City of Newton

Health Care Advisory Committee

First Report

2013

CITY OF NEWTON

BOARD OF ALDERMEN

and

HEALTH CARE ADVISORY COMMITTEE

MEETING AGENDA

Monday, December 2, 2013

7 PM
Aldermanic Chamber

The Board of Aldermen is meeting with the Health Care Advisory Committee for an update on the work of the Health Care Advisory Committee and review of the draft Health Care Advisory Committee Report.

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Executive Summary and Committee's Recommendations

Newton and its workers spent over $47 million on health benefits in FY2013. Mayor Warren and the Board of Aldermen appointed the Health Care Advisory Committee to make recommendations on how to control the cost of health insurance while improving or maintaining the quality of care.

After gathering, analyzing and discussing information from the City, its health plans, and from multiple additional sources, the Committee is pleased to present its first report. The Committee divided its report into seven sections: 1) History and Legislative Background; 2) Newton's Current Health Plans, Cost and Utilization Trends; 3) A Comparison of Newton to Comparable Communities and to the State Group Insurance Commission; 4) Analysis of Retiree Health Benefits (termed Other Post-Employment Benefits or OBEP); 5) Use of Behavioral Incentives, Traditional Disease Management and Wellness Program to Lower Cost and Improve Employee Wellness; 6) Encouraging Employees to Opt-Out of City Coverage; and 7) Opportunities for Community Partnerships. A summary of our findings and recommendations for each section follows:

1. History and Legislative Background

Analysis of the City's health benefits starts with an understanding of the state and federal legislative structure within which the City must operate its health benefits programs. The Committee focused on the implications of the Municipal Health Care Law, enacted in 2011, with the legislative goal of assisting cities and towns in controlling rising health care costs. That local option legislation offers municipalities a more streamlined collective bargaining process for determining health benefits along with the option of joining the state's Group Insurance Commission to have it manage health care purchasing. We also reviewed the recent history of Newton's health care purchasing with particular focus on the City's recent collective bargaining agreements which have assisted it in managing costs. Under its current collective bargaining agreement, the City has been successful in reducing health care costs. In addition to this legislation, in 2012 the state legislature enacted Chapter 224, which establishes new standards for cost containment and information transparency for health plans. Lastly, in 2014, the City will be subject to the new requirements of the Affordable Care Act, including the excise tax on high-cost health plans.

2. Newton's Current Health Plans, Cost and Utilization Trends

The City's health care plans all provide comprehensive health care coverage, including pharmacy, behavioral health and emergency out-of-area care. The City offers employees and non-Medicare-eligible retirees a choice of two similar HMO-style plans (Tufts Health Plan Exclusive Provider Option (THP EPO) and Harvard Pilgrim Health Care Health Maintenance Organization (HPHC HMO)), as well a "high option" plan that in addition covers certain out-of-network care (THP's Pont of Service (POS)). The City also offers two plans for Medicare-eligible retirees. Newton self-insures the health benefits it provides. It pays the actual cost of health care claims and an administrative fee to the insurers with which it contracts. The City manages a health care trust fund to hold the premiums paid by the City and

its workers and retirees, and to pay the health care claims and administrative expenses. Annually, based on information provided to it by its insurers and its benefits consultant, the City sets premium rates to ensure sufficient funds to cover the expected cost of care.

The City's cost of health insurance is predicated on three factors: its subscriber population, the level of health care benefits utilized, and the prices paid for health care services. Newton currently provides health benefits for approximately 5000 employees, retirees and their dependents. Over the period FY2005 to FY2013 the employee population has decreased by 6%, while the retiree population increased by 13%. A challenge for Newton will be to manage simultaneously the cost growth for its active employees and its retirees.

The Committee reviewed available historical data on the use of health services and their cost for the period FY2005 to FY2012, but was challenged by the lack of available data for some years as well as a lack of comparability across health plan reporting. The cost drivers of Newton's health spending are concentrated in a few types of services. Comparing Newton's THP experience with that for the THP average , Newton's per member per month spending is higher for specialty care services, medical-surgical inpatient services, radiology, pharmacy, outpatient facility services and outpatient mental health. In contrast, spending for the HPHC covered members is lower than that for the THP EPO, and only 6% higher than the average HPHC population. More data are needed, however, to be able to understand fully why Newton's costs are higher than average.

The Committee also found that the administrative fees paid by Newton to HPHC were higher than those for THP plans (6.2% compared to 5.2%), a difference equivalent to about $130,000 per year. And, with respect to the reinsurance that the City annually pays to cover catastrophic costs for health care benefits, premiums have exceeded recoveries from the insurer for 8 of the past 10 years.

Recommendations

1. To enhance its planning for health care cost management, the City, working with its benefits consultant and health plans, must organize and analyze health plan enrollment, cost and utilization data at least annually. The data should be maintained in an electronic form readily suitable for analysis. The City should create a single template that can be completed by each plan to make this easier for future comparisons. A proposed template is provided in the Appendix.
2. The City should take full advantage of the expertise available to it from its health benefits consultant.
3. The City, working with its benefits consultant and health plans, should obtain better comparison benchmark data, such as data from other Massachusetts public employers including adjustments for the population's health status (for example, using an industry-standard health status measures, such as DxCG). Proper comparison data are necessary for any serious exploration of opportunities for improvement in the care of City employees.
4. The available evidence suggests that the City is paying higher than average prices for a number of health services. There should be further exploration to determine whether City employees could

reduce spending by directing their care to lower cost providers in the area, particularly for elective services.

5. The City and its employees should explore the future implications of the Affordable Care Act (ACA) "Cadillac" tax and other provisions on the overall cost of employee benefits and the impact they will have on the total compensation available to employees. Efforts to mitigate the impending ACA penalties should be a leading topic in discussions with employees as the tax works to the mutual disadvantage of the City and its employees.
6. The City should plan for a full reprocurement of its health plans, including renegotiation of administrative fees. The city may benefit from inviting additional insurance carriers to bid to provide City health plans.
7. The City should broaden its approach to its annual reinsurance procurement.

3. Comparison of Newton with Comparable Communities and the Group Insurance Commission (GIC)

To enhance the Committee's understanding of Newton's health benefit strategy, we performed a comparative analysis of other municipal purchasers of health insurance, looking at the City of Boston, Town of Brookline, the West Suburban Health Group (a consortium of Metro-west communities), the Minuteman Nashoba Health Group (a consortium of Route 495/Route 2 area communities) and the Group Insurance Commission. With respect to the municipal purchasers, the Committee looked at the numbers and types of health plan offerings, the demographic profile including the percentage share of retirees, the premium costs and net city cost of a comparable health insurance products. In general, the City of Newton was neither the highest nor the lowest on each of the measures. Its percentage of retirees is 54% compared with 52% for Brookline and 49% for Minuteman Nashoba and for West Suburban. Newton was also near average on the cost of its HMO plan. Of note, Boston, unlike Newton, has accepted the Municipal Health Care Act that permits it to use a streamlined collective bargaining system rather than negotiate separately with each of the employee unions. Boston has found that this has enhanced communication between the City and its employees, making decision-making simpler assisting with some of its health and wellness initiatives.

The Committee conducted a more detailed comparison between the Group Insurance Commission's health plan offerings and those of the City. Under state law Newton could exercise the option of joining the GIC for the purchase of employee health care. The GIC acts as a volume purchaser for the Commonwealth and member municipalities. It expends $2.1 billion in purchasing power and currently provides health insurance for more than 400,000 public employees and retirees. The GIC uses a number of tools to drive cost control. The first is its market leverage. The second is access to plan analytics that assign price/quality metrics to hospitals and other providers. Insurers use these scores to designate a provider to a "network tier" or potentially exclude providers from some plan offerings entirely. For a tiered plan, depending on the insurer, the network has either two or three tiers, with the better quality/lower cost providers in the first tier, and lower quality/higher cost providers being placed in the second or third tier. Members then pay less out of pocket for first tier providers and pay more for second or third tier providers. For a limited network plan, subscribers save on their premium price, as lower-value providers are excluded from the plan. The GIC also is in the process of implementing an Integrated Risk-Bearing Organization (IRBO) initiative. The main purpose of the IRBO initiative is to

engage IRBO providers with their patients to provide highly efficient and effective care that aggressively contains health care costs.

Comparison between the plans suggests that Newton is paying more for comparable health plan coverage. While the plan types are somewhat different, the THP EPO Advantage offered by Newton provides a comparable level of benefit support to that of the GIC's THP Navigator PPO plan. Newton family premium is $19,727 annually compared to the GIC plan which costs $18,254. Newton's THP PPO Advantage family premium is $26,877, compared to the GIC's Unicare Indemnity which costs $25,794. At current premiums, the Newton plans in aggregate are $2.4 million more expensive than the GIC plans. This price advantage is more than offset, however, if the City offers a year-end premium "holiday", as it has most recently. Further, the GIC's plans are not strictly comparable to Newton's, and Newton would lose control over parts of its health spending to the GIC and the legislature, if it obtained coverage through the GIC.

Recommendations

8. The City should explore acceptance of the Municipal Health Care Act in order to form a Public Employee Committee (PEC). Currently, Newton must manage relationships with seventeen employee unions. Considering the time and effort involved in reaching collective bargaining agreements, it may be in both the City's and the unions' best interest to form a PEC to better manage health program changes as they come under consideration.
9. The City should evaluate the possible benefits of participation in the Group Insurance Commission (GIC). Joining the GIC poses some trade-offs and risks for Newton and its employees. The cost savings could be considerable while also reducing some administrative burdens on the city. Newton should work to educate its employees on the GIC offerings, so as to better inform the conversation.

4. Other Post-Employment Benefits (OPEB)

The cost of funding retiree health care, a major component of "other post-employment benefits" or OPEB, represents a major financial liability for Massachusetts cities and towns, including Newton. Recently, the Massachusetts Taxpayers Foundation surveyed the 50 largest Massachusetts cities and towns, and found that OPEB liability approximated $20 billion. According to the Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits, it could cost $500 million for the 50 largest municipalities to pay current costs and set aside sufficient funds to account for future OPEB liability. The report recommended legislative changes to help municipalities address the liability.

House Bill 59, proposed by the Governor in January 2013 would limit the cost share that the municipality could assume for retirees to 50% including survivor benefits; require a minimum of 20 years of service for retiree benefit eligibility and pro-rate benefits up to 30 years of service; increase the retirement age for most retirees to 60 (55 for police and fire); and make employees who leave service without retiring ineligible for benefits unless they have at least 25 years of service and retire within 5 years or have 20 years and are enrolled in Medicare Parts A and B. Finally, it authorizes the State's Executive Office of

Administration and Finance to oversee financial sustainability by establishing standards for addressing future OPEB liability.

Newton has already taken steps which are permitted under current state law to address this significant issue. It accepted Chapter 32B, Section 18, requiring all retirees to access Medicare benefits unless they can demonstrate that they are not eligible for Medicare. It arranges for annual audits and reports on the scope of OBEP liability consistent with GASB 45. In 2013, it established an Irrevocable Trust for OPEB funds. In addition, commencing July 1, 2012, the City began contributing 2.5% of base compensation for all newly-hired employees who participate in the City's health insurance plans to the City's OPEB fund, and plan changes were made in 2011 to require newly-hired active employees to select one of the less expensive "Advantage" plans, which has the effect of reducing the City's future retiree health care costs. And, all newly-hired active employees must contribute at least 25% of the costs. Currently, 88% of newly-hired the union members pay 25% and the other 12% pay 30%.

Recommendation

10. The City should closely monitor the actions of the state Legislature as it considers proposed legislation on retirees health benefits (OPEB). If enacted, the legislation could assist the City in reducing its future liability for retiree health benefits.

5. Use of Behavioral Incentives, Traditional Disease Managements and Wellness Programs to Promote Lower Cost, Higher Quality Health Choices and Employee Wellness

Using Incentives to Influence Healthy Behaviors

The Committee considered how incentives may be used to positively affect the choice of providers, encourage the use of high-value health services, and promote wellness. Provider prices in Massachusetts vary widely, much more so than the quality of care provided. Tiered and limited network insurance plans aim to reduce costs by encouraging the use of high-quality, lower cost hospitals and physicians. Savings approximate 7-14%. Current state law (Chapter 224 of the Acts of 2012) requires that health plans provide improved cost information to patients about health services they may need and the providers they consider. Increased use of cost transparency can help Newton's workers choose the right provider while saving money for both Newton and its workers.

Value-based insurance design (VBID) is when insurers create financial incentives for patients to seek out high value health services (like evidence-based preventive screenings or medications to control chronic conditions) and avoid low value health services (like testing or treatment found to be of little or no benefit). Since the passage of the ACA, effective preventive services are required to be covered in full, which the City's health plans now do. The City's health plans currently have limited additional opportunities to expand VBID.

Direct incentives for participation in wellness programs have been a topic of interest among employers for years. Under the ACA, wellness incentives are promoted, allowing employers to discount premiums amounts by 30-50% for participating employees. The Committee expects that such incentives might

secure participation for many employees, but that the effects may be unintentionally discriminatory against lower-paid workers. Both THP and HPHC currently offer wellness benefits, such as health risk appraisals and discounted gym membership.

Recommendations

11. The Committee believes that both tiered network and limited network products are reasonable approaches to reducing spending. Of the two, employees may find tiered networks more acceptable, though the potential savings are also less. The Committee recommends that these options should be discussed with unions and employees as potential options could reduce costs saving money for both the City and employees as well as offering health benefits.
12. The Committee also believes offering incentives for choosing lower cost providers and increased information transparency, can provide employees incentives to make cost-effective decisions. The Committee recommends that the City consider these opportunities as they become available.
13. While the Committee lacks information about the scope of the disease management programs currently offered, lowering copayments on chronic medications or other incentives should be considered. It is unlikely that Value Based Insurance Design (VBID) has the potential for substantial cost savings or improved employee health in the short-run.
14. The Committee recommends consideration of increasing incentives to use higher value prescription medications. The City should explore whether and how Newton's small mail order pharmacy use (5% of spending in HPHC) can be increased, which would save money for the City and its workers.
15. The Committee recommends against charging differential premiums based on risk factors, as we believe that the potential benefits are outweighed by potential harms for a mostly unionized workforce such as in Newton. Concerns about equity and the influence on disparities argue against implementation of programs of this nature.

<u>Traditional Disease Management and Wellness Programs</u>

Disease management (DM) is a system of coordinated interventions aimed both at enrollees and their physicians to improve population health and chronic disease care. Such programs are offered by almost all health plans, but data supporting their effectiveness is sparse. There has been substantial movement over the last decade to create more holistic programs that allow for the integration of all relevant diseases/conditions to be integrated into a single management program. Despite these advances, the literature supporting disease management activities fails to show a convincing benefit to disease management in the form of health gains or cost savings.

HPHC and THP are among the most highly rated health plans nationally. Both plans offer a broad suite of DM programs, though some require "buy up" from the standard offering. It is unknown whether and by how much the City and its employees benefit from the existing DM programs. The health plans did not provide any analysis of the savings or health improvements that their plans created, either for the

City itself or across the all the plans' customers. City officials believe that providing DM programs may contribute to good relations with employees.

Wellness programs aim to improve health and productivity and reduce health care costs, absenteeism, and employee turnover. Wellness programs can include performance of screening tests; behavior modification programs such as smoking cessation and weight loss; educational programs; changes in the work environment, such as the availability healthy food choices; or benefits such as subsidized gym memberships. Workplace wellness is a large industry in itself, and nearly all large employers offer some form of program.

Workplace wellness programs have the potential to influence health status, productivity, and health care costs. There is possible benefit in the mere existence of a wellness program in the positive signal it sends to employees that they are valued in the overall workplace environment. However, solid research on the effectiveness of the different types of wellness programs is lacking. The City has offered various programs and incentives for employees. However, with the exception of the annual flu vaccinations, there has been low participation in these wellness initiatives. As a result, while there has been no formal evaluation, the programs have likely had very modest if any health effects and little or no cost savings.

Smoking cessation and influenza vaccination programs are areas of special interest, as they are two areas where wellness programs have some likelihood of providing significant health benefits. In addition, physical fitness for public safety employees is a concern as public safety employees are at higher risk for injury, disability and premature retirement.

Health risk appraisals (HRAs) are systematic approaches to collecting information from individuals that identify risk factors, provide individualized feedback, and link people with at least one intervention to promote health, sustain function and/or prevent disease. A typical HRA instrument collects information directly from enrollees on demographic characteristics (e.g., gender, age), lifestyle (e.g., smoking, exercise, alcohol consumption, diet), personal medical history, and family medical history. HRAs offer some potential benefits (earlier identification of risk factors and motivation of patient to discuss issue with their physician) and has drawbacks (risk of over diagnosis, lack of employee interest, and lack of follow up on findings). Only three employees participated in the most recent HRA administrations.

Recommendations

16. The Committee recommends that the City monitor developments in program design and outcomes. Programs that use behavioral economics to increase patient engagement are promising, but are currently lacking sufficient data. As these programs develop further and the level of incentives expands as permitted under the ACA, promising universal designs may emerge. At an appropriate time, they City may wish to pilot a program targeting particularly concerning or costly behaviors.
17. The Committee sees little to no potential savings by offering additional or more comprehensive disease management programs beyond those HPHC and THP currently provide.

18. In the absence of demonstrated benefit of current DM programs, the City and employees should consider ending programs that are provided at an additional cost by its current health plans.
19. Innovative programs incorporating incentive payments that improve the effectiveness of disease management programs could be adopted, but current options are lacking and none are recommended at this time. To the extent that additional data become available or programs are developed, they may represent an area for future opportunities.
20. The Committee recommends that the City continue to offer flu vaccinations for all employees, with a goal of vaccinating 100% of employees. .
21. The Committee recommends that the City offer full coverage for smoking cessation programs and medications through PCPs, including those offered by local providers and through the City's health plans.
22. The Committee recommends that the City should consider the availability of wellness programs for cardiovascular fitness and weight reduction for public safety workers.
23. The Committee recommends against the City expending resources on health risk appraisals at this time because of challenges and limitations noted.

6. Encouraging Employee Health Plan Opt-Out to Achieve Financial Savings

Some Newton employees have the option of purchasing health insurance either through the City of Newton or through another source, most commonly an employed spouse's employer. The Committee explored whether this might be worthwhile and under what conditions a program might be implemented. At present, 25% of Newton employees decline health insurance. As a result, any design of an incentive program would be expected not to be cost-effective.

Recommendation

24. The Committee recommends against an employee opt-out program.

7. Community Partnership Opportunities

The Committee discussed whether developing or enhancing relationships between the City and area health care providers could help the City reduce health care costs while addressing the health and wellness of its employees. Historically, Newton Wellesley Hospital (NWH) has provided various employee health services to the City, many at no charge to the City. Services have included pre-employment physicals; work-related injury evaluation and treatment; return-to-work clearance; and an employee assistance program (EAP). Although the contract between the City and NHW has expired, NWH continues to provide these services. Other health care providers are active in Newton or for Newton employees and could partner with Newton to provide services. Atrius Health, which is headquartered in Newton, is the parent organization of Harvard Vanguard Medical Associates, which provides the primary care physician for more Newton employees and dependents than any other medical group. Atrius currently provides certain employee health services to the City of Boston. Several other large providers have offices in Newton, for example, Partners Healthcare (the parent of NWH), Steward Health Care, and Beth Israel Deaconess.

