

ALBANY COUNTY HEALTH CARE FEASIBILITY STUDY



November, 2011 (Revised March 2012)

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Albany County Health Care Feasibility Study

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Background

Albany County retained the Segal Company to:

1. Evaluate the benefit plans offered by the local governments in the County.
2. Review the terms and general cost parameters of alternative funding arrangements available to a groups that would be the size and nature of a contemplated pool made up of the County and local governments in the County. This discussion commences with a review of the different legal structures available to these municipalities if they were to join since this is a key driver of the financial and risk arrangements that will become available to the contemplated consortium.
3. Explore available wellness programs and other contemporary care management techniques. This element of our review will help the County understand the affect of different cost management techniques. In this element, we will not just list available programs but discuss how they might be implemented either to the County or to the contemplated consortium to achieve maximum results in both improvements in the health of covered participants and cost management.
4. Prepare a report that includes a statement of goals and the develops an action plan.

The implementation of any desired alternatives are beyond the scope of this review but we will provide the County with a written timeline and plan for the implementation of the desired alternative after reviewing the contents of this draft and obtaining the County's sense of which direction in which to precede. The timeline will discuss the timing of such things as drafting uniform, detailed specifications to obtain risk, network, care management and administrative services, analyzing responses, interviewing representatives of desired alternatives, negotiating with the most favorable alternatives, selection of a preferred vendor(s) and implementation. This timeline and plan will note how many of our clients share responsibility with their consultant(s) to maximize the value of internal capabilities and the consultant's resources.

The report is broken into the following components:

1. Review of Benefit Plans currently offered by the Municipalities in the County as well as a summary of the County Plan.
2. Review of the alternate funding arrangements available to the contemplated consortium:
 - a. Review of funding alternatives available in the market
 - b. Review of legal arrangements under which the County and local governments could consolidate/pool plans

3. Overview of wellness programs available in the market and a highlights of current wellness programs contained in the current benefits offerings.
4. Action Plan/Timeline (to be added after meeting with County and Municipalities)

The Segal Company, as an employee benefit-consulting firm, does not practice law, issue legal opinions or give advice on compliance with laws and regulations. As a result, any findings and recommendations that Segal offers as part of this feasibility study will be offered solely from a consulting perspective. Segal's conclusions will not be viewed as legal advice on the application of federal or state statutes and regulations. As always, plan sponsors should rely on legal counsel for authoritative advice on the interpretation and application of federal and state laws and regulations.

Summary of Benefit Plans Currently Offered by the Local Governments in the County

Current Participation

The inventory of the current benefit plans offered by the towns, village and city in Albany County is contained in Tab 1. The Summary of Benefits provided by Empire for the County is contained in Tab 1A. Tab 2 summarizes participant counts and rates. We received information from the following Municipalities: Town of Bethlehem, Town of Colonie, City of Cohoes, Village of Green Island, Town of Guilderland and Albany County. We did not receive information from the Town of Coeymans or the Town of New Scotland². The County currently coverage 1,905 active employees and 1,290 retirees. The towns and villages together currently cover 1,097 active employees and 484 retirees³. Of the 479 retirees, 391 are covered under a Medicare Advantage Plan (of this total, 21 are from the Village of Green Island). Forty percent of the total are Albany County are retirees; the corresponding number for the local governments is 29.6%. Forty-six percent of the covered members for Albany County are male compared to 75% for the local governments. Albany County has a younger active population and an older retiree population than the municipalities. An active member for Albany County averages 45.6 years compared to 46.4 for the municipalities, while the average age for the retiree population is 70.1 years for Albany County compared to 67.7 years for the local governments. The overall average age for Albany County is 55.5 years compared to 52.7 for the local governments.

Types of Coverage Currently Offered

When considering whether to consolidate plans, consideration would be given to the number of plan options and the relative differences of these options. All the towns and villages offer health benefits through Capital District Physicians Health Plan (CDPHP) Health Maintenance Organizations (HMO) with different copayment structures⁴. Of the six towns and villages who provided information, all of them provide retiree benefits, with Medicare-Eligible retirees and spouses offered a Medicare Advantage Plan (MAP) through CDPHP.

² The Town of New Scotland provided current rates and participant counts to be included with this study. It is our understanding from information provided by the County that both of these towns provide benefits through a contract with CDPHP.

³ The Village of Green Island did not provide a breakdown of retirees vs. actives as part of its census. They did provide a breakdown of number of retirees enrolled in a Medicare Advantage plan.

⁴ It is our understanding from information provided by the County that the Town of Coeymans provides benefits through a contract with CDPHP.

The County currently provides a Preferred Provider Organization (PPO) benefit through a minimum premium contract with Empire BlueCross which provides in-network benefits (\$15 copayment) and out-of-network benefits (\$280 deductible/ 20% coinsurance). Prescription drugs are administered by Medco. Currently, retirees are covered under this contract. The County has received a proposal to move its Medicare-eligible retirees into a Medicare Advantage Plan effective July 1, 2011.

While not specifically part of this review, provisions for dental benefits are described in the summary tables. The towns and villages also provide life insurance.

Criteria for Eligibility and Cost Sharing for Towns and Villages

In addition to the number of plan options and relative differences of these options, changing plans is generally a matter of collective bargaining. There are a number of different collective bargaining agreements in force that dictate which health benefits are offered and employee premiums, if any and levels of cost-sharing (e.g., copayments and deductibles). Of the towns and villages that provided this information, we found the amount of employee/retiree premiums is generally tied to employees' date of hire with newer employees having a higher premium percentage than longer-term employees. We only received information on collective bargaining agreements (CBAs) currently in force from the Town of Bethlehem and the Town of Guilderland.

Alternative Funding Arrangements

Funding Alternatives

Assessing the overall cost efficiency of a health program requires an understanding of the financial arrangements available for the funding and administration of the plan. These include the following basic funding platforms:

- Conventionally Insured
- Pooled Arrangements
- Minimum Premium
- Community Rated
- Self-Insured

Conventionally Insured

A conventionally insured (or fully insured) contract means the insurance carrier is setting an overall liability for the policyholder. This liability is expressed as a per capita premium rate and is used to determine the maximum exposure for the particular policy period in question. Rates are often –but not always– expressed on an individual and family basis, sometimes with different rates for Medicare primary participants. In most cases, the premium rates are developed by reviewing the group's prior experience to project a future claims liability.

In conventional insurance, the underwriter assessing the risk potential will assign a level of credibility to the claims history. The size of the group and the number of years of experience available will affect the claims credibility determination. A conventionally insured contract can be written as either a participating or a non-participating contract.

- **Participating:** The insurance company will do a year-end financial accounting comparing the premiums earned to the total incurred claims plus expenses. If the premium exceeds the total of claims plus expenses, the policyholder would receive a dividend for the difference. Any deficit that may be incurred (where claims and expense exceed the premium) would not be paid immediately but would be carried forward and may be recouped through favorable experience in future years. Participating contracts are usually available to larger groups.
- **Non-Participating:** the insurance company will keep any gains or losses of incurred claims and expense compared to premium. Smaller groups usually select non-participating contracts.

The **rates** provided by an insurance carrier for a participating (dividend eligible) contract, all things being equal, will be higher than the rates for a non-participating contract as additional claims fluctuation margin and higher risk charges are included in participating contracts. A non-participating contract commonly has a lower claims fluctuation margin, if any, and lower risk charges than a participating contract. However, one of the advantages of a participating contract is that if the claims paid and retention (expenses) are less than premium remitted the entire difference is returned to the policyholder. Hence, the net cost (premium less dividends) for a participating contract may be lower than a non-participating contract. The maximum annual premium exposure is capped for either contract so that the policyholder would never pay more in a policy year than the full rates.

In order for an insurance company to develop a valid conventional rate, industry practice will likely require a minimum of 2 years of **current** (meaning calendar years 2009 and 2010 data at this time) paid claims experience for the underwriter to study trend. Further, regardless of the contract being participating or not, the industry underwriting principles will typically require that an insurance contract be based on the group's prior experience.

Pooled Arrangements

Under a pooled arrangement, the insurance carrier will not use any of the group's claims experience in the setting of the rate. In other words, no credibility would be given to the policyholder's experience. The arrangement is similar to community rating since no experience is used. The main distinction is that the underwriter can establish the pool used to set the rate under a pooled arrangement. In a community rating procedure, a regulatory body sets the rate.

The rate development under a pooled arrangement will be based upon the characteristics of the group, for example, the size, industry, and location. The experience of the overall pool will determine future rates.

Minimum Premium

Under a minimum premium contract, the insurance carrier bears the risk as it does in conventional insurance while offering the policyholder cash flow advantages. This is the current funding arrangement for the County. Under this type of funding arrangement, Albany County funds the claims liability as it occurs, as would be the case under a self-insured plan. Empire sets an annual maximum liability for the County. The setting of the liability cap is similar to the rate development under the conventionally funded program. The only portion that is assessed New York State premium taxes is the retention component of the cost. The risk charges may be higher under a minimum premium arrangement than conventional insurance yet State premium taxes assessed by the carrier will be less than under a conventionally funded program. A year-end financial accounting is performed. Either the insurance carrier or the policyholder may hold the reserve portion. This type of financial arrangement is generally offered to large groups, like Albany County, but would not be available for the Local Governments unless they were part of a pooled arrangement.

Community Rated

A Community Rated platform is another funding alternative. Under community rated programs, the insurance carrier sets the rates under a process governed by law. The same rate is available to all participants in a given community. A community is generally a defined geographic area. A different rate may apply for individual versus group coverage. In New York State, individuals and groups with fewer than fifty employees who participate in their community and Health Maintenance Organizations (HMOs) must use this form of rating. This rating does not allow for a differentiation in rates based upon health status or age. From a historical perspective, during the 1970s and 80s, HMOs were able to offer lower rates than other health programs due to the types of care management employed and the volume discounts that they could drive. This is generally no longer the case as most other health plans have entered into negotiated arrangements with providers and have adopted managed care principles. Currently all the municipalities are insured under HMO contracts issued by Capital Health (CDPHP).

Self-Insured

Another alternative funding arrangement is self-insurance. Under a self-insured program, all the risk would be borne by the sponsor of the health plan. Under such an arrangement, the County would pay for claims as they occur through a banking arrangement. There are several forms of risk inherent in a self-insured arrangement. These include:

- Ordinary risk – higher than normal utilization of benefits in a measuring period
- Large or catastrophic claim risk – unexpected increases in the number or amount of claims incurred by participants in a measuring period.

An important element of risk is the concept of the Law of Large Numbers. The risk is reduced as the base of lives for which the risk is spread increases. Thus, the larger the claims base, the lower the risk potential. A form of protection against anomalies in claims experience and high claimants is stop loss coverage.

Stop Loss can be either specific or aggregate. Under specific stop loss coverage, protection is provided for individual claimants that exceed a certain specified claims level during the year covered. Any claims paid in excess of the stop loss threshold will be reimbursed to the health plan thus becoming the obligation of the stop loss vendor. This provides protection for the policyholder against high individual claimants in a year. Aggregate stop loss coverage provides protection on the Plan's total dollar liability. Total claims for all members are compared to the maximum liability figure. The maximum liability is set by the carrier prior to the policy effective date based on an analysis of the claims data and estimated projected future costs. The maximum liability is generally set at 125 percent of expected claims (threshold level). Any claims in excess of the maximum liability will be pooled, or removed from the health plan's experience, and become the obligation of the stop loss vendor. While this provides protection for a general increase in claims due to change in behavior and/or utilization, the Health Plan is responsible to pay all claims up to the 125 percent threshold level. Note that any claims above the specific stop loss threshold are not counted toward the 125 percent of expected claims aggregate stop loss threshold level.

Under a self-insured program, a plan would be responsible for maintaining any reserves to cover future claims obligations. The County would also need to establish appropriate COBRA rates for terminated employees, dependents and retirees. Obviously, required administration, provider network, care management, customer service, actuarial and other services are available through various service firms including the same firms that provide other forms of insurance.

