

The Utility of Trouble

Municipal Health Plans: Gilded Benefits from a Bygone Era

*The Fifth in a Series of Occasional Reports About
Bringing Systemic Change to Scale in an Era of Limited Resources*

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Massachusetts Taxpayers Foundation

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This report also includes important contributions from MTF Policy Analyst Carolyn Ryan.

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Preface

In recent years, the Boston Foundation has identified the rising cost of health insurance as a serious drain on state and local coffers. Following a 2006 Boston Foundation study, which identified that among the home rule powers denied to Boston and other Massachusetts municipalities is the ability to determine health insurance benefits for employees and retirees, we joined with state and local officials in calling for greater local options to be granted to cities and towns by the state, including the right to set health plans.

Despite the passage in 2007 of a new law allowing municipalities to join the Group Insurance Commission (GIC), and the fact that 15 municipalities in Greater Boston reported savings of more than \$35 million in the first year of joining the GIC, progress has stalled. The high threshold to negotiate into the system, which requires coalition bargaining among municipal unions and a 70 percent union approval—and the associated tradeoffs that cities and towns might be expected to make in order to win that approval—has proved an insurmountable barrier.

Yet when we find cities and towns at the point of laying off promising young teachers and other municipal employees, closing libraries and community centers, reducing hours at parks and turning out the lights at ball fields while we maintain \$10 co-pays, something must change. In the current fiscal year, the City of Boston will spend \$300 million – 13 percent of its budget, more than its entire public safety budget – on health insurance. This rate of spending necessitates cuts to public education and the social safety net that will take years to repair.

On a larger scale, these outdated benefits packages to public employee unions have moved our Commonwealth, and our nation, from being an investment society to solely a maintenance society. We are no longer able to invest in local aid or higher education or public health or the environment, as the resources necessary for these investments are being consumed by the cost of maintaining benefits at rates that could be much lower with the right plan design in place. A report issued by the Boston Foundation and Massachusetts Business Alliance for Education last December put in clear and compelling focus what many have suspected for some time—that our good-faith efforts to close the achievement gap are being erased by the cost of health care.

This report by Bob Carey and the Massachusetts Taxpayers Foundation compares the health care benefits offered to municipal employees with those offered to workers in the private sector and to state and federal employees. It provides further evidence that municipal health care benefits are unsustainable and that municipalities need the authority to manage their costs through plan design now, this year, or the consequences to local budgets will be dire.



Paul S. Grogan
President & CEO
The Boston Foundation

Introduction

Though health care costs are growing everywhere, municipal expenditures on employee and retiree health care are increasing at an alarmingly fast rate that is crippling local budgets. Over the last decade, health care cost growth averaged 10.8 percent per year for Massachusetts municipalities while the state's Group Insurance Commission (GIC) averaged just 6.4 percent annual growth.

Soaring municipal health costs are forcing ever deeper cuts in essential school and municipal services, leading to layoffs of teachers, police officers, firefighters, and other key employees in the vast majority of communities across the Commonwealth.

Through a combination of historical circumstances, municipalities offer exceedingly generous health plans that are very difficult to change. Unlike the state, cities and towns must collectively bargain any changes to health plans, even though the original plan designs were never actually negotiated. This requirement limits municipal officials from making even modest, cost-saving changes.

The purpose of this study is to compare the most popular health insurance plans of 14 cities and towns with two state Group Insurance Commission (GIC) plans, the federal government's Federal Employees Health Benefits Plan for Massachusetts employees, and Massachusetts private employer-sponsored plans. The 14 communities represent an economically diverse selection of small, mid-sized, and large municipalities throughout the state: Beverly, Boston, Chelsea, Franklin, Littleton, Marlboro, Marshfield, Medford, Norwell, Peabody, Salem, Somerville, West Springfield, and Worcester.

Specifically, this report examines premium costs and the members' share of costs for office visits, prescription drugs, high-tech imaging, outpatient surgery, and hospital admissions, as well as deductibles.

This is the seventh report published since 2005 by the Taxpayers Foundation or the Boston Foundation analyzing municipal health care costs. Previously published reports include:

- *A Mounting Crisis For Local Budgets: The Crippling Effects of Soaring Municipal Health Costs*, MTF, July 2005.
- *Municipal Health Reform: Seizing the Moment*, MTF, August 2007.
- *Leveling the Playing Field: Giving Municipal Officials the Tools to Moderate Health Insurance Costs*, The Boston Foundation, March 2010.
- *Municipal Health Care and the GIC: Success and Limitations*, The Boston Foundation and Metropolitan Area Planning Council, August 2010.
- *School Funding Reality: A Bargain Not Kept*, Massachusetts Business Alliance for Education and the Boston Foundation, December 2010.
- *Retiree Health Care: The Brick That Broke Municipalities' Backs*, MTF, February 2011.

