OFFICE OF THE
TOWN MANAGER

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Town of Shrewsbury

MASSACHUSETTS 01545-5398

December 8, 2014

To: Insurance Advisory Committee (IAC)
From: Daniel J. Morgado
Re: WSHG Steering Committee Meeting

On November 18, 2014, the WSHG Steering Committee met in Natick to review the program for Fiscal Year 2015.

The highlights of this meeting were:

1. Confirmation that the Towns of Ashland and Westwood will leave the WSHG and go to the Group Insurance Commission (GIC) on July 1, 2015.

2. Confirmation that the Town of Walpole is also considering leaving the WSHG either for MIIA (Massachusetts Municipal Association) or the GIC. A vote by the Walpole Board of Selectmen is scheduled for December 16th.

3. The loss run for FY 2015 was reviewed and it was noted that it is running in the red a bit more than planned at the moment (attached). The Fallon loss ratio of 111.8% is concerning to me. I am advised that Fallon losses for October were not as bad as July and September so that ratio should fall a bit. We also reviewed large claims (attached).

4. The fund balance (surplus) as of October 31, 2014, was reviewed and found to be $9,689,999. It was $14,843,112 on October 31, 2013. At this point it is very doubtful that any fund balance will be used in setting rates for Fiscal Year 2016.

5. A review of Out-of-Pocket Maximums (OPM) of the various plans (attached). The OPM's will be reviewed as part of the Fiscal Year 2016 rate setting process. OPM's are the limit when a subscriber no longer makes any out of pocket payments. With drug costs now being rolled in, it is necessary for these limits to increase. Note that Fallon has the lowest OPM's of all of the plans.

6. The Steering Committee was advised that the Tufts plan is having issues resigning with the MetroWest Medical Center and Saint Vincent Hospital. If these contracts are not extended beyond December 31, 2014, Tufts members will not be able to access those facilities as in-network.

7. The Steering Committee was advised that a payment of $862,097.04 will be made in January to the Federal government as a transitional reinsurance fee under the provisions of the Affordable Care Act (ACA). This fee was not part of our rate calculation and will impact our fund balance.

8. With loss of at least two communities, the Steering Committee will be meeting on January 27th to:

    - Determine which communities will remain as members in the WSHG for Fiscal Year 2016
    - Review all loss ratios, large claims and cost trending data
    - Start the review of rates for Fiscal Year 2016. We were informed that medical cost trends are running at 4.5% to 6.5% and prescriptions are running 11% to 12% annually.
    - Learn what the GIC may be planning for Fiscal Year 2016 as there is a meeting of the GIC in mid to late December.

On a related matter, on December 2, 2014, I attended a meeting of the Massachusetts Municipal Reinsurance Arrangement (MMRA). The MMRA was formed by joining the Cape Cod Municipal Health Group, the Minuteman Nashoba Health Group and the West Suburban Health Group together in a reinsurance pool for losses that range $300,000 to $800,000. Losses above $800,000 are fully insured by AIG. Under our previous reinsurance process, claims above $300,000 were fully insured after a $500,000 aggregating sum was paid (deductible). The intent of the arrangement, new for Fiscal Year 2015, is to save on the fully insured premium paid.

It will be at least a year before we have a good sense of what our overall savings will be from this arrangement. The MMRA will meet again in May when a picture of losses for Fiscal Year 2015 will be evident.

As part of this meeting, we heard a report from Arthur J. Gallagher & Co. who is the company that is running the joint loss fund. This report dealt with the matter of the cost of prescriptions which I have attached. We are advised that the matter of prescriptions will be the next big cost driver. While the dangers here may be overstated, it bears watching.

I expect to ask for a meeting of the Insurance Advisory Committee after the next Steering Committee meeting on January 27th to provide the latest information about our plan renewals for Fiscal Year 2016.

Please advise me directly with any questions.