Recommendations

25. The City should collect and analyze data pertinent to its agreement with NWH. Utilization rates, costs, and types of services should be available to City staff.
26. The City should engage area health care providers to discuss potential partnerships that could improve the City's existing employee health programs. If found to be valuable, the City should update its agreement with NWH for employment related health services and the employee assistance program. A new agreement should clarify expectations and include reporting requirements and benchmarks for assessment of the effectiveness and value of the services to the City. The City should complete a review of the existing programs prior to extending the contract.

Introduction

As the Commonwealth and the nation have grappled with issues of quality, cost and access in health care, municipalities like Newton have been on the front lines as these issues play out. Municipal governments, their employees and retirees have felt the impact of the high cost of health care, the gaps in quality, and the rapidly changing health care market. Health care costs have immediate financial effects: the city's taxpayers annually fund the large majority of the health premiums, and city employees and retirees bear increasing premium costs and out of pocket expenses. High health care costs also have additional long term effects because the city must provide for future health benefits for current city workers after they have retired. The value of these post-employment benefits is sizable and, at present, only minimally funded. Thus, Newton's health care spending can be expected to grow substantially over the next decades. During FY2013, Newton expended $47.4 million on health benefits, about 15% of total city expenditures.

Newton established the Health Care Advisory Committee in Section 12 of the city ordinances. The Committee is:

> An independent advisory body charged with making recommendations to the mayor and board of aldermen regarding ways to control the cost of employee and retiree health insurance while improving or maintaining the quality of health care available to Newton employees and retirees. Specifically, the committee is charged with reviewing the cost and efficiency of Newton's health benefits plan or plans, examining possible alternative methods of securing health insurance for its participants, and investigating possible avenues of providing better medical care and treatment outside of the traditional model at a lower cost, including wellness, prevention and early detection regimens.[1]

In March and April, 2013, the Mayor and Board of Aldermen named ten individuals to the Committee:

- Kristen Apgar, JD, former General Counsel, MA Executive Office of Health and Human Services (Committee Vice Chair)
- Elizabeth Capstick, MS, former MA Deputy State Auditor and member of the MA Health Care Quality and Cost Council
- John Freedman, MD, MBA, Principal, Freedman Healthcare, LLC, and former Alderman (Committee Chair)
- Dean Hashimoto, MD, JD, Professor of Law, Boston College, and Chief, Occupational and Environmental Medicine, Partners Health Care
- Bruce Landon, MD, MBA, Professor of Health Care Policy and Medicine, Harvard Medical School
- Vinay Mehra, Chief Financial Officer, WGBH
- Peter Neumann, ScD, Professor of Medicine and Director, Center for the Evaluation of Value and Risk in Health, Tufts Medical School

- Daniel Sands, MD, MPH, health IT consultant, and former Director, Healthcare Business Transformation, Cisco Systems
- Dana Gelb Safran, ScD, Senior Vice President, Blue Cross and Blue Shield of Massachusetts
- Eleanor Soeffing, MHSA, Accountable Care Organization Program Officer, Beth Israel Deaconess Care Organization

The Committee began work on April 1, 2013. William Brandel, MPP, PhD candidate in health policy, Brandeis University, and former Alderman, provided extensive support to the Committee's work as its research analyst.

Background and Legislation

Rising health care costs have adversely affected all municipalities in Massachusetts. The Massachusetts Municipal Association, the Massachusetts Taxpayers Foundation, the Boston Foundation, and other organizations have been actively lobbying the Governor and Legislature to take action to help cities and towns. These efforts have resulted in legislation to assist cities and towns in managing health care costs.

Chapter 32B of the General Laws governs the authority of cities and towns to offer and determine health care benefits for their employees and retirees. The statute generally provides for uniform treatment of all employees, and makes any changes in benefit design subject to collective bargaining, often necessitating negotiations with a large number of separate employee bargaining units. In contrast, the state's Group Insurance Commission (GIC), under the provisions of Chapter 32A of the General Laws, is exempted from collective bargaining, and can determine health care benefits, including employee cost-sharing, unilaterally. Over time, the employer share of state employee benefits has been declining, while most municipalities on average pay 80% of their health care costs[2].

The Legislative Response:

In 2007, the state legislature enacted the Municipal Partnership Act (Chapter 67 of the Acts of 2007) adding a new section 19. These local option provisions set up a more streamlined structure for negotiations between the unions and municipalities. Under this statute all unions were represented by a Public Employee Committee (PEC) with weighted representation for each union and a retiree representative. The municipality negotiated with the PEC rather than each individual collective bargaining unit. In addition the Municipal Partnership Act for the first time gave municipalities the option of joining the GIC[3]. However, the 2007 legislation proved to be somewhat limited in effect, because negotiations with the PEC were often cumbersome and frequently ended in impasse.

Four years later in 2011, the Governor and Legislature acted again, passing the Municipal Health Care Act (Chapter 69 of the Acts of 2011) which added new provisions to Chapter 32B, aimed at further facilitating decision-making on health care benefits and clarifying the legislative goal of promoting health care cost savings. Like the Municipal Partnership Act, this legislation is local option. It provides for a Municipal Health Review Panel to resolve a bargaining impasse between the municipality and its PEC. If a local government and its PEC fails to reach agreement within 30 days, the process moves to the

three-person Municipal Review Panel (one union, one local government, one chosen by the Secretary of Administration and Finance) to resolve the dispute. In addition, the legislation continues to offer municipalities the option to join the GIC.

Under the Municipal Health Care Act, cities and towns may offer plans with benefit designs, including employee cost sharing no higher than those offered by the GIC. Health plans offered by the GIC are the benchmark for local municipal plans: the commercial benchmark plan is GIC's Tufts Health Plan Navigator, and the Medicare benchmark is GIC's UniCare State Indemnity Plan/Medicare Extension (OME). The GIC's most-subscribed plans serve as the benchmarks.

Alternatively, a city or town may transfer its employees to the GIC, if it will generate five percent more savings than the local health care plans. Up to 25% of savings can be returned to employees, as mitigation. The city or town must be able to demonstrate the cost savings from its negotiated benefit plan to the State Secretary of Administration and Finance under its regulations. Lastly, all municipalities, whether or not they have accepted the Municipal Health Care Act provisions, are required annually to report to the Secretary of Administration and Finance on their health care cost savings for the prior fiscal year.

The Impact of Legislative Reform

Municipal health insurance reform, and particularly the availability of the option of joining the GIC, has resulted in significant savings to Massachusetts cities, towns and regional school districts. Forty-four cities, towns and regional school districts have joined the GIC, and another 61 used the expedited bargaining procedures under the reform legislation to purchase employee health benefits locally, recognizing significant savings. Moreover, even communities like Newton that did not use the reform process for health benefit negotiations have experienced substantial savings.[4]

Lastly, the Legislature in 2012 enacted additional mechanisms aimed at addressing rising health care costs by enacting Chapter 224, which created new commissions and agencies charged with monitoring and enforcing state benchmarks for health care cost growth, increasing price transparency for health care services for consumers, and placing new focus on wellness and prevention programs[*].

The Affordable Care Act

In addition to changes in state legislation, described above, beginning January 2014, Newton will also be required to comply with the provisions of the federal Affordable Care Act (ACA). The ACA contains a number of requirements which apply to state and local governments that employ 50 or more employees. These include employee notice requirements, the minimum value standard for health care coverage, the affordability standard, and in some instances payment of an employer excise tax on high cost or so-called Cadillac health plans. Briefly described these provisions are as follows:

[*] The official title of the legislation is An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation

Notice Requirements: The ACA requires the City to notify all employees on the coverage options, including information on how to access the Massachusetts Health Connector for those part time employees who may not qualify for employer coverage.

Minimum Value Standard: The City is required to offer a health care plan to all full time employees (defined as employees who work more than 30 hours a week), with the city covering at least 60 percent of health care expenses, taking into consideration copays, co-insurance, deductibles, and out-of-pocket expenses. Currently, Newton, like most Massachusetts cities and towns, meets this requirement.

Affordability. The employee share of the health plans offered by Newton may not exceed 9.5 percent of employees' household incomes. Federal regulations permit cities and towns to have access to such information as W-2 forms to make this determination. Under current arrangements this also does not appear to present difficulties for Newton.

High Cost Plans. The ACA establishes an excise tax on employers, generally referred to as the "Cadillac Tax," which applies to plans costing over $10,200 per year for individuals or $27,500 per year for families. The excise tax does not take effect until 2018; however, Newton's THP POS plans (both Legacy and Advantage plans for individuals and the Legacy plan for families) already exceed the threshold that would trigger the tax. Further, depending upon cost trends, the City's other plans are also at risk of triggering the tax by 2018.

The City of Newton's Experience and Actions

The City of Newton experienced rising health care costs over an extended period. Annual increases in health care costs in the period 2002 to 2011 averaged 8% to 11%. The *Report of Blue Ribbon Commission on the Municipal Budget* (2007) stated that, "Newton's average increase in health insurance costs over the past ten years [1997-2007] has been 11%."[5] Similar findings appeared in the *City of Newton Citizen's Advisory Group, Final Report* (2006)[6].

Employee premium increases between FY04 and FY14 have varied from 0 to 20%, and have averaged 5.2 to 8.1%. Increases in the actual health care expenditures from FY04 to FY13 have ranged from -5.6% to 15.7%, averaging 4%[*]. The degree of year-to-year volatility has made short-term predictions and planning a challenge. The *Blue Ribbon Commission* and the *Citizen Advisory Reports* both proposed that the City consider reviving an earlier effort to obtain special legislation to exempt Newton's health benefits from negotiated agreements, referencing a failed 2006 effort of the state legislature. The reports also suggested that the City should consider joining the Group Insurance Commission in order to reduce its employee health care expenditures.

[*] Premiums and expenditures are related but not directly comparable. Premiums are the projected total health care spending per subscriber for city offered health plans. Expenditures are measured retrospectively, and will vary depending upon the number of city employees and beneficiaries who enroll in coverage, as well as the actual experience of illness and medical services used.

Reponses by the City:

The City has employed a variety of efforts aimed at managing health care costs:

- In 1994, as part of a new procurement of employee health benefits, Newton moved to self-insurance for its Tufts Health Plan (THP) offerings, continuing its Harvard Pilgrim Health Care (HPHC) HMO as a fully-insured plan.
- Six years later, in 2000, Newton converted to self-insurance for Harvard Pilgrim, and currently self-insures for 96% all employees and retirees.
- In 2002, concern about the high cost of prescription drugs led the City to look for alternative purchasing methods.
- Two years later in 2004, Newton began participating in the Canadian Purchasing Program. This has evolved into an imported prescription drug program that continues to provide savings on pharmacy costs[7].
- Around that time, the City formally reprocured its health plans, but anticipated savings were not realized. THP and HPHC remained the most cost-effective options for the City[8].
- Over the past 10 years, the city has worked with its health plans to deploy disease management programs for persons with chronic illnesses, case management programs for persons with serious and complex needs, and wellness programs to promote healthy living.[9]

The City's 2011 Collective Bargaining Agreement, covering FY 2012 -2014, Reduced Health Care Expenditures for the City and Its Employees.

The City did not accept the provisions of the Municipal Health Reform Legislation that would have permitted it to join the Group Insurance Commission or use the more streamlined collective bargaining provisions of the act. However, in 2011, the Warren administration and the City unions agreed to a compensation framework that limited the growth in total compensation—payroll, health benefits and retirement benefits combined—to no more than 2.5% annually, the City's average increase in revenues. Under this framework, the City achieved success in containing the growth of health care costs in order to free up funding that could be used to increase payroll compensation for city workers. The City's successful strategy for reaching agreement with its 17 employee unions resulted in projected savings for FY2012 of $2,794,784, with similar savings anticipated for the subsequent two years[10]. The City also projected that the negotiated changes would be slightly more beneficial to the city than if it had joined the GIC[11]. Of note, savings in this case did not primarily accrue to the City, but rather accrued to the City workers who agreed to trade off increases in health spending for increases in direct compensation.

Impact of the Agreements on Newton Health Insurance.

Fiscal year 2013 marked the first 12-month period where all Newton active and retired employees participated in the new premium plan structure put in place as a result of the 2011 collective bargaining agreements. During FY2013, the City provided health insurance benefits to 2,349 active employees (75% of its work force), to 612 retired employees who are not eligible for Medicare, and to 2,117 Medicare-

eligible retirees. Including dependents, the City provides health insurance coverage to a population of 8,500 people.

A number of substantive changes to the City's health insurance plan offerings, plan design and reimbursement levels were adopted as part of the new agreements. These include:

- Nearly all employees hired after the 2011 effective dates of the agreements are required to pay a 25% share of premium (up from 20%)
- All active employees migrated to "Advantage" plans, which require an annual deductible amount and changes in some copayments
- Only retirees could subscribe to "Legacy" plans, which did not change the copayments or add a deductible
- Agreements with some labor units included minor differences in plan design from one another, but all provided that the total compensation cost growth did not exceed 2.5%
- The City did not change its contribution to retiree health benefits, which remains at 80%

Newton's Health plans

The City of Newton provides health insurance benefits through Harvard Pilgrim Health Care, Tufts Health Plan, and (to a limited degree) Blue Cross Blue Shield of Massachusetts. From Harvard Pilgrim Health Care (HPHC), beneficiaries have one product option, the HPHC Health Maintenance Organization (HMO). The HPHC HMO provides comprehensive health care coverage, including pharmacy, behavioral health and emergency out-of-area care. As an HMO, the HPHC HMO requires patients to choose a primary care physician (PCP), to obtain routine care from in-network providers, and to follow certain other plan requirements*. The HPHC HMO product is offered at two benefit levels, Legacy and Advantage, which differ in the amount of member out-of-pocket cost sharing.

From Tufts Health Plan (THP), beneficiaries have four product options. The THP Exclusive Provider Option (EPO) is essentially an HMO plan and its benefits, requirements, and network are very similar to those of HPHC's HMO. Although offered by competing health plans and having different names, the HPHC HMO and THP EPO can be thought of as virtually interchangeable plans. The THP Point of Service (POS) is a "high option" product that includes all the coverage benefits of the EPO, but also allows the patient the option of choosing out-of-network care, without a referral from her PCP, by paying a higher out-of-pocket amount (20% of the health plan negotiated amount, up to an out-of-pocket maximum). The THP POS may be preferred by patients who often use out-of-area services† (such as early retirees who have moved from Massachusetts) or patients who use providers that are limited in supply in the THP network, such as behavioral health counselors. THP also offers two plans for Medicare-eligible retirees. Blue Cross Blue Shield of Massachusetts (BCBS) offers a plan for Medicare-eligible retirees.

* These include obtaining referrals or prior approval for certain services.

† In City documents, the POS plan is also referred to as the out-of-area (OOA) plan, and the Advantage version of it is technically a Preferred Provider Organization (PPO) plan. In this report, we will only use POS to refer to this plan.

Figure 1. Newton's Health Plans

Carrier	Product	Plan Name	Eligible Beneficiaries	Out-of-Network coverage*	Self- or Fully-Insured	Comments
HPHC	HMO	Legacy	Retirees	No	Self	
HPHC	HMO	Advantage	Actives, Retirees	No	Self	
THP	EPO	Legacy	Retirees	No	Self	
THP	EPO	Advantage	Actives, Retirees	No	Self	Most popular commercial plan
THP	POS	Legacy	Retirees	Yes	Self	Most costly health plan offering
THP	POS	Advantage	Actives, Retirees	Yes	Self	Technically, is a PPO plan
THP	Medicare Supplement	MCP	Medicare-eligible retirees	Yes	Self	Most popular Medicare plan
THP	Medicare Advantage HMO	Medicare Preferred	Medicare-eligible retirees	No	Fully	Formerly called Secure Horizons
BCBS	Medicare Advantage HMO	HMO Blue Medicare	Medicare-eligible retirees	No	Fully	Only 8 subscribers in 2013

*For elective care. All plans cover emergency out-of-network care.

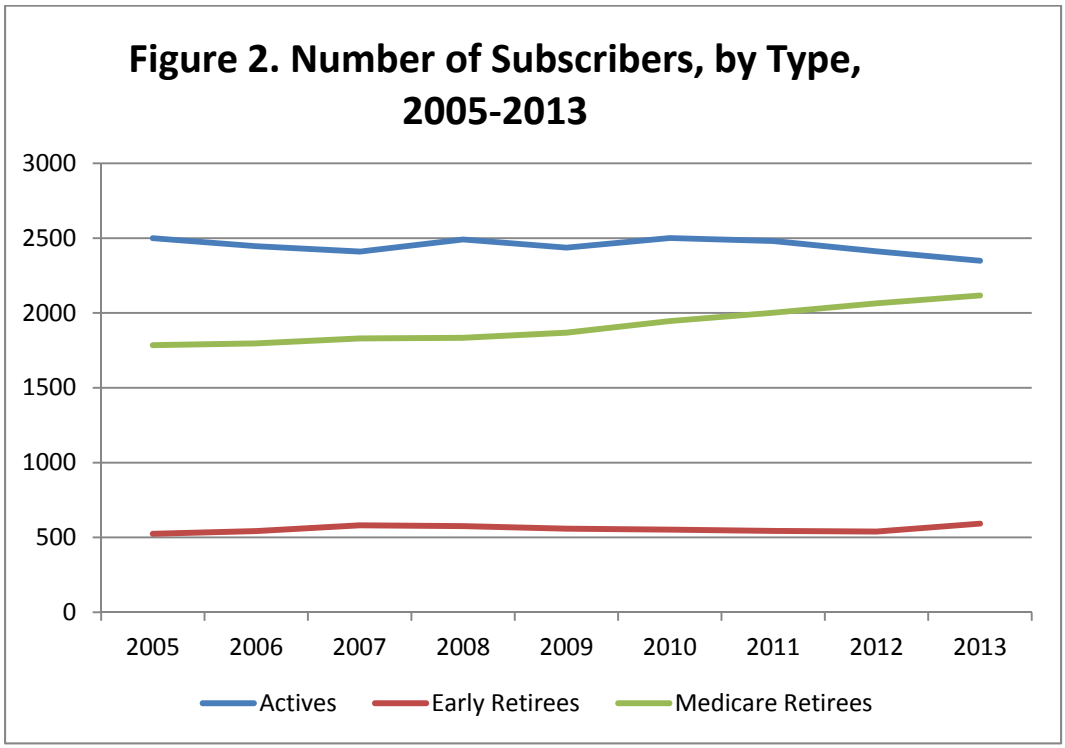
BCBS = Blue Cross Blue Shield; EPO = Exclusive Provider Option; HMO = Health Maintenance Organization; HPHC = Harvard Pilgrim Health Care; MCP = Medicare Complement Plan; POS = Point of Service; PPO = Preferred Provider Organization; THP = Tufts Health Plan

Growth in Retirees/Shift in Plan enrollment

Like most municipalities, Newton's health insurance subscribers comprise three groups: active employees, Medicare retirees, and non-Medicare retirees (see Fig. 2). The latter group is comprised of tenured employees who have retired from working for the City, but who may not be eligible for Medicare. Because these employees are tenured, they are eligible to receive individual and family health insurance coverage from the City of Newton.

The proportion of retirees among City health beneficiaries is growing steadily. From 2005 to 2013, the city added a net of 250 subscribers* to City health plans. However, the number of active employee subscribers fell by 6% while the number of early retiree† subscribers grew 13% and Medicare subscribers grew 19%[12].

Although Medicare plans are less costly than the commercial plans, it is reasonable to expect that Newton retirees will remain on Medicare longer as life expectancies rise. This will increase both the number of retirees remaining on coverage as well as the average cost (since the average age of Medicare retirees will increase).