Findings

This is the first study to compare specific municipal health plans with other employer-sponsored plans in the state, and the findings are unequivocal: municipalities provide employees with far more costly and generous health care benefits than those offered by other employers in both the public and private sectors.

The study finds that municipal health plans have dramatically higher premiums than other public and private plans. One of the key factors driving municipal premiums is the virtual absence of any cost sharing in the form of deductibles or co-payments for office visits and other basic medical services.

The study's findings include:

- For family coverage, the average municipal premium is \$5,600, or 37 percent, higher than the average private sector premium, 33 percent more than the federal plan premium, and 21 percent more than the state's GIC plans.
- In the municipal plans, the average co-payment for a visit to a primary care physician (PCP) is only \$11. State, federal, and private sector employees on average pay almost twice as much for visits to PCPs. Specialist visits averaged only \$14 for municipal workers, while the co-pays were a minimum of \$20 in the GIC plans, \$30 for federal workers, and averaged \$20 for private sector HMO plans.
- Municipal employees pay less for generic prescriptions than other employees and the disparity grows as drug prices increase along a three-tier scale. For a tier 3 prescription drug, municipal employees pay \$31 compared to \$50 for most state and private workers in Massachusetts. Federal workers pay 30 percent of the cost for these same drugs.
- Nine of the 14 communities have no co-pays for most other medical services, including high-tech imaging, outpatient surgery, and inpatient hospitalization, the three largest cost drivers of medical care. The other five communities have no co-payments for high-tech imaging but have co-payments averaging \$128 and \$228 for outpatient surgery and inpatient hospitalization, respectively. At a *minimum*, state, federal, and

private sector workers pay \$75 for high-tech imaging, \$150 for outpatient surgery, and \$250 for an inpatient hospitalization.

- Amazingly, no municipal plan includes a deductible. In the other public and private plans, members are responsible for a minimum deductible of \$250 for individuals and \$700 for families.

These extraordinarily rich municipal benefits result in higher premiums and higher rates of growth than those for health plans sponsored by state, federal, and private sector employers. To be sure, cost sharing through co-payments and deductibles involves some shifting of costs to employees. But the more profound and lasting advantage of cost sharing is to help municipalities control the level and rate of growth of their health care premiums, which benefits the employee as well as the city or town.

With cost sharing employees have a financial incentive to be more selective in using medical services; when services are virtually free there is no impact on consumer behavior. Research has shown that cost sharing can reduce utilization without adversely impacting the quality of health care because members are more likely to forego care with questionable value and use only the services worth the additional cost.¹

Premiums

Municipal health plan premiums are dramatically higher than other employer-sponsored premiums, driven by excessively generous benefits.

In these 14 municipalities, premiums for individual coverage range from just over \$5,750 for an HMO plan in Worcester, which revamped co-pays for certain services, to more than \$9,750 in Beverly for an HMO plan. For family coverage, premiums range from just over \$14,475 in the same Worcester plan to a whopping \$25,785 for a Peabody PPO plan. Appendix A lists the premiums for every plan as well as the employees' share of the premium, which ranges from 15 percent to 50 percent.²

The premiums for municipal plans are staggering when compared with private sector plans in Massachusetts, as shown in **Table 1** and **Appendix A**. On average, these municipalities have annual premiums for individuals that are 39 percent, or nearly \$2,200, more than their private sector counterparts. Every single municipal premium is higher than the average private sector premium. For family coverage, municipal premiums are 37 percent—or \$5,600—higher. Twenty-seven of the 28 municipal plans have family premiums that are higher than the private sector average.

TABLE 1

Average Annual Premiums, by Employer

	Individual	Family
Municipal Plans, Average	\$7,785	\$20,925
State GIC Plans, Average	\$7,098	\$17,285
Federal (FEHBP), Standard Option PPO Plan	\$6,943	\$15,683
AIM 2010 Employer Survey, Average	\$5,592	\$15,324

Even relative to other public sector plans, municipal premiums are remarkably expensive. Compared with the state’s Group Insurance Commission plans, individual premiums in these municipalities are on average \$687, or nearly 10 percent, higher. For families, municipal premiums are more than \$3,600, or 21 percent, higher.

The federal government’s FEHBP plan has premiums that pale compared with the 14 municipalities. On average, municipal premiums are over \$840, or 12 percent, higher than the FEHBP for individual coverage. For families, the difference is truly shocking: municipal premiums are one-third, or \$5,242, more expensive. Medford and Peabody both offer plans that are \$10,000 more expensive.