Cc	Union/Association Presidents	Thomas Gregory	Carolyn Marcotte
	Barbara Malone	Cecelia Wirzbicki	Christine Fowler

GROUP BENEFITS STRATEGIES
WEST SUBURBAN HEALTH GROUP

October, 2014

FUNDING RATE ANALYSIS BY PLAN - Policy Year 7/1/14 - 6/30/15
(Analysis for 3-mos., 7/14-9/14)

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	16,318,262	16,993,837	**104.1%**	($675,575)
Harvard Pilgrim PPO	308,043	695,215	**225.7%**	($387,172)
BCBS Network Blue Rate Saver/Benchmark	3,324,907	2,989,272	**89.9%**	$335,635
Fallon EPO Rate Saver	3,893,580	4,351,536	**111.8%**	($457,956)
Fallon EPO Benchmark	102,867	21,893	**21.3%**	$80,974
Tufts Rate Saver/Benchmark	5,726,888	5,412,868	**94.5%**	$314,020
Tufts POS	18,261	5,293	**29.0%**	$12,968
HPHC Medicare Enhance	1,219,418	1,028,645	**84.4%**	$190,772
BCBS Medex	1,284,850	1,465,379	**114.1%**	($180,528)
	$ 32,197,076	$ 32,963,938		($766,862)
% COSTS/FUNDING:			**102.4%**	

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**	**$1,150,360.47**
FINAL	**FINAL**	**FINAL**	**FINAL**	**FINAL**	**TO DATE**

**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
Report of Excess Stop-Loss Claims

ACCOUNT NAME: WEST SUBURBAN HEALTH GROUP
REINSURANCE CARRIER: Blue Cross Blue Shield
POLICY DATES: 07/01/13 - 06/30/14
PAID DATES: 07/01/13- 06/30/15
STOP LOSS DEDUCTIBLE: $300,000
Excess Claims

PAID THROUGH OCTOBER 2014

Claims last updated 11/18/14 — *reimbursements since 09/18/14*

Carrier	Dep#	Previous Month Total Claims	Additions/ Deletions	Updated Total Paid Claims	Policy Year Deductible	Excess Amt	Claims Applied to Agg. Spec. Prem. ($500,000)	Previously Reported Reimbursements	New Reimbursements	Total Reimbursements	Outstanding Reimbursements	Plan	ICD9 Code	Notes
THP	0	$ 321,125.00	$ 10,229.82	$ 331,354.82	$ 300,000.00	$ 31,354.82	$ 13,263.00	$ 7,850.64	$ -	$ 7,850.64	$ 10,241.18	TERS	20280	fy11 50%
HPHC	0	$ 589,410.51	$ -	$ 589,410.51	$ 300,000.00	$ 289,410.51	$ 289,410.00	$ -	$ -	$ -	$ 0.51	HPHC RS	5712	deceased 8/29/13
HPHC	2	$ 436,732.69	$ 201.99	$ 436,934.68	$ 300,000.00	$ 136,934.68	$ 130,057.00	$ 5,778.96	$ 1,043.47	$ 6,822.43	$ 55.25	HPHC RS	v3001	
HPHC	1	$ 614,681.00	$ -	$ 614,681.00	$ 300,000.00	$ 314,681.00	$ -	$ -	$ 315,681.46	$ 315,681.46	$ (1,000.46)	HPHC RS	515	
FCHP	1	$ 476,355.70	$ -	$ 476,355.70	$ 300,000.00	$ 176,355.70	$ 65,209.00	$ 63,281.36	$ 47,865.29	$ 111,146.65	$ 0.05	FCHP SC	v58.12	fy12 50%, fy13 excess
HPHC	0	$ 417,561.00	$ 7,476.24	$ 425,037.24	$ 300,000.00	$ 125,037.24	$ -	$ 116,789.29	$ 8,247.95	$ 125,037.24	$ -	HEPO RS	1974	deceased 9/30/14
HPHC	0	$ 537,902.26	$ 253.86	$ 538,156.12	$ 300,000.00	$ 238,156.12	$ -	$ 221,149.25	$ 16,968.35	$ 238,117.60	$ 38.52	HEPO RS	v554	deceased 7/10/14
BCBS	3	$ 332,941.00	$ 99,823.00	$ 432,764.00	$ 300,000.00	$ 132,764.00	$ 2,061.00	$ 30,880.28	$ 100,996.19	$ 131,876.47	$ (1,173.47)	NWB RS		
HPHC	0	$ 343,229.36	$ -	$ 343,229.36	$ 300,000.00	$ 43,229.36	$ -	$ 43,229.36	$ -	$ 43,229.36	$ -	HEPO RS	5070	deceased 4/14/14
HPHC	1	$ 485,522.56	$ -	$ 485,522.56	$ 300,000.00	$ 185,522.56	$ -	$ -	$ 185,522.56	$ 185,522.56	$ -	HEPO RS	4162	fy06, fy11, fy13 excess
HPHC	1	$ 313,011.16	$ 1,451.82	$ 314,462.98	$ 300,000.00	$ 14,462.98	$ -	$ -	$ 13,011.16	$ 13,011.16	$ 1,451.82	HEPO RS	1531	
HPHC	1		$ 491,796.43	$ 491,796.43	$ 300,000.00	$ 191,796.43	$ -	$ -	$ -	$ -	$ 191,796.43	HPPO	4271	
		$ 4,868,472.24	$ 611,233.16	$ 5,479,705.40		$ 1,879,705.40	$ 500,000.00	$ 488,959.14	$ 689,336.43	$ 1,178,295.57	$ 201,409.83			
							$ (500,000.00)				$ -			
							$ -				$ 201,409.83			