Establishment of appropriate reserve levels under traditional forms of insurance is calculated and maintained by the insurance company, who retains the ultimate risk. Under self-insured contracts, the development and maintenance of reserves becomes the obligation of the health plan. There are several types of reserves. The following provides a summary of reserve types:

- **Reserve for Pending and Unrevealed Claims:** This reserve, calculated separately for each line of coverage, is used to estimate the liability at year end for:
 - Claims already presented but not yet paid
 - Claims not yet presented but incurred prior to year-end and not yet paid

Under insured contracts, the insurance companies would typically hold the reserve. Upon cancellation of the contract, the company would pay all run-out claims or claims that were incurred before termination but not paid. Some companies will return the balance of the reserve to the policyholder after approximately two years of run-out.

- **Reserve for Claims Fluctuation:** This reserve is used to protect against any sudden increase in the total level of claims payments. Stop loss insurance may be used to reduce the risk due to claims fluctuation.
- **General Contingency Reserve:** This reserve would provide a buffer in the event that income drops significantly in the future or that the health plan sponsor would be curtailed due to a change in economic conditions. The establishment of the reserve level is based upon a measurement of a variety of factors and can be explored in a subsequent memorandum if there is interest in this element of health plan funding.

A determination of the most cost efficient alternative to fund a health program is not the same for every group. Case specifics will determine the appropriate funding mechanism. Typically, for a group the size of Albany County (alone or when combined with the Local Governments), where there is a modest risk (due to the Law of Large Numbers as explained above), a conventional fully insured or minimum premium arrangement on a participating (dividend eligible) basis would be favorable due to the known maximum liability over the policy period and modest risk charges. A “Retrospective Premium arrangement” would allow Albany County to withhold the payment of the claims fluctuation margin in the premium payments. Note that these monies can be “called” by the insurance carrier at settlement if necessary.

There are certain drivers in choosing the appropriate funding for a health program. The drivers include the ability or desire of the health plan sponsor to:

- Tolerate financial and legal risk
- Tolerate volatile cash flow demands
- Avoid mandated state insurance laws
- Avoid or reduce insurance premium taxes
- Reduce insurance carrier retention charges
- Select optimal service delivery networks and select its' own administrative services

Factors that Drive Costs of Medical Services in Albany County

If a consortium were to be developed covering the County and local governments, certain financial elements, discussed below, are likely to result in a savings in cost. In addition, the program would likely become fully credible. This will allow the contemplated consortium to observe and manage the factors that drive the cost of medical services. Medical costs change for three reasons: inflation, utilization and intensity.

Inflation is the change in the unit cost of the same item or service over time. While medical inflation is higher than general inflation, it is the smallest contributor to medical cost changes. Managed care organizations, like Empire Blue Cross, contract with facilities, physicians and drug companies in a manner that manages the unit cost of care. Once a health plan is credible, it is important for the sponsor to understand how providers' unit costs are determined. As with many goods and services, unit costs are different and change at different rates in different regions. We have not compared the cost of the health plans in place at the County and local governments to the cost of the New York State Health Insurance Plan (NYSHIP or Empire Plan) since the benefits are different. However, since health care costs are generally lower in Albany County than the State generally, we would expect that –on a benefit adjusted basis- the cost of a locally based health care plan would be lower than the NYSHIP Plan. This should be confirmed once the costs of a consortium are projected. Regarding the change in unit costs, a credible health benefits plan must monitor how its claims administrator contracts with providers and must be aware of changes in unit costs in order to measure value.

Similarly, changes in **utilization** must be monitored. Economists generally consider health care to be a superior good. That means that as income or available funds increase, more care is provided. This is not just a matter of consumer preferences or provider practices. As populations age and live longer with diseases being managed, more care is provided. Health plan administrators provide substantial efforts to see that the quantity of care provided is controlled as well as possible. As with unit costs, a credible health plan must monitor how its claims administrator manages the quantity of care provided.

Efforts to control utilization include pre-approval and other quantity limitations on prescription drugs, hospital pre-admission and discharge planning programs and monitoring physician practice patterns to optimize the use of diagnostic tests and various forms of therapy. In addition, a later section of this report discusses care management programs that are available to help address this element of health care cost and trend.

The third element cost and cost changes is similar to quantity but has some different characteristics. **Intensity** is the change in the mix of care being provided. For example, new technology results in more effective diagnostic procedures and new prescription drugs. Often these new resources are more expensive than the old resources. Sometimes, new procedures, technology or prescriptions are less expensive. As time goes on and the array of alternatives increases, it becomes more important that mix of care paid in a group health care plan is managed to optimize the mix. A health care plan's objective should be to cover the most appropriate level of care. As with the other two variables, the contemplated consortium should employ a claims administrator that monitors and optimizes the mix of services.

Efforts to make sure that increases in intensity are consistent with prudent medical practice include step therapy for prescription drug programs, hospital discharge planning to encourage home health care when medically appropriate, and carve out programs for physical therapy, and chiropractic mental health imaging and other elements of care.

Consolidation of Plans

Pooling Experience

Generally, small local governments typically have fully-insured contracts. As discussed in the previous section, in New York State individuals and groups with fewer than 50 employees who participate in their community and HMOs must use a community rated platform. Groups under a certain size, typically 300 employees, typically have a non-participating contract where the carrier keeps any margin experienced during an accounting period. Groups over this size but still under 1,000 may have a participating arrangement which allows for excess premium to be returned. Currently, the local governments of Albany County are each independent buyers of health care and are all covered under community-rated HMO contracts with CDPHP that cover active members and their families as well as early retirees (those under age 65) and range in size between 52 and 840 employees. Medicare-eligible retirees are covered through CDPHP Medicare Advantage plans. The County contract is currently a minimum premium contract and there are 1,905 employees and 1,290 retirees covered under that contract. Drug benefits are self-funded with Medco acting as the pharmacy benefit manager (PBM).

Claims Experience and Credibility

If the local towns and the County pooled to create one Plan, it would certainly be large enough to be considered fully-credible as it will bring together close to 5,000 employees. Depending on the legal provisions by which the groups combine the plans (either

through an Article 47 or Article 44), this allows the combined plan to either self-fund or an insurance company to rate the plan based solely on the historical claims experience of the entire plan which typically produces a smoother trend line for renewal rate increases. This contrasts with the current state where the local governments are rated using the HMO community pool.

Program Management and Administrative Costs

In insured or self-insured arrangements, multiple employer plans in New York State, to our knowledge, are paying in the general range of 5% – 10% of claims for administration and 1% – 5% of claims for risk. Individually, the combined administration and risk charged to plans (as defined above) by carriers is scaled based on health plan size and funding arrangement. For a health plan with 300 employees these charges would be about 20% for a health plan, with between 250 – 500 employees these charges would be approximately 15%, and for a health plan with between 500 – 1,000 employees these charges would be approximately 12%. This can represent substantial premium savings to individual plans with a smaller population than these levels. On the other hand, over 5,000 employees, the marginal savings becomes minor.

As purchasers of community rates programs, the local governments in Albany County are paying a rate based on the experience of the community purchasing insurance along with an expense load applied to these programs, typically currently 35% of premium. Beginning in 2011, under the Affordable Care Act, the law requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities. Insurance companies in the large group market must spend at least 85 percent of premium dollars on medical care and quality improvement activities. Insurance companies that are not meeting the medical loss ratio standard will be required to provide rebates to their consumers. Insurers will be required to make the first round of rebates to consumers in 2012. How this will operate remains to be seen.

PLEASE NOTE that these principles and amounts are generalizations and broad estimates to demonstrate an order of magnitude since the local governments were unable to supply their own claims experience. As a general matter, a group plan based on the collective experience is likely to be more favorable to the population in the community pool. In addition, to the lower expense load that is likely to be applied to a group the size of the contemplated consortium, from 10 to 15 percent, getting claims details will allow for the customized management of those claims.

Financial Impact of Consolidating the County's and Local Governments' Plans

To commence consideration of consolidation, the following table represent the cost impact of switching all current active employees covered by the towns into a combined Plan presuming the County's benefit level will be offered to all local governments and the local governments' experience will transmit to the local governments.

	Monthly Premium		Additional Cost	Additional cost %
	Current	Based on Albany County's Cost		
Town of Bethlehem	\$230,949	\$258,681	\$27,732	12.0%
Town of Colonie	540,164	662,138	121,974	22.6%
Coeymans	-	-	-	0.0%
Cohoes	143,300	161,809	18,509	12.9%
Green Island	37,917	43,646	5,729	15.1%
Town of Guilderland	167,239	202,261	35,022	20.9%
New Scotland	34,066	40,452	6,386	18.7%
Albany County	2,185,480	2,185,480	-	0.0%
Total Monthly Premium	\$3,339,115	\$3,554,467	\$215,352	6.4%
Total Annual Premium	\$40,069,400	\$42,653,600	\$2,584,200	6.4%

As illustrated above, the cost would increase for all the municipalities if they were to join the County's plan. However, most of the cost increase would be due to plan design as the municipalities are in community rated HMOs and the County offers a Point of Service (POS) plan with low copayments and an out-of-network benefit. As discussed earlier, HMOs rates are set by the state and claims experience is not available to contract holders. POS plans have similar claims and care management tools as HMOs; they can be experience rated.

However, there is no reason to change benefits in order to consolidate. Benefit levels are a function of bargaining and budget constraints. There is nothing that would prohibit the consolidated "plan" from offering multiple benefit designs that sustain current design. For example, the municipalities could be offered an Exclusive Provider Organization (EPO) product which could mimic the current HMO plan design and would allow for experience rating. While this should be confirmed with legal counsel, we think that this would even satisfy the pooling requirements of an Article 47 approach as a pooling formula can be developed to account for benefit differences.

If current benefits could be sustained, then of course, the cost differences among the local governments would be a function of the groups' claims experience. Since the towns' claims history was not available, the claims variations risk can be managed with low attachments points.

Non-Measurable Financial Benefits of Consolidating the County's and Local Governments' Plans

In addition to the financial considerations, there are several other benefits that can be realized by combining plans that may be harder to specifically measure.

These include alleviating the local governments of the administrative burden of choosing (and, far more important, monitoring) health plan options and managing communications, processing premium payments, collecting employee contribution, and handling enrollment. Of course, these four tasks must be provided at the employer level. However, we have found that a collective approach to designing systems to efficiently accomplish them, perhaps with employing the services of the insurance carrier(s) or third party firms that are more economical when obtained for a larger group, is more easily done with a larger consortium rather than by small employers.

Beyond this important relief, a consortium can offer better communications and customer service to address the particular needs of the covered population. Where communications material is currently provided, it is in the form of the insurance company certificate or pre-package material that is not targeted to the needs of the employee population. Should the local governments combine with the County, targeted communications could be prepared for the plan that would be more effective in communicating the value of the benefits and help individuals with decisions and enrollment. We have found that such a customized approach has a very positive effect on customer service with measurable effects on productivity, understanding and satisfaction with the plan and even the health of the covered population.

Most important, the disease management and wellness feature of the current programs, which are discussed in this report, are all available on a generic basis. For the reasons noted in this report, we think that it is appropriate that a contemporary health plan offer such services. We question, however, if the most appropriate programs are being offered to the most appropriate people in the most appropriate way. We have found that this is typically not the case unless a targeted fact based effort is undertaken. Because of the size and the nature of the benefits provided to the local municipalities (pooled and community rated programs), the local governments cannot currently provide targeted disease management or wellness programs to their population participants. Should the plans combine, it would be easier and cost-effective to provide participants with meaningful communications material and to promote a culture of wellness across the County.

How to Pool Local Governments and the County

Should Albany County decide it wishes to pursue such an option, the structure and under what governance this would be accomplished need to be addressed. Currently in New York State, governmental employers are allowed to pool under Article 47 by setting up a Municipal Cooperative Health Benefits Plan which are self-insured arrangements that must follow certain criteria established by the State. There are currently 10 Article 47 Plans in New York State. These types of plans cannot be insured. The other option involves establishing an Employee Welfare Fund under Article 44. Under such an arrangement, it appears that the plan could either be insured (and experience-rate) or self-insured. There are currently four plans maintained pursuant to Article 44 in New York State.

Article 47 – Municipal Cooperative Health Benefits Plan

Under Article 47, Municipal cooperative health benefit plan’ . . . means any plan established or maintained by two or more municipal corporations pursuant to a municipal cooperation agreement for the purpose of providing medical, surgical or hospital services to employees or retirees of such municipal corporations and to the dependents of such employees or retirees. The term ‘municipal corporation’ means a county outside the city of New York, a city, a town, a village, a board of cooperative educational services, fire district or a school district.