Even though the majority of municipal plans in this study are HMOs and should have the least expensive premiums, municipal benefits are so extraordinarily generous that the HMO premiums are frequently more expensive than the PPO premiums for plans offered by other employers. Even municipal employees paying only 10 percent of the premium costs stand to save hundreds of dollars with modest plan adjustments.

Savings for All

The most frequently cited argument against adjusting municipal health plans is that it merely shifts the costs onto municipal employees. The reality is very different—for many employees the savings through reduced premiums would more than offset the additional costs for office visits or other services.

For example, an employee enrolled in Beverly’s BCBS HMO plan currently pays 20 percent of the \$9,768 premium. If the town were to re-design that plan to match the state GIC’s Harvard Pilgrim PPO, that premium could be reduced to \$7,236. Paying 20 percent of the premium, the Beverly employee would save just over \$500 per year for his share of the premium.

Under the re-designed plan, the increases in most co-payments would be modest, so an employee would need significant medical treatment, including hospitalization, to spend more than the \$500 in savings in any given year.

Similarly, a Medford employee enrolled in family coverage in the Tufts EPO contributes 20 percent, or just over \$4,880 per year, towards the premium. If Medford implemented cost sharing to match the GIC, the total family premiums could plummet from more than \$24,400 to \$17,674. The employee’s annual share would drop by more than \$1,300.

Even employees in the municipalities that have added cost sharing for outpatient surgery and hospital admissions would benefit from entering into a plan in line with the GIC. In Marlboro, employees enrolled in the town’s Tufts EPO plan pay 30 percent of the total premium. If the town shifted employees to a plan similar to the state’s PPO plans, employees would save \$335 for individual coverage and \$1,738 for family coverage every year. At the same time, most co-pays would either stay the same or increase by only a few dollars.

Office Visits

Office visits to primary care physicians (PCPs) and specialists are the most popularly used benefit by health plan members. Both healthy and sick members rely on these visits for prevention and treatment. As shown in **Table 2** and **Appendix B**, members of the municipal health plans reviewed for this report pay on average just \$11 for PCP office visits and \$14 for specialists—far less than employees in the state, federal, and private sector must pay in their employer-sponsored plans.

TABLE 2

Co-Payments for Physician Office Visits, by Employer

	Primary Care (PCP) Co-Payments	Specialist Co-Payments
Municipal Health Plans, Average	\$11	\$14
State GIC, Tufts PPO Plan	\$20	\$25 – Tier 1 \$35 – Tier 2 \$45 – Tier 3
State GIC, HPHC PPO Plan	\$20	\$20 – Tier 1 \$35 – Tier 2 \$45 – Tier 3
Federal (FEHBP), Standard Option PPO Plan	\$20 (Preferred) 35% (Participating)	\$30 (Preferred) 35%(Participating)
Private Employers, AIM 2010 Survey, HMO Plan	\$20	\$20
Private Employers, AIM 2010 Survey, PPO Plan	\$19	\$19

Somerville employees can choose from multiple plans that require only \$5 co-pays for visits to both PCPs and specialists. Most other communities charge the same—either \$10 or \$15—for visits to both PCPs and specialists. Only Franklin, Salem, and Worcester have adopted health plans that charge members a higher co-payment for a visit to a specialist.

For state employees enrolled in the GIC’s Tufts or Harvard Pilgrim PPO plans, members pay \$20 for a routine visit to their PCP (e.g., internist, family practitioner, pediatrician), nearly twice as much as the average municipal worker’s co-payment. While Salem and Franklin have adopted tiered co-payment systems for PCP visits, only at the maximum tier do co-payments reach \$20.

In these GIC plans, specialist visits (e.g., cardiologist, oncologist, gastroenterologist) cost more because the GIC has a tiered cost sharing structure that encourages members to use less costly physicians through variable co-payments. Depending on the tier of the specialist, a member of Tufts plan is charged \$25, \$35, or \$45, while under Harvard Pilgrim’s plan the co-payments are \$20, \$35, or \$45 for specialist office visits.

Even when using the lowest cost option, federal employees pay almost twice what municipal health plan members pay for any office visit. The federal government’s standard PPO plan charges members different co-payments depending on whether the physician is in the “preferred” or “participating” category. Members

pay \$20 for a visit to a preferred PCP, while they pay 35 percent co-insurance if they use a participating PCP. A visit to a preferred specialist will cost an FEHBP member \$30, while their share of the cost for a participating specialist is 35 percent.