12 claimants

Prepared by
GROUP BENEFITS STRATEGIES

11/18/2014

WEST SUBURBAN HEALTH GROUP
Report of Claims at 50%+

ACCOUNT NAME: WEST SUBURBAN HEALTH GROUP
REINSURANCE CARRIER: Blue Cross Blue Shield
POLICY DATES: 07/01/13 - 06/30/14
PAID DATES: 07/01/13- 06/30/15
STOP LOSS DEDUCTIBLE: $300,000

PAID THROUGH OCTOBER 2014

Claims last updated 11/18/14

Carrier	Dep#	Previous Month Total Claims	Additions/ Deletions	Updated Total Paid Claims	ICD9 Plan Type	Code	
THP	0	$ 164,145.90	$ 154.61	$ 164,300.51	THP RS	*deceased 12/31/13*	
THP	0	$ 168,070.23	$ 2.87	$ 168,073.10	THP RS	*deceased 11/19/13*	
FCHP	0	$ 210,678.00	$ (0.25)	$ 210,677.75	FCHP SC	*733.13*	
HPHC	1	$ 215,161.35	$ -	$ 215,161.35	HEPO RS	*1961*	
HPHC	0	$ 271,623.26	$ -	$ 271,623.26	HEPO RS	*4210*	*fy12 50%*
HPHC	0	$ 209,055.11	$ 10,680.70	$ 219,735.81	HEPO RS	*termed 4/30/14*	
FCHP	0	$ 272,654.12	$ 309.50	$ 272,963.62	FCHP SC	*162.3*	
BCBS	1	$ 174,844.80	$ 26,057.69	$ 200,902.49	NWB RS	*termed 7/31/14*	
BCBS	0	$ 165,102.63	$ -	$ 165,102.63	NWB	*deceased 1/17/14*	
HPHC	0	$ 162,224.60	$ (16.68)	$ 162,207.92	HEPO	*1623*	
HPHC	1	$ 243,260.53	$ (655.36)	$ 242,605.17	HEPO RS	*1501*	
HPHC	1	$ 186,550.75	$ -	$ 186,550.75	HEPO RS	*0389*	
HPHC	0	$ 197,104.49	$ (903.18)	$ 196,201.31	HEPO RS	*9828*	
HPHC	0	$ 210,990.94	$ (1,155.36)	$ 209,835.58	HEPO RS	*72403*	
HPHC	0	$ 189,895.71	$ -	$ 189,895.71	HEPO RS	*51189*	
HPHC	0	$ 260,808.13	$ (2,621.44)	$ 258,186.69	HEPO RS	*1809*	
HPHC	0	$ 257,747.27	$ 127.64	$ 257,874.91	HEPO RS	*5780*	
HPHC	0	$ 200,574.83	$ (548.16)	$ 200,026.67	HEPO RS	*44023*	
FCHP	1	$ 188,521.93	$ -	$ 188,521.93	FCHP SC	*v58.11*	
HPHC	0	$ 257,886.65	$ (1,994.01)	$ 255,892.64	HEPO RS	*41401*	
BCBS	1	$ 196,488.92	$ 3,066.86	$ 199,555.78	NWB RS		