Article 47 of the Insurance Law, §4701(a) states that: “Cooperative health risk-sharing agreements allow public entities to: share, in whole or part, the costs of self-funding employee health benefit plans; provide municipal corporations, school districts and other public employers with an alternative approach to stabilize health claim costs; lower per unit administration costs; and enhance negotiating power with health providers by spreading such costs among a larger pool of risks.”

Article 44 Welfare Funds

Under Article 44 of the New York Insurance Law, medical benefits can be provided through an “employee welfare fund”. For these purposes, an employee welfare fund is a trust fund maintained by one of more employers with one or more labor unions, directly or indirectly through trustees. The benefits can be provided through the purchase of insurance or otherwise. In order to qualify under this Article, the trustees must register the fund with the Insurance Department within three months of commencing operations. As a general rule, only governmental entities may form Article 44 employee welfare funds.

There are a few advantages to using this form for providing welfare benefits. If the fund is self-insured, then the fund may escape some of the mandates under New York state law that apply to insured funds.⁵ On the other hand, if the fund is fully insured and qualifies as a collectively bargained welfare benefit trust under Insurance Law Section 4235(c)(1)(D), then the fund might be able to avoid the community rating requirements that might apply.⁶

⁵ See February 20, 2003 opinion of the Insurance Department's Office of General Counsel exempting an Article 44 fund from the state Women's Health and Wellness Act of 2002 at <http://www.ins.state.ny.us/ogco2003/rg030224.htm>

⁶ See December 28, 2004 opinion of the Insurance Department's Office of General Counsel exempting a Taft-Hartley Fund from the small group rules. However, the language of the opinion implies that other trust established under collective bargaining agreements may qualify. See the opinion at <http://www.ins.state.ny.us/ogco2004/rg041226.htm>

In making this decision, Albany County would need to consider several items:

Issue to Consider	Article 47 – Municipal Cooperative Health Benefits Plan	Article 44 – Employee Welfare Fund
Definition	Municipal Cooperative Health Benefit Plan means any plan established or maintained by two or more municipal cooperatives pursuant to a municipal cooperative agreement for the purpose of providing medical, surgical or hospital services to employees , retirees and such dependents. Maintained by the County/Local Governments.	Any Trust Fund established or maintained jointly by one or more employers with one or more labor organizations, to provide employee benefits by the purchase of insurance or annuity contracts or otherwise.
Establish/Application Process	In order to establish an Article 47 Plan, a group would have to obtain a Certificate of Authority in order to establish and maintain a Municipal Cooperative Health Benefit Plan in accordance with Article 47 of New York Insurance Law. A copy of the application is attached.	The Trustees of the Fund would have to register the Fund with the superintendent (of Insurance) within three months of commencing to do business in the State in the form and content.
Funding Mechanisms	Must be self-insured with certain reserve requirements including stop loss.	Insured or “otherwise”; appears to be exempt from community rating.
Mandates	Minimum standards regarding benefits and participation. Must maintain stop-loss insurance. Generally subject to NY State insurance mandates.	Not an Employee Retirement Income Security Act of 1974 (ERISA) Plan as a governmental plan. If self-insured, would not be subject to NYS mandates unless article 44 requires compliance. If New York Insurance policies are purchased must comply with mandates.

Issue to Consider	Article 47 – Municipal Cooperative Health Benefits Plan	Article 44 – Employee Welfare Fund
Oversight/Filings	New York State. Must also file approval with the superintendent a description of material changes; an annual report showing the financial condition and affairs of the plan (including an annual independent financial audit statement and independent actuarial opinion) within 120 days after the close of the plan year; quarterly reports describing current financial status.	New York State. Annual Statement/Annual Report; Statement from Insurance company and service provider.
Governing Board	Group of persons designated in the Municipal Cooperative to be responsible for administering the Plan.	One or more employers together with one or more labor organizations whether directly or through Trustees. Trustees are individuals who are charged with or have the general power of administration of the fund.
Plan Benefits and Disclosure	Plan document distributed to each participating employer and unions and SPD to all participants. SPD is subject to regulation as if it were a health insurance subscriber certificate.	Per written document.
Audit	Superintendent may examine the affairs of the plan as often as deemed necessary but not less than once every 3 years to no more than 5 years.	The superintendent may examine the affairs of any fund as often as he deems necessary at least once every 5 years.

Issue to Consider	Article 47 – Municipal Cooperative Health Benefits Plan	Article 44 – Employee Welfare Fund
Participation	Number of covered employees participating in the plan shall be at least 2,000.	No minimum.
Design	Minimum Standards	Including but not limited to medical, surgical, or hospital care or benefits.
Standards	Must have facilities and personnel or contracted with service provider(s) to service the plan. Must establish a fair and equitable process for claims review and appeals. Must allow all eligible employees to enroll in the plan.	Trustees are fiduciaries.

Establishing a Trust Fund

This report notes the challenges to the two most powerful approaches: establishing a plan under either Article 44 or Article 47 of the Insurance Law. A third, simpler approach of maintaining current benefits and carrier relationships might be accomplished by establishing a trust fund at the County and allowing local governments to obtain desired coverage, care management, risk and administrative arrangements through that trust. This option is included because the County has a minimum premium arrangement with Empire Blue Cross and a self-funded prescription drug program and the seven participating local governments have insured arrangements with CDPHP for all benefits for non-Medicare eligible retirees. All eight governments have Medicare Advantage Plans for their Medicare eligible retirees. While the County’s financial arrangement is more efficient than the local governments – mainly due to its larger size - its benefits are richer.

A number of groups of school districts have formed health care consortia in the Capital Region that employ this approach. This approach would have to first be reviewed with the County Attorney’s office and the following discussion only addresses operational and financial elements, as Segal does not practice law. Segal has, without mentioning the County or the local governments by name, reviewed this potential option with CDPHP.

CDPHP has responded that, unless an Article 44 approach is taken, they would not be willing to adjust the financial arrangement for groups with under fifty employees because of the State’s community rating requirements. The reasons for this are discussed in the in this report. Accordingly, the following savings estimates are only applied to the local governments with over fifty employees.

The premise behind the savings estimate is that the reduction in risk charges and other expense elements associated with having a single large group of about 4,800 employees and retirees (the total count of all governments that elected to participate in the study) is marginally lower than what the factors are for multiple smaller. This is supported by noting the percent of premium formula retention breakdown for conventional insurance assessed by CDPHP for groups of the following sizes:

Group Size	<500	500-1,000	1,000-2,000	>2,000*
Retention	10.7%	10.4%	10.2%	9.9%
Risk	0.5%	0.5%	0.5%	0.5%
Margin	1.0%	1.0%	1.0%	1.0%
GME/Network Access	0.9%	0.9%	0.9%	0.9%
Total	13.1%	12.8%	12.6%	12.3%

By contrast, the current Empire Blue Cross expense formula produces an expense load that represents about 9% of the County premium equivalents under its minimum premium arrangement. This study discusses the differences between conventional insurance and minimum premium regarding rate development, sponsor net cost and sponsor risk, all of which affects a health plan’s finances. Obviously, greater savings will be experienced by the local governments if they were to become part of the County’s arrangement with Empire Blue Cross. These considerations have been discussed previously, with and without moving to the County’s benefit level, a typical feature of both Article 44 and Article 47 Plans.

Further, given the current benefit levels and relationships with CDPHP, if the local governments with over fifty lives were to combine, then they could consider changing to an arrangement that CDPHP offers called Shared Health. This will represent two advantages to the groups. First, the expense load will be smaller. If the groups were combined for the purpose of this purchase, the expense load would be about 10%. Even if CDPHP would not combine them, the load would be no higher than 11% for the smallest group. More important, CHPHP would not collect any difference between the claims expenses and the expense load. The amount of this actual margin (versus the 1.0% pro forma margin added to the rate in the expense formula) can be considerable, particularly as care management programs discussed herein become effective.

The actual experience of the four local governments with over fifty lives (Bethlehem, Colonie, Cohoes and Guilderland) was not available for the purposes of this report to confirm additional savings. However, if this approach is desirable, an analysis can be done with the local governments and CDPHP to investigate which local governments might benefit from such an arrangement and how much additional savings this approach might generate. Presuming a 10% actual margin, combining and adopting a Shared Health arrangement might save the following local governments the following annual amounts. If this approach is desired, these savings can be confirmed with CDPHP.

<u>Town</u>	<u>Potential Savings</u>
Town of Bethlehem	\$270,000
Town of Colonie	\$640,000
Cohoes	\$170,000
Town of Guilderland	\$200,000

These estimates are based on information provided by CDPHP on their Shared Health arrangement which includes an aggressive care management and tailored wellness programs and a minimum premium arrangement. Included in these costs are administrative expenses, risk, margin and GME (covered lives assessment).

Aside from the possibility of this move, savings and administrative relief will be enjoyed if the County and local governments joined together to purchase administrative services needed to support both basic services as well as additional services to assess, implement and monitor needed claims control and care management services.

As an additional matter of background, the County does not have an insurance commission added to its expense load (as it pays an independent consultant directly) but the other local governments have commission loads built into their CDPHP premium rates. The commission load charged by CDPHP is from 2.0% to 3.5% (the exact factors were not available, as the discussion with CDPHP did not include mention of particular contract holders).

These rates represent annual revenue of between \$275,000 to \$480,000 for the groups included with this study. This balance could be used to perform the following services, which have the potential to obtain the following sets of services that can represent significant value to all parties:

- It will outsource the enrollment, recordkeeping and general service tasks currently being performed by staffs at the local governments to a professional organization. This will not only free up internal resources but will also result in process improvements such as more accessible data, better enrollee communications and service as well as access to specialized services such as eligibility audits to help assure accuracy.
- It will allow for a general oversight of the various contemporary care management services. Our study discusses the various care management programs that Empire Blue Cross and CDPHP make available to plan participant. We note that an appropriate array of services are available but also note that in order to be effective claims usage data must be reviewed and particular programs should be encouraged and monitored that address particular needs.
- It will provide a forum to allow the collective group to gather and monitor claims experience. As circumstances and market conditions change, this will allow the timely study of such issues as moving to CDPHP's Shared Health arrangement, self funding prescription drugs in the CDPHP plans and purchasing them through a collective arrangement either with the County or other available group purchasing arrangement, collectively moving to another carrier and/or risk arrangement with one of the current carriers.
- It will provide a forum for all participating governments to share best practices in plan design and cost sharing.
- It will provide a platform to consider the prospects of realizing additional savings by employing an Article 44 or Article 47 approach at some time in the future.
- It will provide a forum for the collective consideration of opportunities and challenges that emerge as the provisions of PPACA become effective.

If these services were to be performed by a qualified third party firm, they can both relieve the County and the local governments of responsibilities performed by staff and add value in the above areas. This can result in significant additional savings to all governments, including the County.

Effect of PPACA on Consideration to Consolidate

Grandfathering

The health care reform law (the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act) contains extensive new benefit plan mandates for both insured and self-insured group health plans. The law is often referred to as the “Affordable Care Act” or ACA. If they have not already done so, the County and each of the towns will need to assess the impact of the Affordable Care Act on each of the plans offered to employees. There are a number of requirements that apply to all plans whether or not they are “grandfathered” health plans and additional requirements for plans that are not considered “grandfathered.” Whether the County plan or the municipalities’ plans are grandfathered plans is outside the scope of this report. However, should Albany County decide to pursue the option of consolidating plans, it is important to note that any consolidated plan (or plans) would have to comply with the requirements under the Act. In addition, it would be necessary to assess the impact of a potential consolidation of plans on the grandfathered status of the County plan, which would likely serve as the consolidated plan, paying particular attention to the so-called “anti-abuse rules” discussed below. We informally asked the municipalities about their efforts in regard to implementation of ACA requirements as well as their status as a grandfathered plan. None of the groups that we talked with had given either much consideration.

Interim final regulations addressing grandfathering under the Affordable Care Act state that a group health plan that provided coverage on March 23, 2010 generally is also a grandfathered health plan with respect to new employees (whether newly hired or newly enrolled) and their families who enroll in the grandfathered health plan after March 23, 2010.⁷ This general rule is subject to two exceptions called the “anti-abuse rules.”