Source: City of Newton

If this trend continues, it will swell the size of pension and OPEB liability (covered in a separate section). A challenge for Newton will be to manage simultaneously the cost growth for both its active employees and retirees.

Ultimately, the City's cost of health insurance is predicated on three factors: its subscriber population; the level of utilization of health care benefits; and the prices paid for health care services. All of these come together to determine the prices of health insurance premiums. Barring an unforeseen reduction

* A subscriber is an employee or retiree who is eligible for and elects health benefits through the City, either for themselves alone or for themselves and their family.

† Early retirees are employees who have retired from active service, are eligible for City health benefits, and are not eligible for Medicare. The large majority are retirees below the age of 65. The rest are retirees over the age of 65 who are ineligible for Medicare.

in headcount, the City's best options for controlling cost are through slowing the growth in health care spending or increasing the share of cost borne by employees. The Committee focused its efforts on approaches to slowing the growth of health care spending.

Unlike active employees, who have all migrated to the lower-cost Advantage plans, non-Medicare retirees have the option to enroll in the Legacy plans, which do not require a deductible. For this reason, Legacy plans are a more expensive option than the Advantage plans. For example, the Harvard Pilgrim Legacy premium is $21,993 for a family in 2014, compared to $19,878 for the Advantage version of the same product – a 10% difference in cost[13] (see Fig. 3).

Figure 3: Newton Health Insurance Premiums and Growth Rates

Legacy	**FY 2010**		**FY 2011**		**FY 2012**		**FY 2013**		**FY 2014**	
Harvard Pilgrim Individual	$ 6,868	11%	$ 7,348	7%	$ 7,862	7%	$ 7,862	0%	$ 8,098	3%
Harvard Pilgrim Family	$ 18,652	11%	$ 19,958	7%	$ 21,353	7%	$ 21,353	0%	$ 21,993	3%
Tufts EPO Individual	$ 6,678	9%	$ 6,678	0%	$ 7,546	13%	$ 7,546	0%	$ 7,924	5%
Tufts EPO Family	$ 18,074	9%	$ 18,074	0%	$ 20,424	13%	$ 20,424	0%	$ 21,699	6%
Tufts POS Individual	$ 9,838	5%	$ 9,838	0%	$ 11,119	13%	$ 11,119	0%	$ 11,730	5%
Tufts POS Family	$ 23,845	5%	$ 23,845	0%	$ 26,944	13%	$ 26,944	0%	$ 28,426	6%
Advantage Plans										
Harvard Pilgrim Individual	NA		NA		$ 6,727		$ 6,727	0%	$ 6,996	4%
Harvard Pilgrim Family	NA		NA		$ 19,113		$ 19,113	0%	$ 19,878	4%
Tufts EPO Individual	NA		NA		$ 6,844		$ 6,844	0%	$ 7,186	5%
Tufts EPO Family	NA		NA		$ 18,787		$ 18,787	0%	$ 19,727	5%
Tufts PPO Individual	NA		NA		$ 10,563		$ 10,563	0%	$ 11,091	5%
Tufts PPO Family	NA		NA		$ 25,597		$ 25,597	0%	$ 26,877	5%

Source: City of Newton

Over the last decade, the Legacy plans have averaged 5-8% annual cost increase. The Advantage plans are 5.4 to 13.6% less expensive than their Legacy counterparts, the equivalent of removing 1-2 years' worth of historical premium increases. Over the last decade, the cost growth of the THP Medicare Preferred plan has grown by 2.8% annually on average, a fraction of the growth rate of the commercial plans.

How the City Funds Employee Health Care

Until 1994, the City purchased fully-insured health plans. With a fully-insured plan, the City and its beneficiaries paid a known, fixed premium payment each month for health insurance on behalf of employees, retirees, and their dependents. The premium was negotiated each year between the City and its health plans. Once the premium was set, the City (and its employees/retirees) paid the monthly premiums. The health plans were responsible for paying the claims for all medical services used. Under a fully-insured arrangement, the health plan, not the City, is financially responsible for the health care claims.

Starting in 1994, the City began to self-insure. Under its self-insured plans, instead of paying a known, fixed amount to the health plans each month, the City pays the actual dollar amount of the incurred health care claims, and in addition pays administrative fees to the health plan. By becoming self-insured the City is exposed to financial risk if health care claims turn out to be larger than anticipated. However, that risk is offset by the lower total cost of health benefits, exemption under ERISA[*] from certain expenses that fully-insured plans must pay, and greater flexibility to design the health plan. Due to the lower overall cost for the purchaser, most large employers and municipalities choose to self-insure. To reduce the financial risk to the City of having unexpectedly large claims, the City purchases a re-insurance policy[†], and has established a health insurance trust fund that contains financial reserves to cover unexpected costs.

When self-insured, there is no "premium" to pay to the health plan. Instead, the City must set aside an amount every month to cover the cost of anticipated health care claims. The City does this by projecting the expected amount of claims as "working rates" (the self-insured equivalent of premiums) that the City and its beneficiaries contribute into health care trust funds, which in turn pay for the health care claims, administrative fees, and re-insurance premiums. In this report, the terms premiums and working rates are used interchangeably.

[*] ERISA (the federal Employee Retirement Income Security Act) governs self-insured health plans and exempts self-insured plans from certain state regulations.

[†] The City's reinsurance policy covers the costs of any individual beneficiary whose claims costs exceed $250,000 during the year.

Figure 4. Comparison of Fully-Insured and Self-Insured Arrangements

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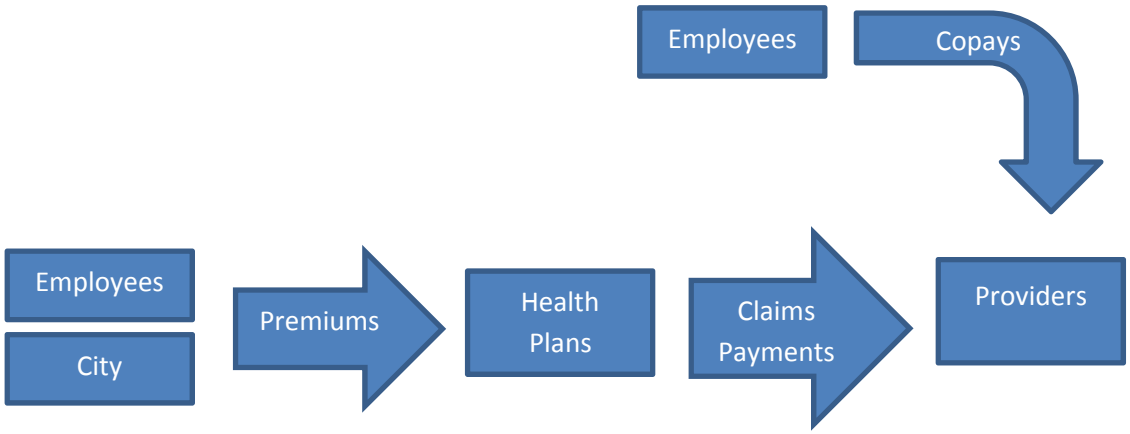
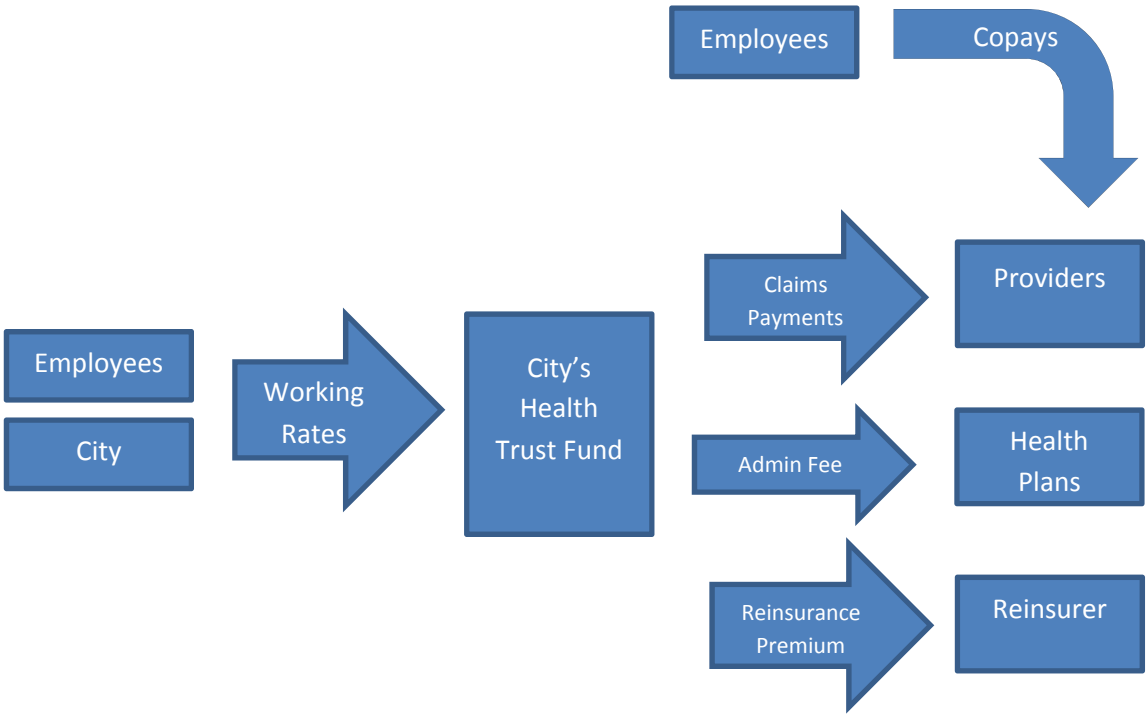
Fully Insured:

Organization and Flow of Funds in a Fully-Insured Health Insurance Arrangement



Self-Insured:

Organization and Flow of Funds in a Self-Insured Arrangement



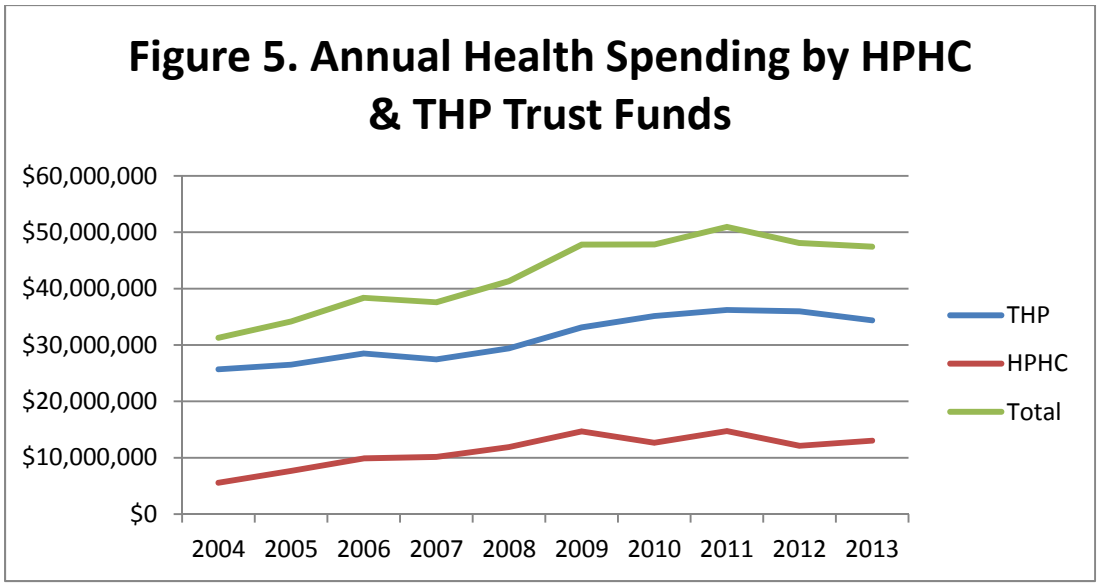
The working rates are set based upon the year's forecasted expenditure for each health plan. If the working rate is higher than actual expenditures, a surplus balance will accrue in the trust funds. If the working rate is below expenditures, the balance in the trust funds will fall. To avoid the trust funds running short of funds, City financial policies[14] direct the City to maintain a surplus balance equal to 1.5-2 months of health costs. When the surplus grows larger, the City has the option of a premium holiday, which permits the City and employees to forgo a portion of the contribution that would otherwise be required. For example, in FY2013, the City declared a 3-week premium holiday for all its self-insured plans, returning 5.8% of premium contributions to subscribers and the City, which moved $1.6 million of the savings to the Rainy Day Stabilization Fund.

Retirees Health Care and Medicare

The City also provides health benefits to retirees eligible for Medicare. Newton has adopted Section 18 of Chapter 32B, which requires retirees over 65 who are eligible for Medicare to enroll in it. The City offers Medicare-eligible retirees three health plan options: THP Medicare Complement Plan (MCP), THP Medicare Preferred, and HMO Blue Medicare. THP MCP is a "Medigap" plan that covers much of the copayments and deductibles that would otherwise be the responsibility of the Medicare patient. THP MCP also includes drug coverage. THP MCP covers everything that Medicare covers, and the beneficiary may obtain those services, without referrals, from any provider across the country.
THP Medicare Preferred and HMO Blue Medicare are Medicare HMOs, which provide comprehensive coverage of all services that Medicare covers, and additional benefits, though the beneficiary is required to choose a PCP, obtain referrals, and follow other requirements typical of HMO plans. In exchange for these restrictions, the cost of coverage is typically less than with the Medicare complement plan and the covered benefits are greater (e.g. elimination of or lower cost sharing for many services; including dental coverage, etc.). For retirees who are not eligible for Medicare, the City offers HPHC's HMO, THP's EPO and THP's POS[*].

The City's health expenditures from the HPHC and THP trust funds are presented in Figure 5.

[*] Retirees who retired prior to the effective dates of the newly bargained contracts (in 2012) are eligible to enroll in the HMO, EPO and POS plans at two different levels of benefit: the Legacy plan that maintains the copayment and deductibles level at pre-2012 levels, or the Advantage plan with higher copayments and deductibles.



Source: City of Newton

Since FY2004, total health care spending has increased from $31.3 million to $47.4 million, an average of 4.2% per year. During this period, HPHC spending increased more rapidly than THP's (8.9% vs. 3.0% per year). Year-to-year variation is large, as shown in Figure 6.

Figure 6. Variation in Annual Health Care Spending

Health Trust Fund	Average Increase ± Standard Deviation	Smallest Annual Increase	Largest Annual Increase
HPHC	8.9 ± 18.6%	-17.8%	37.3%
THP	3.0 ± 5.6%	-4.4%	12.6%
Total	4.2 ± 7.4%	-5.6%	15.7%

Source: HCAC analysis of City of Newton data

In 2013, the City expended $47.4 million on health care, below the peak of $50.9 million in 2011 and slightly below 2009's $47.8 million expenditure.

Cost and Utilization Trends

The Committee reviewed available historical data on the use of health services and their costs from FY2005 to FY2012, the most recent year for which data are available. To do this, the Committee relied on the data that were provided to it by the City's health plans and the data that the City had on file. To enhance the reliability of our analysis, we attempted to understand the utilization data across the three plans offered to active employees and pre-Medicare retirees: HPHC HMO, THP EPO and THP POS. This effort was challenging, however, because data were unavailable for some years or were provided only in paper formats. In addition, the HPHC and THP reports are formatted differently and use different

categories for medical services, limiting cross-plan analysis. Further, important information about the employees enrolled and comparison populations (such as average health status) was unavailable, and successive annual reports often did not use consecutive 12-month periods.

As a result, the Committee has focused this analysis on overall trends and the more consistent patterns seen over time, primarily in the THP EPO. Future attempts to examine cost and utilization trends would benefit from greater standardization and expansion of the source data.

Figure 7. Newton Health Insurance Enrollment Census.

Newton Health Insurance Enrollment Census		Active Employee Subscribers		Non Medicare Retired		Medicare Retired	
Plan Name	Plan Type	Ind.	Family	Ind.	Family		Total
Tufts EPO Legacy	HMO			199	119		318
Tufts EPO Advantage	HMO	563	753				1316
Tufts POS Legacy	POS	31	94	109	46		280
Harvard Pilgrim Advantage	HMO	411	497				908
Harvard Pilgrim Legacy	HMO			80	59		139
Tufts MCP	Medicare Supplement					1910	1910
Secure Horizons						199	199
Medicare HMO Blue						8	8
Subtotal		1005	1344	388	224	2117	5078
Total		**2349**		**612**		**2117**	**5078**

Source: City of Newton

Tufts Health Plan EPO.

The EPO has about five times as many subscribers as the POS, and 60% more than the HCHP HMO. For that reason, and because the data for this plan are the most complete, this analysis will focus on the THP EPO.

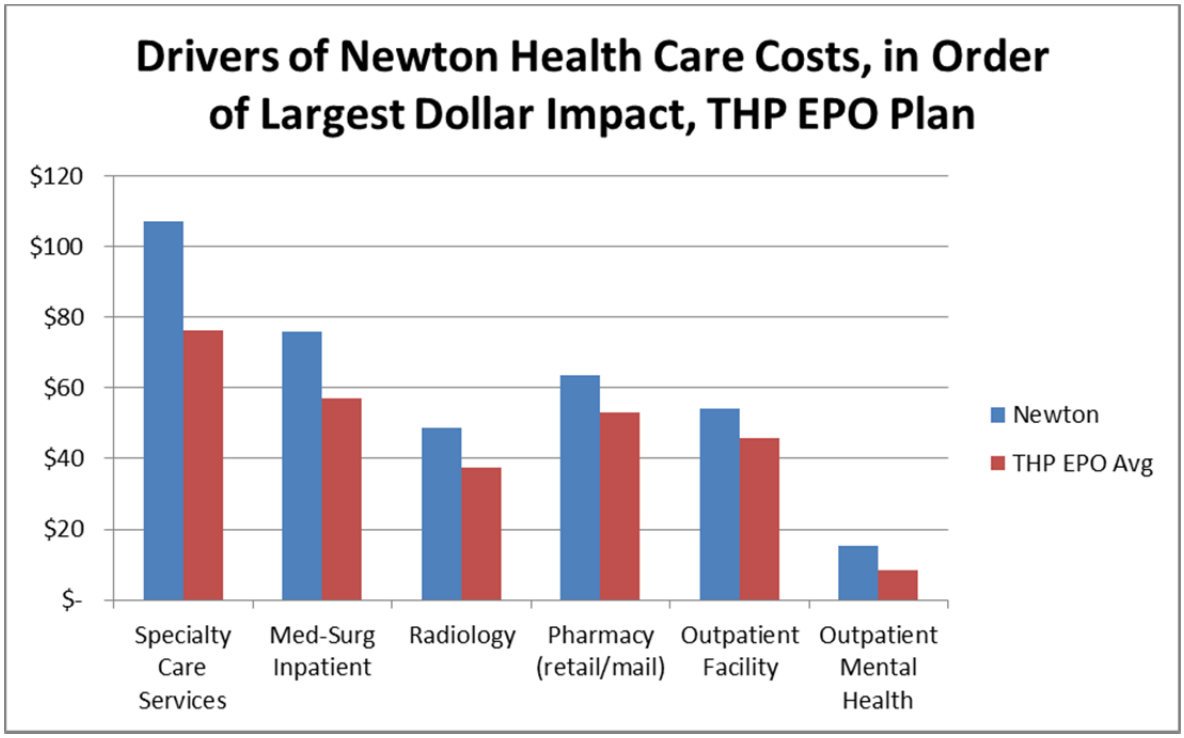
From 2005 to 2010, Newton's total EPO spending per member per month (PMPM) was 8 to 23% higher than THP's EPO plan-wide average. Part of this difference is almost certainly due to the older age, for Newton enrollees (average age 36-39 years) as compared to the THP average (average age 33-35). In addition, municipal employees have generally greater health risks than do non-public employees, so comparison to the overall health plan book of business may not be a relevant comparison. We do not have sufficient available data however, to determine by how much Newton members may have a greater illness burden than the comparison population.