THP	0	$ 160,063.14	$ 3,289.07	$ 163,352.21	THP RS	*deceased 9/30/14*	
FCHP	0	$ 193,706.30	$ -	$ 193,706.30	FCHP SC	*338.3*	*fy13 50%*
FCHP	0	$ 240,559.00	$ -	$ 240,559.00	FCHP SC	*v58.11*	
HPHC	0	$ 178,211.67	$ -	$ 178,211.67	HEPO RS	*55321*	
HPHC	0	$ 194,632.90	$ (192.17)	$ 194,440.73	HEPO RS	*1749*	
HPHC	0	$ 195,823.59	$ (650.50)	$ 195,173.09	HEPO RS	*27702*	
HPHC	1	$ 168,908.08	$ -	$ 168,908.08	HEPO RS	*deceased 4/24/14*	
HPHC	1	$ 158,167.42	$ 196.06	$ 158,363.48	HEPO RS	*72141*	
THP	0	$ 150,296.93	$ 495.43	$ 150,792.36	THP RS	*1541*	
BCBS	0	$ 237,362.43	$ 4,579.09	$ 241,941.52	NWB RS		
HPHC	3	$ 207,631.61	$ -	$ 207,631.61	HEPO RS	*74510*	
HPHC	0	$ 183,849.20	$ (655.36)	$ 183,193.84	HEPO RS	*deceased 10/13/14*	
HPHC	0	$ 250,690.93	$ -	$ 250,690.93	HEPO RS	*40391*	
HPHC	0	$ 190,974.66	$ -	$ 190,974.66	HEPO RS	*v5482*	
HPHC	1	$ 157,659.05	$ 92.66	$ 157,751.71	HEPO RS	*1749*	
		$ 7,271,927.06	$ 39,659.71	$ 7,311,586.77			

37 claimants

Prepared by
GROUP BENEFITS STRATEGIES

11/18/2014

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 OCTOBER 2014

Claims last updated 11/17/14

Carrier	Dep#	Previous Month Total Claims	Additions/ Deletions	Updated Total Paid Claims	Plan Type	Code	
THP	0	$ -	$ 269,411.13	$ 269,411.13	THPRS	*5070*	
HPHC	1	$ -	$ 179,176.47	$ 179,176.47	HPHRS	*53081*	*fy14 excess*
HPHC	0	$ -	$ 169,292.91	$ 169,292.91	HPHRS	*5722*	***deceased 10/13/14***
HPHC	1	$ -	$ 179,598.66	$ 179,598.66	HPHRS	*41071*	*fy11 50%*
		$ -	$ 797,479.17	$ 797,479.17			

4 claimants

WEST SUBURBAN HEALTH GROUP
AFFORDABLE CARE ACT (ACA)

Out-of-Pocket Maximum (OOP Max) Requirements

OOP Maximum Limits for CY2015: $6,600 for an Individual plan, and
$13,200 for a Family plan.

These limits apply to Non-Grandfathered plans. WSHG's plans are non-grandfathered.