- One rule applies when the principal purpose of a business restructuring (such as a merger) is to cover new individuals under a grandfathered health plan. The goal of this rule is to prevent grandfathered status from being bought and sold as a commodity in commercial transactions.
- The second rule affects transfers of employees from one grandfathered plan (or benefit package) into another grandfathered plan (or benefit package) in situations where there is no bona fide employment-based reason for the transfer. This rule prevents a plan from circumventing the limits on changes that cause a plan to lose grandfathered status by transferring employees from one plan to another. If this rule applies to the consolidation under consideration, to determine whether or not the consolidated plan remains

⁷ See 26 C.F.R. § 54.9815-1251T(b), 29 C.F.R. § 2590.715-1251(b), and 45 C.F.R. § 147.140(b), published in 75 Fed. Reg. 34538 (June 17, 2010).

grandfathered would require comparing the terms of the consolidated plan with those of each of the individual plans of the towns (as in effect on March 23, 2010) and treating the consolidated plan as if it were an amendment of the towns' plans.

Following is a Frequently Asked Questions (FAQs) that was recently posted on the DOL/EBSA website regarding implementation of the market reform provisions of the Affordable Care Act that deals with the anti-abuse rule discussed above. The FAQ was prepared jointly by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments)⁸:

Q1: What is the scope of the anti-abuse rule in paragraph (b)(2) of the interim final regulations relating to grandfather status? In particular, what is a "bona fide employment-based reason" for employees enrolled in a benefit package that is being eliminated to be transferred into another benefit package?

A: The interim final regulations relating to status as a grandfathered health plan generally state that transferring employees from one grandfathered plan or benefit package (transferor plan) to another (transferee plan) will cause the transferee plan to relinquish grandfather status if amending the transferor plan to replicate the terms of the transferee plan would have caused the transferor plan to relinquish grandfather status. However, the interim final regulations also provide that this rule applies only if there was no bona fide employment-based reason to transfer the employees.

For purposes of paragraph (b)(2) of the interim final regulations relating to status as a grandfathered health plan, the Departments interpret the term "bona fide employment-based reason" to embrace a variety of circumstances. These circumstances (under which a transfer would not cause cessation of grandfather status) include, but are not limited to, any of the following:

- When a benefit package is being eliminated because the issuer is exiting the market;
- When a benefit package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement);
- When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;
- When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or
- When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

⁸ <http://www.dol.gov/ebsa/faqs/faq-aca6.html>

The foregoing is not intended to be an exhaustive list of circumstances that will be deemed to satisfy the bona fide employment-based reason condition. There may be many other circumstances in which a benefit package is considered to be eliminated for a bona fide employment-based reason.

If maintaining grandfathered status of the consolidated plan is an objective for the County, legal counsel should review whether these “anti-abuse rules” apply to the consolidation and what impact they would have on the grandfathered status of the consolidated plan.

Exchanges

The passage of the ACA adds a backdrop to the consideration to consolidate, especially in light of the establishment of Exchanges. Any consideration as to whether or not to consolidate will need to take into consideration deliberate action as to what is best for taxpayers and covered employees.

Exchanges will be introduced in 2014 and will be established by the states. An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges are intended to create more efficient and competitive markets for individuals and small employers.

Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value for consumers. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy. Beginning with an open enrollment period in 2013, Exchanges are suppose to help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges are intended to assist eligible individuals to receive premium tax credits or coverage through other Federal or State health care programs. By providing one-stop shopping, Exchanges are intended to make purchasing health insurance easier and more understandable.

Plans that are offered through the exchange must offer a uniform level of benefits. The Exchange benefits levels include:

- Bronze: benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan
- Silver: 70% of the full actuarial value
- Gold: 80% of the full actuarial value
- Platinum: 90% of the full actuarial value
- Young Invincible (under 30)

- Employer Selects Level - Employers that opt to provide coverage for their employees through the Exchange do so by selecting a level of coverage. The employee may then choose from any qualified health plan available through the Exchange that offers coverage at that level

In 2014, the Individual Mandate will take effect. Under the mandate, individuals will need to have minimum essential coverage or pay a monthly penalty. The amount of the penalty is phased beginning at \$95 in 2014 to \$695 or 2.5% of income, whichever is higher, in 2016. No penalty is assessed if the cost of coverage exceeds 8% of household income or an individual has a short coverage lapse (3 months or less).

Individuals are eligible for a premium assistance tax credits for those with household incomes between 100 and 400% of the federal poverty level (FPL). To be eligible for the subsidy, the individual must:

- be a resident of the state where the exchange is established;
- not be incarcerated at the time of enrollment;
- be a citizen or legally documented immigrant currently residing in the United States;
- have household income between 100% and 400% of FPL;
- not be claimed as a dependent on anyone's tax return; and
- not be eligible for minimum essential coverage through an employer-sponsored plan, Medicare, Medicaid, CHIP, TRICARE, the VA or any other coverage deemed acceptable by HHS.

Individuals who are eligible for coverage through their employers are generally ineligible for the premium assistance tax credits. However, employees may apply for the premium assistance tax credit when their employer-sponsored coverage is below 60% of actuarial value or the employee premiums exceed 9.5% of household income.

Free Rider Penalty

Starting in 2014, a Free Rider Penalty will be assessed to employers with 50 or more employees, including public sector employers as follows. If an employer does not offer coverage (and one employee receives a tax credit in the Exchange), then the employer is subject to the penalty. The penalty is \$2,000 times the total number of full-time employees. In order to calculate FTEs, the employer must aggregate hours of part-time employees to create the total number of employees but may subtract the first 30 workers when paying assessment. If the employer does offer coverage but coverage is unaffordable or actuarial value is less than 60%, the penalty is \$3,000 times the number of full-time employees getting tax credit in Exchange (penalty maximum). A full-time employee is defined as an employee working 30 hours per week.

Wellness Benefits

Over 50% of deaths in the U.S. are attributed to lifestyle and such lifestyle issues are controllable, so it is no wonder that wise employers emphasize wellness to their employee population. Worksite wellness programs provide benefits for both the employer and the employee, and the employee's newfound education and motivation often trickles down to the dependents of that employee.

Studies show that for every 100 adults in America, 23-30% smoke, 55% or more are overweight or obese, 80% don't exercise regularly, 30% are prone to low back pain, 35% are under significant stress. While an individual has no control of certain risk factors such as their age, gender or family history, certain personal lifestyle behaviors ARE controllable such as smoking, nutritional intake affecting obesity and cholesterol levels, physical activity/exercise, etc. Surveys suggest that only 23% of us are aware of the wellness programs offered by our employer-sponsored health plans.

Wellness Offerings of Current Carriers

Capital Health offers a number of wellness and preventive programs as part of their standard benefit offerings. As all the benefits offered by the towns/village and city are insured and subject to state mandates, they all offer well baby/child visits, annual physicals and ob/gyn exams as well as screenings like mammograms and PSA. Diabetes management and benefits are also mandated in New York and would be required to be provided in each of the plan options. Capital Health also offers other wellness benefits like a Diabetes and Weight Management Program, Smoking Cessation, and Fitness Center Discounts. Empire offers an array of wellness programs through its *360° Health® – Health Solutions* program. Information as to what, if any, programs the County and municipalities are taking advantage under their current contracts was not available for this review.

Definitions

- **Wellness** is an intentional choice of lifestyle characterized by personal responsibility, balance and maximum personal enhancement of physical, mental and spiritual health.⁹
- **Wellness Program** is an organized program to assist employees and their family members in making voluntary behavior changes that reduce their health risks and enhance their individual productivity.¹⁰
- **Health Promotion** is the science and art of helping people change their lifestyle to move toward a balance of physical, emotional, social, spiritual and intellectual health. Such lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior and create environments that support good health practices.¹¹

⁹ Wellness Council of America, 1990

¹⁰ Wellness Council of America, 1990

¹¹ American Journal of Health Promotion

Objective of a Wellness Program

The **primary objective of a wellness program is to change the behavior of individuals toward a healthier lifestyle.** This objective acknowledges that such positive behavioral changes will positively impact the employer's costs (e.g. cost of the health plan, productivity, absenteeism, disability, workers' compensation injury/recovery).

Although the objective of a wellness program is the promotion of a healthy lifestyle and the reduction or elimination of risk factors such as smoking, obesity, stress/depression, the outcomes of such programs have traditionally not been carefully measured. For example, if the program offers weight loss or smoking cessation benefits, then the outcome would be to determine the percentage of participants who actually stopped smoking or who lost weight. However, such outcome reports are not often captured.

Further, many employers do not have an organized and meaningful plan of action for their wellness program and instead simply add an array of wellness services without a firm roadmap. There might be a health risk appraisal (HRA) questionnaire that only asks about a patient's known medical history or smoking habits but no questions to assess symptoms that could foreshadow an undiagnosed health problem. Some employers run an annual health fair inviting all sorts of vendors to display a booth without any direction as to what the employer is trying to accomplish at the health fair. Some employers have walking clubs and onsite weight reduction classes but all are poorly attended.

Meaningful Wellness Program Planning

A meaningful wellness action plan should focus on the risk factors that people can change that impact that employer's health care costs, loss of productivity and absenteeism. Think of it as trying to focus on the common denominator for the most commonly reported causes of death, disability, and expensive health care claims. Those common denominators are virtually the same for every employer in the US and comprise the "**modifiable health risk factors:**"

- **obesity**
- **stress/anxiety/depression**
- **elevated cholesterol/lipid mismanagement**
- **high blood pressure**
- **smoking**
- **lack of exercise**

Employers may have a different risk factor as their #1, 2 or 3 most common, but virtually all US employers currently have the same six modifiable health risk factors.

The common **levels of intervention** within a wellness program include:

- (a) **communication and awareness** (e.g., newsletters, health fair, posters),
- (b) **screening and assessment programs** (e.g., health risk profile, blood pressure, body fat testing),

(c) education and lifestyle programs (e.g., weight loss class, self-help kits, stress management workshops), and

(d) behavioral change support systems (e.g., buddy system, cafeteria programs, onsite fitness centers, smoking cessation products).¹²

Well-planned wellness programs assure that they address each of these four levels of intervention striving to start with (a) and move toward (d) with each risk factor. Further, the employer should assure that their wellness program efforts are coordinated with existing medical plan benefits, prescription drug benefits, incentives/rewards, worksite policies, financial resources, current wellness endeavors in departments other than the HR/Benefits departments.

Organized wellness planning often includes a strategic wellness committee made up of HR/Benefits staff and key staff in other departments of the employer's organization who might assist in brainstorming and promoting the wellness program such as staff that work with Disability, FMLA and other leaves, Workers' Compensation/Safety/Risk Management, etc.

How Do Individuals Know They Are "At Risk"?

People with health risk factors generally use more medical care than people with no risk status. The more risk factors a person has the greater their chance of high claim costs along with disability and early death. But are all employees and their family member aware of their own risk factors and the behavior they do every day that makes them at risk for future high claims, disability or premature death? Many employers choose to use a tool to help their employees and their family members identify which and how many risk factors they possess. The tool is a questionnaire called a health risk appraisal or health risk assessment (HRA). This tool allows the employee/family member along with the employer to evaluate the types of risk factors that exist. The HRA results can help an employer prioritize which of the six main risk factors they employer's wellness program should focus on.

As employee turnover and reorganization of the employer's staff occurs, health risk appraisal results can vary, necessitating changes in the focus of wellness programs. Annual HRA completion allows the employee and employer to track improvement in risks over time.

A word to the wise however, there is no standard HRA tool used in the US...numerous variations exist and not all variations ask enough questions to assure that the person is screened for all six common health risk factors. HRAs can be paper-based or web-based. Web-based HRAs are less expensive to administer than paper-based questionnaires.

Some employers pay for biometric testing such as blood testing of cholesterol or blood sugar, weight, fitness, etc. and add those results to the HRA before the summary is reported to the employee. This of course adds an additional cost to the fee for the HRA tool.

Some employers add a lifestyle/wellness coaching process (for an added cost) to their HRA process. This process identifies the individuals with 2 or more major risk factors according to their HRA results and targets them for telephonic coaching. Coaching phone calls are generally made to these higher risk individuals every 3-4 months to try to educate and motivate them to reduce their risks.

