Enhance with PDP - HPHC projections		
Medicare Enhance expected Medical claims/contract/mo. CY16:	$ 137.94	*2.8% Annualized Trend*
HPHC Proposed Administrative Fee, CY 16 (1.5% increase):	33.47	
Est. GBS fee, CY16:	4.25	
HPHC-Proposed funding rate for Medical + Fees, CY16:	$ 175.66	
Medicare Part D/AETNA PDP Premium, CY16 (3.0% increase)	$ 158.00	
HPHC 's proposed full funding rate, CY16:	**$ 333.66**	*1.6% increase over CY15 rate*

Current (CY15) Full funding rate, CY15	$ 328.33

Rate $342.00

Assessments/Projections on the Matter of the “Cadillac Tax”

WEST SUBURBAN HEALTH GROUP

Assessment for Reaching Thresholds for the Cadillac Tax

40% TAX on amount above $10,200 for an Individual plan and
40% TAX on amount above $27,500 on a Family plan.

Assume 7% rate increase/year

Thresholds are higher for "qualified retirees" who are 55 and older and non-Medicare eligible and for certain high risk professions, including police & fire: $11,850/$30,950.

EXAMPLES:

HPHC PPO		Ind./Mo.	Individual/Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 2,268	$ 27,216	N/A	$ 5,036	$ 60,432	N/A
FY17	Estimated	$ 2,427	$ 29,121	N/A	$ 5,389	$ 64,662	N/A
FY18	Estimated	$ 2,597	$ 31,160	$ 8,384	$ 5,766	$ 69,189	$ 16,795
FY19	Estimated	$ 2,778	$ 33,341	?	$ 6,169	$ 74,032	?
FY20	Estimated	$ 2,973	$ 35,675	?	$ 6,601	$ 79,214	?

Network Blue - Rate Saver		Ind./Mo.	Ind./Year	Tax per subscriber	Family/Mo.	Family/Yr.	Tax per subscriber
FY16	Actual	$ 843	$ 10,116	N/A	$ 2,261	$ 27,132	N/A
FY17	Estimated	$ 902	$ 10,824	N/A	$ 2,419	$ 29,031	N/A
FY18	Estimated	$ 965	$ 11,582	$ 553	$ 2,589	$ 31,063	$ 1,425
FY19	Estimated	$ 1,033	$ 12,393	?	$ 2,770	$ 33,238	?
FY20	Estimated	$ 1,105	$ 13,260	?	$ 2,964	$ 35,565	?

Network Blue - Benchmark		Ind./Mo.	Ind./Year	Tax per subscriber	Family/Mo.	Family/Yr.	Tax per subscriber
FY16	Actual	$ 814	$ 9,768	N/A	$ 2,181	$ 26,172	N/A
FY17	Estimated	$ 871	$ 10,452	N/A	$ 2,334	$ 28,004	N/A
FY18	Estimated	$ 932	$ 11,183	$ 393	$ 2,497	$ 29,964	$ 986
FY19	Estimated	$ 997	$ 11,966	?	$ 2,672	$ 32,062	?
FY20	Estimated	$ 1,067	$ 12,804	?	$ 2,859	$ 34,306	?

HPHC EPO -Rate Saver		Ind./Mo.	Ind./Year	Tax per subscriber	Family/Mo.	Family/Yr.	Tax per subscriber
FY16	Actual	$ 736	$ 8,832	N/A	$ 1,918	$ 23,016	N/A
FY17	Estimated	$ 788	$ 9,450	N/A	$ 2,052	$ 24,627	N/A
FY18	Estimated	$ 843	$ 10,112	None	$ 2,196	$ 26,351	None
FY19	Estimated	$ 902	$ 10,820	?	$ 2,350	$ 28,196	?
FY20	Estimated	$ 965	$ 11,577	?	$ 2,514	$ 30,169	?

WEST SUBURBAN HEALTH GROUP

Assessment for Reaching Thresholds for the Cadillac Tax

Assume 7% rate increase/year

40% TAX on amount above $10,200 for an Individual plan and
40% TAX on amount above $27,500 on a Family plan.

Thresholds are higher for "qualified retirees" who are 55 and older and non-Medicare eligible and for certain high risk professions, including police & fire, $11,850/$30,950.

HPHC EPO -Benchmark		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 709	$ 8,508	N/A	$ 1,851	$ 22,212	N/A
FY17	Estimated	$ 759	$ 9,104	N/A	$ 1,981	$ 23,767	N/A
FY18	Estimated	$ 812	$ 9,741	None	$ 2,119	$ 25,431	None
FY19	Estimated	$ 869	$ 10,423	?	$ 2,268	$ 27,211	?
FY20	Estimated	$ 929	$ 11,152	?	$ 2,426	$ 29,115	?

