LIVINGSTON COUNTY HEALTH CARE FEASIBILITY STUDY

Original Date Issued: July 30, 2008
Revised: October 29, 2008

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Background

Livingston 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. Preparation of a report which includes a statement of goals and the development of 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 Local Governments 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 highlights of current wellness programs contained in the current benefits offerings.

4. Action Plan/Sequence of Judgement

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 and villages in Livingston County is contained in Exhibit 1. This table also summarizes the current number of covered employees/retirees for each town or village as well as eligibility requirements and total premium costs. The Summary of Benefits provided by Excellus for the County is contained in Tab 1A. The towns and villages together currently cover 202 active employees and 23 retirees. The County Plan covers 625 active employees and 75 retirees.

Types of Coverages Presently Offered

When considering whether to consolidate plans, consideration would be given to the number of plan options and the relative differences of these options. In summary, all the local governments in the County offer an option that is insured under a community rated contract with either Preferred Care or Excellus (Blue Cross Blue Shield). Of the 9 villages and 17 towns, 8 offer options insured by Preferred Care, 16 offer options insured by Excellus, one (the Village of Leicester) does not have any covered employees and one (Town of York) has benefits through the NYS Teamsters Council Health and Hospital Fund. Most of the options offered by either Preferred Care or Excellus are HMOs/EPOs and have no or limited out-of-network benefits available.

While there are several different plan designs offered by each village and town, seven of the towns and villages that offer a Preferred Care product offer a choice between the three Tri-Vantage products (250-2). Two of these are HMOs with a $10 (Active Lifestyle HMO) and $15 (Family Focus HMO) office copayment and no out-of-network provision. The third, the Tri-Vantage Health Alternative has a $20 office copayment and an out-of-network provision that pays 75% after a $250 deductible up to a benefit maximum of $25,000 per year. All towns and villages have the prescription drug rider that has a copayments for retail drugs of $10 for Tier 1 drugs, $25 for Tier 2 or $40 for Tier 3 drugs and mail order drugs with a 2.5 times copayments for a 90 day supply. The premiums for these three products are all the same.

The same clustering is true for the Excellus offerings. Seven of the towns and villages offer the Blue Choice Select product. This package has a $15 PCP office copayment and no out-of-network benefit. The benefit includes prescription drug coverage that has copayments for both retail and Mail order of $5 for Tier 1 drugs, $20 for Tier 2 or $35 for Tier 3 drugs and mail order drugs 90 day supply. Six towns and villages offer one of the Blue Cross EPO packages.

While not specifically part of this review, nine of the towns and villages provided information on dental benefits and offer a stand–alone dental plan that is with Excellus/Blue Cross or Guardian.

The County currently provides a choice between BluePoint 2B and 2D plans which has an out of network benefit and prescription drugs.

Criteria for Eligibility and Cost Sharing for Towns/Villages

In addition to the number of plan options and relatives 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 cost sharing, if any. All the local towns and villages cover full-time employees with cost-sharing arrangements from no employee contributions up to a high of 50% of the cost. Several of the towns and villages allow part time employees to buy into the plan but at 100% of the premium. Twelve towns/villages require cost sharing of either a percentage of premium or a flat dollar amount). The amount of this cost sharing is generally tied to employees' date of hire with newer employees having a hirer cost-sharing percentage than longer-term employees. Three towns/villages pay for single only coverage with the employee able to pay the difference between the single rate and the employee plus one or family. Ten towns/villages pay 100% of the premium. One village does not offer any coverage. Of the 26 towns/villages, 7 have an opt-out provision for employees with other coverage and 4 make an annual contribution to an FSA/HRA.

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. The premium rate development is derived by a review of the group's prior experience to measure the future projected claims liability.

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. Currently, only six months of experience are available for the County Plan and as yet, this would not be considered creditable. As time goes on and more experience has emerged from the County's plan, the County could employ that experience in renewal rates (i.e. become more credible). As an aside to objectives of the study, The County should consider its population and risk tolerance and address this during the next twelve months should a decision to form a consortium not be made.

An 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 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.

Typically, groups the size of the contemplated consortium can consider a participating arrangement. The County could also consider this by itself but that should be aware of the risk associated with the potential to earn a dividend as noted in the following paragraph.

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 2006 and 2007 data at this time) paid claims experience for the underwriter to study trend for a group either the size of the County or the contemplated consortium. 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.

Because the towns and villages each have fewer than fifty covered employees and retirees, they are currently insured on a community rated basis (discussed below). Accordingly, the insurance companies do not release experience as part of the renewal exercise. This represents a challenge in obtaining an experience rate for the contemplated consortium.

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. Under this type of funding arrangement, Livingston County would be funding the claims liability as it occurs, as would be the case under a self-insured plan. The insurance carrier would set 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 would be assessed New York State premium taxes is the retention component of the cost. The risk charges may be higher under a minimum premium arrangement 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 the contemplated consortium or possible Livingston County alone (upon receipt of sufficient experience) but would not be available for the Local Governments separately.

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, (1) individuals, (2) groups with fewer than fifty employees/retirees as well as (3) 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 towns and villages are under 50 employees and are community-rated. The County plan was community rated until September of last year.

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, Livingston County 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 Livingston County (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 Livingston 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 Livingston County

If a consortium were to be developed covering the County and local governments, certain financial elements -discussed below- are likely to result is 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 Excellus, 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 Livingston 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 the prescription drug program, hospital discharge planning to encourage home health care when medically appropriate, and carve out programs for physical therapy, and chiropractic, mental health, imagining and other elements of care.