Cost Benefit Analysis

¹² Guidelines for Employee Health Promotion, 1992

Some cost benefit analyses have suggested that by the mere fact of adding a wellness program, overall medical claims costs have decreased. The problem with this assumption is that too many variables exist which could also be impacting the change in medical claims. Therefore, to carefully determine whether or not the specific wellness program truly impacted medical claim costs, there should be a detailed analysis tracking the individuals who participate in the wellness program, their progress on each specific wellness objective and the impact of their new found wellness on their specific health claims costs, productivity, absenteeism, short term disability claim costs and workers' compensation.

A research article discussed the impact of various modifiable risks and the associated impact on health claim costs. This article notes that individuals at risk for stress and depression had the highest overall claims costs. The worksite is becoming a more stressful environment. The invention of the pager, cell phone, email, laptop and voice mail has erased traditional boundaries of work allowing virtually any setting to be work-oriented. This information suggests that wellness programs may want to focus on identifying employees and other individuals who are at risk from the pressures of stress and identify ways to help them before they develop more costly physical symptoms of stress such as high blood pressure, overeating, alcohol/drug abuse, etc. Such identification and early intervention of employees under stress and at risk for depression is likely to lead to lower claim costs.¹³

One company's results with their Johnson & Johnson Health and Wellness Program, initiated in 1995 and reported in 2002, calculated that there was a savings of \$224.66 per employee per year for the four years examined. The savings were primarily from reduced inpatient days, mental health visits and outpatient doctor's office visits. The J&J program focused on prevention, self-care, risk-factor reduction and disease management along with better coordination of existing health and productivity management programs. Additionally because of financial incentives to participate, approximately 90% of the employees participated in the program.¹⁴

Tangible short-term benefits of wellness programs¹⁵ are supposed to result in:

- improved morale (attitude, behavior, enthusiasm, loyalty)
- reduced turnover
- increased recruitment potential
- reduced absenteeism
- improved productivity

Long-term, wellness efforts should lower health care costs.

¹³ Goetzel et al, Journal of Occupational and Environmental Medicine, October 1998

¹⁴ Ozminkowski, Ronald, Journal of Occupational and Environmental Medicine, January 2002.

¹⁵ www.welcoa.org

Promotion of Wellness Programs

Wellness programs that have been in place for many years often need evaluation, restructuring and renewed marketing/promotion efforts. It is important to advertise the wellness program consistently, involve employees to help promote the program, vary the program components, and continually strive to increase participation.

Support from senior management as well as a philosophy of wellness throughout the employer's work site is crucial in assuring the development and continued success of a wellness program. For example, if the employer promotes weight loss, yet serves high calorie, high fat foods at staff meetings, the message to the employees becomes muddled.

On the other hand, those employers who embrace a wellness philosophy in their worksite including such things as healthy foods in the vending machines, clearly identified calorie and fat intake on food in cafeteria line products, onsite fitness equipment, etc., are likely to have greater success in their wellness program. To these employers, wellness is more than a brochure or poster...they embrace a culture of health and wellness every day.

Rewards/incentives and penalties can be implemented to boost participation in wellness programs and to provide an incentive to behavior change. Remember however that rewards/penalties that focus on changing behavior are regulated by federal HIPAA non-discrimination regulations regarding bona fide wellness programs, as well as Americans with Disability Act (ADA) and Equal Employment Opportunity Commission (EEOC) regulations in the design of wellness programs, particularly incentives/rewards.¹⁶ Further, most tangible (movie tickets, t-shirts) and monetary incentives/rewards are taxable income to the employee.

Wellness Integrated with Disease Management

While promoting wellness through the implementation of a formal program, comprehensive benefit coverage, continuous advertising and incentives for participation, the employer should not lose track of the fact that some employees simply cannot alter their genetic predisposition to certain diseases or won't change their lifestyle. Unmanaged risk factors will eventually lead to disease.

As such, a wellness program should integrate with the employer's efforts to manage individual with chronic diseases. The integration of disease management efforts along with wellness programs, workers' compensation programs, disability management programs, and medical case management efforts, is important to assure that there is consistency, follow-through and coordination in the approach to help individuals with risk factors change their behavior.

Best Practices in Wellness Programs

The most successful wellness programs have some commonalities. They include:

- **upper management support for the wellness program (including financial/budget support),**
- **a day to day champion (Health Educator, Wellness Director) or team of champions** (employee committee) supporting and guiding the wellness endeavor,

¹⁶ <http://www.dol.gov/dol/pwba/public/pubs/faqs.htm>

- an **interdisciplinary team approach involving more than just the human resource or employee benefits department, emphasis on quality of life improvement not just cost cutting,**
- **data gathering that measures** baseline metrics as well as ongoing measurement and reporting of program results,
- **constant and directed communication to employees** (and family members if also included in the wellness program) regarding the wellness program,
- **remembering that wellness (and disease management) is all about “changing behavior” and how difficult that is for humans to do.**

Action Items and Implementation Timeline Template

Action Items and Implementation Timeline Template	
Determine Applicable Regulatory Framework: <ul style="list-style-type: none"> > Article 44 > Article 47 > Trust Fund (County with Local participation) 	
Identify Participating Local Governments	
Identify Board members	
Draft Trust Agreement	
Identify Trust Institution	
Purchase Fiduciary insurance	
Convene first Board Meeting: <ul style="list-style-type: none"> > Determine Funding Medium > Select Service Providers (draft RFP) 	
Draft Documents <ul style="list-style-type: none"> a. Plan documents / SPD b. Participation agreements/CBA language 	

Action Items and Implementation Timeline Template	
Evaluate pricing / eligibility rules/ contribution arrangements	
Evaluate requests for modifications to standard plan and/or eligibility rules	
Government Filings/Petition to IRS to qualify Trust as a VEBA under IRC 501(c)(9), as applicable, and therefore exempt from taxation on earnings	
<p>Implementation</p> <ul style="list-style-type: none"> > Claims administration > Member Services > Eligibility and Administrative (Compliance) <ul style="list-style-type: none"> a. Enrollment Process (Open Enrollment and ongoing) b. Termination/Continuation of Coverage: COBRA/USERRA administration/HIPAA certificates c. HIPAA (Privacy/security/EDI standards) d. Retirees/Medicare Part D notices e. Dependent and domestic partner > Notification/Communication 	

Tab 1 – Summary of Benefit Plans Currently Offered by the Local Governments

Plan	Village/Town	Description of Plan
Empire/PPO	Albany County	<p>PPO/In-Network Office copayment - \$15 Outpatient hospital surgery - \$0 ER copayment - \$50 (waived if admitted within 24 hours)</p> <p>PPO/Out-of-Network Office copayment - Deductible and coinsurance Outpatient hospital surgery - Deductible and coinsurance ER copayment - Deductible and coinsurance (waived if admitted within 24 hours)</p> <p>Medco Rx Rx \$0/\$15/\$30 (Drug E) Rx \$5/\$15/\$30 (Drug D) Rx \$5/\$5/\$5 (Drug A) Rx \$7/\$7/\$7 (Drug B) Rx \$10/\$10/\$10 (Drug C)</p>

Plan	Village/Town	Description of Plan
CDPHP/HMO	Town of Guilderland	HMO/In-Network Only Office copayment - \$25 Outpatient hospital surgery - \$75 copayment ER copayment - \$100 Rx \$10/\$30/\$50, 2.5x mail order
Medicare Advantage PPO/CDPHP	Town of Guilderland	CDPHP Medicare Advantage Medical PPO In Copayments PCP = \$10/ Specialist = \$15 ER = \$50 Urgent Care = \$35 Ambulance = \$75 Outpatient Surgery = \$125 DME Coinsurance = 20% Hearing Services = \$15 Hearing Aid Allowance (3 yr) = \$600 Vision Services = \$15 Eyewear Allowance = \$80 Medical PPO OON Copayments IP = \$500 PCP = \$10 / Specialist = \$15 ER = \$50 Urgent Care = \$35 Ambulance = \$75 Outpatient Surgery = \$125 DME Coinsurance = 20% Hearing Services = \$15 Vision Services = \$15 Rx Plan 503 = \$10/\$25/\$40/\$40 No Deductible or Coverage Gap. Rx includes Enhanced Formulary

Plan	Village/Town	Description of Plan
	Town of Bethlehem	Rx \$5/\$25/\$40
NYS Empire Plan (NYSHIP)	Town of Colonie	<p>NYS Empire Plan (NYSHIP)</p> <p>Physician Services</p> <p>Office Visits = \$20 copay</p> <p>Annual Adult Physical = \$20 copay</p> <p>Annual Gynecological Exam = \$20 copay</p> <p>Well Baby Visits = Covered in Full</p> <p>Hospital Services</p> <p>Inpatient = No Copay</p> <p>Outpatient Surgery = \$60 Copay</p> <p>Laboratory Services = \$20 copay</p> <p>Radiology and Imaging = \$20 copay</p> <p>Emergency Room = \$70 Copay</p> <p>Urgent Care = \$20 copay</p> <p>Ambulance = \$35 Copay, \$50 up to 50 Miles, \$75 Over 50 Miles</p> <p>Physical = \$20 copay</p> <p>Speech = \$20 copay (medically Necessary and Supervised by Your Physician)</p> <p>Chiropractic Benefits = \$20 copay</p> <p>Home Health Care = Call for Prior Authorization (Paid in Full)</p> <p>Skilled Nursing Facility - Call for Prior Authorization (Paid in Full)</p> <p>Prosthetic Devices and Durable Medical Equipment = Call for Prior Authorization (Paid in Full)</p> <p>Outpatient Mental Health Services = \$20 copay</p> <p>Inpatient Mental Health Services = 100%</p>

Plan	Village/Town	Description of Plan
NYS Empire Plan (NYSHIP) (cont.)	Town of Colonie	<p>Chemical Abuse and Dependency Outpatient Services = \$20 copay Inpatient Detoxification Services = No Copay Inpatient Rehabilitation Services = No Copay</p> <p>Prescription Drug Coverage = 30 day Participating Pharmacy or Mail Service Generic = \$5 Formulary = \$15 Non Formulary \$40</p> <p>Prescription Drug Coverage = 31 - 90 days Participating Pharmacy Generic = \$10 Formulary = \$30 Non Formulary \$70</p> <p>Prescription Drug Coverage = 31 - 90 days Mail Service Generic = \$5 Formulary = \$20 Non Formulary \$65</p> <p>*The above chart describes services utilizing network providers. Utilizing non-network providers is subject to deductibles and coinsurance</p>

Plan	Village/Town	Description of Plan
CDPHP/EPO	Town of Colonie	<p>Physician Services Office Visits \$20 Per Visit Annual Adult Physical = Covered in Full Annual Gynecological Exam = Covered in Full Well Baby Visits = Covered in Full</p> <p>Hospital Services Inpatient = \$500 Copay (Individual 2 Copays, Family 3 Copays Per Calendar Year) Outpatient Surgery = \$75 Copay</p> <p>Diagnostic Testing Laboratory Services = \$20 Copay (Waived if Provider is a Designated Lab) Radiology and Imaging = \$20 Copay (Waived if Provider is Preferred)</p> <p>Emergency Care Emergency Room = \$50 Per Visit Urgent Care = \$30 Per Visit Ambulance = \$50 Copay</p> <p>Therapy Physical = \$20 Per Visit (30 Visits Each Per Benefit Period) Speech = \$20 Per Visit (Up to 20 Visits Per Benefit Period)</p> <p>Chiropractic Benefits = \$20 Per Visit Home Health Care = Covered in Full Skilled Nursing Facility = \$500 Per Visit (UP to 45 Days Per Benefit Period) Prosthetic Devices and Durable Medical</p>

Plan	Village/Town	Description of Plan
CDPHP/EPO (cont.)	Town of Colonie	<p>Equipment = 50% Coinsurance Mental Health Outpatient Mental Health Services = \$20 Per Visit Inpatient Mental Health Services = \$500 Copay</p> <p>Chemical Abuse and Dependency Outpatient Services = \$20 Per Visit Inpatient Detoxification Services = \$500 Copay Inpatient Rehabilitation Services = \$500 Copay</p> <p>Prescription Drug Coverage participating Pharmacy or Mail Service Generic = \$10 Copay 30 Day Supply Formulary = \$20 Copay 30 Day Supply Non Formulary = \$35 Copay 30 Day Supply Mail Order: 2.5 Copays for 90 Day Supply</p>
CDPHP/EPO 25/40	Town of Colonie	<p>CDPHP EPO 25/40 Physician Services Office Visits = \$25 Per Visit Annual Adult Physical = Covered in Full Annual Gynecological Exam = Covered in Full Well Baby Visits = Covered in Full</p> <p>Hospital Services Inpatient = \$500 Copay (Individual 2 Copays, Family 3 Copays Per Calendar Year) Outpatient Surgery = \$100 Copay</p>