In 2012, Newton's EPO spending jumped to 41% above the THP average: $611 vs. $433 PMPM. This may in part reflect a shift of older members switching from the POS product to the EPO (the average age in the EPO rose to 43 in 2012).

Cost Drivers

Newton's higher spending is concentrated in a few types of service. For the most recent three years* of data, specialty health care (office visits and procedures performed by specialist physicians) was the leading driver, accounting for about $31 PMPM, or 30% of the total gap between Newton's spending and the average THP EPO spending. Other drivers include medical-surgical hospital care ($19), radiology ($11), pharmacy ($10), outpatient facility ($9), and outpatient mental health ($7). See Figure 8.

Figure 8. Divers of Newton Health Care Costs.



Source: Tufts Health Plan

For four of these categories (outpatient facility, outpatient mental health, specialty care, and radiology), the PMPM spending was driven by both higher use of these services and higher prices paid for these services, compared to the THP average[15]. For medical-surgical inpatient and pharmacy, the increased cost was driven by higher use, exclusively.

* 2009, 2010, and 2012 data were available

Harvard Pilgrim Health Plan (HPHC).

Direct comparison with the HPHC HMO plan is not possible, for the reasons mentioned above. However, some insights are possible. Overall spending on the HPHC HMO plan has recently been lower than THP EPO ($405 vs. $611 PMPM) and Newton's HPHC spending is just 5% above the HPHC average. Based on the available data, we cannot determine why the spending patterns are so different, but the relative age and health of the Newton members who enroll in HPHC is thought to be quite different from those who enroll in THP. For example, a greater proportion of school employees choose HPHC while more "cityside" employees choose THP, and school employees may have lower health risks. The Committee had no access to health status data for Newton enrollees, or to any comparison data on the age, sex or health status of a benchmark population.

In addition to the cost and utilization trends discussed, the so-called "Cadillac Tax" has implications for the cost of health care for Newton employees. The "Cadillac Tax" applies to plans costing over $10,200 per year for individuals or $27,500 per year for families. Although the excise tax does not take effect until 2018, Newton's THP POS plans (both Legacy and Advantage plans for individuals and the Legacy plan for families) already exceed the threshold that would trigger the tax. Indeed, depending upon cost trends, the City's other plans are also at risk of triggering the tax by 2018. The City could be liable to pay the excise tax, equal to 40% of the cost of the health plan that exceeds the threshold. It would add to the total cost of health benefits, requiring an offset in the benefits budget or elsewhere in the city's finances. Therefore, there is a need for the City and its employees to take steps to avoid the adverse impact of the tax.

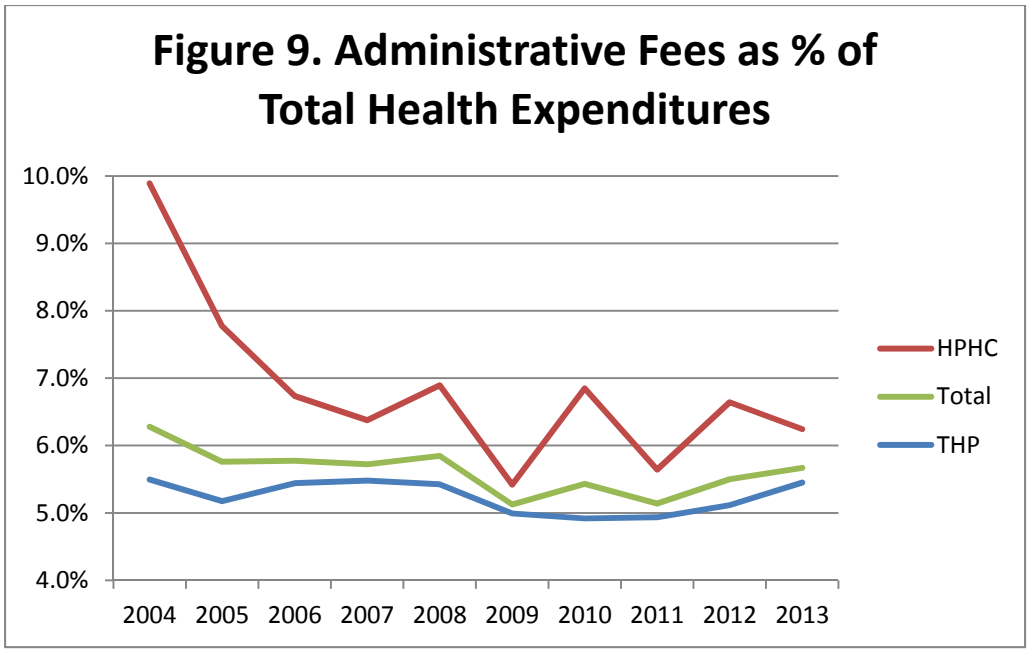
Administrative Costs

The Committee also examined the non-medical expenses of the City's health care trust fund. The City pays administrative fees to HPHC and THP as well as reinsurance premiums to Swiss Re, the City's reinsurance carrier. Figure 9 shows how the average administrative fees have slightly declined over time and that HPHC's fees consistently exceed THP's.

The reason for HPHC's higher fee is unclear. HPHC administers just one plan (HPHC HMO) while THP administers a total of four[*], which should give a cost advantage to HPHC. HPHC's fee has averaged one percentage point higher (6.2% vs. 5.2%) over the past three years. If the HPHC's fee were the same as THP's, the City and its employees would have saved $130,000 in FY13.

[*] Self-insured plans include THP EPO, THP POS, and THP PPO for actives and early retirees, and THP MCP for Medicare-eligible retirees. THP's Medicare Preferred is not counted in this analysis, as it is a fully-insured plan.

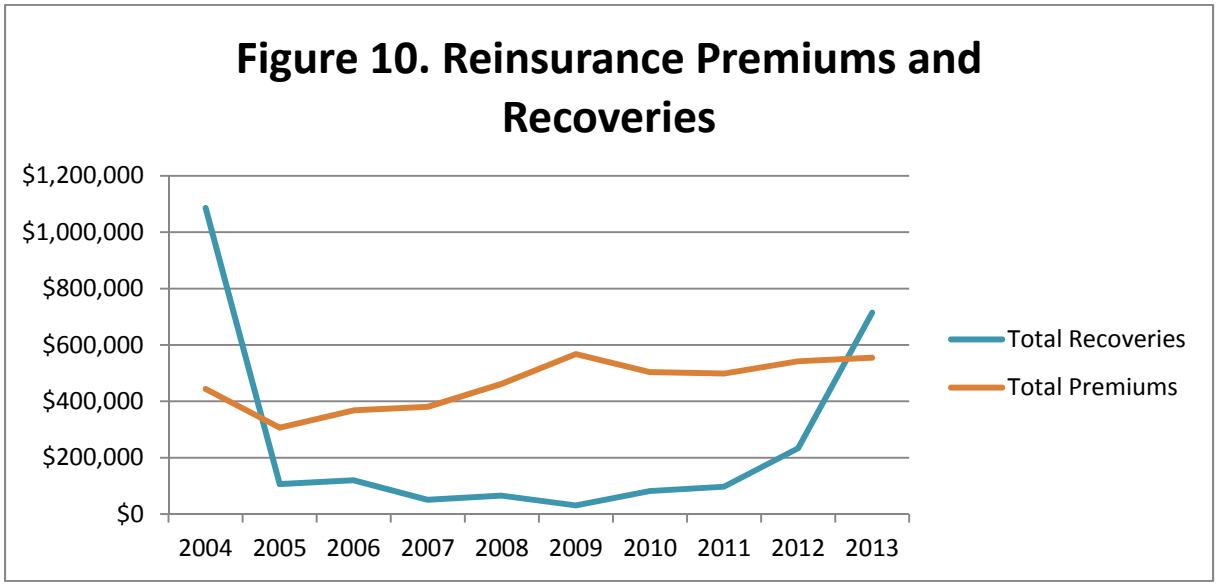
Figure 9. Administrative Fees as Percentage of Total Health Expenditures



Source: Harvard Pilgrim Health Care

Figure 10 shows the history of the City's reinsurance premiums and reinsurance recoveries. Premiums paid exceeded recoveries in all but two of the past 10 years. On average, the reinsurance policy pays back 56 cents to the City for every dollar in premiums (and just 34 cents per dollar in premiums since 2005). This low average benefit that the City obtains in exchange for its premiums suggests an opportunity for saving money on reinsurance.

Figure 10. Reinsurance Premiums and Recoveries



Source: City of Newton

The City has struggled to find competitive pricing for its reinsurance[16], though reinsurance is a semi-commoditized product and most large employers have been successful in obtaining it at reasonable rates[17]. Without a formal procurement of the reinsurance policy, we cannot know what the range of policies and prices available to the City are. While whatever reinsurer the City uses is entitled to a profit for taking on the risk, the Committee believes that the average premium may be significantly reduced.

Recommendations

Data and Decision Making:

1. To enhance its planning for health care cost management, the City, working with its benefits consultant and health plans, must organize and analyze health plan enrollment, cost and utilization data at least annually. The data should be maintained in an electronic form readily suitable for analysis. The City should create a single template that can be completed by each plan to make this easier for future comparisons. A proposed template is provided in the Appendix.
2. The City should take full advantage of the expertise available to it from its health benefits consultant.
3. The City, working with its benefits consultant and health plans, should obtain better comparison benchmark data, such as data from other Massachusetts public employers including adjustments for the population's health status (for example, using an industry-standard health status measures, such as DxCG). Proper comparison data are necessary for any serious exploration of opportunities for improvement in the care of City employees.

Opportunities to Reduce Cost:

4. The available evidence suggests that the City is paying higher than average prices for a number of health services. There should be further exploration to determine whether City employees could reduce spending by directing their care to lower cost providers in the area, particularly for elective services. The tax should also be incorporated in future city budgets and planning.
5. The City and its employees should explore the future implications of the Affordable Care Act (ACA) "Cadillac" tax and other provisions on the overall cost of employee benefits and the impact they will have on the total compensation available to employees. Efforts to mitigate the impending ACA penalties should be a leading topic in discussion with employees as the tax works to the mutual disadvantage of the City and its employees.
6. The City should plan for a full reprocurement of its health plans, including renegotiation of administrative fees. The city may benefit from inviting additional insurance carriers to bid to provide City health plans.
7. The City should broaden its approach to its annual reinsurement procurement

Analysis of Comparable Community Health Insurance Coverage

To better understand Newton's health care benefit strategy and performance, the Committee performed a comparative analysis with other municipal purchasers of health insurance. This analysis was intended not only to demonstrate how Newton's employee health insurance compared or differed from other communities, but also to potentially discover what program characteristics might most impact premium cost.

The defining attributes of Newton's structure as a purchaser includes the City's geography and frequently used providers; the number of employees and health insurance subscribers – both active and retired – who comprise its employee population; the age and gender of its members; and the City's self-insured structure. Using these criteria, the Committee requested premium, plan, and population demographic data for analysis from the following purchasing entities: City of Boston, the Town of Brookline, the West Suburban Health Group, the Minuteman Nashoba Health Group, and the Massachusetts Group Insurance Commission (GIC).

City of Boston

Much larger in population than Newton, Boston has a subscriber population of over 29,000 employees and retirees. Of those, just over 15,000 are active subscribers, 4,300 are non-Medicare retirees, and 9,500 are Medicare retirees. Like Newton, Boston is self-insured. The City of Boston estimates that it will spend $287 million on premium costs in 2014[18]. This expenditure level makes Boston the second largest purchaser of health insurance in the state after the GIC. It is roughly one-fifth the size of the GIC, but more than five times the City of Newton. Boston offers 5 commercial health plans to its active employees and non-Medicare retirees, and offers 6 plans to its Medicare population.

Town of Brookline

While smaller in population than Newton, Brookline shares a similar geography and demographic profile. Brookline provides insurance to approximately 3,000 employees and retirees – comprised of approximately 1,350 active employees and 1,600 retirees. The Town reached agreement in 2009 that it would join the GIC, beginning in FY 2011. As such, Brookline's insured population selects its plans through the GIC, and the town realized $5.6 million in savings FY 2011.[19]

Purchasing groups

A 1990 statute (M.G.L. c. 32B, sec. 12), enables towns to create joint health purchasing groups, allowing them to benefit from being in a larger pool. This led to the creation of the West Suburban Health Group, Minuteman Nashoba Health Group, the Cape Cod Health Purchasing Group, and other groups throughout Massachusetts. The enabling legislation was a response to the dearth of bargaining power that towns had with Blue Cross Blue Shield, which at that time was the dominant health insurance provider in the state. The purchasing groups are governed

by a steering group and finance committee, usually having representation of the treasurer from each of its member municipalities. Because of their relative proximity to Newton, the Committee included the West Suburban Health Group and the Minuteman Nashoba Health Group as part of its analysis.

West Suburban Health Group (WSHG) is a self-insured purchasing group formed in 1990 that is comprised of 14 towns in the "metro west" area of Boston, and includes neighboring towns of Wellesley and Needham. WSHG is self-insured and spends approximately $100 million per year to cover a total membership of 40,000. It subscribers select from 17 different commercial health plans. WSHG also has a representation of Medicare retirees, 4,331, who select from 7 Medicare plans.[20]

Minuteman Nashoba Health Group (MNHG) is a self-insured purchasing group also organized in 1990, comprised of 12 towns and six school districts located northwest of Boston near the 495 corridor, spanning from Concord to Pepperell and Lancaster. As of July, 2012, the co-operative manages roughly 4,000 health plan subscribers, covering almost 8,000 members. The co-operative offers four HMO plans to active employees and non-Medicare retirees, plus three Medicare supplemental plans for retirees. The co-operative pays 50% premium support for Medicare retirees. For FY 2012, the projected cost for self-funding these plans was $41 million.[21] A key aspect of MNHG's strategy is that the vast majority of Minutemen Nashoba participants use either Emerson Hospital or Nashoba Valley Medical Center. For this reason, it offers a limited set of health insurance plans that are optimized to cover care at these facilities. By providing a reduced set of plans, the co-operative believes that it can better control its cost of insurance.

Group Insurance Commission

The Group Insurance Commission (GIC) is the state purchasing agency which procures health insurance coverage for state employees and their dependents. In addition, in 2007, the GIC was opened for participation by municipalities and other public entities, such as school districts. As of 2013, the GIC has over 400,000 subscribers, making it by far the largest health insurance purchasing pool in the state. GIC health expenditures exceeded $1.6 billion in 2012, of which $320 million represented the participation of cities, towns and other local governmental entities.

The GIC offers 19 plans from six insurance carriers that include Fallon Community Health Plan, Harvard Pilgrim, Health New England, Neighborhood Health Plan, Tufts and UniCare. Of these, 12 are commercial plans are offered to active employees and non-Medicare retirees, and 7 plans are for its Medicare population[22]. Because Newton has the option of joining the GIC should the GIC's offerings and premiums prove attractive, this option is discussed in further detail in the following section.

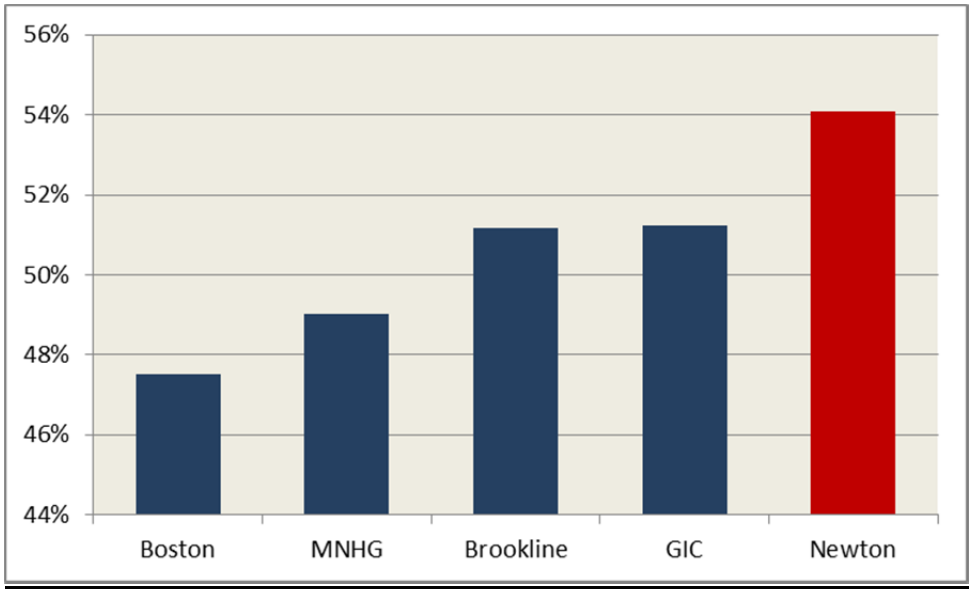
While not one of these purchasing entities by itself provides a close facsimile to the City of Newton for the purpose of program comparison, the purchasers do share a broad range of attributes that are useful for comparison. In addition to all being subject to Massachusetts statutes, the purchasers are largely

located within the I-495 corridor surrounding the Boston area. Like Newton, each of these communities purchases insurance for both active and retired populations, and each purchases some level of health insurance from either Harvard Pilgrim Health Care or Tufts Health Plan. All must negotiate with their respective unions to determine premium split and, to some level plan design. And, each is challenged by the issue of health insurance cost pressures with an increasingly aging population that it must, by statute, continue to provide access to and cost support for health insurance. From each purchaser, the Committee requested ten years of data to describe the plans offered to active employee, non-Medicare retiree and Medicare retiree populations; the premium cost and premium split with employees; and how many subscribers were enrolled in each individual plan. In addition to requesting the quantitative data, we interviewed each purchaser to help inform our understanding of why they adopted their respective strategy relative to their covered populations. These conversations helped us understand their model of governance, the needs of their populations, as well as understand the cultural and political dynamics and history with insurance providers, which all factor into health insurance purchase decisions. From this collected data, we constructed a descriptive profile to analyze their health insurance data in comparison to Newton's:

Actives Employees vs. Non-Medicare Retirees vs. Medicare Retirees

Newton's retiree employee population is steadily rising; however, its current mix of Medicare and non-Medicare retiree subscribers is generally in line with its peers. (See Fig. 11) Out of the six purchasers, Newton has the second highest retiree rate at 54%. This compares to 48% for Boston, 49% for MNHG and 51% for Brookline and the GIC.

Figure 11. Percent of Retired Municipal Subscribers



Plans offered (Commercial and Medicare)

Of the six purchasers, the four not affiliated with the GIC are all self-insured. Brookline, which participates in the GIC, pays predetermined premium rates to the GIC, and in this respect, is fully-insured for health benefits. What health insurance plans are offered by each purchaser is largely the result of their respective collective bargaining history with their employee unions. The exceptions here would be the GIC (and its participant, Brookline), which is exempt from negotiating benefits through collective bargaining under state law. All told, the six purchasers (including Newton) offer an array of 57 commercial plans to their employees and non-Medicare retirees, and over a dozen plans to the purchasers' Medicare retirees. After the GIC, WSHG offers the broadest array of total plans to its subscribers (17), while MNHG offers the fewest (7). Newton offers ten plans, which is roughly the mean of all the purchasers.