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/retirees and HMOs must use a community rated platform. This is the case with all the local governments in the County. Groups under a certain size, typically 300 employees/retirees, 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 towns and villages of Livingston County are each independent buyers of health care and are all covered under community-rated contracts with either Preferred Care or Excellus and range in size between 2 and 22 employees. The County contract was community rated until September 2007 at which time, the contract with Excellus was renegotiated as an experience rated contract. Currently, there are 700 employees/retirees covered under that contract.

Increasing the size of the County Plan by allowing participation of local governments would allow both the County and the local towns and villages to realize economy of scale. There would be lower per capita administrative expenses and risk charges as well as access to a broader array of risk options that will allow for a more desirable and more efficient cost sharing arrangement. This should result in less volatility and lower trend. In addition, the participants in the combined plan would no longer have to purchase individual community rates contracts. Health insurance is voluntary and small groups and individuals (which have separate community pools) tend to make a purchase decision based on their likelihood of needing the coverage compared to the cost of the coverage. Individuals and groups under 50 must be community rated. Groups over fifty can obtain any funding arrangement they can negotiate with an insurance company. Therefore, groups over fifty tend to seek to be experience rated if their expected experience is favorable to the community group. These buying patterns leave the community pools with rates that are typically higher than what larger groups negotiate. If the local governments could combine into a consortium, it very well may enjoy the type of savings the County saw when it moved to experience rating last year. In addition, the contemplated consortium would also allow the combined plan to access market's best practices by leveraging purchasing arrangements. The combined plan would only purchase the services deemed necessary and desirable and have the ability to better negotiate pricing and service terms as well as take advantage of alternative funding possibilities.

Claims Experience and Credibility

If the local towns and villages and the County pooled to create one Plan, it would likely to be large enough to be considered fully-credible if it can be bring together more than 1,000 employees. Depending on the legal provisions by which the groups combine the plans (either through a plan allowed in Article 44 of the State Insurance Law or Article 47 or under an alternative to Article 47 as proposed in Bill 11374, discussed below), 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 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 Livingston County are paying a rate based on the experience of the community purchasing insurance along with an expense load applied to these programs, typically 35% of premium. Should the local governments decide to join a consortium, a group plan based on their collective experience is likely to be more favorable to the population in the community pool. In addition, a low expense load is likely to be applied to a group the size of the contemplated consortium.

PLEASE NOTE that these principles and amounts are generalizations and broad estimates to demonstrate an order of magnitude. There are significant differences among specific insurance companies and significant differences warranted by differences in plan design, administrative arrangement and funding method that will affect these generalizations.

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

We have asked Excellus to develop a projected incurred claims cost for the local governments because they are providing coverage for most of the eligible participants. To help them extrapolate the cost for the additional participants enrolled in one of the other plans, we also submitted plan designs and census information. Since Excellus has access to its participants' claims histories, they were in the best position to project the incurred claims cost of a combined population for the contemplated consortium. However, they indicated they were unable to provide the data in the format that was requested without official notice of the local governments joining a consolidated program. As an alternative, they provided information on the County's current plan of benefits. The BluePoint 2B plan is the richer of the two plans and the majority of the county's population are enrolled in the 2B option. The BluePoint 2D option is similar to the Option 2B with higher cost-sharing (higher office copayment, inpatient deductible as well as higher cost-sharing on the out-of-network benefit). As an aside, offering employees a choice between two plan is common and it allows them to make decisions on cost and design that best suit their needs. However, we usually recommend offering plans that not as similar as these two. This is discussed in detail below.

The following two tables represent the cost impact of switching all current active employees covered by the towns and villages into the County's BluePoint 2 Option B or D experienced-rated contracts. This is included for illustrative purposes only since the actual rates for a combined plan would be based on all the factors discussed in this report., However, it does give the County an idea of the cost impact of switching the towns and villages into a consortium. While the overall cost savings is only estimated at 3.7% if every participant were switched to BluePoint 2B, the estimated savings for each individual town or village varies widely with a number of towns and villages actually experiencing an increase in costs thus offsetting some of the savings. For those towns and villages that would experience a cost increase, this is largely a function of plan design as these groups would be moving from an inexpensive plan with higher participant cost-sharing and no out-of-network provision to a plan with lower participant cost sharing and an out-of-network benefit. For the towns and villages in plans that are more comparable to the County's current in-network offerings (the Blue Choice Select), there would be an out-of-network benefit and potential cost savings for moving to the County's experience-rated plan..

As noted in the next steps summarized in the cover letter, we recommend establishing two plan designs and going back to Excellus to obtain a set of rates for those plans. While the drivers of which employees will select which of the plans is typically a function of the collective bargaining process, modeling can then be employed to project the savings that is likely to be obtained from offering those plans on a consolidated basis.