Plan	Village/Town	Description of Plan
		<p>Diagnostic Testing Laboratory Services = \$40 Copay (Waived if Provider is a Designated Lab) Radiology and Imaging = \$40 Copay (Waived if Provider is Preferred)</p> <p>Emergency Care Emergency Room = \$100 Per Visit Urgent Care = \$35 Per Visit Ambulance = \$100 Copay</p> <p>Therapy Physical = \$40 Per Visit (30 Visits Each Per Benefit Period) Speech = \$40 per Visit (Up to 20 Visits Per Benefit Period)</p> <p>Chiropractic Benefits = \$40 Per Visit Home Health Care = Covered in Full Skilled Nursing Facility = \$500 Per Visit (Up to 45 Days Per Benefit Period) Prosthetic Devices and Durable Medical Equipment = 50% Coinsurance</p> <p>Mental Health Outpatient Mental Health Services = \$40 Per Visit Inpatient Mental Health Services = \$500 Copay</p> <p>Chemical Abuse and Dependency Outpatient Services = \$25 Per Visit Inpatient Detoxification Services = \$500 Copay Inpatient Rehabilitation Services = \$500</p>

Plan	Village/Town	Description of Plan
		Copay Prescription Drug Coverage participating Pharmacy or Mail Service Generic = \$4 Copay 30 Day Supply Formulary = 50% Copay (Cost of Prescription) Non Formulary = 50% Copay (Cost of Prescription) Mail Order = 2.5 Copays for 90 Day Supply
CSEA – Gold 12 Vision	Town of Colonie	CSEA – Gold 12 Vision 7/1/10 – 6/30/11 = \$18.97 7/1/11 – 6/30/12 = \$19.35
Guardian	Town of Colonie	Guardian Vision Individual = \$11.47 Family = \$24.66
CDPHP	Village of Green Island	CDPHP Primary Care Office Visit = \$25.00 Specialist Visit = \$25.00 Inpatient Hospital = none Outpatient Hospital Surgery = \$75.00 Emergency Room Care = \$100.00 Prescription Drugs = \$10/\$25/\$40 Deductible/Coinsurance = n/a Medicare Advantage Copayment Primary Care Office Visit = \$25.00 Specialist Visit = \$25.00 Inpatient Hospital = \$500.00 Outpatient Hospital Surgery = \$125.00 Emergency Room Care = \$50.00 Prescription Drugs = \$10/\$25/\$40 Deductible/Coinsurance = n/a Currently employees pay a 15% contribution rate if they were hired prior to June 1, 2005 and 25% if after

Plan	Village/Town	Description of Plan
CDPHP	City of Cohoes	CDPHP HMO \$20 Copay Plan HMO \$25 Copay Plan Medicare Choice Plan (C & D)
CDPHP	Town of Bethlehem	CDPHP Emergency Room = \$100 Prescription Drugs = \$5/\$25/\$40

Tab 2 – Participant Counts, Eligibility Rules, Cost Sharing, Rates and Aggregate Costs for the Towns/Villages

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Bethlehem	243 employees: 101 Employee 49 employee plus one 93 Family 97 Medicare Advantage	<p>Medical CDPHP \$15.00 copayment, \$100 ER copay, Drug \$5/\$25/\$40</p> <p>Single = \$517.52 Two Person = \$1,035.07 Family = \$1,375.93</p> <p>Plan 21: Retiree Single = \$253.20</p> <p>Dental The Town shall provide a Dental Care program for all members in accordance with the terms provided by the present carrier. The Town will pay the “employee” portion and members with family coverage under the New York medical insurance plan will pay “dependent” cost.</p>	\$255,477.94 (Medical)

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Colonie	NYS Empire Plan	Medical Rates	Medical – Aggregate Cost
	1 Employee employee plus one 6 Family 34 Medicare 20 Double Medicare	Few Retirees in this Plan NYS Empire Plan Single = \$693.92 Family = \$1,513.92 Medicare = \$405.64 Double Medicare = \$937.31 1 Over/1 Under 65 = \$1,225.62	
	CDPHP 196 Single 135 Two Person 235 Family 58 Medicare 52 Double Medicare 16 1 Over/1 under 65	CDPHP EPO \$20 copayment, \$500 copayment inpatient/\$50 ER, Prescription Drugs \$10/\$20/\$35 copayment, Mail order 2.5 x 90 days	
	CDPHP (25/40 Plan) 12 Single 5 Two Person 12 Family	Single = \$519.67 Family = \$1,039.32 Medicare = \$213.00 Double Medicare = \$426.00 1 Over/1 Under 65 = \$732.67 CDPHP (25/40 Plan) \$25 copayment, \$500 copayment inpatient/ \$50 ER, Prescription Drugs \$4/generic/50%/50% Cost of Prescription (Formulary non- formulary Brand) Individual = \$431.98 Two Person = \$836.97 Family = \$1,152.35	

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
		Dental Rates CSEA - Horizon Dental 7/1/10 - 6/30/2011 = \$76.78 7/1/11 - 6/30/2012 = \$80.62 Guardian Individual = \$29.77 Family = \$96.27	
Coeymans			
City of Cohoes	HMO 25 32 Employee 30 employee plus one 46 Family HMO 20 18 Employee 14 employee plus one 12 Family 21 Medicare Choice Plan	Medical Rates HMO 25 32 Employee 30 employee plus one 46 Family HMO 20 18 Employee 14 employee plus one 12 Family 21 Medicare Choice Plan	Medical – Aggregate Cost

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Village of Green Island	19 Employee 6 employee plus one 16 Family 21 Medicare Advantage	<p>Medical Rates</p> <p>CDPHP HMO \$25/\$25 copayment</p> <p>Drug \$10/\$25/\$40 copayment</p> <p>Single = \$467.33 (\$522.28 effective June 1, 2011) Two Person = \$934.65 (\$1,044.54 effective June 1, 2011) Family = \$1,245.92 (\$1,357.90 effective June 1, 2011)</p> <p>Plan : Retiree Single = \$253.70 (\$280.10 effective June 1, 2011)</p> <p>Currently employees pay a 15% contribution rate if they were hired prior to June 1, 2005 and 25% if after</p>	Medical – Aggregate Cost
Town of Guilderland	58 Employee 107 employee plus one 25 Family 71 Medicare Advantage	<p>Medical Rates</p> <p>Section 2: The Town shall provide health insurance coverage under the CDPHP Plan, inclusive of a Drug Prescription Program. The Town shall pay the full cost of premiums for employees, and 60% of the cost of premiums for the employee's dependents. For employees hired prior to January 1, 1986, the Town shall pay 75% of the cost</p>	Medical – Aggregate Cost

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
		<p>of premiums for the employee's dependents. For employees hired prior to January 1, 1986, the Town shall pay 75% of the cost of premiums for the employee's dependents. The CDPHP benefit package that the Town agrees to provide is attached in Appendix "C." If the current health insurance carrier either cancels or modifies the current benefit package(s), CSEA and the Town agree to reopen negotiations solely on the issue. In addition, the Town agrees to provide CSEA with reasonable advance notice, if the above circumstances are to occur.</p> <p>Section 4: Effective January 1, 1998, an employee who is eligible for coverage under the Town's health insurance program, but elects to forego medical coverage, will receive a payment equal to forty percent (40%) of the cost of the health insurance coverage. Such payments will be made on a prorated basis during December. Effective January 1, 2008, the 40% payment shall be capped at \$1,250.00/year. An employee will have the option of reactivating health insurance coverage for the forthcoming year by notifying the Town in</p>	

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
		<p>writing on or before September 15th of each year with reactivation beginning on January 1 of the following year. However, if the health insurance coverage of the employee's spouse terminates or fails to cover the employee for any reason during a year in which the employee elects to participate in the health Insurance Buy-Out Program, the employee will notify the Town in writing immediately and the Town will reactivate the employee's health insurance coverage. It is understood that the Town retains the right to recover any overpayments.</p> <p>Single = \$496.26 Two Person = \$992.52 Family = \$1,290.27</p> <p>Plan : Retiree Single = \$195.20</p>	

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
		<p>Dental Rates</p> <p>The Town shall provide dental insurance coverage available for all employees. Effective January 1, 2008, the Town will pay for individual dental coverage. If the employee elects family coverage, the employee will pay the difference between the individual premium and the family premium to maintain that coverage.</p> <p>Guardian PPO Single = \$44.02 (effective 1/1/2010) Family = \$108.15 (effective 1/1/2010)</p> <p>CDPHP Medicare Advantage Dental Reimbursement = \$150.00</p>	Dental – Aggregate Cost
New Scotland	18 Employee employee plus one 20 Family	Single = \$500.97 Two Person = \$ Family = \$1,252.42	

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Albany County	2,751 employees: 1,397 Employee 935 employee plus one 864 Family	<p>Medical Rates</p> <p>Active Emp All Employees (except PBA, PEF, & DA Inv.) Single = \$569.66 Two Person = \$1,250.94 Family = \$1,591.19</p> <p>Active Jail Single = \$569.66 Two Person = \$1,250.94 Family = \$1,591.19</p> <p>Active Emp PBA, PEF, DA Inv. Single = \$578.25 Two Person = \$1,273.38 Family = \$1,614.34</p> <p>Plan I: Retiree (Medicare Aged) Single = \$613.27 Two Person = \$1,226.54</p> <p>Plan II: Retiree (Medicare Aged) Single = \$270.53 Two Person = \$541.06</p> <p>Plan II: Retiree (Non-Medicare) Single = \$610.06 Two Person = \$1,357.52 Family = \$1,699.66</p> <p>Plan III: Retiree (Medicare Aged) Single = \$587.10 Two Family = \$1,174.20</p>	Medical – Aggregate Cost

Towns/Village	Participants/Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
		Plan III: Retiree (Non-Medicare) Single = \$387.36 Two Person = \$774.71 Family = \$1,099.81 Plan IV: Retiree (Medicare Aged) Single = \$548.17 Two Person = \$1,096.34 Plan IV: Retiree (Non-Medicare) Single = \$578.25 Two Person = \$1,273.38 Family = \$1,487.87 Plan V: Retiree (Medicare Aged) Single = \$535.67 Two Person = \$1,071.34 Plan V: Retiree (Non-Medicare) Single = \$569.66 Two Person = \$1,250.94 Family = \$1,466.53	
		Dental Rates	Dental – Aggregate Cost
		Delta Dental County Single = \$25.60 Family = \$61.35 Delta Dental Sewer District Single = \$45.25 Family = \$104.50	

Tab 3 – Summary of Demographics

Albany County

Age Distribution By Gender

Age Group	Female	Male	Total
20 - 24	9	13	22
25 - 29	73	53	126
30 - 34	116	103	219
35 - 39	88	103	191
40 - 44	132	166	298
45 - 49	150	169	319
50 - 54	192	189	381
55 - 59	226	191	417
60 - 64	179	165	344
65 - 69	139	94	233
70 - 74	121	76	197
75 - 79	86	69	155
80 - 84	96	43	139
85 - 89	73	29	102
90 - 94	29	8	37
95 - 99	14	2	16
Grand Total	1,723	1,473	3,196
Percent	54%	46%	100%
Actives*	957	948	1,905
Retirees*	765	525	1,290
Average Age Actives	45.7	45.6	45.6
Average Age Retirees	71.6	67.8	70.1
Average Age All Members	57.2	53.5	55.5

Not including 4 participants in COBRA

All other Villages, Towns and Cities (All Adults/Employees and Spouse)

Age Distribution By Gender

Age Group	Female	Male	Total
20 - 24	2	19	21
25 - 29	24	55	79
30 - 34	15	86	101
35 - 39	16	99	115
40 - 44	29	127	156
45 - 49	49	174	223
50 - 54	52	174	226
55 - 59	46	168	214
60 - 64	43	116	159
65 - 69	44	74	118
70 - 74	20	42	62
75 - 79	22	28	50
80 - 84	25	31	56
85 - 89	13	23	36
90 - 94	6	9	15
95 - 99	2	0	2
Grand Total	408	1,225	1,633
Percent	25%	75%	100%
Actives*	271	878	1,149
Retirees*	137	347	484
Average Age Actives	48.9	45.6	46.4
Average Age Retirees	72.5	65.9	67.7
Average Age All Members	56.8	51.3	52.7

* All members of the Town of Green Island are assumed to be actives

Tab 4 – Summary of Wellness Provisions

- Services in GREEN are the 6 Key Modifiable Risk Factors (*that most Americans are at risk for*): Smoking/Tobacco use, Obesity, Elevated Cholesterol and/or HDL/LDL/triglyceride imbalance, High Blood Pressure, Lack of Exercise, Stress/Anxiety/Depression.
- Services in RED mean they are Recommended by at least 2 national agencies (such as Healthy People 2010, Am Cancer Assoc, CDC, US Preventive Services Task Force, US specialty medical organizations such as ACOG) as of 2007, and should, at a minimum, be part of a comprehensive wellness/health promotion program. Such services are aimed at preventing disability and premature death by early identification of the disease or reduction of risk factors known to contribute to disability or death. These commonly include cancer screening diagnostic tests. These agencies recommend “normal” screening ages however, most agencies recognize that screening at an earlier age is appropriate for people with certain family history or risk factors.
- Services in BLACK mean there is no national agency recommendation or less than two agencies suggest the service but the plan sponsor may currently offer the service or want to add it to their Wellness Program in the future.