Tufts Navigator -Rate Saver		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 797	$ 9,564	N/A	$ 2,088	$ 25,056	N/A
FY17	Estimated	$ 853	$ 10,233	$ 33	$ 2,234	$ 26,810	N/A
FY18	Estimated	$ 912	$ 10,950	$ 750	$ 2,391	$ 28,687	$ 1,187
FY19	Estimated	$ 976	$ 11,716	?	$ 2,558	$ 30,695	?
FY20	Estimated	$ 1,045	$ 12,536	?	$ 2,737	$ 32,843	?

Tufts Navigator -Benchmark		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 769	$ 9,228	N/A	$ 2,015	$ 24,180	N/A
FY17	Estimated	$ 823	$ 9,874	N/A	$ 2,156	$ 25,873	N/A
FY18	Estimated	$ 880	$ 10,565	$ 365	$ 2,307	$ 27,684	$ 184
FY19	Estimated	$ 942	$ 11,305	?	$ 2,468	$ 29,622	?
FY20	Estimated	$ 1,008	$ 12,096	?	$ 2,641	$ 31,695	?

Assessment for Reaching Thresholds for the Cadillac Tax

Assume 7% rate increase/year

40% TAX on amount above $10,200 for an Individual plan and
40% TAX on amount above $27,500 on a Family plan.

Thresholds are higher for "qualified retirees" who are 55 and older and non-Medicare eligible and for certain high risk professions, including police & fire.

Fallon Select- Rate Saver		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 611	$ 7,332	N/A	$ 1,647	$ 19,764	N/A
FY17	Estimated	$ 654	$ 7,845	$ (2,355)	$ 1,762	$ 21,147	N/A
FY18	Estimated	$ 700	$ 8,394	None	$ 1,886	$ 22,628	None
FY19	Estimated	$ 749	$ 8,982	?	$ 2,018	$ 24,212	?
FY20	Estimated	$ 801	$ 9,611	?	$ 2,159	$ 25,907	?

Fallon Select - Benchmark		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 591	$ 7,092	N/A	$ 1,591	$ 19,092	N/A
FY17	Estimated	$ 632	$ 7,588	N/A	$ 1,702	$ 20,428	N/A
FY18	Estimated	$ 677	$ 8,120	None	$ 1,822	$ 21,858	None
FY19	Estimated	$ 724	$ 8,688	?	$ 1,949	$ 23,389	?
FY20	Estimated	$ 775	$ 9,296	?	$ 2,085	$ 25,026	?

Fallon Direct- Rate Saver		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 570	$ 6,840	N/A	$ 1,531	$ 18,372	N/A
FY17	Estimated	$ 610	$ 7,319	$ (2,881)	$ 1,638	$ 19,658	N/A
FY18	Estimated	$ 653	$ 7,831	None	$ 1,753	$ 21,034	None
FY19	Estimated	$ 698	$ 8,379	?	$ 1,876	$ 22,506	?
FY20	Estimated	$ 747	$ 8,966	?	$ 2,007	$ 24,082	?

Fallon Direct - Benchmark		Ind./Mo.	Ind./Year	Tax per Ind. subscriber	Family/Mo.	Family/Yr.	Tax per Family subscriber
FY16	Actual	$ 550	$ 6,600	N/A	$ 1,480	$ 17,760	N/A
FY17	Estimated	$ 589	$ 7,062	N/A	$ 1,584	$ 19,003	N/A
FY18	Estimated	$ 630	$ 7,556	None	$ 1,694	$ 20,333	None
FY19	Estimated	$ 674	$ 8,085	?	$ 1,813	$ 21,757	?
FY20	Estimated	$ 721	$ 8,651	?	$ 1,940	$ 23,280	?

Projections of the Impact of GIC Plan Design Changes on the WSHG Benchmark Plans

Rate Saver Plans	Subscribers on 5/11/15	Estimated impact on claims from plan design changes: Deductible increase	Inpatient co-pay increase	Day surgery co-pay increase	Specialist co-pay increase	Rx co-pay increases	All plan design changes
Harvard Pilgrim	4243	*-6.56%*	*-0.19%*	*0.20%*	*-0.78%*	*-0.58%*	***-8.18%***
Tufts	1326	*-4.60%*	*-2.67%*	*-1.58%*	*-1.41%*	*-1.00%*	***-8.67%***
Fallon	1203	*-3.20%*	*-0.50%*	*-0.10%*	*-1.20%*	*-0.90%*	***-5.79%***
BCBS	769	*-3.90%*	*-0.20%*	*-0.20%*	*-0.70%*	*-0.20%*	***-5.14%***
Total Subscribers	**7541**						