Premium Comparison with Blue Point 2 Option B – Actives Only

Towns/Villages	Premium		Savings[3]	Percent Savings
	Current[1]	Based on the County's rates[2]		
Town of Lima (Preferred Care EPO 1)	$2,822.60	$3,860.89	($1,038.29)	-36.8%
Town of Caledonia (Blue Cross EPO Balance Opt 6)	$3,718.25	$4,795.27	($1,077.02)	-29.0%
Village of Nunda (Blue Cross EPO Balance Opt 5)	$2,306.08	$2,926.51	($620.43)	-26.9%
Town of Nunda (Blue Cross EPO Balance Opt 5)	$4,151.25	$5,257.74	($1,106.49)	-26.7%
Village of Dansville (Blue Cross EPO Balance Opt 5)	$10,124.68	$12,826.39	($2,701.71)	-26.7%
Town of Mt. Morris (EPO Blue Healthy Choices)	$4,569.21	$5,044.26	($475.05)	-10.4%
Village of Avon (Preferred Care Tri-Vantage)	$10,385.35	$11,352.56	($967.21)	-9.3%
Town of Geneseo (Preferred Care Tri-Vantage)	$9,430.97	$9,474.36	($43.39)	-0.5%
Town of Livonia (Preferred Care Tri-Vantage)	$14,424.91	$14,492.55	($67.64)	-0.5%
Village of Caledonia (Preferred Care Tri-Vantage)	$5,011.88	$5,034.82	($22.94)	-0.5%
Town of Conesus (EPO Blue Healthy Choices)	$5,715.64	$5,729.65	($14.01)	-0.2%
Town of Avon (Preferred Care Tri-Vantage)	$5,981.86	$5,978.64	$3.22	0.1%
Town of Leicester (Preferred Care Tri-Vantage)	$4,475.90	$4,465.61	$10.29	0.2%
Town of West Sparta (Preferred Care Tri-Vantage)	$2,013.24	$2,001.57	$11.67	0.6%
Village of Lima (Blue Cross Value)	$4,403.65	$4,332.80	$70.85	1.6%
Village of Livonia (Blue Cross Value)	$2,732.06	$2,686.96	$45.10	1.7%
Town of York (NYS Teamsters H&W Fund)	$5,019.11	$4,918.64	$100.47	2.0%
Town of Ossian (Blue Choice Select)	$784.56	$711.46	$73.10	9.3%
Village of Mt Morris (Blue Choice Select)	$13,923.81	$10,773.91	$3,149.90	22.6%
Town of Sparta (Blue Choice Select)	$3,788.74	$2,926.51	$862.23	22.8%
Town of Springwater (Blue Choice Select)	$5,924.25	$4,555.72	$1,368.53	23.1%
Village of Geneseo (Blue Choice Select)	$18,553.78	$14,271.88	$4,281.90	23.1%
Town of North Dansville (Blue Choice Select)	$2,316.55	$1,778.65	$537.90	23.2%
Town of Portage (Blue Choice Select)	$3,651.03	$2,803.14	$847.89	23.2%
Town of Groveland (Preferred Care Comprehensive)	$3,648.61	$2,357.30	$1,291.31	35.4%
Total Monthly Premium	**$149,877.97**	**$145,357.79**	**$4,520.18**	
Annual Premium	**$1,798,500**	**$1,744,300**	**$54,200**	**3.0%**

[1] Calculated based on the current rates for each town/village which reflect the current benefits of the town/village.
[2] Calculated based on the current Plan B rates for the County which reflect the current benefits of the County.

Premium Comparison with Blue Point 2 Option D – Actives Only

Towns/Villages	Premium		Savings[3]	Savings
	Current[1]	Based on the County's rates[2]		
Town of Lima (Preferred Care EPO 1)	$2,822.60	$3,597.52	($774.92)	-27.5%
Town of Caledonia (Blue Cross EPO Balance Opt 6)	$3,718.25	$4,468.13	($749.88)	-20.2%
Village of Nunda (Blue Cross EPO Balance Opt 5)	$2,306.08	$2,726.91	($420.83)	-18.2%
Town of Nunda (Blue Cross EPO Balance Opt 5)	$4,151.25	$4,899.09	($747.84)	-18.0%
Village of Dansville (Blue Cross EPO Balance Opt 5)	$10,124.68	$11,951.51	($1,826.83)	-18.0%
Town of Mt. Morris (EPO Blue Healthy Choices)	$4,569.21	$4,700.09	($130.88)	-2.9%
Village of Avon (Preferred Care Tri-Vantage)	$10,385.35	$10,577.98	($192.63)	-1.9%
Town of Geneseo (Preferred Care Tri-Vantage)	$9,430.97	$8,828.07	$602.90	6.4%
Town of Livonia (Preferred Care Tri-Vantage)	$14,424.91	$13,503.89	$921.02	6.4%
Village of Caledonia (Preferred Care Tri-Vantage)	$5,011.88	$4,691.40	$320.48	6.4%
Town of Conesus (EPO Blue Healthy Choices)	$5,715.64	$5,338.74	$376.90	6.6%
Town of Avon (Preferred Care Tri-Vantage)	$5,981.86	$5,570.70	$411.16	6.9%
Town of Leicester (Preferred Care Tri-Vantage)	$4,475.90	$4,160.94	$314.96	7.0%
Town of West Sparta (Preferred Care Tri-Vantage)	$2,013.24	$1,864.99	$148.25	7.4%
Village of Lima (Blue Cross Value)	$4,403.65	$4,037.17	$366.48	8.3%
Village of Livonia (Blue Cross Value)	$2,732.06	$2,503.64	$228.42	8.4%
Town of York (NYS Teamsters H&W Fund)	$5,019.11	$4,583.21	$435.90	8.7%
Town of Ossian (Blue Choice Select)	$784.56	$662.92	$121.64	15.5%
Village of Mt Morris (Blue Choice Select)	$13,923.81	$10,038.83	$3,884.98	27.9%
Town of Sparta (Blue Choice Select)	$3,788.74	$2,726.91	$1,061.83	28.0%
Town of Springwater (Blue Choice Select)	$5,924.25	$4,244.86	$1,679.39	28.3%
Village of Geneseo (Blue Choice Select)	$18,553.78	$13,298.00	$5,255.78	28.3%
Town of North Dansville (Blue Choice Select)	$2,316.55	$1,657.30	$659.25	28.5%
Town of Portage (Blue Choice Select)	$3,651.03	$2,611.83	$1,039.20	28.5%
Town of Groveland (Preferred Care Comprehensive)	$3,648.61	$2,196.45	$1,452.16	39.8%
Total Monthly Premium	**$149,877.97**	**$135,441.08**	**$14,436.89**	
Annual Premium	**$1,798,500**	**$1,625,300**	**$173,200**	**9.6%**

[1] Calculated based on the current rates for each town/village which reflect the current benefits of the town/village.
[2] Calculated based on the current Plan B rates for the County which reflect the current benefits of the County.
[3] Numbers in parenthesis indicate additional cost for the town/village

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

In addition to the financial considerations, there are several non-financial benefits that can be realized by combining plans. These include alleviating the local governments of the administrative burden of choosing health plan options, communications, processing premium payments, collecting employee contribution, and handling enrollment. In addition, because of the size and the nature of the benefits provided (community rated packages offered by insurers), the local governments (and it would not be cost-efficient to do so) do not currently provide targeted communications to plan participants. Where communications material if provide, it is in the form of the insurance company certificate or pre-package material that is not targeted to 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. As we discuss in the last section of this report, most of the plans contain wellness benefits. Currently, the communications material does not actively promote the availability of there benefits or champion Wellness. 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.