Wellness Plan Considerations

Wellness/Preventive Services/Benefits	Purpose
Adult Physical Exam Benefit (an office visit including blood pressure weight, personal and family history, physical exam, breast exam, testicular exam, skin cancer exam)	General Health Maintenance
Screening Mammogram (one screening age 35-39 and then annually)	Breast Cancer Screening
Screening Prostate Specific Antigen (PSA) blood test (for males starting at least at age 50)	Prostate Cancer Screening
Annual Screening Pap Smear (annually for female when sexually active)	Cervical Cancer Screening
Screening for Sexually Transmitted Diseases (STD) including Chlamydia, Syphilis and Gonorrhea Infections (annually for sexually active women ages 25 and younger and other women at risk)	Screening for these bacterial sexually transmitted diseases (STDs) to help prevent pelvic/genital infections in women and men
FOBT: fecal occult blood test screening --- a take home lab test (e.g., guaiac lab test or newer fecal immunochemical test (FIT) such as InSure to take home, collect specimen and send in to lab)	Colon Cancer screening
Screening Colonoscopy (or Sigmoidoscopy)	Amer. Cancer Society, Amer. College of Radiology and u.S. Multi-Society Task Force on Colorectal Cancer suggest Colon Cancer Screening should include any of the following: <ul style="list-style-type: none"> • Flexible sigmoidoscopy every 5 years • Colonoscopy every 10 years • Double contrast barium enema every 5 years • CT colonography (virtual colonoscopy) every 5 years
	3/2005 US Preventive Services Task Force recommends a one-time screening for

Wellness/Preventive Services/Benefits	Purpose
Screening Abdominal Ultrasound (once for men ages 65 to 75 years who have ever smoked)	abdominal aortic aneurysm using ultrasound in men age 65 to 75 years who have ever smoked. http://www.ahrq.gov/clinic/uspstf/uspsaneu.htm
Well Child Exam benefit (e.g., office visit)	General Health Maintenance
Well Child Immunizations (birth to age 18)	Prevention of Communicable Diseases
Adult immunizations: <ul style="list-style-type: none"> • Annual Influenza (flu) shot • MMR • Meningitis • Polio • Hepatitis A • Hepatitis B • Pneumococcal (age 65 and older or people with chronic disease/risk factors) • Tetanus Booster (Td) • HPV vaccine (e.g. Gardasil) for females 9-26 years • Shingles vaccine (e.g. Zostavax) for adults age 60 and older • Chickenpox (varicella) 	
Cholesterol or lipid panel Screening Test	Screening for abnormal Cholesterol, HDL, LDL, triglycerides
Blood Pressure measurement (during <u>other than</u> a Drs. Office visit, such as during an annual health fair)	Assess for high blood pressure and monitor blood pressure
Home use self-care Blood Pressure Monitor device is payable?	Assess/monitor blood pressure
Home use self-care Scale to monitor weight is payable?	Assess/monitor weight gain/loss
Smoking/tobacco (nicotine) Cessation: OTC stop smoking products payable?	
Prescription products payable?	
Behavioral health counseling for smoking/tobacco addiction?	
Screening for smoking such as carbon monoxide breath testing, oximetry tsting?	
Screening for Nicotine Dependence (such as use of the Fagerström test for nicotine dependence or CAGE test; http://www.aafp.org/afp/20000801/579.html)	
Payment for any other smoking/tobacco cessation services such as programs that use hypnosis, injections, laser treatment, acupuncture, etc?	

Wellness/Preventive Services/Benefits	Purpose
Blood glucose screening lab work	Diabetes screening
Hearing Screening Exam (also called an audiometry exam)	Hearing loss screening
Vision Screenign Exam	Screening for glaucoma, retinal exam for diabetes
Treatment of High Blood Pressure and Abnormal Lipids (such as Cholesterol, LDL, HDL, Triglycerides)	Treat elevated blood pressure to help prevent stroke, kidney disease, heart disease and eye problems. Treat lipid abnormalities to help prevent cardiovascular disease like heart attack, stroke, etc.
Dietitian/Nutrition Counseling	Healthy Dietary Habits, Weight Management, etc.
Non-worksite Support for Weight Loss Programs (e.g. Weight Watchers, Jenny Craig, South Beach, etc. at <u>OTHER than</u> the worksite)?	Weight Management
Weight Loss Rx drugs payable?	Weight Management
Weight Loss (Bariatric) Surgery payable?	Weight Management
EAP counseling (telephonic and/or onsite)?	Stress, anxiety and depression support/counseling
Stress and/or depression screening questionnaire?	Stress/anxiety/depression screening and early identification
Outpatient Visits for Behavioral Health (mental health and substance abuse)	Stress, anxiety and depression support/counseling
Massage payable in medical plan?	Stress reduction and distraction
Screening for both alcohol and drug misuse (such as the AUDIT screening tool)	Early wrning for drug/alcohol misuse
Education about recognition of physical and behavioral signs of abuse and neglect including domestic violence and support options (such as EAP, shelters, crisis centers, protective agencies, etc.)	Recognition of domestic violence issues and reduction of stress/anxiety
Chiropractic services payable in Medical Plan(s)?	Musculoskeletal alignment
Acupuncture and/or acupressure payable?	Nerve pathway alignment
Hypnosis payable in the medical plan (such as for smoking cessation or weight loss)?	Method to enhance suggestibility to change

Wellness/Preventive Services/Benefits	Purpose
Health Risk Appraisal (HRA) questionnaire	Awareness of risks using self-reported information. Alerts individuals of risks.
Misc. biometric screening laboratory tests for other than cholesterol and glucose (e.g. CBC, chemistry panel, liver panel, thyroid panel, urinalysis, etc.	Screening for diseases depending on the composition of the lab studies performed.
Bone Mass Measurement Screening X-Ray (e.g, dual energy X-ray absorptiometry (DEXA) scan, CPT code 77080)	Osteoporosis Screening
Maternity Management for perinatal education, or identification and counseling for high risk pregnant women?	Promote maternal/newborn health
Preconception (pre-pregnancy) education classes (e.g. encourage no smoking, no alcohol/drugs, take prenatal vitamins for at least 3 months before conceiving, HIV screening test, manage any chronic diseases)	Encourage optimal maternal health BEFORE a pregnancy occurs to help reduce birth defects
Pay for prenatal vitamins under Rx benefit?	Promote maternal/newborn health
Skin cancer education (e.g. what to look for, who is at higher risk, how to avoid, efforts to encourage a physician visit for a total body skin examination)?	Educate about skin cancer
Skin cancer screening	Screening for skin cancer
Dental Preventive care: • Dental exam and cleaning (at least 2 times/year)	Promote oral health; screen for oral cancer
• Dental screening x-rays (e.g. bitewing and/or full-mouth)	Screens for dental health problems that can lead to medical conditions like cardiac problems
Oral Cancer Screening • Coverage for Oral Brush Biopsy (a tool to identify precancerous and cancerous cells in the mouth that is approved by the American Dental Association).	Screens for oral cancer
Added Dental Support for Periodontal Conditions/Diabetes	
a) Four (4) periodontal maintenance visits/year, or 2 general cleanings and 2 periodontal visits/year.	
b) Two (2) applications of topical fluoride varnish in a year, following periodontal surgery.	
Reminders provided on need for, value of twice a year dental exam and cleanings?	Promote oral health; screen for oral cancer
Podiatry visits payable for routine foot care for at least individuals who are diabetic or have vascular or neurological problems affecting the sensation in	Promote foot health in people unable to adequately feel when foot problems are

Wellness/Preventive Services/Benefits	Purpose
their feet?	developing.
Directive written to the medical plan claims administrator(s) to process claims under the medical plan that re coded with education CPT codes (e.g. 98960, 98961, 98962) and HCPCS codes, (e.g., G0108, G0109, G0177, S9453, S9449, S9454, etc)	Promotes payment for professionals to provide health education to patients at point of diagnosis
Pay for Pedometers for employees?	Promote physical exercise
Gym or fitness center membership or discounts for membership (e.g. YMCA)	Promotes fitness and exercise for weight loss, cardiovascular benefit and stress reduction
Education specific to How to read Food Labels?	Promotes healthy nutritional intake
Education on vitamin supplementation (what kinds, how much, how often, side effects and interaction with drugs, etc)	Promote healthy nutritional intake
Health Fair (usually annually)	Promotes education and screening depending on how designed.
Onsite Fl Shots	
<ul style="list-style-type: none"> Wellness/health promotion information or links found on website/intranet 	
If website contains wellness information do they track website stats on utilization (when do people log on, what topics do they visit, how long do they visit, etc.)	Understand usefulness of website information and try to target the audience
Have any online progress tracking tools such as tracking weight loss, food intake, exercises, etc.	Promotes fitness, weight loss, knowledge about health risks
Have any calculators such as BMI Calculator, calories burned, waist-hip ratio, basal metabolic rate, cost of smoking, etc?	Promotes fitness, weight loss, knowledge about health risks
Have a 24 hour telephonic nurse triage program to access nurses if have health questions?	Promotes access to self-education on health issues
Is the phone number for the 24-hour triage program ON the participant ID cards (front or back)?	Promotes access to self-education on health issues
Have a 24-hour telephonic health information access line?	Promotes access to self-education on health issues by listening to audio tapes
Have any Wellness Coaching services (onsite or telephonic) performed by health professionals for high-risk people who need guidance and support in	Facilitates changing behavior through education

Wellness/Preventive Services/Benefits	Purpose
modifying a health risk factor?	
How does client communicate with employees at all locations (e.g. interoffice mail, e-mail, intranet, first class mail, etc.)	Helps to understand how future wellness education can be disseminated to reach employees and family
Employee Newsletter: <ul style="list-style-type: none"> • Completely devoted to wellness • Contains periodic wellness info 	
Worksite Bulletin Boards address Wellness?	Promotes health education
Have a Picnic, Spring Outing, Summer Family Event where exercise and physical games are included (e.g. softball, rollerblading, swimming, bike riding, hiking, volleyball, Frisbee, etc.)?	
Have any health professionals routinely onsite in the worksite (e.g. onsite medical clinic, occup. Medical nurses, etc)?	Access to health professionals
Have any disability plan coordinators?	Access to existing staff who commonly address health issues and have stats on why disability occurs in this population, and such staff should be able to coordinate timely return to work and modified duty.
Have any health/wellness rewards or incentives (or disincentives, penalty) built into any medical, disability, return to work or work comp programs/premiums?	Promotes health and reward for success.
Have any Disease Management services? If so, is it a formal program run as an “opt out” model?	Focuses on self-help for those with chronic diseases.
Have an employee committee to provide input on health promotion/wellness efforts?	Employees tend to support what they help create.
Have a Wellness/health promotion Coordinator/Manager or Director who does or will champion wellness efforts?	Ideal to have a “cheerleader” to support and manage health promotion services.
Does the Wellness Champion subscribe to Health Promotion Journals to keep up to date on new ideas, research and keep challenged (e.g. American Journal of Health Promotion, Calif Jo of Health Promotion, WELCOA newsletter http://www.welcoa.org/jointhelist.php, Amer Jo of Health Behavior, Amer College of Sport Medicine Health And Fitness Journal, Natl Wellness Institute, etc)?	Education of the “cheerleader” whose job is to bring ideas to the wellness program
Have a formal Wellness Business Plan, budget and vision statement?	Identifies commitment of organization who has a formal program with defined