On renewal in CY15, OOP maximums must include pharmacy co-pays; whereas, currently they do not except for Fallon plans. **Fallon added Rx co-pays to the OOP max effective 7/1/14.**

Categories of benefits:

Health plans may have OOP maximums on different categories of benefits such as separate OOP maximums for medical and pharmacy. The sum of the OOP maximum amounts for different categories of benefits may not exceed the overall OOP maximum limits. For example, an *Individual* plan could have a $4,000 medical OOP max and a $2,600 pharmacy OOP max because the total of the two would be $6,600 which is the allowed amount.

OOP Maximums for PPOs:

The ACA requires OOP maximums on In-Network benefits only. It does not require OOP maximums on Out-Of-Network (OON) benefits, although Plan Sponsors are free to add **OOP maximums to OON benefits.**

WSHG Current OOP Maximums:

BCBS, HPHC, Tufts Rate Saver & Benchmark HMOs –
$2,000 per member, not to exceed $4,000 per Family.

Fallon Rate Saver HMOs –
$1,000 per member, not to exceed $2,000 per Family.

Fallon Benchmark HMOs –
$2,000 per member, not to exceed $4,000 per Family.

HPHC PPO -
In-Network: $2,000 per member, not to exceed $4,000 per Family;
Out-of-Network: $1,600 per member, not to exceed $3,200 per Family.

Tufts POS* –
In-Network: $2,000 per member, not to exceed $4,000 per Family;
Out-of-Network: $1,500 per member, not to exceed $3,000 per Family.

**Plan to be eliminated 7/1/15.*

Arthur J. Gallagher & Co.
BUSINESS WITHOUT BARRIERS™

High Cost of Prescription Medication

December 2, 2014

Agenda

- Increased Cost of Drug Treatment
  - Specialty drugs
  - High cost brand products
  - Higher cost of generics
- Where are drug costs headed
- What is the FDA-Food and Drug Administration doing
- What are clients doing

Defining Specialty Drugs? $$$$

- Treatment of chronic and/or complex diseases requiring clinical management
- High cost injectable, infused, oral, inhaled, or biotech drug
- Complicated distribution channels
- Specific storage requirements
- Complex side effect/adverse drug reaction monitoring profile
- Specific lab requirements
- Manufacturers requirements
- Supplies related to the administration of the therapy

Specialty Drug Trends

- About 50% of specialty spend is found in medical and 50% in Pharmacy
- Specialty drug cost PMPY spend is expected to double in next three years to more than $200 PMPY
- Specialty drug cost and utilization will increase about 15% annually
- Specialty drug spend projected to be more than $150 billion in 2014
- Specialty drug growth trend is projected at 20-25% per year
- Specialty drug costs are estimated to be 50% of all clients drugs costs by 2018, if not sooner