Should Livingston County decide it wishes to pursue such an option, the structure and under what governance this would be accomplished needs 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 is a self-insured arrangement that must follow certain criteria established by the 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 either could be insured (and experience-rate) or self-insured.

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. Private sector multiemployer plans are subject to ERISA and not New York Insurance Law.

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.[1] 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.[2]

Article 47 Municipal Cooperative Health Benefits Plan

Under Article 47, a 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.

[1] 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

[2] 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

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.” As there is a participation minimum currently part of Article 47 (a municipal cooperative agreement must cover at least 2,000 employees/retirees) this may not provide to be a viable option for the County unless A11374 is enacted, as described below.

Bill A11374

There is currently a proposed Act before the Legislature that authorizes a county to enter into a cooperative agreement with school districts, towns and villages in their county to provide health care benefits for employees. This bill is intended to ease the participation burden (of at least 2,000 employees/retirees) that is currently a requirement of municipal cooperative agreements

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

Issue to Consider	Article 44 – Employee Welfare Fund	Article 47 – Municipal Cooperative Health Benefits Plan	Bill No A11374 Ease restrictions on participation in a municipal health benefit plan
Definition	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.	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 , retires and such dependents. Maintained by the County/Local Governments.	Notwithstanding the provisions of article 47 of the insurance law, or any other provision of law to the contrary, a county shall be authorized to enter into a municipal cooperative agreement authorized by article 5-G of the general municipal law, with one or more school districts, towns or villages, to provide health care benefits or establish a health care plan for their respective employees. Such county is authorized to charge an administrative fee to a municipality for participation in such agreement.
Establish/Application Process	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.	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.	Same as Article 47.

Issue to Consider	Article 44 – Employee Welfare Fund	Article 47 – Municipal Cooperative Health Benefits Plan	Bill No A11374 Ease restrictions on participation in a municipal health benefit plan
Funding Mechanisms	Insured or "otherwise"; appears to be exempt from community rating.	Must be self-insured with certain reserve requirements including stop loss.	Same as Article 47.
Mandates	Not an 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 polices are purchased must comply with mandates.	Minimum standards regarding benefits and participation. Must maintain stop-loss insurance. Generally subject to NY State insurance mandates.	This Bill would ease the restrictions on participation by authorizing a county to enter into a municipal cooperative agreement with one or more school districts, towns or villages in order to provide health care benefits or establish a health care plan for their respective employees. County is authorized to charge an administrative fee for participation in such agreement. Assume all other mandates would be the same as for municipal cooperative health benefit plan.

Issue to Consider	Article 44 – Employee Welfare Fund	Article 47 – Municipal Cooperative Health Benefits Plan	Bill No A11374 Ease restrictions on participation in a municipal health benefit plan
Oversight/Filings	New York State. Annual Statement/Annual Report; Statement from Insurance company and service provider.	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.	Same as Article 47.
Governing Board	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.	Group of persons designated in the Municipal Cooperative to be responsible for administering the Plan.	Same as Article 47.

Issue to Consider	Article 44 – Employee Welfare Fund	Article 47 – Municipal Cooperative Health Benefits Plan	Bill No A11374 Ease restrictions on participation in a municipal health benefit plan
Plan Benefits and Disclosure	Per written plan document.	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.	Same as Article 47.
Audit	The superintendent may examine the affairs of any fund as often as he deems necessary at least once every 5 years.	Superintendent may examine the affair of the plan as often as deemed necessary but not less that once every 3 years to no more than 5 years.	Same as Article 47.
Participation	No minimum.	Number of covered employees participating in the plan shall be at least 2,000.	This Bill would ease the restrictions on participation by authorizing a county to enter into a municipal cooperative agreement with one or more school districts, towns or villages in order to provide health care benefits or establish a health care plan for their respective employees.

Issue to Consider	Article 44 – Employee Welfare Fund	Article 47 – Municipal Cooperative Health Benefits Plan	Bill No A11374 Ease restrictions on participation in a municipal health benefit plan
Design	Including but not limited to medical, surgical, or hospital care or benefits.	Minimum Standards	Same as Article 47.
Standards	Trustees are fiduciaries.	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.	Same as Article 47.

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% do not 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 in Current Benefit Offerings

Currently, there are a number of wellness components offered by Preferred Care or Excellus. As all the products 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 provided in each of the plan options. Preferred Care offers other wellness benefits like a Personal Health manager, online resources, Preferred Care Wellness Center, Health Dollars, and community discounts. The Excellus/Blue Cross Plans offer Health Living Program that includes a Health Risk Assessment tool, web-based programs on things like a healthier diet, weight loss and diabetes, Health Coaching, nutritional counseling and a 24/7 online information page.

Definitions

- **Wellness** is an intentional choice of lifestyle characterized by personal responsibility, balance and maximum personal enhancement of physical, mental and spiritual health.[1]
- **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.[2]
- **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.[3]

[1] Wellness Council of America, 1990

[2] Wellness Council of America, 1990

[3] 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).[1]

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.