Wellness/Preventive Services/Benefits	Purpose
	purpose, vision, budget and top management support.
Top Management has provided a written statement in support of the Wellness Program	Demonstrates/reinforces top management support for the wellness program
Have any reporting on the level of participation of individuals in any current wellness programs that are being offered? (e.g. class attendance)	Measurement of effectiveness of wellness efforts
Provide any announcements on health topics of the month (e.g. Feb is American Heart month, October is national breast cancer awareness month, September is national prostate cancer awareness month)?	Promote health awareness. See also: http://www.healthfinder.gov/library/nho/ or http://www.welcoa.org/observances
Bring in speakers from the community to address health topics in a “lunch and learn” environment? After work?	Promote health awareness and strengthen credibility of message.
Give/mail employees self-help, self-care brochures or books?	Promote self-care/education
Employees have access to an onsite library? (could assist with self-help, self-care wellness related brochures, books, videos, DVDs, CDs)	Promote self-care/education
Email or postcard reminder system for mammo/pap tests, childhood immunizations, colonoscopy, etc.?	Promote adherence to preventive care
Cardiopulmonary resuscitation (CPR) and first aid training?	Promote energy preparedness along with self-care education
Education about HIV transmission?	Reduce fears about co-workers with HIV, promote safe sex
Managing Menopause education?	With older employees dealing with menopause, education on this life phase can reduce stress
Have a wellness program Interest survey?	Obtain feedback on types of wellness programs of interest to the group in order to design a custom program
Have a wellness program Satisfaction survey?	Obtain feedback on program in order to make modifications and increase use
New hires indoctrinated to the array of worksite wellness programs available (e.g., at their new hire orientation)?	Promote health education and awareness of the employer’s wellness program
Have any Concierge-type personal services (such as shoe repair, haircuts, onsite dry cleaning/laundry, mending clothes, errand services, package	Conveniences that help reduce employee stress/anxiety caused by the volume of

Wellness/Preventive Services/Benefits	Purpose
mailing, delivery stamps, banking, ticket order/delivery, flower orders, travel agent, meal delivery, prescription drop off/pick-up, driver for pick-up/drop off for car repairs, car wash/oil change, child care/elder care support, house/pet sitters, child camps/sitters, film processing, gift wrapping, eyeglasses repair, watch repair/battery replacement, etc.)?	work and personal responsibilities, helping employees be more productive.
Formal written Strategic Communications Plan for Wellness in place? (e.g. addressing audience, topics/message, frequency, method of communication, costs etc.)	Formal method to effectively and consistently keep wellness and health promotion in audience's mind and readily visible.
In what ways do you currently measure your organization's absenteeism and productivity (such as tracking FMLA type of requests/duration of request, sick time type and duration, STD type and duration, employee turnover percentage, etc.)	Baseline measure of health status of employees. Can be used as a benchmark to measure success of wellness program in the future.
Smoking/tobacco (nicotine) Cessation:	
Smoke free worksite policy in all locations?	
Worksite free from ability for employees to purchase cigarettes?	
Worksite Weight Loss Programs (e.g., Weight Watchers, Jenny Craig, South Beach, etc.)	Weight Management
Worksite massage services, massage recliners or rocking chairs available in the worksite?	Stress reduction and distraction
Quiet room available at worksite (e.g. lactation room, meditation room)?	Stress reduction and distraction
Onsite Child Care Facility/Center	Stress reduction for working parents
Vacation time tracked and encourage employees to take it (e.g., especially employees who use <50% of their vacation time each year).	Stress reduction
Mandatory Pre-employment Drug Testing?	Early warning for drug/alcohol misuse
Mandatory or Random Drug Testing at worksite of existing employees?	Early warning for drug/alcohol misuse
Screening for both alcohol and drug misuse (such as the AUDIT screening tool)	Early warning for drug/alcohol misuse
Education about recognition of physical and behavioral signs of abuse and neglect including domestic violence and support options (such as EAP, shelters, crisis centers, protective agencies, etc.)	Recognition of domestic violence issues and reduction of stress/anxiety
Preconception (pre-pregnancy) education classes (e.g., encourage no smoking, no alcohol/drugs, take prenatal vitamins for at least 3 months	Encourage optimal maternal health BEFORE a pregnancy occurs to help

Wellness/Preventive Services/Benefits	Purpose
before conceiving, HIV screening test, manage any chronic diseases)	reduce birth defects
Have an Executive Physical Exam benefit (e.g., send top executives for a free comprehensive physical exam with lab and diagnostic testing)?	Screen for potential health risks.
Allow employees to go for Dr visits during work hours?	Promote employee health
Scale for employee to weigh self at worksite?	Monitor weight
Pay for Pedometers for employees?	Promote physical exercise
Worksite showers/locker room?	Promotes fitness and exercise for weight loss, cardiovascular benefit and stress reduction
Worksite fitness equipment (such as treadmill, stationary bike, free weights, jump ropes, etc.)?	Promotes fitness and exercise for weight loss, cardiovascular benefit and stress reduction
Fitness Testing available? (including flexibility, muscle strength and endurance, etc)	Establish baseline for fitness and track changes
Onsite fitness trainer?	Promotes fitness exercises and motivates change in behavior
Onsite fitness classes such as stretching, yoga, tai chi, etc?	Promotes fitness exercises and motivates change in behavior
Reimbursement available for fitness equipment through employer, medical/health reimbursement flex account (Health FSA) or Health Savings Account (HSA)?	Promotes fitness and exercise for weight loss, cardiovascular benefit and stress reduction
Bike racks in parking lot/garage or onsite bicycles available for employees?	Promotes exercise
Walking path at worksites?	Promotes exercise
Employer sets aside workday time to have employees stretch/exercise?	Promotes exercise
Walking distances mapped and advertised (such as distance between buildings, distance from desk to copier, etc.?)	Promotes exercise
Formal policy on employees taking the stairs instead of elevator?	Promotes exercise
Worksite vending machines: <ul style="list-style-type: none"> • Filled with only healthy foods or • Healthy food plus candy/chips or • Cost of healthy food signif. Less than cost to buy unhealthy food 	Promotes healthy eating
Worksite vending machine lists calories, fat, sugar, salt on items? Healthy snacks easily identifiable?	Promotes healthy eating

Wellness/Preventive Services/Benefits	Purpose
Employer policy on requirement to serve only healthy food choices at in-house worksite meetings (e.g., fruit, gum, veggies, nuts, yogurt, salads instead of bagels, donuts, sandwiches, candy & cookies)?	Promotes healthy eating
Worksite cafeteria lists foods with calorie, fat or healthy choice reminders?	Promotes healthy eating
Worksite cafeteria follows healthy food preparation guidelines such as steaming/roasting, low-fat, low calorie, salt substitute, limited frying, low carbohydrate, etc.?	Promotes healthy eating
Worksite cafeteria prices low calorie foods less than high calorie foods?	Promotes healthy eating
Education on How to read Food Labels?	Promotes healthy eating
Education on vitamin supplementation (what kinds, how much, how often, side effects and interaction with drugs, etc)	Promote healthy nutritional intake
Health Fair (usually annually)	Promotes education and screening depending on how designed
Onsite Flu Shots	
How does client communicate with employees at all locations (e.g. interoffice mail, e-mail, intranet, first class mail, etc.)	Helps to understand how future wellness education can be disseminated to reach employees and family
Employee Newsletter:	
<ul style="list-style-type: none"> • Completely devoted to wellness • Contains periodic wellness info 	
Worksite Bulletin Boards address Wellness?	Promotes health education
Have any health professionals routinely onsite in the worksite (e.g., onsite medical clinic, occup. Medical nurses, etc.)?	Access to health professionals
Onsite Safety Equipment: have any requirement for employees to use certain equipment on the job (e.g. safety hat, safety glasses, back belt, ergonomic seating, seatbelt, helmet, etc.)	Promotes health and prevention of work related injury
Have a Safety program for work comp/OSHA? (e.g. hearing screening, vision screening, back safety, ergonomic workstations, etc.)	Access to existing programs to address certain health issues
Back Care Education and/or classes (teaching anatomy, stressing weight loss, lifting techniques, posture, role of abdominal muscles, ergonomics, stretching, heat therapy, muscle massage, etc)	Promotes education on prevention of reoccurring low back pain
Have any disability plan coordinators?	Access to existing staff who commonly address health issues and have stats on why

Wellness/Preventive Services/Benefits	Purpose
	disability occurs in this population, and such staff should be able to coordinate timely return to work and modified duty.
Have any health/wellness rewards or incentives (or disincentives, penalty) built into any medical, disability, return to work or work comp programs/premiums?	Promotes health and reward for success.
Have an employee committee to provide input on health promotion/wellness efforts?	Employees tend to support what they help create.
Have a Wellness/health promotion Coordinator/Manager or Director who does or will champion wellness efforts?	Ideal to have a “cheerleader” to support and manage health promotion services.
Does the Wellness Champion subscribe to Health Promotion Journals to keep up to date on new ideas, research and keep challenged (e.g. American Journal of Health promotion, Calif Jo of Health Promotion, WELCOA newsletter http://www.welcoa.org/jointhelist.php, Amer Jo of Health Behavior, Amer College of Sport Medicine Health And Fitness Journal, Natl Wellness Institute, etc)?	Education of the “cheerleader” whose job is to bring ideas to the wellness program
Have a formal Wellness Business Plan, budget and vision statement?	Identifies commitment of organization who has a formal program with defined purpose, vision, budget and top management support.
Top Management has provided a written statement in support of the Wellness Program	Demonstrates/reinforces top management support for the wellness program
Have any reporting on the level of participation of individuals in any current wellness programs that are being offered? (e.g. class attendance)	Measurement of effectiveness of wellness efforts
Bring in speakers from the community to address health topics in a “lunch and learn” environment? After work?	Promote health awareness and strengthen credibility of message.
Supply employees with any health related magazines in their break room/lunch rooms (e.g., fitness magazine, healthy food prep, etc.)?	Promote self-care/education
Have a plan for worksite cardiac emergency events that includes purchase of an automated external defibrillator (AED) and training and refresher training?	Promote emergency preparedness for life-threatening worksite cardiac event.
New hires indoctrinated to the array of worksite wellness programs available (e.g., at their new hire orientation)?	Promotes health education and awareness of the employer’s wellness program.

Wellness/Preventive Services/Benefits	Purpose
Have any employer policies on worksite wellness or healthy environment?	Processes to help change the culture of the worksite to be healthy-friendly
Have any Concierge-type personal services (such as shoe repair, haircuts, onsite dry cleaning/laundry, mending clothes, errand services, package mailing, delivery stamps, banking, ticket order/delivery, flower orders, travel agent, meal delivery, prescription drop off/pick-up, driver for pick-up/drop off for car repairs, car wash/oil change, child care/elder care support, house/pet sitters, child camps/sitters, film processing, gift wrapping, eyeglasses repair, watch repair/battery replacement, etc.)?	Conveniences that help reduce employee stress/anxiety caused by the volume of work and personal responsibilities, helping employees be more productive.
Formal written Strategic Communications Plan for Wellness in place? (e.g., addressing audience, topics/message, frequency, method of communication, costs, etc.)	Formal method to effectively and consistently keep wellness and health promotion in audience's mind and readily visible.
In what ways do you currently measure your organization's absenteeism and productivity (such as tracking FMLA type of requests/duration of request, sick time type and duration, STD type and duration, employee turnover percentage, etc.)	Baseline measure of health status of employees. Can be used as a benchmark to measure success of wellness program in the future.

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