Increased Cost of Drug Treatment

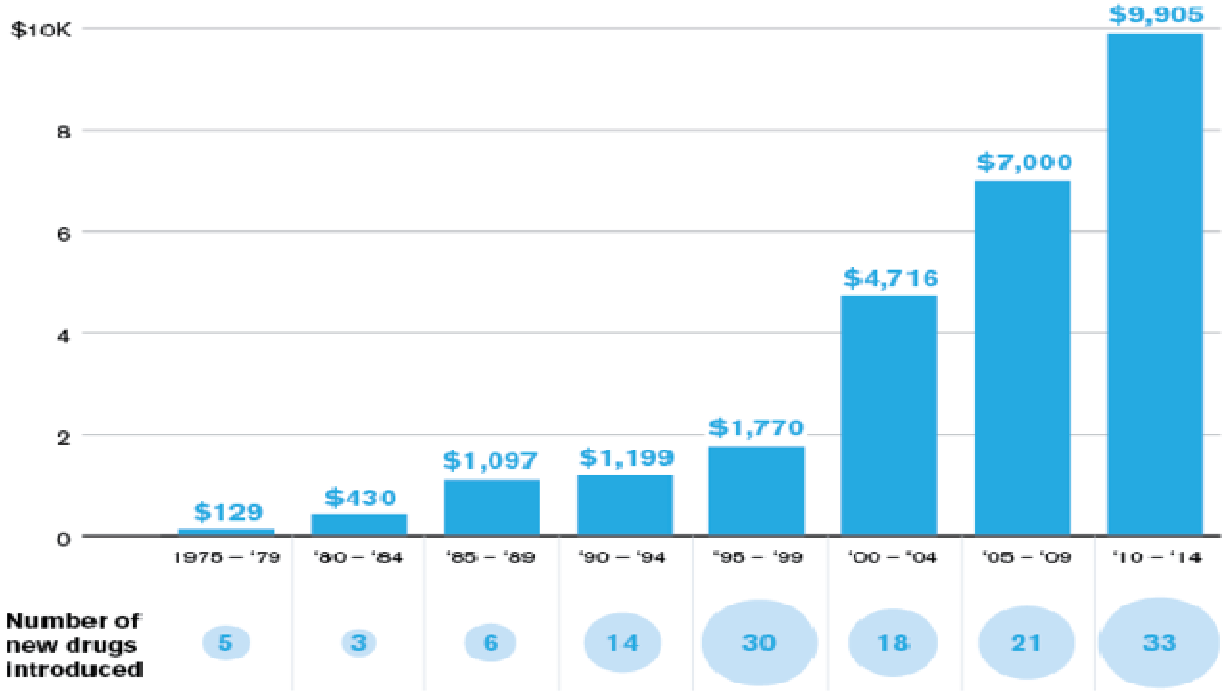
- Specialty medications
  - Hepatitis
    - Sovaldi- $84,000 per treatment
    - Harvoni-$96,000 per treatment
    - Olysio- $66,000 per treatment
  - Cancer
    - 19 products approved in 2013-104
    - $10,000 to over $100,000 per treatment
  - Diabetes
    - Now over $300 million in drug costs annually

Cancer Drugs

Cancer Drugs Hit Market at Ever-Higher Prices

U.S. prices for new cancer drugs have soared since the 1970s despite an increasing number of available brands.

Median monthly cost for new cancer drugs during the five-year period



Note: Costs are monthly Medicare prices for each drug the year it was introduced, adjusted for inflation.

Source: Peter Bach and Geoffrey Schnorr at Memorial Sloan Kettering Cancer Center

Bloomberg Graphics

Increased Cost of Traditional Drugs

- Brand medications
  - Average wholesale price for 30 days is greater than $250
  - Average wholesale price for 90 days is great than $750
  - Average cost per day of new brand products is over $10 per day

- Generic medications
  - Average wholesale cost of 30 days is greater than $90
  - Average wholesale cost of 90 days is greater than $250
  - Average cost of generic products are now almost $1 per day
  - Some generic products have gone up as much as 8000%
  - Average increase is greater than 10% per year

Increased Cost of Compound Drugs

- Compound prescriptions
  - Those prescriptions where the pharmacist must mix two or more active ingredients together
  - Liquid medications for impeded swallowing or for children
  - Dermatological or topically applied medications
  - Greater than 100% increase in utilization in past three years
  - Greater than 300% increase in cost in past three years
- Exclusions have become common
- Limit on submitted cost
- Prior authorization required

What is FDA doing

- Biosimilars
  - "generics" for specialty drugs
  - Will be 25-50% less than the brand name specialty drugs
  - First ones set top come out in 2015
    - Copaxone for MS
    - Betaserone
    - Some cancer drugs
- Generics
  - More monitoring of the cost of generics
  - Import from other countries
  - Faster approval process
  - Will have to pay rebates if inflate faster then federal inflation rate
- Specialty Drugs
  - Limits on prices
  - Limits on cost increases
- Other measures

What are clients doing

- Formulary restrictions
- Formulary exclusions
- Plan design changes
  - Increase in tiers
  - Increase in co-insurance
- Clinical programs
  - Prior authorizations
  - Quantity limits
  - Step therapy
  - Adherence and compliance programs
- Market check or RFP review process
- Carving out the pharmacy benefit