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

[1] Guidelines for Employee Health Promotion, 1992

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

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.[1]

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.[2]

Tangible short-term benefits of wellness programs[3] are supposed to result in:

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

[1] Goetzel et al, Journal of Occupational and Environmental Medicine, October 1998

[2] Ozminkowski, Ronald, Journal of Occupational and Environmental Medicine, January 2002.

[3] www.welcoa.org

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

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 ADA and EEOC regulations in the design of wellness programs, particularly incentives/rewards.[1] 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 will not 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),**

[1] http://www.dol.gov/dol/pwba/public/pubs/faqs.htm

- **a day to day champion (Health Educator, Wellness Director) or team of champions** (employee committee) supporting and guiding the wellness endeavor,
- 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.**

It does not appear as if the County or towns/villages have undertaken a well-planned wellness program to address the levels of intervention mentioned above. Should the local governments and County merge, the administrator of such a combined plan could spear-head such a program. Having a combined plan would make data gathering and communications more efficient that would allow the County to develop a wellness program that would eventually reduce demand for medical services as all of these things are done under the expectation that they will provide better cost management. Cost management may not always be cost reduction but "cost avoidance." In addition to cost management, there are other non-financial benefits to a wellness program that include: Better health. Better understanding. Better administration. Better cost management is best measured by tracking changes in elements that likely result in cost being lower than they otherwise are. This becomes clear over time. When the things that are tracked are measured, the plan would apply a model to turn the change into "savings" in a reasonable way.

Action Plan/ Sequence of Judgments

The report and the following sequence of judgments were reviewed with the Board during the September 22, 2008 meeting. At that meeting, it was generally agreed that it was desirable to pursue a consortium in order to consolidate the plans of the local government and the county. Because of the legal requirements around creating a consortium (either under Article 44 or 47), the Board will direct Counsel to research the specifics of consolidation. At the same time, the Board will begin to address the other items in the following sequence of judgments to determine the design, financial arrangement, case management and vendors.

ISSUE / DECISION	SUGGESTION
LEGAL STRUCTURE	
Determine under which section of the NYS Insurance law the consortium should be maintained.	Since all the local governments' current plans cover less than fifty families, New York State community rating requirements come into play. Public sector health care plans in New York State currently have two options to join together to enjoy the economies associated with larger numbers. These alternatives involve the participation of collective bargaining agents. Once a structure is determined, design appropriate governance documents as well as the governments labor relations teams will need to apprise their unions of the objectives of the contemplated arrangement.
PLAN OF BENEFITS	
Determine by looking at the benefit levels currently being offered, if there is merit to limiting the number of benefit options. If so, determine: ▪ Benefit options that should be maintained ▪ What long-term objectives should drive future changes in Plan design.	While benefit levels and contribution requirements are typically a matter of collective bargaining, we recommend offering two levels of benefits. One should be similar to the County's current plans and the other similar to one of the more modest benefit levels currently being provided by the local governments. The responsible parties will need to develop specific benefit levels and work with the governments labor relations teams to build them into bargaining agreements.

ISSUE / DECISION	SUGGESTION
FINANCIAL ARRANGEMENT	
Determine if the consortium should fully pool the experience of all governments. If the experience is pooled, determine: ▪ if there should be financial consequences to a local government exiting the pool. ▪ On what basis the governments' contribution requirements should be set. ▪ Regardless of the financial arrangement from one government to another, how the consortium should bear risk. ▪ If it should be insured, and if so, on what basis. ▪ If not, should stop-loss coverage be obtained ▪ If the consortium should hold reserves and/or have the responsibility to assess governments additional amounts if needed.	Regardless of the legal structure employed, participation rules regarding entry, exit and rate development need to be adopted. Financial and governance elements need to be addressed by the participating governments. Once participation and rate development rules have been developed, authorized parties can consider the relative merits of different risk arrangements. The contemplated consortium is large enough to consider self-insurance. Consideration should be tempered by the fact that the County itself only has one year of experience known and the local governments' experience is still only known to Excellus at this point. Excellus has indicated that they will issue a rate (or presumably a rate equivalent if self-insurance is desired) if the local governments announce their intention to from a consortium. We recommend that Excellus be asked to develop illustrative rates under various funding arrangements for plan levels desired and that consideration of the most appropriate form be given when the cost difference is known. The contemplated consortium and the governments themselves will need to address risks they might have to bear under different financial arrangements.

ISSUE / DECISION	SUGGESTION
CASE MANAGEMENT	
Determine ▪ Which care management tools that are available to a contemporary health care plan should be incorporated into the plan(s) design and administrative systems. ▪ How these plans should be monitored and changed over time to best address the needs of participants and the local governments.	The most effective way to improve participants' health and manage costs is by getting the best possible understanding of the characteristics of the covered population and their pattern of benefit utilization. Only then can a plan sponsor be assured that any programs they care to offer are properly directed. Particularly since the covered population here is coming from community rated plans, we recommend that the array of care management programs noted in the report only be considered after demographic and utilization information is carefully studied. The report notes a broad array of possible programs that plans the size and nature of the contemplated consortium are currently offering. Which ones belong in the contemplated plans and how they should be developed and implemented should be based on the particular characteristics and utilization patterns of the covered group. In addition, changes in health and health care utilization are not singular. Getting the best possible understanding of demographics and utilization will allow changes to be monitored to measure if desired trends are being achieved.