Like state and federal employees, private sector employees pay more for office visits. According to AIM’s 2010

Co-Insurance

While co-insurance is standard practice in health plans across the country, it has not yet been embraced in the Massachusetts market. Co-insurance, unlike fixed co-payments, exposes the member to the actual cost of care and allows for a constant adjustment of the member’s share of these costs. It also keeps pace with medical inflation and can provide a more direct financial incentive for members to access lower cost providers and services.

Because physicians—even those within a particular specialty—are not paid a standard rate by each health insurer, co-insurance also exposes the member to different cost sharing amounts depending upon the carrier’s reimbursement arrangement with the physician.

For example, Harvard Pilgrim Health Care reports that it pays cardiologists between \$263 and \$419 for an office visit, while gastroenterologists are paid between \$216 and \$374.³ A plan with 35 percent co-insurance, like FEHBP’s PPO plan, means that the member’s share of the cost for an office visit to a cardiologist would range from \$92 to \$147, while the member would pay between \$76 and \$131 to see a gastroenterologist.

TABLE 3

Co-Payments for Prescription Drugs, by Employer

	Tier 1 (primarily generic)	Tier 2 (preferred brand)	Tier 3 (non-preferred brand)
Municipal Health Plans, Average	\$8	\$16	\$31
State GIC, Tufts PPO Plan	\$10	\$25	\$50
State GIC, HPHC PPO Plan	\$10	\$25	\$50
Federal (FEHBP), Standard Option PPO Plan	20%	30%	30%
Private Employers, AIM 2010 Survey, HMO Plan	\$13	\$28	\$49
Private Employers, AIM 2010 Survey, PPO Plan	\$13	\$28	\$47

survey, for private sector employer-sponsored HMO plans in the Commonwealth the average co-payment for an office visit was \$20, regardless of the physician's specialty designation. Private sector employees pay almost twice as much as municipal employees for PCP office visits and 40 percent more for specialist office visits.⁴

Prescription Drugs

Prescription drugs are another widely used benefit for which municipal plan members pay far less than members of other employer-sponsored plans. The more expensive the drug, the greater the discrepancy.

Most health plans have tiered prescription programs, with the tiers based on cost and availability of generics. Municipal employees' drug co-payments average \$8 for tier 1 (primarily generics), \$16 for tier 2 (preferred brand-name drugs that often do not have generic versions), and \$31 for tier 3 prescriptions (non-preferred brand name drugs that frequently have generic versions).

The small range between tier 1 and tier 3 is problematic because members have little incentive to opt for less expensive drugs, which contributes to higher premiums. As shown in **Table 3**, it costs the average municipal plan member only \$23 more to select a brand name drug instead of the generic version—even though the actual price difference can be hundreds of dollars. Appendix C details prescription drug co-payments for each plan.

On the other hand, designing prescription drug tiers so that plan members have a strong incentive to choose

Pharmacy Benefit Management

In addition to higher cost sharing, the GIC uses a number of pharmacy benefit management strategies to encourage members to use lower cost drugs. These strategies, which are used by most health plans, include quantity limits, prior authorization, mail order incentives for chronic condition medications, and more aggressive initiatives such as the "generics preferred" program.

Generics preferred requires GIC members who are prescribed a brand name drug for which there is a generic equivalent to pay the full difference in cost between the generic and the brand-name drug. For example, a member who is prescribed Synthroid instead of the generic equivalent to treat hypothyroidism would pay the generic co-payment of \$10 plus the difference in cost between Synthroid and the generic. According to Costco.com, 100 tablets of Synthroid retails for \$75.33, while 100 tablets of the generic retails for \$10.83. Thus, a GIC member who requests Synthroid would be responsible for almost all of the drug's cost (\$10 co-pay plus \$64.50).

lower-cost generics is common practice among other employers. State employees covered by the GIC's Tufts and HPHC PPO plans pay \$10, \$25, and \$50 in a similar three-tier system. The FEHBP plan uses a co-insurance model for prescriptions, with members responsible for 20 percent of the cost of tier 1 drugs and 30 percent for tiers 2 and 3. In the state's private sector, employer-sponsored plans provide prescription drug benefits comparable to the state's GIC plans with co-payments averaging \$13 for tier 1, \$28 for tier 2, and \$49 for tier 3.

High-Tech Imaging, Outpatient Surgery, and Inpatient Hospitalization

The majority of municipal plans in this report require no co-payment *at all* for virtually all other major medical services, including the three largest cost drivers of medical care: high-tech imaging (e.g., MRI, CT, and PET scan), outpatient surgery, and inpatient hospitalization. Combined with the lack of deductibles, many municipal employees receive essentially free access to sophisticated health care. **Table 4** and **Appendix B** detail each plan’s co-payments for these services.

High-Tech Imaging

No municipal plan included in this report requires any member cost sharing for high-tech imaging.