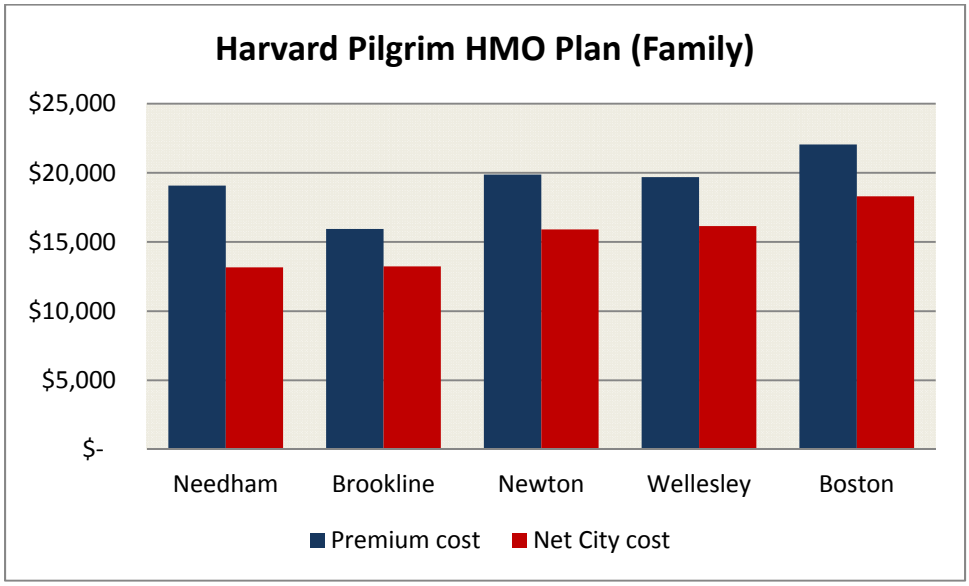
The purchasers each pay a different level of premium contribution, and many offer varying premium levels among their own plans and employee populations. Newton's contribution rates for employees hired before 2011 are at 80%, while new hires generally receive 75% premium support. Members of AFCSME 3092 and H Grade employees, roughly 300 employees combined, receive 70% premium support in exchange for a lower co-pay for prescription drugs.[23]

The City of Boston offers premium contributions ranging from 73 – 83% for its non-Medicare population, with the higher rate of support going toward the lower cost premiums. For retirees, Boston offers 90% premium support. After joining the GIC, Brookline raised its premium support level from 75% to 83%.[24]

In the case of WSHG and MNHG, the groups use their negotiating power to secure a common rate structure, however, premium support is negotiated between each participating municipality and its unions, as part of their respective compensation structures. As examples of this variability within WSHG, for one plan, Needham offers 76% support for individuals and 69% for families, while Walpole offers 80% for both individuals and families for employees hired before 2002 and reduces that to 70% for employees hired after 2002.

All told, because of the different plans and their widely fragmented support structures, only a general comparison can be made across a subset of similar plans. Each purchaser offers a version of an HMO plan from Harvard Pilgrim to its active employees. Similarly, each purchaser offers version of a Tufts Medicare HMO supplement to its Medicare retirees. This provides the opportunity to conduct a rough comparison between the plans' pricing and each purchaser's premium support level.

Figure 12. Harvard Pilgrim HMO



To perform the comparison, Harvard HMO (family) plans were selected from the respective purchaser municipalities, which included Boston, Newton and Brookline. Because of the varying premium support level, two neighboring towns, Needham and Wellesley, were selected from WSHG co-operative. Harvard HMO (family) was selected because it was the most popular plan in these respective municipalities, except for Newton, where it is the second most popular plan. Also, the family version of this plan is more popular than the individual version in all of these selected municipalities.

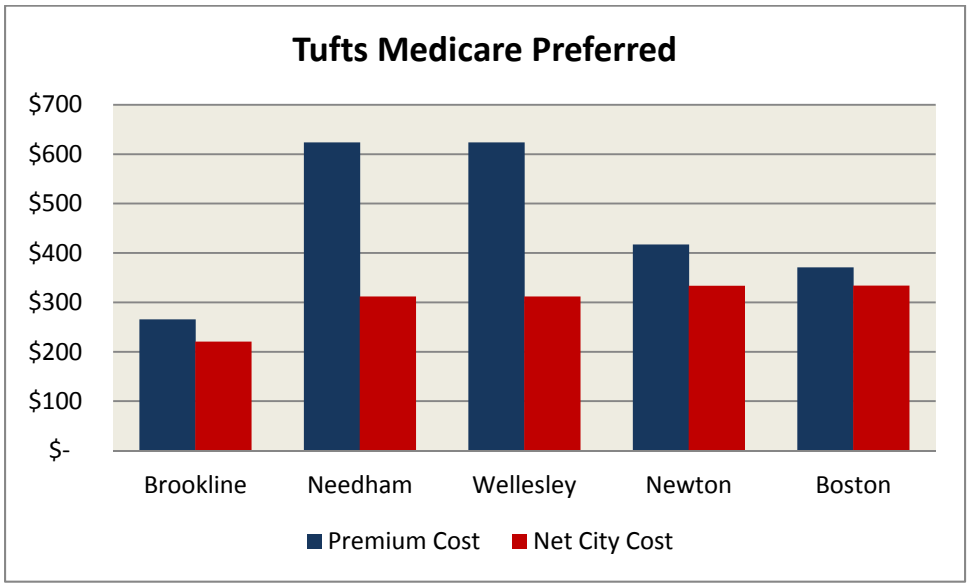
While these plans are not exactly the same, they are generally similar in terms of coverage. The variances are generally found in whether there is a deductible associated with the plan or not. Boston, Needham and Wellesley's Harvard HMO plans do not have a deductible. Newton's Harvard HMO Advantage enrollees pay a $500 deductible, while those in Brookline, who get Harvard HP Primary Choice form the GIC, pay a $750 deductible. Once the deductible is met, the insured no longer pay a deductible for the remainder of the calendar year.

Aside from the deductible, each of the Harvard HMO family plans is generally similar, with some differences at the margins. Each plan charges a co-pay of $75-100 for an emergency room visit. All plans require a co-pay of between $15-25 for a PCP office visit; require a referral to a specialist, where they pay a co-pay is $10 higher than what they pay for the PCP visit. Each plan has a tiered pharmacy co-pay schedule, etc.

Each of the five municipalities offers premium support ranging from 69% (Needham) to 83% (Boston, Brookline). Wellesley offers 79%, while Newton provides 80% (except new hires at 75%). The mean cost of the Harvard HMO (family) premium for these five municipalities is $19,329, while the mean level of premium support is 79%, or $15,244. Again, Newton is in the middle with the second highest premium at $19,878, and in the middle with 80% premium support. After the premium split is applied to the cost,

Newton's share of cost is $15,902, again in the middle of the pack. And, Newton's new premium support level (75%) places it at the low end of the spectrum, with $14,909 net share of cost.

Figure 13. Newton has average cost burden for Medicare supplement



The five neighboring municipalities offer a varying selection of Medicare supplemental insurance plans to their Medicare retirees, however, all offer Tufts Medicare Preferred (TMP), which provides a direct cost comparison. TMP charges a premium of $417, of which the City pays 80%. Of the other neighboring municipalities, Brookline pays the least, $266, for TMP (per its membership in the GIC), but offers 83% premium support. WSHG members, Needham and Wellesley, pay the highest cost at $624/mo. At the same time, Wellesley and Needham offer the minimum premium support allowed by law, 50%, to their Medicare retirees. Boston, which pays $371/mo. for TMP, offers 90% support to their Medicare retirees. The mean cost that these municipalities pay for TMP is $417. With the average premium support level at 71%, the mean net cost is $302. Newton's premium support is above the mean, but is at the median of these five communities. However, its net cost, $334, is the same as Boston and at the top of the cost range. Brookline pays the lowest net cost at $220, while Needham and Wellesley are each at the median at $312. In summary, Newton's benefit design, cost sharing with employees/retirees, and premium levels are in line with comparison municipalities, at least at a high level analysis.

Public Employee Committee

Under current Municipal Health Care Law, Newton may opt to form a Public Employee Committee (PEC) for negotiations across all unions. The PEC serves as a collective bargaining group comprised of the municipalities' employee unions and a retiree representative. Creating a PEC is a prerequisite step toward joining the GIC. However, a PEC can be utilized for other purposes. For example, the City of Boston has formed a PEC, largely to better facilitate negotiations with its 36 unions. As Boston explores modifying programs for wellness, disease management or EAPs, the PEC serves as a conduit for on-going communication, rather than requiring individual negotiations with every one of its affected unions.

Benefit Design Changes

As another option under the Municipal Health Care Law, municipalities are empowered to unilaterally redesign benefits, including cost sharing (copays, deductibles, etc.), provided that the benefits be at least as generous as the GIC benchmark plan[*]

The Option of Joining the Group Insurance Commission

As described above, cities and towns have the option of transferring their employees to the GIC, provided that this move would generate more than 5% savings on health plan costs. And, if this option is chosen, the city or town can return to up to 25% of the cost savings to employees.

The GIC acts as a volume buyer of health insurance for state employees and municipalities, currently providing health insurance to over 400,000 members, resulting in substantial purchasing power and political clout. Whether an individual municipality will gain by GIC membership depends, however, on its current health insurance program and costs, the needs of its community, and whether the GIC provides a clear improvement over existing options.

The GIC offers three major benefits to its members: first, a wide breadth of health plans; second lower prices gained by its purchasing power; and third reduced the administrative burden and costs.

The GIC offers 12 commercial plans for active employees and non-Medicare retirees. It also offers seven different plans for Medicare retirees. The commercial plans include HMO, PPO and indemnity plans from various insurers, all of which essentially cover the gamut of available plan structure allowed in Massachusetts. The offered plans have varied copays and deductibles, and some include tiered or limited networks. Generally speaking, the larger the cost sharing or limits on provider choice for the member, the lower the premium price.

Each year, following negotiations with insurers, the GIC announces its upcoming rates. All municipalities – regardless of size, employee or retiree demographics, or actuarial analysis – pay the same amount for premiums. For example, the town of Brookline and the City of Lowell each pay the same premium amount for the Tufts Navigator product. The local municipality's discretion in premium cost is limited to determining the premium cost split with their employees. Based on the outcome of negotiations with their PEC, one municipality may offer 90% premium support for that plan, while another may offer 60%. In sum, by joining the GIC, the municipality outsources aspects of health insurance administration that it had performed when directly engaged with insurers. The GIC administers insurance negotiations with the plans, COBRA benefits, dependent eligibility, retiree transition to Medicare, HIPAA notifications, and going forward, ACA requirements. These operations are funded through a 1% service charge which is rolled into the premium price25. Municipalities continue to be responsible for enrolling and terminating employee benefits and ensuring that payroll and pension deductions are transferred to the GIC for premium payment. The municipality is also responsible for reconciling GIC reports with its own internal benefit tracking data.

[*] THP's Navigator is the commercial benchmark and UniCare State Indemnity Plan/Medicare Extension is the Medicare benchmark

The GIC uses a number of tools to drive cost control. The first is market leverage, using its size to hold down insurance costs, contractually requiring its health plans to agree to strict cost controls. The second is access to plan analytics that measure the price and quality performance to hospitals and physicians. Insurers use these scores to designate a provider to a "network tier" or potentially exclude providers from the network entirely. For a tiered plan, depending on the insurer, the network has either two or three tiers, with the better quality/lower cost providers in the first tier, and lower quality/higher cost providers being placed in the second or third tier. Members then pay less (through cost-sharing) for first tier providers and pay more for second or third tier providers. For a limited network plan, subscribers save on their premium price.

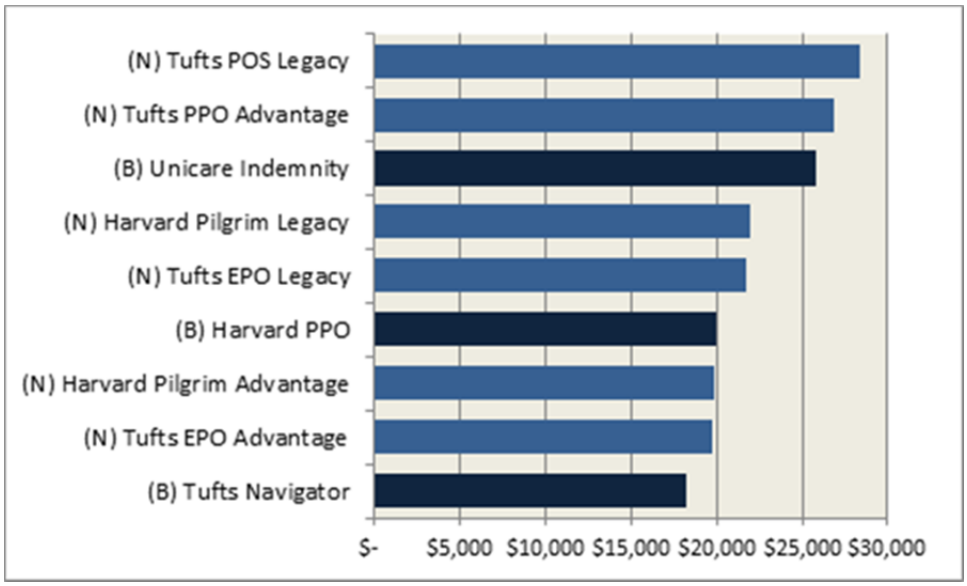
Going forward, the GIC also intends to hold cost growth down by implementing an Integrated Risk-Bearing Organization (IRBO) initiative[26]. One component of the IRBO initiative is that the active employees and non-Medicare retirees in the GIC will be required to identify a primary care provider (PCP), much like HMO (and EPO) plans require. As PCPs act as a low-cost first line of treatment and can help eliminate redundant or unnecessary services or unnecessarily expensive providers, the GIC believes that it can work with insurers to hold down health insurance costs. Other IRBO components include enhanced population health management, preventive care, and the re-engineering of high-volume high-cost episodic care. To this end, the GIC is aiming to attain 75% IRBO enrollment by 2016, and, through that to hold cost growth at 0%, with -2% for the two subsequent years.

Comparing Newton's Current Health Plans' Cost with the GIC's

Newton can potentially save money by enrolling its subscribers in the GIC. Fig. 14 demonstrates how Newton's Advantage premiums compare with a selection of similar plans offered by the GIC. To provide a more structured comparison, the family premiums for two Advantage plans used by Newton employees are contrasted with a selection of widely-used plans offered by the GIC.

While the plan types are different, the Tufts EPO Advantage (family) offered by Newton offers a comparable level of benefit support to that of the Tufts Navigator PPO (family) plan. The Newton plan premium is $19,727 annually compared to the GIC plan at $18,254. Another example would compare the Newton Tufts POS Advantage (family) plan, which costs $26,877, versus the GIC's Unicare Indemnity (family), which costs $25,794. Only Newton's HPHC individual plan is less expensive than the GIC's ($6,996 vs. $8,169). See Figure 14.

Figure 14. Newton- GIC Premium Cost Comparison (Family Plan)



Source: City of Newton; Group Insurance Commission

In aggregate, FY14 premiums suggest that Newton would save $2.4million annually in the GIC; however, if Newton continues to offer premium holidays, the GIC would cost $650,000 more (Figure 15).

Figure 15. Potential Savings at FY14 Rates with GIC

Health Plan Comparison	Total Premiums Paid (No Holiday)	Premiums with Newton 5.8% Holiday
Newton HPHC	$ 14,700,067	$ 13,851,986
GIC HPHC	$ 15,093,238	$ 15,093,238
Net Savings	$ (393,171)	$ (1,241,252)
Newton THP Low option	$ 23,059,095	$ 21,728,763
GIC THP Low option	$ 21,652,470	$ 21,652,470
Net Savings	$ 1,406,625	$ 76,293
Newton THP High option	$ 5,456,473	$ 5,141,677
GIC Indemnity option	$ 5,158,339	$ 5,158,339
Net Savings	$ 298,134	$ (16,662)
Newton Medicare	$ 10,557,738	$ 10,006,111
GIC Medicare	$ 9,479,659	$ 9,479,659
Net Savings	$ 1,078,080	$ 526,453
Newton Plans Total	$ 53,773,374	$ 50,728,537
GIC Plans Total	$ 51,383,706	$ 51,383,706
Total Savings	$ 2,389,668	$ (655,169)

A switch to the GIC requires thoughtful consideration of several issues. The first consideration is the issue of choice. Currently, Newton active enrollees are free to subscribe to any of its three Advantage products. GIC members can choose from 12 different products. Joining the GIC offers more choices to workers, which is likely perceived as added value. However, the additional choices make projecting potential savings more difficult, as any employee could choose the most comparable GIC plan (as in the projections above), or may choose a more or less costly option. While Newton subscribers have traditionally demonstrated a striking loyalty to insurer brand (Tufts or Harvard Pilgrim), there is no guarantee that this selection would continue when presented other options.

Another issue that must be taken into account is the level of premium support from the purchaser. It has been the practice of some municipalities to raise their premium support level to "reward" their employees for joining the GIC. This is not required under law, but if a change in premium support is contemplated, the City would need to take this into account. A small change in premium support can easily negate any savings to the City and markedly increase the savings for employees.

Another consideration is the City's actuarial accuracy in setting working rates. If the last two years' experience is applicable, then the FY14 effective working rates would be reduced by 5.8% to account for three weeks' worth of premium "holidays." After this discount is applied, the City's most popular plan, THP EPO, becomes effectively break-even (savings of $76,000, down from $1,400,000 without a premium holiday), as compared to the GIC. The likelihood of a premium holiday is an important consideration in projecting savings.

The issue of plan design and network tiering will also factor into plan comparisons. Network tiering would represent an out-of-pocket cost increase for many Newton subscribers, as many of them use a physicians or hospitals from higher cost tiers, including Newton-Wellesley Hospital and Massachusetts General Hospital, for medical treatment. Because neither Partners, Newton-Wellesley or Mass General are rated as Tier 1 providers by Tufts or HP, many Newton subscribers could expect to pay more out-of-pocket for medical treatment. This could result in as little as a nominal cost difference for a specialist visit[*] or represent a difference of hundreds of dollars more for a hospital admission. The more intensely the subscriber uses these providers, the more it will impact their out of pocket costs. For Newton members who use Tier 1 facilities, they could expect to see savings in their out-of-pocket costs under GIC plans.

Another factor that must be considered is that the GIC, unlike Newton, does not operate from a trust fund. If there is a shortfall in the funds to cover medical costs, the GIC has either to request additional funding from the Legislature or to cut benefits. During the 2010 budget crisis, the GIC increased the cost-sharing burden for employee subscribers at mid-year. The Newton self-insured trust has effectively buffered the City and its employees and retirees from this type of benefit reduction. As a trade-off, under the GIC the City would have health care costs fixed in advance each year. In essence, the City would effectively be fully-insured through the GIC.

[*] Newton's EPO and PPO Advantage plans require a co-pay of $35 for a specialist office visit. The GIC Tufts Navigator and Unicare Indemnity plans each charge copays of $25, Tier 1; $35, Tier 2; $45, Tier 3, for specialist visits.

The City's administrative costs would be lower under the GIC. The City would no longer need to fund the health insurance trust funds or pay for their administration. It would not need to negotiate, purchase, and administer re-insurance. The City would still need to track eligibility of employees, retirees and dependents, and administer payroll deductions of premiums. The GIC would provide analytical oversight and reporting.