ISSUE / DECISION	SUGGESTION
VENDORS	
Determine: ▪ Which vendors should be considered to service the consortium. ▪ How they should be selected. ▪ How they should be monitored and evaluated. ▪ If these vendors should be supplemented with coordinating resources at the County and, if so, how should those resources be funded.	The health plan market in the County's geographic area is becoming more competitive. It now contains both the large national health insurance companies and national and regional benefit administration firms that can offer substantial claims administration, network development and maintenance, care management and customer service. If a consortium is developed, it will be a very attractive client to these firms. However, as noted above, Excellus is the custodian of the claims information that will allow for the development of initial costs. We recommend that negotiations be entered into with Excellus for initial rates (or rate equivalents) and that care management programs be developed with their assistance in the initial period. However, the presentation of regular, detailed data and report summaries should be part of that negotiation. As data is collected, the contemplated consortium will be in a position to measure the value provided by Excellus and make judgments about alternatives. We can help design appropriate reports to allow for the monitoring of the contemplated program and its carrier. Of course, this recommendation is subject to the governments procurement rules. Should rules require bidding of insurance or administrative services, we can offer suggestions on how best to proceed.

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

Plan	Village/Town	Description of Plan
Preferred Care Tri-Vantage Active Lifestyle 250-2	Village of Avon Village of Caledonia Town of Avon Town of Geneseo Town of Leicester Town of Livonia Town of West Sparta	Dependent to 26 PCP Copayment $10/Adult; $20/Sick Child Specialist copayment $20 Emergency room copayment $40 Hospital $100/Admission No out-of-network benefits DME/EXT Pros/Orthotics 50%; $5000 DME/$15,000 Orthotic annual maximum Annual Eye wear Domestic Partner - same/opposite 6 months diabetic drug/supply copay $20 Mental health Carve out Rx $10.$25.$40, 2.5x mail order
Preferred Care Tri-Vantage Family Focus 250-2	Village of Avon Village of Caledonia Town of Avon Town of Geneseo Town of Leicester Town of Livonia Town of West Sparta	Dependent to 26 PCP Copayment $15/Adult; no charge/$5 Sick Child Specialist copayment $20 Emergency room copayment $50 Hospital $100/Admission (no charge child) No out-of-network benefits DME/EXT Pros/Orthotics 50%; $5000 DME/$15,000 Orthotic annual maximum Annual Eye wear Domestic Partner - same/opposite 6 months diabetic drug/supply copay $20 Mental health Carve out Rx $10.$25.$40, 2.5x mail order

Plan	Village/Town	Description of Plan
Preferred Care Tri-Vantage Healthy Alternative 250-2	Village of Caledonia (only group with employees currently enrolled in this option) Village of Avon Town of Avon Town of Geneseo Town of Leicester Town of Livonia Town of West Sparta	Dependent to 26 PCP Copayment $20/Adult/Sick Child Specialist copayment $20 Emergency room copayment $50 Hospital $100/Admission DME/EXT Pros/Orthotics 50%; $5000 DME/$15,000 Orthotic annual maximum Annual Eye wear Out-of-network coverage at 75% for care without a referral, up to $25,000 after a $250 deductible Domestic Partner - same/opposite 6 months diabetic drug/supply copay $20 Mental health Carve out Rx $10/$25/$40/ 2.5x mail order
Preferred Care Comprehensive 101-1	Town of Groveland	$5 copay PCP/ $10 Specialist Adult and Child Preventive Care No out-of-network benefits Diabetic Care Vision Care/annual eye wear Health Dollars Rx coverage: Retail - 90 day supply payable at 50%; mail order - $15 generic copayment/$75 brand name Durable Medical Equipment, External Prosthetics and Orthotics
Preferred Care Opportunity - Single	Town of Ossian	
Preferred Care EPO 1	Town of Lima	$15 copay PCP and Specialist Vision - $15 copay, 20% eyewear discount Rx $10/$30/$50

Plan	Village/Town	Description of Plan
Blue Choice Select (package #450)	Village of Geneseo Village of Mt Morris Town of North Dansville Town of Ossian Town of Portage Town of Sparta Town of Springwater	Blue Choice Select/$15 PCP/specialist No out-of-network benefits Inpatient – covered in full; $50 emergency copayment Blue Choice Select Vision Rider Blue Choice Select Eyewear Rider Blue Choice Select/ 3-tier Drug Card: $5/20/35 Blue Choice Extended Select Medical Domestic Partner Coverage (Mt. Morris)
Blue Choice Value (package #444)	Village of Lima Town of Livonia	Blue Choice Value Basic w/$20 PCP copay Inpatient - covered in full after $240 copay No out-of-network benefits Blue Choice Value Eyewear rider Blue Choice Value Vision Rider Excellus Rx 3-tier : $10/$25/$40 Flexible Spending account Blue Choice Value Domestic Partner Coverage (Mt. Morris)
Blue Cross EPO Balance Opt 5 (package #011)	Village of Dansville Village of Nunda Town of Nunda	EPO Balance Opt 5 with $20 copayment ($250 inpatient deductible); no out of network Dependents covered until age 26/Students are covered until age 26 Vision/$60 eyewear Domestic Partner Drug Choices: $10/$25/$40 ($0 children to 19); mail order 2 copays - 90 days

Plan	Village/Town	Description of Plan
Blue EPO Balance Opt 6 (package #010)	Town of Caledonia	Blue EPO Balance Opt 6 with $25 copayment ($250 inpatient deductible); no out of network Dependents covered until age 26/Students are covered until age 26 Vision/$60 eyewear Domestic Partner Drug Choices: $10/$25/$40 ($0 children to 19); mail order 2 copays - 90 days
EPO Blue Healthy Choices	Town of Mt. Morris Town of Conesus	EPO Blue Healthy Choices with $100 Inpt Copay Chemical Dep Detox/$100 Inpt Deduct Age 26/26 DME - no Foot Orth Eyewear Hospice/$100 Inpt Deduct Skilled Nursing Facility/ $100 Inpt Deduct Domestic Partner Drug Choices: $10/$25/$40 - $0 Gen<19/mail order 2 copays - 90 days