In contrast, state employees covered by the GIC’s Tufts or HPHC plans pay \$100 for such procedures. FEHBP members pay 15 percent of allowable charges for imaging, as long as they use a preferred provider. With the cost of an MRI in Massachusetts ranging from \$751 for a lower back MRI to as much as \$1,680 or more for a brain MRI, a member’s share of the cost can range from \$113

to \$252.⁵ Among private sector employer-sponsored plans in the state, the average co-pay for high-tech imaging is between \$75 (PPO) and \$93 (HMO), as reported by AIM’s 2010 employer benefits survey.

Outpatient Surgery

In nine communities, there is no member co-payment for outpatient surgery. Just five of the 14 communities reviewed—Franklin, Marlboro, Salem, West Springfield, and Worcester—have implemented outpatient surgery co-payments, ranging from \$100 to \$150.

While outpatient surgery cost sharing is rare in municipal plans, it is universal in the other plans included in this report. State workers enrolled in either of the two GIC plans have a co-payment of \$150 for an outpatient surgical procedure. Federal employees in Massachusetts shoulder either 15 percent or 35 percent of the cost, depending on whether the surgeon is a “preferred” or “participating” provider. In Massachusetts, the cost to have arthroscopic knee surgery, which is commonly done on an outpatient basis, can range from \$3,729 to as much as \$6,017.⁶ For an FEHBP plan member, the individual’s share of an arthroscopy from a preferred provider could range from \$556 to \$903.⁷

TABLE 4

Co-Payments for High-Tech Imaging, Outpatient Surgery, and Inpatient Hospitalization, by Employer

	High-Tech Imaging	Outpatient Surgery	Inpatient Hospitalization
Nine Municipalities, Average	None	None	None
Five Municipalities with Outpatient/Hospitalization Cost Sharing, Average	None	\$128	\$228
State GIC, Tufts PPO Plan	\$100	\$150	\$300 – Tier 1 \$700 – Tier 2
State GIC, HPHC PPO Plan	\$100	\$150	\$250 – Tier 1 \$500 – Tier 2 \$750 – Tier 3
Federal (FEHBP), Standard Option PPO Plan	15% – preferred 35% – participating	15% – preferred 35% – participating	\$250 – preferred \$350+35% – participating
Private Employers, AIM 2010 Survey, HMO Plan	\$94	\$273	\$483
Private Employers, AIM 2010 Survey, PPO Plan	\$75	\$199	\$372

According to AIM’s survey, plans offered by private sector employers in Massachusetts require average co-payments of \$199 (PPO) and \$273 (HMO) for outpatient surgery.

Inpatient Hospitalization

Nine communities offer plans that require no member co-payment for inpatient hospitalization. The same five communities that implemented outpatient surgery cost sharing—Franklin, Marlboro, Salem, West Springfield, and Worcester—have also added inpatient hospitalization co-payments between \$200 and \$250. Only Franklin and Salem have implemented tiered benefit systems to encourage members to select lower cost facilities.

Other than the plans in the nine municipalities, no employer-sponsored plan reviewed in this study provides members with free hospital stays. A member of the state’s GIC HPHC plan is responsible for a minimum \$250 co-payment for a hospital admission; members of the Tufts PPO plan must pay at least a \$300 co-payment. These plans also have a tiered system for hospital admission, like the prescription benefit, which encourages members to obtain quality care from less costly hospital facilities.

The federal government’s FEHBP plan also provides a financial incentive for members to choose preferred hospitals: members pay \$250 for admission to a preferred hospital but must pay \$350 plus 35 percent of the cost if they use a “non-preferred” one.

Private sector coverage in Massachusetts includes inpatient hospitalization co-payments that average \$372 (PPO) or \$483 (HMO).

Deductibles

Health plans frequently include annual deductibles, or out-of-pocket minimums, that members must pay before certain benefits are applicable. Like co-payments, deductibles are a form of cost sharing that lowers premiums. Some plans cover high tech imaging, outpatient surgery, and inpatient hospitalization only after the member has met this deductible.

While more and more employers in Massachusetts, including the state and federal government, have adopted health plans with deductibles, no municipal plan in this report has a deductible.

As shown in **Table 5**, the state’s plans include deductibles of \$250 for individual coverage and \$750 for family coverage. Federal workers’ deductibles are \$350 for individuals and \$700 for families. Among private sector employers, the average deductible for an HMO plan is \$914 for individuals and \$1,897 for family coverage. In PPO plans, the average deductible is \$744 (individual) and \$1,618 (family).