The future cost trends for the GIC and Newton are unknown. The GIC's ambitious plans call for sharp reductions in the rate of cost growth which, should they occur, would be shared with participating municipalities. Indeed, the GIC has kept its premium increases lower than Newton's over recent years.[*] Lastly, should the City join the GIC, it would require a five-year commitment, which may be revoked at that the end of that time.

The City's and workers' control over health benefits is generally diminished by joining the GIC. Should the City remain self-insured, it could use the data at its disposal to monitor population health and utilization, and potentially intervene to positive effect. The City's and its plans' histories of doing so is not strong. The City's relatively small number of covered lives makes actuarially sound analyses challenging. In concert with other programs, such as wellness, disease management or EAP, the City could potentially help control premium costs by reducing utilization or by working to improve the health of their population. While the GIC is working on enhancing its data reporting and integration capabilities, from a practical standpoint an individual municipality's ability to track its own population is lost.

Recommendations

8. The City should explore acceptance of the Municipal Health Care Act in order for form a Public Employee Committee (PEC). Currently, Newton must manage relationships with seventeen employee unions. Considering the time and effort involved in reaching collective bargaining agreements, it may be in both the City's and the unions' best interest for form a PEC to better manage health program changes as the come under consideration
9. The City should evaluate the possible benefits of participation in the Group Insurance Commission (GIC). Joining the GIC poses some trade-offs and risks for Newton and its employees. The cost savings could be considerable while also reducing some administrative burdens on the city. Newton should work to educate its employees on the GIC offerings, so as to better inform the conversation.

[*] Based on GIC annual reports and City of Newton's published working rates for its Legacy plans, the rate of increase for GIC premiums increased by 4% between 2007-2012, compared to over 5% by Newton during the same time period.

Other Post-Employment Benefits (OPEB)

Scope and Nature of the Issue

The cost of funding retiree health care, referred to as "other post-employment benefits" or "OPEB" represents a major financial liability for Massachusetts cities and towns, including Newton. As early as 2004, the Government Standards and Accounting Board (GASB) was calling on state and local governments to report on these liabilities as part of their fiscal audits. Their standard was subsequently established as GASB 45. More recently, the Massachusetts Taxpayers Foundation conducted a survey of the 50 largest Massachusetts cities and towns, and found that OPEB liability was very significant, approximating $20 billion[27]. All of the municipalities were on a "pay as you go" basis, meaning that they only appropriated sufficient funds to pay current retiree health benefits, but did not set aside funds for future liabilities. The report urged the state to enact legislation to raise the eligibility age for retiree health benefits, cap the local contribution rate for retiree health benefits at 50%, provide authority for municipalities to unilaterally adjust plan designs for retiree health, require all eligible employees to enroll in Medicare, and require cities and towns to detail OPEB costs in their annual budgets.

In response to the serious financial issues raised by the report along with other analyses, the State Legislature established a *Special Commission to Study Retiree Healthcare and Other Non-Pension Benefits*[28]. The Commission's final report, issued in January 2013, cited a potential $30 billion in municipal OPEB liabilities. Under the current fiscal environment it could cost $500 million for the 50 largest municipalities to pay current costs and set aside sufficient funds to account for future OPEB liability. The Commission determined that the extensive scope of the municipal liability was the product of the dramatic increases in healthcare costs generally, as well as the expanding size of the eligible municipal retiree population, which is expected to grow 2.1% over the next ten years. In large part the growth in eligible retirees is due to the low threshold for eligibility with only 10 years of service required; the ability of part-time employees to receive full benefits; and the fact that employees do not have to retire directly from a city or town to receive benefits. In addition, cities and towns have traditionally paid generous retiree benefits. None of the municipalities pay less than 50% of the benefit cost, and according to a recent survey conducted by the Massachusetts Municipal Association in 2013, large-sized communities (500 or more subscribers) average 73% for pre-Medicare and Medicare ineligible retirees, and 70% for Medicare supplement health benefits[29].

Specific recommendations from the report were to:

- Increase years of service for eligibility from 10 years to 20 years
- Increase minimum age for retirement from 55 to 60 for most employees and from 50 to 55 for police and fire
- Pro-rate benefits based on years of service
- Require the retiree to be employed by city or town at time of retirement with exceptions for more than 20 years of service
- Require survivors receiving retiree health to contribute at least 50%
- Require competitive procurement every five years

- Set aside funds to pay future liability in addition to payment solely of current benefits, and
- Establish an irrevocable OPEB trust to assure that funds set aside are used solely to defray the costs of future retiree health benefits.[30]

Currently, House Bill 59, proposed by the Governor in January 2013 in response to the Commission report, is pending before the legislature. If enacted it would: limit the share that the city or town could assume for retirees to 50% including survivor benefits; require a minimum of 20 years of service for retiree benefit eligibility and pro-rate benefits up to 30 years of service; increase the retirement age for most retirees to 60 (55 for police and fire); and make employees who leave service without retiring ineligible for benefits unless they have at least 25 years of service and retire within 5 years or have 20 years and are enrolled in Medicare Parts A and B. Finally, it authorizes the State's Executive Office of Administration and Finance to oversee financial sustainability by establishing standards for addressing future OPEB liability.

However, even under current state law there are provisions which can assist communities in addressing their OPEB liability. Chapter 32B, section 9A permits a permits city or town to charge back another town for a portion of health benefits when the retiree was also employed by that town. Section 9B of Chapter 32B permits a local community to determine the share that it will pay for retiree health benefits, although it sets a floor at 50%. Section 18 of Chapter 32B requires municipal retirees, who are eligible, to participate in Medicare. And, Section 20 of Chapter 32B provides the local option of establishing an irrevocable trust for OPEB liabilities.

The City of Newton is already taking actions to address the pressing OPEB liability issue:

- The City has accepted Chapter 32B, Section 18, to require all retirees to access Medicare benefits unless they can demonstrate that they are not eligible for Medicare.
- The City currently arranges for annual audits and reports on the scope of OPEB liability consistent with GASB 45.
- On May 6, 2013, the City established an Irrevocable Trust for OPEB funds (Ordinance No. A-20.)
- Commencing July 1, 2012, the City began contributing 2.5% of base compensation for all newly-hired employees who participate in the City's health insurance plans to the City's OPEB fund. As of June 20, 2013, a total of $538.537 has accumulated in the trust fund.
- Plan changes were made in 2011 to require newly-hired active employees to elect one of the less expensive "Advantage" plans, when they retire, which has the effect of reducing the City's future retiree health care costs. And, all newly-hired active employees must contribute at least 25% of the costs. Currently, 88% of newly-hired union members pay 25% and the other 12% pay 30%.

Recommendation:

10. The City should closely monitor the actions of the state Legislature as it considers proposed legislation on retirees health benefits (OPEB). If enacted, the legislation could assist the City in reducing its future liability for retiree health benefits.

Use of Behavioral Incentives and Traditional Disease Management and Wellness Programs to Promote Lower Cost, Higher Quality Health Choices and Employee Wellness

This section considers the ways in which Newton could focus on improving overall employee health and wellness by encouraging cost-effective choices through seeking lower-cost, higher-value providers. Beyond the basic design of health insurance benefits, employers have a number of potential approaches that can help influence employee health and health spending. Broadly, these include approaches that rely on financial incentives to influence enrollee choices or health behaviors, and traditional programs that are designed either to improve chronic disease management or improve overall wellness. The Committee examined each of these types of approaches, beginning with the use of incentives and concluding with traditional disease management and wellness programs. We also examined the use of health risk appraisals, which can be used to collect data about employee health conditions and behaviors. The discussion of each approach includes a summary and recommendations that take into account options that are currently available in the market.

Using Financial Incentives to Influence Healthy Behavior

Among the most important levers for influencing employee behavior, both with respect to care seeking and healthy behaviors, is the use of financial incentives. Some of the most promising approaches are designed using lessons learned from behavioral economics[*]. In this section, the Committee focuses on the use of incentives to influence members in three areas: choosing a provider (physician and hospital choice); chronic disease management; and wellness and health promotion. Below, we briefly describe the use of incentives in each of these areas, summarize the pertinent literature and limitations, and identify opportunities that the City could pursue in each of areas.

Influencing Choice of Provider

Provider payment rates vary widely in Massachusetts. Much of this variability is driven by the market power of various provider organizations, with market power arising from sheer size, inclusion of hospitals with the highest perceived quality or reputations, or geographic factors in which a provider has a local monopoly. Another factor contributing to escalating expenses is the fact that high-cost academic medical centers account for approximately 45% of hospital admissions in the state[31], considerably higher than the rest of the country.

The disparities in pricing exist despite the lack of any associated differences in quality. Although quality cannot yet be fully and accurately measured, the Attorney General's Office has shown that the available measures of process of care (doing the right thing at the right time), patient experience (patients' own ratings of the care they receive), and outcomes of care (such as mortality, complications and

[*] Behavioral economics departs from the typical utility maximizing view of classical economics to incorporate design features into incentive programs that overcome inherent biases in decision making that often lead to suboptimal choices. A simple example is the use of varying levels of copayments to promote desired choices, but the principles may be applied to influence behavior in a number of different domains, with varying implications for both current and future health expenses for the City.

readmissions) do not demonstrate any relationship with the price paid for health care.[32] Yet, some providers frequently used by Newton employees are among the most expensive in the state and therefore offer an opportunity for cost savings by seeking similar services of similar quality at lower cost sites.

Currently, two types of health plan offerings help steer employees to lower cost/higher quality (i.e., higher value) physicians and hospitals: tiered networks and limited networks. Neither of these has been offered by the City[*]. Other options have the potential for even greater impact on spending, such as reference pricing plans. Under these reference pricing, employees must pay the difference between the a particular provider's charge and the "reference" price, which typically is equal to the lowest or second lowest available price for the service from any local provider. These plans are not currently available in our market, although this could change in the next several years.

Tiered Networks

Both HPHC and THP offer tiered-network plans (e.g., HPHC Choice Net, THP Navigator). Under these plans, employees pay lower copayments when choosing "preferred" physicians or being admitted to "preferred" hospitals. Members who select providers who are not in the preferred tier still have insurance coverage, but they must pay a higher copayment. Thus, access to specific providers is not restricted under these arrangements. Generally there are either two or three tiers, and premium savings can approach 10%. To achieve savings, tiered plans must successfully steer some patients from their lower-value providers to higher-value ones, saving cost for themselves and purchaser. Patients with longstanding provider relationships or who are undergoing complex care are less likely to change providers. Compared to an HMO, tiered plans may be viewed as less attractive, as some choices result in greater out-of-pocket costs. The attractiveness of tiered and narrow network plans also is determined by the geographic location of the covered employees and current care seeking behaviors. By far, the hospital used most by Newton employees is Newton-Wellesley. For 2013, THP includes Newton-Wellesley Hospital as Tier 1 (preferred) for medical-surgical admissions and pediatrics, and Tier 2 for obstetrics. HPHC lists Newton-Wellesley as Tier 2 for all services. For a Newton employee who is a current patient there, the tiered network options may not be viewed as attractive, although copayments for the Tier 2 hospitals may not be seen as excessive. However, employees may be influenced over time to choose lower-cost preferred providers.

Evidence of the impact of tiered networks on consumer choices is just beginning to emerge, but it shows that differential copayments can lead to changes in choice of hospital or specialists[33]. In many cases, however, enrollees are unaware of the tier of their physician or hospital, and need to be better educated about their choices. However, should Newton's health plans adopt a tiered plan and as a result shift employees to higher-value providers, both employees and the City could reap considerable savings.

[*] The GIC offers examples of both.

Limited Networks

Limited network health plans restrict patient access to only the higher-value providers. Unlike tiered plans, the patient does not have the option of paying a higher copayment to access an out-of-network provider (who simply would have been a higher tier provider in a tiered plan). Often limited network products will have more substantial savings, but geographic coverage and employee choice would be more limited[34]. Currently, both HPHC and THP offer limited network products, as well as tiered network products.

Newton could adopt tiered or limited network plans through the GIC or directly from its current carriers. THP estimates savings of 14.4% with a tiered network and 11.1% with a limited network. HPHC estimates savings of 7% for a tiered and 10% for a limited network[35].

Transparency Initiatives and Related issues

Chapter 224 of the Acts of 2012[36] requires that health plans make negotiated prices available to enrollees by fall 2013. Companies such as Castlight[37] (working with HPHC) have well-developed methods for making these types of data available to consumers. In and of themselves, it is unlikely that such initiatives will have much of an effect on health seeking behaviors because enrollees have little motivation to seek out higher value providers under traditional insurance benefits. However, when combined with incentives like a tiered network or a high deductible, tools such as these could be powerful motivators of provider selection.

In addition, it is likely that there will be innovations in these types of plan offerings in the next several years. For instance, HPHC offers an option called "Save-On" that pays enrollees small amounts of money for choosing a lower cost provider for imaging services. This program is funded by the employer, but reduces spending as the incentives offered to the enrollee are lower than the amount of savings. However, programs like Save-On could reduce coordination of care if providers are unable to access test results from outside of their facility. This problem may be ameliorated as robust information exchange is implemented over the next several years. As noted earlier, reference pricing options are being piloted, wherein the insurer will only cover procedures up to the price of one of the lower cost providers that also meets quality standards. The employee would pay the full difference in price. Early evidence from a pilot program demonstrates significant shifts from high- to low-price facilities for orthopedic surgery[38].

Recommendations

11. The Committee believes that both tiered network and limited network products are reasonable approaches to reducing spending. Of the two, employees may find tiered networks more acceptable, though the potential savings may be less. The Committee recommends that these options should be discussed with unions and employees as potential options to reduce costs, saving money for both the City and employees as well as offering health benefits.
12. The Committee also believes programs offering incentives for choosing lower cost providers, and increased information transparency, such as that required by Chapter 224, and

operationalized through the City's health plans, can provide employees incentives to make cost-effective decisions. The Committee recommends that the City consider these opportunities as they become available.

Value-based Insurance Design

Value-based insurance design (VBID) programs also promote the use of high value services, such as preventive care, by reducing copayments (sometimes to $0 or even a cash payment to the member) to reduce barriers to care. VBID plans may lower copayments for specific drugs to promote adherence to medications for important chronic health conditions, such as diabetes or hypertension. Similar approaches include waiving all patient copayments for preventive health exams and recommended screening tests, such as mammography, PAP testing, and colon cancer screening. Now however, Section 2713 of the Affordable Care Act mandates full employer coverage of services rated as "A" or "B" by the US Preventive Services Task force, so these VBID features have already become universal offerings. Consistent with this requirement, the health plans currently offered by the City now provide first dollar coverage for these preventive services. As a result, there appear to be few additional opportunities for improvements in promoting the use of high value care.

Adjusting copays for recommended specific services or drugs has also been shown to increase adherence, with most studies showing that reducing or eliminating copayments in various medication classes improves adherence rates by ~3-6%[39]. Studies examining the impact of VBID on total medical spending for selected populations have shown inconsistent results, with some studies showing that the program pays for itself (i.e., generating savings that cover the costs of the all the copayments that have been waived, including those for patients who were adherent to start with), but few showing significant savings, and none reporting longer term outcomes.

Thus, the opportunities for meaningful savings seem fairly limited, although these programs may have some impact on health and spending for these relatively limited populations of patients over the longer term. Most Newton employees are employed by the City for a longer duration (with the exception of the school system) so long term savings may be possible. Instituting lower copayments for recommended chronic medications may offer modest savings the City. For HPHC, approximately 5-10% of the population has a chronic disease such as diabetes, hypertension, or hypercholesterolemia. THP has enrolled almost 600 individuals with diabetes in their disease management program. It appears as if THP already waives many copayments for these diabetics. On the positive side, VBID programs demonstrate a commitment to employee health and thus also may have additional positive effects among employees.

VBID designs can also be used to discourage the use of services judged to be of low value. For instance, copayments can be increased for services such as MRIs for low back pain that are considered to be of little to no clinical benefit. Similarly, almost all health plans have instituted higher copayments for emergency room visits (typically $75-$150) in order to decrease inappropriate ER use[40]. Recently, the *Choosing Wisely* campaign of the American Board of Internal Medicine has been promoting lists of low value services identified by numerous specialty societies[41]. Committee review of these low value

services, however, showed that few or none are candidates for differential copayments because each service may be high value in some specific clinical settings[42]. In other words, instituting additional VBID features would be technically difficult and may not result in benefit to the City or its workers.

Recommendations

13. While the Committee lacks information about the scope of the disease management programs currently offered, lowering copayments on chronic medications or other incentives should be considered. It is unlikely that Value Based Insurance Design (VBID) has the potential for substantial cost savings or improved employee health in the short-run.
14. The Committee recommends consideration of increasing incentives to use higher value prescription medications. The City should explore whether and how Newton's small mail order pharmacy use (5% of spending in HPHC) can be increased, which would save money for the City and its workers.

Direct Incentives for Wellness

Overview

Direct incentives to encourage wellness are becoming an increasing topic of interest and have generated much interest, but as currently implemented are not likely to be particularly effective or generate much savings. More recently, however, guided by the tenets of behavioral economics, some promising and innovative programs have been developed. Wellness incentives programs may take on two forms: varying the employee's premiums to encourage healthy behaviors, and providing specific incentives distinct from premiums to promote healthy behaviors.

Adjusting Premiums*:* In some firms, employees who smoke, are inactive, or are overweight may be charged a higher premium if they fail to participate in wellness programs or fail to achieve certain results. Employees who participate and succeed may be charged a lower premium. However, such programs also discourage those with these characteristics from seeking employment and might also stigmatize employees with the targeted behaviors. Section 2705 of the ACA promotes such incentives, allowing employers to increase the value of the incentives to up to 50% of the premium amount if the program addresses smoking (and 30% otherwise). While there are provisions to assure that health-contingent wellness programs must follow non-discriminatory rules,[43] incentives of these magnitudes have never been widely used and raise concerns for several reasons. Poor and minority populations are more likely to be affected by these programs, thus rendering them regressive and discriminatory. In addition, the design, which masks the incentives in the form of money withheld from paychecks, is not in line with current knowledge of behavioral economics, which calls for more frequent and highly visible incentives[44]. Finally, use of such incentives in the short run is a zero sum game, as higher premiums for those with risk factors are offset by lower premiums for others. To the extent that such differential prices results in behavior change, however, there could be longer run savings for the city and its employees as well as health improvements for individuals.

Direct Incentives and Incorporating Behavioral Economics*:* Direct incentives have been used in the context of wellness programs to reward employees for engaging in healthy behaviors. For instance,

many firms offer a reward for regularly exercising, enrolling in an educational or nutrition program, completing a health risk appraisal. Such programs are common, but rewards in terms of health improvement are generally small. One problem with such programs is that the incentives often go to those who were already engaged in healthy behaviors, thus resulting in payments that were unnecessary to encourage the desired behavior. In addition, the incentives are often designed in ways that are insufficient to motivate sustained behavior change. Thus, the vast majority of these types of incentive programs are likely to result in additional spending rather than cost savings, although there is some potential for positive longer term effects.

More recently, programs that are designed based on the principles of behavioral economics have been developed and tested. The most prominent examples of programs that have shown some success in motivating behavior changes have been in the area of smoking cessation and weight loss. Where innovative programs with higher levels of incentives (or more frequent levels of lower frequent incentives) have been combined with other design principles that seek to minimize feelings of regret or harness social influences. One frequent objection posed to these programs is that they may reward those with unhealthy behaviors, while they inherently penalize those who do not have such unhealthy behaviors to start with. In addition, many of these programs are new and data are lacking about the optimal design and incentive structures.