Plan	Village/Town	Description of Plan
BluePoint 2 Option B	Livingston County	Co-payment - $15 in-network copayment Out-of-Network – Deductible - $300/$600/$750; Co-Insurance – 20%; OOP Maximum - $300/6000/7500 Unlimited Lifetime Maximum Inpatient Detox/Rehab (44 IP Days) Routine Eye Exams/Eyewear Elective Sterilization Medical Supplies DME & Prosthetics Nutritional Counseling Acupuncture Hearing Exams Hearing Aids Emergency Room $50 Prescription drugs - $5/$15/$30; 2 copayments for 90 days Mail Order supply Dependent/Student to age 19/23
BluePoint 2 Option D	Livingston County	Co-payment - $20 in-network copayment Out-of-Network – Deductible - $500/$1,000/$1,250; Co-Insurance – 25%; OOP Maximum - $300/6000/7500 Unlimited Lifetime Maximum Inpatient Detox/Rehab (44 IP Days) Routine Eye Exams/Eyewear Elective Sterilization Medical Supplies DME & Prosthetics Nutritional Counseling Acupuncture Hearing Exams Hearing Aids Emergency Room $50; Inpatient copayment - $100 Prescription drugs - $10/$25/$40; 2 copayments for 90 days Mail Order supply Dependent/Student to age 19/23

Plan	Village/Town	Description of Plan
NYS Teamsters Council Health and Hospital Fund	Town of York	$15 copay PCP and Specialist $1million lifetime max DME/prosthetic/medical supplies - covered in full Rx $7/$14/$30 retail (30days), $14/$28/$60 mail (90day) Skilled nursing facility (unlimited) - covered in full Hearing Aid ($1000)/exam ($250) every 3 years

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
Village of Avon	16 actives (2 members "opt out") Local 9650 of NYS Law Enforcement Officers Union DC 82, AFSCME – FT Employees offered dollar amount equal to current premium of Preferred Care Tri-Vantage; Opt-out provision equal to ½ of current premium. Local 200United SEIU – FT Employees offered a dollar amount equal to current premium of Blue Choice Select Single, Two-Person, Family with no Spouse or Family – Opt out provision - $2,500 in cash or applied toward deferred compensation. Non-Union Employee – Group A and B – Village pays base amount ($280.30) plus 50% of cost exceeding base amount and employee pays other 50%. $300 HRA	Preferred Care Tri-Vantage: Single = $329.17 Two Person = $740.65 Family = $855.84	4*$329.17=$1,316.68 3*$740.65=$2,221.95 8*$855.84=$6,846.72 Total = $10,385.35

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Village of Caledonia	12 employees: 7 active 5 retirees Village provides medical coverage for all FT employees. Pays 80% of medical and dental expenses for those employed less than 15 years and 90% of those with 15 or more years of continuous services.	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.26 Two Person = $808.38 Family = $934.11	2*$359.26=$718.52 3*$808.38=$2,425.14 2*$934.11=$1,868.22 Total = $5,011.88
Village of Dansville	20 actives: 1 Sub-Depts 5 Single 6 Two-Person 7 Family Local 967D, Council 82, AFSCME – Coverage provided to each FT employee in accordance with type of coverage (single, family, etc.). DOh before 6/1/06 - Employee pays 10% toward cost DOH after 1/1/06 - 15% toward cost. CSEA – BC/BS Choice Select provided for all Full time employees; Employer pays 90% of insurance premium and employee pays 10% on a pre-tax basis. $500 contributed annually to an FSA.	Blue EPO Balance 5 (#011): 012 - Single - $279.51 013 - Two person - $642.82 009 - Family No Spouse - $704.14 014 - Family - $740.93	4*$279.51=$1,118.04 6*$642.82=$3,856.92 1*$704.14=$704.14 6*$740.93=$4,445.58 Total = $10,124.68

Towns/Village	Participants	Rates (Actives Only)	Aggregate Costs
Village of Geneseo	19 employees: 17 actives 2 retirees (one retiree pays full premium, one retiree uses sick bank to pay for coverage) SEIU, Local 200United – Employees DOH on or after 1/1/91 - provided with health insurance at the conclusion of probationary period. Employee contributions $10/pay period/ family or two-person and $5/single coverage. If other coverage, opt-out provision. Police – New employees eligible after employed for 6 calendar months. Employees contribute $18/month/family and $16/two-person and $8/individual. Annual enrollment including buy-out provision - $600/single, $900/two-person and $1,000/family.	Blue Choice Select (#450): 012 - Single - $459.31 013 - Two person - $1,056.21 014 - Family - $1,217.01	4*$459.31=$1,837.24 2*$1,056.21=$2,112.42 12*$1,217.01=$14,604.12 Total = $18,553.78

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Village of Leicester	No covered employees		
Village of Lima	6 actives: 2 Single 1 Two Person 3 Family Village pays 100% of cost of medical (employees pay 100% for Dental benefits).	Blue Cross Value (#444): 012 - Single - $359.49 013 - Two person - $826.84 014 - Family - $952.61	2*$359.49=$718.98 1*$826.84=$826.84 3*$952.61=$2,857.83 Total $4,403.65
Village of Livonia	3 actives Village pays 100% of premium.	Blue Cross (#444) 012 - Single - $359.00 013 - Two person - $826.84 014 - Family - $952.61"	1*$826.84=$826.84 2*$952.61=$1,905.22 Total = $2,732.06