TABLE 5

Plan Deductibles, by Employer

	Individual	Family
Municipal Health Plans, Average	\$0	\$0
State GIC, Tufts PPO Plan	\$250	\$750
State GIC, HPHC PPO Plan	\$250	\$750
Federal (FEHBP), Standard Option PPO Plan	\$350	\$700
Private Employers, AIM 2010 Survey, HMO Plan	\$914	\$1,897
Private Employers, AIM 2010 Survey, PPO Plan	\$744	\$1,618

Conclusion

The findings of this report highlight the urgency for municipalities to bring their health care benefits to an affordable level. Without action, communities will be forced to make even more painful and severe cuts to education and other basic services.

Municipalities need the tools to respond to their skyrocketing health insurance costs. The Legislature must provide local officials the authority to adjust plan design outside of collective bargaining—the same authority the state has with its employees—to help Massachusetts cities and towns manage the costs of premiums while still providing benefits that are at least comparable with those enjoyed by state employees.

This report is designed to inform and to encourage decisions that will move Massachusetts cities and towns

beyond the gilded health plans designed for another era to affordable, realistic plans for a 21st century economy.

Methodology

Many municipalities, the state, and federal government all offer employees a choice among several health plans. Rather than analyze all plans for each employer, this study includes only those plans that cover a majority of employees.

In total, this study compares premiums and cost sharing for 31 specific plans: 28 municipal plans, two state plans, and one federal plan. All but four municipalities have two plans in the study; the exceptions are three plans for Somerville and Worcester and one plan for Boston and West Springfield. Each municipality provided benefit booklets, rate sheets, and the employee share of premium contributions. All information on the state's GIC plans and the federal health insurance plan is publicly available.

Since there is no "typical" private sector plan, this study compares municipal plans with the average benefits in HMO and PPO plans as found in the 2010 statewide survey of employer benefits conducted by the Associated Industries of Massachusetts (AIM).

Appendix A:

Total Premiums and Employer Contributions, by Employer

Employer	Plan Carrier	Plan Type	Annual Individual Premium	Employer Share	Annual Family Premium	Employer Share
Beverly	BCBS-MA ⁹	HMO Blue	\$8,054	\$6,443 (80%)	\$21,042	\$16,833 (80%)
	HPHC	HMO	\$9,768	\$7,814 (80%)	\$25,170	\$20,136 (80%)
Boston	HPHC ¹⁰	HMO	\$7,514	\$6,387 (85%)	\$20,212	\$17,180 (85%)
Chelsea	HPHC	HMO	\$7,514	\$6,199 (82.5%)	\$20,212	\$16,675 (82.5%)
	BCBS-MA	Blue Choice	\$8,733	\$6,550 (75%)	\$22,532	\$16,899 (82.5%)
Littleton	BCBS-MA	HMO Blue	\$6,264	\$4,384 (70%)	\$16,428	\$11,500 (70%)
	BCBS-MA	PPO	\$7,704	\$5,393 (70%)	\$20,196	\$14,137 (70%)
Marshfield	BCBS-MA	Network Blue HMO	\$7,116	\$3,558 (50%)	\$18,984	\$9,492 (50%)
	HPHC	HMO	\$7,536	\$3,768 (50%)	\$20,076	\$10,038 (50%)
Medford ⁸	Tufts	POS	\$8,603	\$6,882 (80%)	\$25,684	\$20,547 (80%)
	Tufts	EPO	\$8,195	\$6,556 (80%)	\$24,412	\$19,530 (80%)
Norwell	BCBS-MA	Network Blue HMO	\$7,116	\$5,693 (80%)	\$18,984	\$15,187 (80%)
	HPHC	HMO	\$7,536	\$6,029 (80%)	\$20,076	\$16,061 (80%)
Peabody	BCBS-MA	HMO Blue	\$7,610	\$6,468 (85%)	\$20.44	\$17,370 (85%)
	BCBS-MA	Blue Care Elect PPO	\$9,696	\$8,242 (85%)	\$25,785	\$21,917 (85%)
Salem	BCBS-MA	HMO Blue NE	\$7,800	\$5,850 (75%)	\$21,205	\$15,829 (75%)
	BCBS-MA	HMO Blue NE Options	\$6,496	\$4,872 (75%)	\$17,577	\$13,182 (75%)
Somerville	BCBS-MA	HMO	\$9,352	\$7,949 (85%)	\$25,093	\$21,329 (85%)
	HPHC	HMO	\$8,661	\$7,362 (85%)	\$23,480	\$19,958 (85%)
	Tufts	EPO	\$8,468	\$7,198 (85%)	\$25,203	\$21,423 (85%)
Franklin	BCBS-MA	HMO Blue NE	\$6,273	\$4,265 (68%)	\$16,274	\$10,901 (68%)
	BCBS-MA	PPO Blue Options	\$7,176	\$3,588 (50%)	\$19,986	\$9,993 (50%)
Marlboro	Tufts	EPO	\$7,714	\$5,400 (70%)	\$20,157	\$14,110 (70%)
	Tufts	PPO	\$8,986	\$5,392 (60%)	\$23,553	\$14,132 (60%)
West Springfield	BCBS-MA	Network Blue NE HMO	\$6,672	\$5,004 (75%)	\$17,532	\$13,149 (75%)
Worcester	BCBS-MA	Blue Choice POS	\$8,587	\$6,440 (75%)	\$22,514	\$16,886 (75%)
	Fallon Direct	HMO	\$5,758	\$4,319 (75%)	\$14,778	\$11,083 (75%)
	Fallon Select	HMO	\$7,065	\$5,299 (75%)	\$18,308	\$13,731 (75%)
State	HPHC	PPO	\$7,236	\$5,789 (80%)	\$17,674	\$14,140 (80%)
GIC	Tufts	PPO	\$6,959	\$5,567 (80%)	\$16,896	\$13,517 (80%)
FEHBP	BCBS	PPO	\$6,943	\$4,697 (68%)	\$15,683	\$10,503 (67%)
AIM 2010 Survey	N/A	HMO Plan	\$5,436	\$3,860 (71%)	\$14,748	\$10,324 (70%)
	N/A	PPO Plan	\$5,748	\$4,081 (71%)	\$15,900	\$10,971 (69%)