Both HPHC and THP offer some incentives to promote health behaviors, such as completing a health risk appraisal or joining a gym. Neither plan, however, currently offers innovative programs designed based on lessons from behavioral economics. Additional discussion of current options is found below related to wellness programs in general.

Recommendations

15. The Committee recommends against charging differential premiums based on risk factors, as we believe that the potential benefits are outweighed by potential harms for a mostly unionized workforce such as in Newton. Concerns about equity and the influence on disparities argue against implementation of programs of this nature.
16. The Committee recommends that the City monitor developments in program design and outcomes. Programs that use behavioral economics to increase patient engagement are promising, but are currently lacking sufficient data. As these programs develop further and the level of incentives expands as permitted under the ACA, promising universal designs may emerge. At an appropriate time, they City may wish to pilot a program targeting a particularly concerning or costly behaviors.

Traditional Disease Management and Wellness Programs

Disease Management

Overview

Disease management (DM) is a system of coordinated interventions aimed both at enrollees and their physicians to improve population health and chronic disease care. Such programs are offered by almost

all health plans, but data supporting their effectiveness is sparse. There has been substantial movement over the last decade to create more holistic programs that allow for the integration of all relevant diseases/conditions to be integrated into a single management program. These types of programs eliminate duplicative contacts and are more straightforward for both enrollees and physicians. Despite these advances, however, the literature supporting disease management activities fails to show a convincing benefit to disease management in the form of health gains or cost savings. The most important determinant of the cost effectiveness of such programs is the degree to which they are targeted to those most likely to benefit. For the sickest, most costly patients, disease management is likely cost effective. When less sick individuals are included (companies providing these services have incentives to enroll more enrollees), the potential benefit is diluted and the programs might end up resulting in a net increase in costs.

The disease management literature is extensive but inadequate as most studies lack equivalent control groups. Often, pre-post designs are used and, as a rule, the sickest patients in one period will be less costly in the next period when they improve (so-called regression to the mean), a finding that would have been observed with or without the program. CMS recently conducted a large randomized trial of numerous DM programs and, on the whole, found that the programs were ineffective in saving money[45].

HPHC and THP are among the most highly rated health plans nationally. HPHC offers a broad suite of disease management and care management programs, with just a small number of these requiring an additional premium (buy-up). However, given the very small number of Newton employees who qualify for these additional programs, it is unlikely that there is substantial potential for cost savings or improved health that would result. Currently, there are 303 Newton employees who are eligible for HPHC programs and, of these, 235 are enrolled, including 68 deemed of higher risk. Relatively few additional employees would be eligible for the few “add on” programs that are not included in the basic plan. Similarly, THP also offers a comprehensive suite of DM programs, but little information is available on current enrollment or pricing. It is unknown whether and by how much the City and its employees benefit from the existing DM programs. The health plans did not provide any analysis of the savings or health improvements that their plans created, either for the City itself or across the all the plans’ customers. City officials believe that providing DM programs may contribute to good relations with employees.

Recommendations

17. The Committee sees little to no potential savings by offering additional or more comprehensive disease management programs beyond those HPHC and THP currently provide.
18. In the absence of demonstrated benefit of current DM programs, the City and employees should consider ending programs that are provided at an additional cost by its current health plans.
19. Innovative programs incorporating incentive payments that improve the effectiveness of disease management programs could be adopted, but current options are lacking and none are recommended at this time. To the extent that additional data become available or programs are developed, they may represent an area for future opportunities.

Traditional Wellness Programs

Overview

Workplace wellness programs are "opportunities available to employees at the workplace or through outside organizations to start, change, or maintain health behaviors."[46] Such programs can include a variety of options, including performance of screening tests; behavior modification programs such as smoking cessation and weight loss; educational programs; changes in the work environment, such as the availability healthy food choices; or benefits such as subsidized gym memberships. Workplace wellness is today a $6 billion industry[47], and over 94% of large employers (> 200 employees) offered programs in 2012[48]. Large companies are more likely to offer programs and to administer their own; smaller companies that offer programs often use the same organization that administers their health plan or a third-party administrator. Wellness programs aim to improve health and productivity and reduce health care costs, absenteeism, and employee turnover.

Workplace wellness programs have the potential to influence health status, productivity, and health care costs. Workplace wellness may use incentives or disincentives based upon participation or achievement of certain health measures, and may include a variety of programs. There is possible benefit in the mere existence of a wellness program in the positive signal it sends to employees that they are valued in the overall workplace environment. However, solid research on the effectiveness of the different types of wellness programs is lacking. The Affordable Care Act regulations require health outcome-related incentives to be part of wellness programs, and offer safeguards to assure access and alternatives for employees who due to health-related conditions cannot participate in the programs without a reasonable alternative.

The City has experimented with various wellness programs. These include an annual employee and retiree health fair, a monthly employee newsletter, regular "lunch and learn" events, annual flu vaccinations, health maintenance clinics, Zumba classes, a police/fire fitness assessment and training program, and "wellcoins" (a virtual currency) redeemable at local businesses for a range of healthy choices (see *direct incentives* section above). Past programming has also included competitions among city departments to achieve health goals with raffle prices, an online health portal, and some targeted programming to promote annual physicals and encourage employees to establish relationships with primary care providers. There have also been incentive-based health insurer benefits, such as diabetes disease management programs that encourage regular checkups and a fitness center rebate for employees who provide proof of belonging to a fitness center (see Direct Incentives for Wellness in above). However, with the exception of the annual flu vaccinations, there has been low participation in these wellness initiatives. As a result, while there has been no formal evaluation, the programs have likely had very modest if any health effects and little or no cost savings. As examples, the lunch and learn sessions typically have attracted 10 people and only a handful of employees have participated in health maintenance clinics and Zumba. The City's health portal was abandoned due to low participation. Only three employees completed the health risk appraisals offered by HPHC and THP.

Smoking cessation and influenza vaccination programs are areas of special interest. The rationale for these programs is the personal benefit for all employees and improved employer-employee relations,

along with a likely health and financial benefits for employees and financial benefit for the City (although it will be difficult to establish empirically). Additional financial benefits for the City include a possible reduction in absenteeism and health care costs for those who are vaccinated during the flu season. For smoking cessation, there may be reduced health care costs, possibly as soon as 3 years after the smoking cessation program is implemented. To increase participation, the City may consider financial incentives for the smoking cessation programs (see the discussion above on incentives related to patient behaviors). In either case, however, it will be difficult for the City to identify and track specific savings. Thus, the primary explicit benefit to the City will likely be improving employer-employee relations.

Physical fitness is a particular concern for public safety employees because of the physical fitness standards under Mass. General Laws, Section 61A and the high costs associated with disability and premature retirement. Wellness programs aimed at weight reduction, exercise, and smoking cessation may be especially worthwhile. There is a national movement led by the National Institutes of Occupational Safety and Health to promote programs like these as part of a "Total Worker Health initiative" integrating both work-related and non-work related conditions, since overall health may affect the likelihood of work-related injuries. Well-crafted, targeted programs may improve employee health. However, at this point there is insufficient evidence to expect cost savings or health gains. There may be "intangible" benefits on employee morale as it sends that messages that the city cares about them.

Recommendations

20. The Committee recommends that the City continue to offer flu vaccinations for all employees, with a goal of vaccinating 100% of employees.

21. The Committee recommends that the City offer full coverage for smoking cessation programs and medications through PCPs, including those offered by local providers and through the City's health plans.

22. The Committee recommends that the City should consider the availability of wellness programs for cardiovascular fitness and weight reduction for public safety workers.

Health Risk Appraisals (HRAs)

Overview

Health Risk Appraisals (HRAs) are systematic approaches to collecting information from individuals that identify risk factors, provide individualized feedback, and link people with at least one intervention to promote health, sustain function and/or prevent disease. A typical HRA instrument collects information directly from enrollees on demographic characteristics (e.g., gender, age), lifestyle (e.g., smoking, exercise, alcohol consumption, diet), personal medical history, and family medical history. In some cases, physiological data (e.g., height, weight, blood pressure, cholesterol levels) are also obtained.[49] The use of health risk appraisals to assess employee health has increased in recent years. HRAs are more prevalent at larger companies.

In theory, HRAs can screen for issues not identified or addressed by physicians due to time limitations, although this may also lead to over diagnosis. Evidence suggests that financial incentives can increase HRA completion rates, though completing the HRA is only a first step toward improving health, and no established evidence demonstrates that HRAs produce savings or improved outcomes. Discussing one's HRA results with a physician likely helps to achieve necessary medical follow up. Some research has shown that HRAs may lead to more patient follow up for certain conditions (e.g., hearing and mobility impairment) than others (e.g., cognitive impairment)[50]. HRAs currently lack standardization or formats for specific populations (e.g., individuals with chronic conditions). Newton employee enthusiasm for HRA seems to be low, as only three employees participated in the most recent HRA administrations. Though incentives could be used to increase participation rates, the size of such incentives needed to achieve success is not clear. Moreover, it is not clear whether the increase application of HRAs would yield information that the City or employees would act upon. The City can still pursue other wellness initiatives in the absence of expanded use of HRAs.

Recommendations

23. The Committee recommends against the City expending resources on health risk appraisals at this time because of challenges and limitations noted.

Encouraging Health Plan Opt-Out by Employees to Achieve Financial Savings in Newton

Some Newton employees have the option of purchasing health insurance either through the City of Newton or through another source, most commonly an employed spouse's employer. If the City could encourage employees to obtain health insurance through alternative sources that would save substantial money. The Committee explored whether this might be worthwhile and under what conditions a program might be implemented.

A detailed analysis of this issue is included in the Appendix. Briefly, about 25% of Newton employees decline health insurance through the City. If the City offered incentives to employees not to subscribe to City health plans, a considerable sum would be payable to these 25%. As a result, any design of an incentive program would be expected either to be ineffective or to cost more than it would save.

Recommendations

24. The Committee recommends against an employee opt-out program.

Community Partnership Opportunities

The Committee discussed whether developing or enhancing relationships between the City and area health care providers could help the City reduce health care costs while addressing the health and wellness of its employees.

Existing partnership with Newton Wellesley Hospital

The City of Newton has an agreement with Newton-Wellesley Hospital (NWH) to provide certain services that the City offers for its employees. Some of these services are provided at no cost to the City. The City's original agreement with NWH ended in 2005 and was extended until 2011. It has not been extended since, yet the arrangement seems to be continuing on a *de facto* basis.

Under the original, services for employees who are injured on the job or to meet other employment related requirements are provided, in part, by NWH. NWH provides the following work-related injury services through a sub-contract with a Needham-based clinic, Kadre:

- Initial evaluation and one follow up visit - no cost to the City.
- Additional care for injuries - charged to the City at the rates set by the state's Center for Health Information Analysis.
- Pre-hire exams, including police/fire medical certification examinations, blood tests, x-rays, and lifting assessment – no cost to the City.
- Medical Surveillance services (including lead surveillance programs for users of the police firing ranges) – routine testing for employees who are exposed to potentially hazardous material – no cost for lab work, or x-rays facility charges; charges for physician and radiologist fees assessed to the City.
- Return-to-work clearance exam (non-work related injuries) – no cost to the City.

The available utilization data for these services was incomplete, including only subsets of employees (e.g. municipal staff, but not teachers, firefighters or police); not all services (e.g., work-related injury services, but not other services); and for inconsistent periods of time (e.g., differing partial years' data. As a result we are unable to assess the scope of services provided through the agreement with NWH or the value of those services.

The Committee believes that data regarding the number of employees referred for the services at NWH or its subcontractor, as well as the type and frequency of services received, should be compiled and readily available to City human resource and budget staff. This type of data, for multiple fiscal years, is essential to an analysis of the ongoing value of this agreement. Depending on the utilization of services, the city may want to explore the possibility of broadening the list of services covered under this arrangement or obtaining similar services from other providers.

Also under the agreement, Employee Assistance Program (EAP) services are also provided to City employees by NWH through its Partners EAP Program (the same program that NWH employees use). This program offers a free hotline, counseling for a range of personal and work-related issues for employees, as well as consultations for managers. An initial assessment and up to 6 visits are covered at no cost to the City. EAP counselors help employees find the best continuing treatment options covered by their own health insurance.

According to the *EAP Utilization Summary* that was provided to the Committee, between 7/1/2012 and 5/31/2013, 31 new, reopened and pre-existing cases were reported, along with 17 managerial

consultations. Unfortunately, a report covering the entire fiscal year is not available and reports for prior fiscal years were not available to review for this report.

EAP services are extremely important to employees, especially those experiencing stresses on or outside the job. It is not possible to assess the financial or clinical value of this aspect of the agreement with NWH without adequate utilization data.

Potential Partnership Opportunities

The Committee was also interested in exploring possible partnerships with other health care providers. Atrius Health is an alliance of six physician organizations, is the largest independent physician organization in the state, and has its corporate offices located in Auburndale. Three of its clinical offices are located just outside the City, in Wellesley, Watertown, and West Roxbury.

Committee members met with representatives of one of the Atrius organizations - Harvard Vanguard Medical Associates (HVMA) - to better understand their operations and to begin a discussion about how they could work with the City.

The HVMA representatives described a variety of community-focused activities that they offer and suggested that Newton might be able to partner with them on the following activities:

- Flu clinics;
- Providing health-related materials;
- Providing information on selecting primary care physicians (they advised that the City encourage all Newton employees to select a Primary Care Physician);
- Co-sponsoring health fairs for employees and Newton residents; and,
- Offering lectures on wellness topics for employees and Newton residents, including the value of health risk assessments.

They pointed out that such a partnership between the City and HVMA would be largely contingent on the number of City employees who receive health care from Harvard Vanguard physicians.

According to data received from HPHC and THP, approximately 22.7% of City employees and their family members receive their care from a primary care physician associated with an Atrius physician organization. Based on these numbers and the experience of Atrius with the City of Boston[*], it could be worthwhile pursuing a partnership with them for some or all of the services described above to enhance the City's existing health and wellness initiatives (Annual Health Fairs, Flu and Shingles Vaccination Clinics, Health Maintenance Clinics, Monthly Lunch and Learn Program and the Monthly Employee Newsletter).

[*] The City of Boston has recently contracted with Atrius to assist Boston on population management. Initially they are developing analytics on the health needs of Boston employees by utilizing claims data, for example, to identify employees who are in need of follow up care. In the future, Boston may contract with Atrius to provide outreach to these employees and/or screening services.

A broader partnership with Partners Heathcare may also be a valuable avenue for the City to consider. Partners is the parent company of Partners hospitals and physicians, including NWH. Partners is second to Atrius with 18.4% of the City employees and family members choosing a primary care physician associated with Partners. As with Atrius, Partners may be interested in offering assistance to the City's health and wellness efforts, beyond the current arrangement with NWH.

Recommendations:

25. The City should collect and analyze data pertinent to its agreement with NWH. Utilization rates, costs, and types of services should be available to City staff.

26. The City should engage area health care providers to discuss potential partnerships that could improve the City's existing employee health programs. If found to be valuable, the City should update its agreement with NWH for employment related health services and the employee assistance program. A new agreement should clarify expectations and include reporting requirements and benchmarks for assessment of the effectiveness and value of the services to the City. The City should complete a review of the existing programs prior to extending the contract.

Conclusion

Health insurance is both a major budget item and a critical benefit to City workers, retirees and their dependents. The Health Care Advisory Committee has reviewed the history, the context and, where possible, the performance of Newton's health benefits programs. Over the past decade or more, Newton has been largely successful in administering effective and innovative programs. The Committee makes a number of recommendations for how the City can continue to improve the cost-effectiveness and the oversight of its health benefits programs.

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Cayla Saret, research assistant to Peter Neumann

Kyla Minton, Julia Miller and Ben Stewart at Freedman Healthcare, LLC

Appendices

Appendix 1. Newton HCAC recommended data

All health plan data should be provided in a manipulable electronic format, such as a spreadsheet. The City should have a routine process for taking in, collating, and reviewing the health plan data.

A. Enrollment

Number of subscribers and dependents, by plan
Member months of enrollment, by plan
Enrollment by subscriber demographic (active, retiree)

B. Financial Analysis

Medical costs, including claims-based payments and any non-claims-based payments (e.g., capitation fees, provider management fees, supplemental payments, bonuses, etc.)
Administrative fees including fees paid for optional programs, such as disease management
High cost claimant analysis

C. Medical Care

Demographics
Age/sex
Risk score (measure of the illness burden of the population, such as DxCG, normalized against the health plan average)
Benchmark comparison data for

1. Health plan overall
2. Health plan comparable clients (i.e., public employers)

Quality
Clinical quality (HEDIS clinical quality measures and CG-CAHPS patient experience ratings for Newton enrollees as compared to benchmark)
Clinical outcomes, if available

Utilization and Cost
Utilization, including per member per month (PMPM) costs, utilization rates (typically as units per 1000 members per year), and cost/unit; for all standard types of service (e.g., office visits, inpatient admissions, lab tests, as organized by Berenson-Eggers Type of Service (BETOS) or other acceptable standard); all cost and utilization data must be shown in comparison to benchmarks above
Reports should be available at minimum annually. City may benefit from quarterly reporting.
An annual report from the health plan identifying cost and utilization patterns along with identified opportunities and recommendations for lowered costs or improved quality

Place of Service
For major types of service, a listing of the major providers, each provider's volume, and each provider's average cost

Summary and trends by place of service (e.g., inpatient facilities by admits, days and costs; ambulatory surgery and radiology by hospital-based vs. freestanding facility)
High/low cost leaders for major types of service

Pharmacy
Pharmacy utilization summary
Top drugs and therapeutic classes by utilization and cost
Pharmacy costs by therapeutic class
Specialty pharmacy utilization and highest volume drugs