Benchmark Plans	Subscribers on 5/11/15	Estimated impact on claims from plan design changes: Deductible increase	Inpatient co-pay increase	Day surgery co-pay increase	Specialist co-pay increase	Rx co-pay increases	All plan design changes
Harvard Pilgrim	10	*-0.74%*	*-0.29%*	*-0.19%*	*-0.88%*	*-0.62%*	***-2.69%***
Tufts	1	*-0.66%*	*-2.67%*	*-1.10%*	*-1.41%*	*-1.00%*	***-6.67%***
Fallon	81	*-0.80%*	*-0.50%*	*-0.20%*	*-1.20%*	*-0.90%*	***-3.55%***
BCBS	22	*-0.70%*	*-0.10%*	*-0.30%*	*-0.30%*	*-0.90%*	***-2.30%***
Total Subscribers	**114**						

West Suburban Health Group

Possible Plan Design Changes for 7/1/16

HMO

WSHG Benchmark Plan (ChoiceNet)		GIC		HPHC	
Plan Design Feature	*Current co-pays*	*Plan Design Feature*	*Co-pays on 7/1/15*	% change for WSHG	Claims Decrement for WSHG
Deductible		**Deductible**			
Per member	$250	*Per member*	$300		
Family of 2	$500	*Family of 2*	$600	*-0.74%*	0.9926
Not-to-exceed per family	$750	*Not-to-exceed per family*	$900		
Inpatient copay*	$300/300/700 Mental Sub Abuse is $200	**Inpatient copay**	$250/500/1500	*-0.29%*	0.9971
Outpatient surgery copay	$150	**Outpatient surgery copay**	$250	*-0.19%*	0.9981
Specialist copays	$25/35/45	**Specialist copays**	$30/60/90	*-0.88%*	0.9912
Rx copays (Mail copays are 2.0 x Retail except for Tier 3)	$10/25/50 Retail; $20/50/110 Mail.	**Rx copays** (Mail copays are 2.5 x Retail)	$10/30/65 Retail; $25/75/165 Mail.	*-0.62%*	0.9938
Total Est. Savings from moving to GIC Benchmark plan design - Computed Overall				***-2.69%***	**0.9731**
Priced Overall†				*-2.55%*	0.9745

†The difference is not the same when each decrement is taken separately due to interdepencies in the pricing model

*Pricing assumes HPHC Choicenet claims distribution and cost relativities

West Suburban Health Group

Possible Plan Design Changes for 7/1/16

HMO

WSHG Tufts Navigator Benchmark Plan		GIC		TUFTS		
Plan Design Feature	*Current co-pays*	*Plan Design Feature*	*Co-pays on 7/1/15*	% change for WSHG	Claims Decrement for WSHG	
Deductible		**Deductible**				
Per member	$250	*Per member*	$300			
Family of 2	$500	*Family of 2*	$600	*-0.66%*	0.9934	
Not-to-exceed per family	$750	*Not-to-exceed per family*	$900			
Inpatient copay	$300/700 Mental /Sub Abuse is $300	**Inpatient copay**	$250/500/1500	*-0.34%* N/A *-2.67%*	0.9966 N/A 0.9733	for $500/$750 for $500/$1500
Outpatient surgery copay	$150	**Outpatient surgery copay**	$250	*-1.10%*	0.9890	
Specialist copays	$35	**Specialist copays**	$30/60/90	*-1.41%*	0.9859	for $60/no tiers
Rx copays (Mail copays are 2.0 x Retail except for Tier 3)	$10/25/50 Retail; $20/50/110 Mail.	**Rx copays** (Mail copays are 2.5 x Retail)	$10/30/65 Retail; $25/75/165 Mail.	*-1.00%*	0.9900	

Total EST. Savings from moving to GIC Benchmark plan design but with $500/$750 inpt. co-pays:	*-4.43%*	0.956
Total EST. Savings from moving to GIC Benchmark plan design but with $500/$1500 inpt. co-pays:	*-6.67%*	0.933