Appendix B: Member Co-Payments, by Employer

Employer	Carrier	Plan Type	Annual Deductible	Office Visits/PCP Specialist		High-Tech Imaging	Outpatient Surgery	Inpatient Hospitalization
Beverly	BCBS-MA	HMO Blue	\$0	\$15	\$15	\$0	\$0	\$0
	HPHC	HMO	\$0	\$15	\$15	\$0	\$0	\$0
Boston	HPHC	HMO	\$0	\$10	\$10	\$0	\$0	\$0
Chelsea	HPHC	HMO	\$0	\$10	\$10	\$0	\$0	\$0
	BCBS-MA	Blue Choice	\$0	\$10	\$10	\$0	\$0	\$0
Littleton	BCBS-MA	HMO Blue	\$0	\$15	\$15	\$0	\$0	\$0
	BCBS-MA	PPO	\$0	\$15	\$15	\$0	\$0	\$0
Marshfield	BCBS-MA	Network Blue HMO	\$0	\$15	\$15	\$0	\$0	\$0
	HPHC	HMO	\$0	\$15	\$15	\$0	\$0	\$0
Medford	Tufts	POS	\$0	\$10	\$10	\$0	\$0	\$0
	Tufts	EPO	\$0	\$10	\$10	\$0	\$0	\$0
Norwell	BCBS-MA	Network Blue HMO	\$0	\$15	\$15	\$0	\$0	\$0
	HPHC	HMO	\$0	\$15	\$15	\$0	\$0	\$0
Peabody	BCBS-MA	HMO Blue	\$0	\$10	\$10	\$0	\$0	\$0
	BCBS-MA	Blue Care Elect PPO	\$0	\$15	\$15	\$0	\$0	\$0
Salem	BCBS-MA	HMO Blue NE	\$0	\$5	\$5	\$0	\$0	\$0
	BCBS-MA	HMO Blue NE Options	\$0	\$10/\$15/\$20	\$25	\$0	\$100	\$200/\$400
Somerville	BCBS-MA	HMO	\$0	\$5	\$5	\$0	\$0	\$0
	HPHC	HMO	\$0	\$5	\$5	\$0	\$0	\$0
	Tufts	EPO	\$0	\$5	\$5	\$0	\$0	\$0
Franklin	BCBS-MA	HMO Blue NE	\$0	\$10/\$15/\$20	\$25	\$0	\$100	\$200/\$400
	BCBS-MA	PPO Blue Options	\$0	\$10/\$15/\$20	\$25	\$0	\$100	\$200/\$400
Marlboro	Tufts	EPO	\$0	\$15	\$15	\$0	\$150	\$250
	Tufts	PPO	\$0	\$15	\$15	\$0	\$150	\$250
West Springfield	BCBS-MA	Network Blue NE HMO	\$0	\$10	\$10	\$0	\$150	\$250
Worcester	BCBS-MA	Blue Choice POS	\$0	\$10	\$20	\$0	\$150	\$250
	Fallon Direct	HMO	\$0	\$10	\$15	\$0	\$100	\$200
	Fallon Select	HMO	\$0	\$10	\$20	\$0	\$150	\$250
State GIC	HPHC	PPO	\$250 (I)/\$750 (F)	\$20	\$20/\$35/\$45	\$100	\$150	\$250/\$500/\$750
	Tufts	PPO	\$250 (I)/\$750 (F)	\$20	\$25/\$35/\$45	\$100	\$150	\$300/\$700
FEHBP	BCBS	PPO	\$350 (I)/\$700 (F)	\$20 (Pref)/35%	\$30/35%	15%/35%	15%/35%	\$250
AIM 2010 Survey	N/A	HMO	\$914 (I)/\$1,897 (F)	\$20	\$20	\$94	\$273	\$483
	N/A	PPO	\$744 (I)/\$1,618 (F)	\$19	\$19	\$75	\$199	\$372