Appendix 2. Financial Comparison of City and GIC

	Annual	FY14			0.942307692	Total City Savings		Total City Save w/Holiday		Total Employee Savings		Total Employee Savings w/holiday	
		Premium $	Enrolled	Premium * Enrolled	With 5.8% Premium Holiday Discount	80%	75%	80%	75%	20%	25%	20%	25%
N	Harvard Pilgrim Individual Advanta	$ 6,996	411	$ 2,875,208		$ 2,300,166	$ 2,156,406	$ 2,167,465	$ 2,031,998	$ 575,042	$ 718,802	$ 541,866	$ 677,333
N	Harvard Pilgrim Family Advantage	$ 19,878	497	$ 9,879,426		$ 7,903,541	$ 7,409,569	$ 7,447,567	$ 6,982,094	$ 1,975,885	$ 2,469,856	$ 1,861,892	$ 2,327,365
N	Harvard Pilgrim Individual Legacy	$ 8,098	80	$ 647,818		$ 518,254	$ 485,863	$ 488,355	$ 457,833	$ 129,564	$ 161,954	$ 122,089	$ 152,611
N	Harvard Pilgrim Family Legacy	$ 21,993	59	$ 1,297,615		$ 1,038,092	$ 973,211	$ 978,202	$ 917,065	$ 259,523	$ 324,404	$ 244,551	$ 305,688
	Newton Subtotal			$ 14,700,067	$ 13,851,986	$ 11,760,053	$ 11,025,050	$ 11,081,589	$ 10,388,989	$ 2,940,013	$ 3,675,017	$ 2,770,397	$ 3,462,996
B	Harvard PPO I	$ 8,169	491	$ 4,010,979		$ 3,208,783	$ 3,008,234	$ 3,208,783	$ 3,008,234	$ 802,196	$ 1,002,745	$ 802,196	$ 1,002,745
B	Harvard PPO F	$ 19,932	556	$ 11,082,259		$ 8,865,807	$ 8,311,694	$ 8,865,807	$ 8,311,694	$ 2,216,452	$ 2,770,565	$ 2,216,452	$ 2,770,565
	GIC Subtotal			$ 15,093,238	$ 15,093,238	$ 12,074,590	$ 11,319,928	$ 12,074,590	$ 11,319,928	$ 3,018,648	$ 3,773,309	$ 3,018,648	$ 3,773,309
	Net Difference			$ (393,171)	$ (1,241,252)	$ (314,537)	$ (294,878)	$ (993,002)	$ (930,939)	$ (78,634)	$ (98,293)	$ (248,250)	$ (310,313)
N	Tufts EPO Individual Advantage	$ 7,186	563	$ 4,045,966		$ 3,236,773	$ 3,034,474	$ 3,050,036	$ 2,859,408	$ 809,193	$ 1,011,491	$ 762,509	$ 953,136
N	Tufts EPO Family Advantage	$ 19,727	753	$ 14,854,100		$ 11,883,280	$ 11,140,575	$ 11,197,706	$ 10,497,849	$ 2,970,820	$ 3,713,525	$ 2,799,426	$ 3,499,283
N	Tufts EPO Individual Legacy	$ 7,924	199	$ 1,576,820		$ 1,261,456	$ 1,182,615	$ 1,188,680	$ 1,114,387	$ 315,364	$ 394,205	$ 297,170	$ 371,462
N	Tufts EPO Family Legacy	$ 21,699	119	$ 2,582,210		$ 2,065,768	$ 1,936,657	$ 1,946,589	$ 1,824,927	$ 516,442	$ 645,552	$ 486,647	$ 608,309
	Newton Subtotal			$ 23,059,095	$ 21,728,763	$ 18,447,276	$ 17,294,321	$ 17,383,010	$ 16,296,572	$ 4,611,819	$ 5,764,774	$ 4,345,753	$ 5,432,191
B	Tufts Navigator I	$ 7,526	762	$ 5,734,842		$ 4,587,874	$ 4,301,132	$ 4,587,874	$ 4,301,132	$ 1,146,968	$ 1,433,711	$ 1,146,968	$ 1,433,711
B	Tufts Navigator F	$ 18,254	872	$ 15,917,628		$ 12,734,102	$ 11,938,221	$ 12,734,102	$ 11,938,221	$ 3,183,526	$ 3,979,407	$ 3,183,526	$ 3,979,407
	GIC Subtotal			$ 21,652,470			$ 16,239,353	$ 17,321,976	$ 16,239,353	$ 4,330,494	$ 5,413,118	$ 4,330,494	$ 5,413,118
	Net Difference			$ 1,406,625	$ 76,293	$ 1,125,300	$ 1,054,969	$ 61,034	$ 57,220	$ 281,325	$ 351,656	$ 15,259	$ 19,073
N	Tufts PPO Individual Advantage	$ 11,091	31	$ 343,825		$ 275,060	$ 257,869	$ 259,191	$ 242,992	$ 68,765	$ 85,956	$ 64,798	$ 80,997
N	Tufts PPO Family Advantage	$ 26,877	94	$ 2,526,449		$ 2,021,159	$ 1,894,837	$ 1,904,554	$ 1,785,519	$ 505,290	$ 631,612	$ 476,139	$ 595,173
N	Tufts POS Individual Legacy	$ 11,730	109	$ 1,278,583		$ 1,022,866	$ 958,937	$ 963,855	$ 903,614	$ 255,717	$ 319,646	$ 240,964	$ 301,205
N	Tufts POS Family Legacy	$ 28,426	46	$ 1,307,616		$ 1,046,093	$ 980,712	$ 985,741	$ 924,133	$ 261,523	$ 326,904	$ 246,435	$ 308,044
	Newton Subtotal			$ 5,456,473	$ 5,141,677	$ 4,365,179	$ 4,092,355	$ 4,113,341	$ 3,856,258	$ 1,091,295	$ 1,364,118	$ 1,028,335	$ 1,285,419
B	Unicare Indemnity I	$ 11,051	140	$ 1,547,179		$ 1,237,743	$ 1,160,384	$ 1,237,743	$ 1,160,384	$ 309,436	$ 386,795	$ 309,436	$ 386,795
B	Unicare Indemnity F	$ 25,794	140	$ 3,611,160		$ 2,888,928	$ 2,708,370	$ 2,888,928	$ 2,708,370	$ 722,232	$ 902,790	$ 722,232	$ 902,790
	GIC Subtotal			$ 5,158,339	$ 5,158,339	$ 4,126,671	$ 3,868,754	$ 4,126,671	$ 3,868,754	$ 1,031,668	$ 1,289,585	$ 1,031,668	$ 1,289,585
	Net Difference			$ 298,134	$ (16,662)	$ 238,507	$ 223,601	$ (13,330)	$ (12,497)	$ 59,627	$ 74,534	$ (3,332)	$ (4,166)
N	Tufts MCP	$ 5,006	1910	$ 9,561,536	$ 9,009,909	$ 7,649,229	$ 7,171,152	$ 7,207,927	$ 6,757,432	$ 1,912,307	$ 2,390,384	$ 1,801,982	$ 2,252,477
N	Tufts Medicare Preferred**	$ 5,006	199	$ 996,202	$ 996,202	$ 796,962	$ 747,151	$ 796,962	$ 747,151	$ 199,240	$ 249,050	$ 199,240	$ 249,050
	Newton Subtotal			$ 10,557,738	$ 10,006,111	$ 8,446,191	$ 7,918,304	$ 8,004,889	$ 7,504,583	$ 2,111,548	$ 2,639,435	$ 2,001,222	$ 2,501,528
B	Tufts Medicare Complement	$ 4,631	1910	$ 8,845,286	$ 8,845,286	$ 7,076,229	$ 6,633,965	$ 7,076,229	$ 6,633,965	$ 1,769,057	$ 2,211,322	$ 1,769,057	$ 2,211,322
B	Tufts Medicare Preferred	$ 3,188	199	$ 634,372	$ 634,372	$ 507,498	$ 475,779	$ 507,498	$ 475,779	$ 126,874	$ 158,593	$ 126,874	$ 158,593
	GIC Subtotal			$ 9,479,659	$ 9,479,659	$ 7,583,727	$ 7,109,744	$ 7,583,727	$ 7,109,744	$ 1,895,932	$ 2,369,915	$ 1,895,932	$ 2,369,915
	Net Difference			$ 1,078,080	$ 526,453	$ 862,464	$ 808,560	$ 421,162	$ 394,839	$ 215,616	$ 269,520	$ 105,291	$ 131,613
N	Newton Total			$ 53,773,374	$ 50,728,537	$ 43,018,699	$ 40,330,030	$ 40,582,829	$ 38,046,403	$ 10,754,675	$ 13,443,343	$ 10,145,707	$ 12,682,134
B	GIC Total			$ 51,383,706	$ 51,383,706	$ 41,106,964	$ 38,537,779	$ 41,106,964	$ 38,537,779	$ 10,276,741	$ 12,845,926	$ 10,276,741	$ 12,845,926
	Net Difference			$ 2,389,668	$ (655,169)	$ 1,911,734	$ 1,792,251	$ (524,135)	$ (491,377)	$ 477,934	$ 597,417	$ (131,034)	$ (163,792)

*Total premium or working rate paid for all enrollees in the product

**Tufts Medicare Preferred is a fully-insured product, so no city premium holiday is available

DRAFT DISCUSSION DOCUMENT – WORK IN PROGRESS

Appendix 3. Health Plan Opt-Out by Employees Analysis

Introduction

Some Newton employees have the option of purchasing health insurance either through the City of Newton or through another source, most commonly an employed spouse's employer. If the City could encourage employees to obtain health insurance through alternative sources that could save substantial money. The Committee explored whether this might be worthwhile and under what conditions a program might be implemented.

Current Status

Newton currently offers employees an option to purchase individual or family insurance, through HPHC and THP. A weighted average of net City costs per employee[51] across the various plans is:

Plan Type	Number Enrolled FY12	Cost Per Employee
Individual Plan	**987**	**$5,506**
Family Plan	**1355**	**$15,513**

Family health benefits cost considerably more than individual benefits, largely because of the greater number of individuals covered, and the employee contribution compensate for on 20-25% of this difference. The City therefore might achieve cost savings if employees who have health insurance available from a spouse or domestic partner opted out of purchasing health insurance from the City.

That said, some companies are no longer permitting employees to purchase health insurance for their families or domestic partners if the spouse or domestic partner has this benefit available through their own employer.[52] This could be an option for the City.

Motivations

An employee would only make the decision to choose an alternative source for health insurance if they:

1. Receive a financial benefit from doing so, and
2. The alternative insurance is at least comparable to the insurance offerings through Newton.

From the City's perspective, the greater the financial incentive paid to employees to opt-out of all or part* of their Newton-provided health plan, the less Newton benefits. For example, if Newton paid a $6000 per year incentive to individuals to opt-out of Newton-provided insurance, Newton would not save money, since the average cost to the city for an individual is less than $6000.

The greater the employee's financial incentive, the more attractive an option switching becomes to the employee. In addition, employees who are low utilizers of healthcare services would likely be more easily swayed to change their current healthcare insurance. The City would most benefit when employees who are high utilizers of healthcare services opt-out of Newton-provided insurance, but these employees may be least likely to switch.

* For example, by changing from family to individual coverage

Research shows that people more likely to opt out are the younger, healthier individuals[5354]. As a result, the long-term impact of the opt-out would be to increase the cost of the remaining risk pool, thereby driving up the cost of premiums.

In addition, because of the greater cost to the City of family plans, Newton benefits the most when employees who have family plans opt out. Unfortunately low utilizers are less likely to be purchasing family plans.

Available data on the success of opt-out programs are limited and suggest a conversion rate of about 1%.

The table below summarizes the factors that most likely affect behavior:

Employee motivation to opt-out of Newton-provided health plan

	Positive Motivation	Negative Motivation
Healthcare service utilization	Low	High
Plan type	Individual	Family
Incentive paid	High	Low

Newton's motivation for employee to opt-out of City-provided health plan

	Positive Motivation	Negative Motivation
Healthcare service utilization	High	Low
Plan type	Family	Individual
Incentive paid	Low	High

In the table below we have illustrated what we could expect to happen with a 1% conversion rate with different incentive payments using weighted average estimates of Newton's share of healthcare costs.

Individual Plans

Incentive Pmt/Yr	Opt-Out Rate	Number Opting Out	Annual Savings
$0	1.00%	24	$132,142
$1,000	1.00%	24	$108,142
$2,000	1.00%	24	$84,142
$3,000	1.00%	24	$60,142

Family Plans

Incentive Pmt/Yr	Opt-Out Rate	Number Opting Out	Annual Savings
$0	1.00%	24	$372,319
$3,000	1.00%	24	$300,319
$4,000	1.00%	24	$276,319
$5,000	1.00%	24	$252,319

If we double the conversion rate to 2%, we get the following projections:

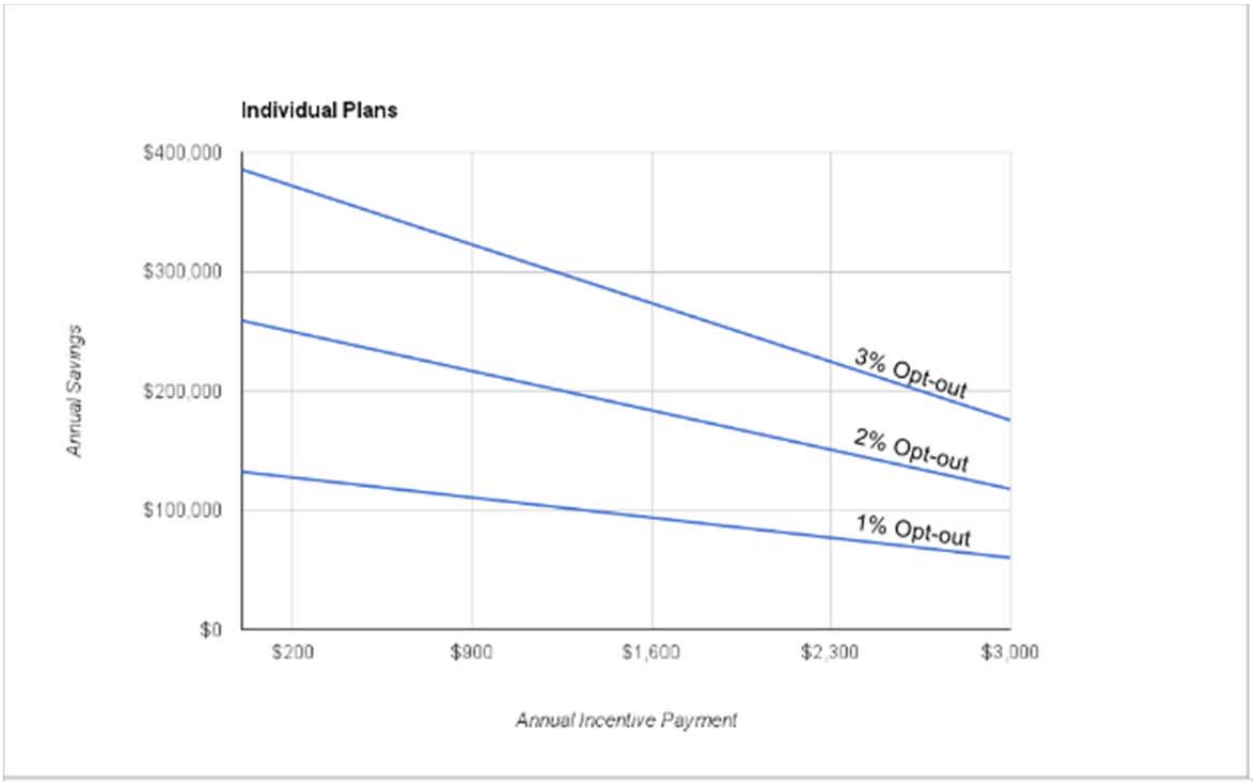
Individual Plans

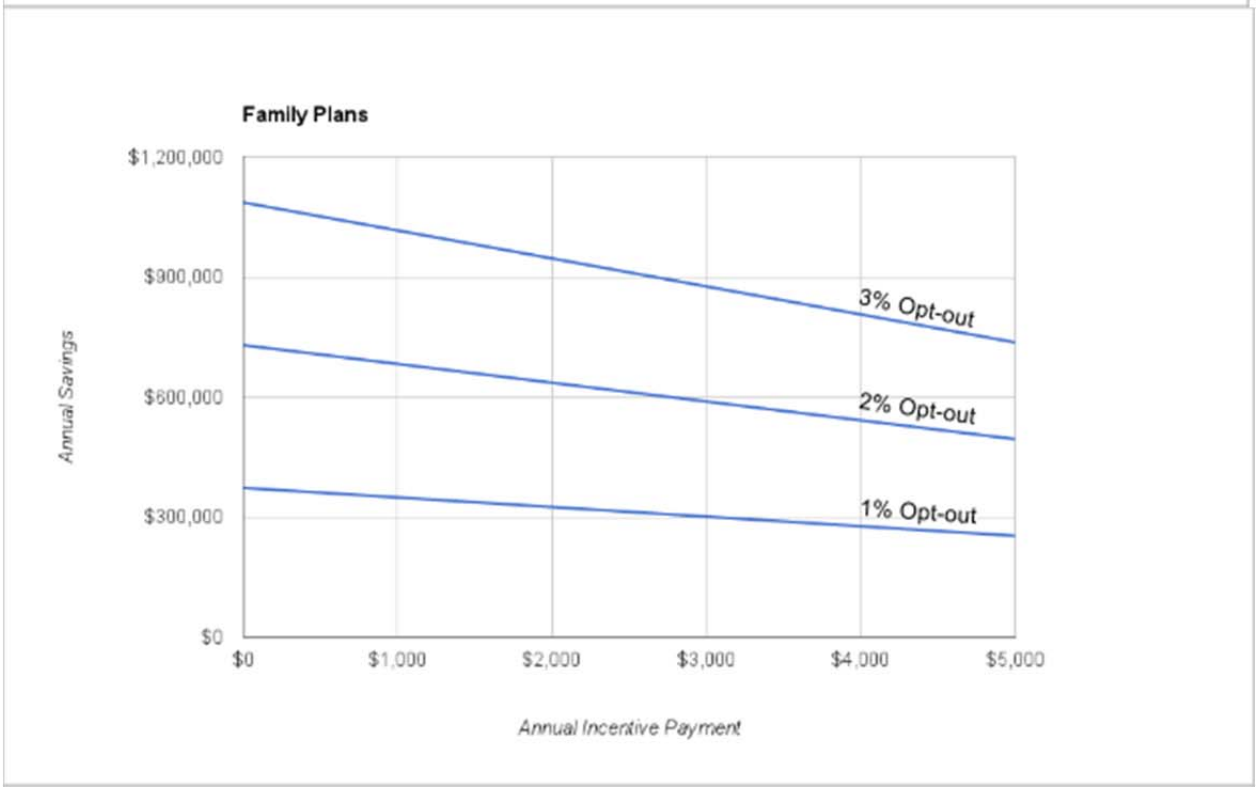
Incentive Pmt/Yr	Opt-Out Rate	Number Opting Out	Annual Savings
$0	2.00%	47	$258,778
$1,000	2.00%	47	$211,778
$2,000	2.00%	47	$164,778
$3,000	2.00%	47	$117,778

Family Plans

Incentive Pmt/Yr	Opt-Out Rate	Number Opting Out	Annual Savings
$0	2.00%	47	$729,126
$3,000	2.00%	47	$588,126
$4,000	2.00%	47	$541,126
$5,000	2.00%	47	$494,126

If we plot these, we get:





The financial outcomes calculated above exclude the additional cost the City would incur if it paid incentives to all employees who opt out of coverage, including those currently eligible but unenrolled. The City has 751 unenrolled employees as of 2013. Assuming a 1% opt out rate, the health coverage savings would approximate $504,000. The average incentive for the 799 employees (751 currently unenrolled plus 48 newly opting out) could be no greater than about $500 for the program to achieve even modest savings.

Observations

1. If we assume that it is not worthwhile implementing a change unless it results in a savings of $500,000, we see that this never occurs in the case of individuals or families opting out as long as incentives are also paid to employees who are already opted out.
2. If Newton were to offer an opt-out plan, there would likely be a mix of those on individual plans and those on family plans. These illustrations do not take that mix into consideration, but as mentioned we expect that more individuals than families are likely to switch. Thus, the savings may be overestimated in out model.
3. These models were done using average healthcare costs. If we were to model this using only low to moderate utilizers (those least likely to switch), we may require much higher opt-out rates (or lower incentive payments) to achieve significant savings.
4. Given that approximately 25% of eligible employees are already not choosing to purchase health insurance through the City, if Newton were to pay an incentive for employees not to purchase insurance through Newton it would have to pay the fee to those already opting out, as well. When incorporating this into the models, only the most optimistic estimates avoid net losses to the City.

Limitations

The Committee analyzed the best data and evidence available to it. It would be useful to model outcomes based on whether low utilizers vs. moderate to high utilizers opt-out, but we do not have data on distribution of healthcare costs across employees. The Committee was not able to gather many data points on opt-out programs in other populations.

Conclusion

A strategy of encouraging employees to opt out of Newton-provided health insurance could yield health cost savings, but any net financial benefits would at best be modest. The savings would be even less if those on individual plans switched, or if only healthy employees switched, leaving the remaining risk pool sicker on average. We would argue that, if feasible, it may not even be worthwhile to offer incentives to those with individual plans.

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