West Suburban Health Group

Possible Plan Design Changes for 7/1/16

HMO

WSHG Fallon Benchmark		GIC		Fallon	
Plan Design Feature	*Current co-pays*	*Plan Design Feature*	*Co-pays on 7/1/15*	% change for WSHG	Claims Decrement for WSHG
Deductible *Per member* *Family of 2* *Not-to-exceed per family*	 $250 $500 $750	**Deductible** *Per member* *Family of 2* *Not-to-exceed per family*	 $300 $600 $900	*-0.80%*	0.992
Inpatient copay	$300 Mental/SubAbuse-no copay	**Inpatient copay**	$250/500/1500 *	*-0.50%*	0.995
Outpatient surgery copay	$150	**Outpatient surgery copay**	$250	*-0.20%*	0.998
Specialist copays	$35	**Specialist copays**	$30/60/90 *	*-1.20%*	0.988
Rx copays (Mail copays are 2.0 x Retail except for Tier 3)	$10/25/50 Retail; $20/50/110 Mail.	**Rx copays** (Mail copays are 2.5 x Retail)	$10/30/65 Retail; $25/75/165 Mail.	*-0.90%*	0.991
Total Estimated Savings from moving to GIC Benchmark plan design:				***-3.55%***	**0.964**

*** When GIC has tiered copays and the WSHG does not, the WSHG employers may use Ch. 32B, Section 21-22 to bargain to the middle co-pay tier.**

West Suburban Health Group

Possible Plan Design Changes for 7/1/16

HMO

WSHG Network Blue Benchmark		GIC		BCBS	
Plan Design Feature	*Current co-pays*	*Plan Design Feature*	*Co-pays on 7/1/15*	% change for WSHG	Claims Decrement for WSHG
Deductible		**Deductible**			
Per member	$250	*Per member*	$300		
Family of 2	$500	*Family of 2*	$600	*-0.70%*	0.993
Not-to-exceed per family	$750	*Not-to-exceed per family*	$900		
Inpatient copay	$300/700 Mental Sub Abuse is $300	**Inpatient copay**	$250/500/1500	*-0.10%*	0.999
Outpatient surgery copay	$150	**Outpatient surgery copay**	$250	*-0.30%*	0.997
Specialist copays	$35	**Specialist copays**	$30/60/90	*-0.30%*	0.997
Rx copays (Mail copays are 2.0 x Retail except for Tier 3)	$10/25/50 Retail; $20/50/110 Mail.	**Rx copays** (Mail copays are 2.5 x Retail)	$10/30/65 Retail; $25/75/165 Mail.	*-0.90%*	0.991
Total Est. Savings from moving to GIC Benchmark plan design:				***-2.28%***	**0.977**

G.L. Chapter 32B, Sections 21-23

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PART I ADMINISTRATION OF THE GOVERNMENT
TITLE IV CIVIL SERVICE, RETIREMENTS AND PENSIONS
CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 21 Manner of changing health insurance benefits; estimation of savings; approval of agreement; immediate implementation; time for review; distribution of savings; regulations

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

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

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

otherwise be disproportionately affected.

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

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

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

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

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

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

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

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CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 22 Copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; increases

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

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

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

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

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

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

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CHAPTER 32B CONTRIBUTORY GROUP GENERAL OR BLANKET INSURANCE FOR PERSONS IN THE SERVICE OF COUNTIES, CITIES, TOWNS AND DISTRICTS, AND THEIR DEPENDENTS
Section 23 Transfer of subscribers to commission; notice; transfer to Medicare of eligible subscribers; withdrawal from commission coverage; group coverage provided by commission; deficit in claims trust fund by self-insured political subdivision; administration of coverage for transferred subscribers by commission; reimbursement of commission for coverage costs; withdrawal from commission

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

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

commission.

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

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

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

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

regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

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

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

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

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare

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

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

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or change eligibility standards for health insurance under the definition of "employee" in section 2.

(i) Notwithstanding any other general or special law to the contrary, in the event that an agreement, either executed or modified, was reached by an appropriate public authority and the public employee committee to transfer all subscribers, for whom the authority provides health insurance coverage, to the commission under this section, its retirees, surviving spouses and their dependents may enroll in the dental insurance plan provided by the commission to retirees, surviving spouses and their dependents insured under chapter 32A, at premium contribution ratios that requires retirees, surviving spouses and their dependents to contribute 100 per cent of the dental insurance premium and administrative fee. The commission shall provide dental insurance coverage, under its plan for retirees, surviving spouses and their dependents insured under chapter 32A, to retirees, surviving spouses and their dependents who elect the coverage under this subsection, as it so provides health insurance coverage under this section. The commission may charge an administrative fee, which shall not be more than 1 per cent of the cost of total dental insurance premiums for the retirees, surviving spouses and their dependents who enroll in the dental insurance plan under this subsection, to be determined by the commission which shall be considered as part of the cost of coverage for purposes of determining the contributions of the political subdivision and its retirees, surviving spouses and their dependents to the cost of insurance coverage by the commission.