Appendix C:

Member Co-Payments for Prescription Drugs, by Employer

Employer	Carrier	Plan Type	Tier 1 (Generic)	Tier 2 (Preferred Brand)	Tier 3 (Non-Preferred Brand)
Beverly	BCBS-MA	HMO Blue	\$10	\$20	\$35
	HPHC	HMO	\$5	\$15	\$35
Boston	HPHC	HMO	\$10	\$20	\$35
Chelsea	HPHC	HMO	\$5	\$10	\$25
	BCBS-MA	Blue Choice	\$5	\$10	\$10
Littleton	BCBS-MA	HMO Blue	\$10	\$20	\$35
	BCBS-MA	PPO	\$10	\$25	\$50
Marshfield	BCBS-MA	Network Blue HMO	\$10	\$20	\$35
	HPHC	HMO	\$10	\$20	\$35
Medford	Tufts	POS	\$5	\$10	\$10
	Tufts	EPO	\$5	\$10	\$25
Norwell	BCBS-MA	Network Blue HMO	\$10	\$20	\$35
	HPHC	HMO	\$10	\$20	\$35
Peabody	BCBS-MA	HMO Blue	\$10	\$15	\$30
	BCBS-MA	Blue Care Elect PPO	\$10	\$15	\$30
Salem	BCBS-MA	HMO Blue NE	\$5	\$10	\$25
	BCBS-MA	HMO Blue NE Options	\$10	\$20	\$40
Somerville	BCBS-MA	HMO	\$5	\$10	\$10
	HPHC	HMO	\$5	\$10	\$25
	Tufts	EPO	\$5	\$10	\$25
Franklin	BCBS-MA	HMO Blue NE	\$10	\$20	\$40
	BCBS-MA	PPO Blue Options	\$10	\$20	\$40
Marlboro	Tufts	EPO	\$10	\$20	\$35
	Tufts	PPO	\$10	\$20	\$35
West Springfield	BCBS-MA	Network Blue NE HMO	\$10	\$20	\$35
Worcester	BCBS-MA	Blue Choice POS	\$10	\$20	\$35
	Fallon Direct	HMO	\$10	\$20	\$35
	Fallon Select	HMO	\$10	\$20	\$35
State	HPHC	PPO	\$10	\$25	\$50
GIC	Tufts	PPO	\$10	\$25	\$50
FEHBP	BCBS	PPO	20%	30%	30%
AIM 2010 Survey	N/A	HMO	\$13	\$28	\$49
	N/A	PPO	\$13	\$28	\$47

Endnotes

1. Gruber, J. "The Role of Consumer Copayments for Health Care: Lessons from the RAND health Insurance Experiment and Beyond," Kaiser Family Foundation, October 2006.
2. State law requires the municipality to contribute at least 50 percent of premium costs.
3. Massachusetts Medical Cost Data, accessed on HPHC's web page (www.harvardpilgrim.org) on March 5, 2011.
4. Under the new federal health care law, routine preventative visits will not be subject to co-payments. Plans in existence prior to the law's enactment are exempt unless they make material changes in benefits. Plans may also voluntarily eliminate co-payments for routine preventative visits, as the GIC will do effective July 1, 2011.
5. Pricing information from HPHC's web site, Massachusetts Medical Cost Data, accessed at www.harvardpilgrim.org on 03/05/2011.
6. Pricing information from HPHC's web site, Massachusetts Medical Cost Data, accessed at www.harvardpilgrim.org on 03/05/2011.
7. The FEHBP includes an out-of-pocket maximum of \$5,000 for services provided by a "preferred" provider.
8. Medford offers employees with one dependent the option of enrolling in "employee + 1" coverage, instead of "family" coverage. This results in higher premiums for family coverage, because it effectively increases the size of each "family" and eliminates two-person families from this rate basis type.
9. Blue Cross Blue Shield of Massachusetts
10. Harvard Pilgrim Health Care