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (actives Only)	Aggregate Costs
Village of Mt Morris	22 employees: 15 actives (5 opt out) 6 retirees (1 opt out) / 1 COBRA Mount Morris Police Benevolent Association – Current and new hires offered Blue Choice Select at no cost; pays difference between Blue Choice Select and other insurance. Opt-Out: $2,500 per year. SEIU Local 200United – DOH before 6/1/06, employees provided with health insurance at no cost (Blue Choice Select or Blue Health Choice and SEBF Dental). DOH after 6/1/06: employee pays difference between cost of insurance and credits: 6/1/08 - $340/month 6/1/09 - $355/month Non-police/Non-union: DOH before 6/1/07: No cost to employee and may switch between Blue Choice Select and Health Choice/SEBF Dental or credit for opt-out of $340/month; DOH after 6/1/07 - may choose health insurance health insurance coverage from any plan the Village offers and pay percentage of premium: 6/1/08 – 12%; 6/1/09 – 14%; Opt-out, credit of $340/month.	Blue Choice Select (#450): 009 - Sub-Depts - $1,156.57 012 - Single - $459.31 013 - Two person - $1,056.21 014 - Family - $1,217.01	1*$1,156.57=$1,156.57 5*$459.31=$2,296.55 3*$1,056.21=$3,168.63 6*$1,217.01=$7,302.06 Total = $13,923.81

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Village of Nunda	4 actives All FT employees covered for health insurance – 90 paid by Village/10% paid by Employee. Opt-out provision - $1,800/year. Non-eligible employees may pay full cost of premium	Blue Cross EPO Balance Opt 5 (#011): Single = $279.51 Two Person = $642.82 Family No Spouse = $704.14 Family = $740.93	1*$279.51=$279.51 2*$642.82=$1,285.64 1*$740.93=$740.93 Total = $2,306.08
Town of Avon	16 employees: 8 actives 8 retirees Eligible for Single coverage with following employee contributions – Single coverage - 2%; employee/Spouse – 5%; family – 8% Employees employed with Town prior to 2001 are eligible for family coverage. $300 HRA annual contribution.	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.26 Two Person = $808.38 Family = $934.11	4*$359.26=$1,437.04 1*$808.38=$808.38 4*$934.11=$3,736.44 Total = $5,972.86

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Caledonia	8 employees: 7 actives (one opt out) 1 retiree Non-Highway: FT employees 100% paid by Town or $2500 annual opt-out amount. Retirees – 25+ - 80% for 5 years 20+ - 70% for 5 years 15+ 60% for 5 years after retirement. Highway – Same as Non-Highway	Blue EPO Balance Opt 6 (#010): 009 - Sub-Depts - $691.19 012 - Single - $274.35 013 - Two person - $631.00 014 - Family - $727.30 018 - Med Second - $274.35 020 - Fam Medsec - $727.30 025 - 2 Pers Med Second - $631.00	1*$274.35=$274.35 2*$631.00=$1,262.00 3*$727.30=$2,181.90 Total = $3,718.25
Town of Conesus	6 actives Highway Association Affiliated with Local 1170 CWA: 100% of cost for FT employees; $2,500 to an HRA account; $2000 group catastrophic co-payment account. Opt-out provision - 50% of difference of the cost in either a single or family plan, as qualified. FT employees hired after 1/1/08, must complete 6 months of continuous FT employment and contribute $30/week for health care coverage.	Blue Cross Select (#98&99): 012 - Single - 013 - Two person - $2,213.22 quarterly rate (737.74/month) 014 - Family - $2,548.23 quarterly rate (849.41/month) Blue Cross (#010): 010 = $2,527.56 quarterly rate (single 842.52/month)	1*$842.52=$842.52 (single) 2*$737.74=$1,475.48 4*$849.41=$3,397.64 Total = $5,715.64

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Geneseo	13 employees (one with Dental only): 2 Single 5 Two Person 5 Family SEIU Local 200United (Highway employees): FT employees – coverage paid in full by Town. Employee Reference Handbook – FT employee – coverage paid in full by Town; Part-time employees are not covered but may purchase policy through Town.	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.26 Two Person = $808.38 Family = $934.11	2*$359.26=$718.52 5*$808.38=$4,041.90 5*$934.11=$4,670.55 Total = $9,430.97

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Groveland	5 actives: 4 Single 1 Family Highway Association, CWA Local 1170: FT employees DOH before 1/106 – 100% for single coverage; 80% of cost for family coverage; DOH after 1/1/06 – employee pays 50% of cost of coverage; Probationary employees eligible after first month of probationary employment; opt-out provision - $100/month in compensation.	Preferred Care Comprehensive 101-1 Single = $552.82 Family = $1,437.33	4*$552.82=$2,211.28 1*$1,437.33=$1,437.33 Total = $3,648.61
Town of Leicester	8 actives: 5 Single 1 Two Person 2 Family Highway and Water Employees – FT employees DOH after 1/1/87 – employee pays 25% of cost; DOH after 1/1/02 – employee pays 40% of cost..	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.50 Two Person = $808.92 Family = $934.74	5*$359.50=$1,797.50 1*$808.92=$808.92 2*$934.74=$1,869.48 Total = $4,475.90

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Lima	5 actives: 1 Single 2 Two Person 2 Family FT employees who were covered as of 1/1/05 receive 100% employer paid insurance; All new FT employees with DOH after 1/1/05 pay 25% of the premium after one full month of FT employment.	Preferred Care EPO 1 Single = $255.60 Two Person = $587.87 Family = $695.63	1*$255.60=$255.60 2*$587.87=$1,175.74 2*$695.63=$1,391.26 Total = $2,822.60

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Livonia	18 actives Employee Policy Handbook – FT employees – Town pays 100% of premium for family/individual coverage DOH prior to 1/1/99; DOH after 1/1/99 – Town pays 85% of premium; PT employees may enroll in plan but pay 100% of premium. Section 125 plan for payroll deductions. SEIU Local 200United: First month of employment, $15/pay period toward coverage.	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.26 Two Person = $808.38 Family = $934.11	1*$359.26=$359.26 7*$808.38=$5,658.66 9*$934.11=$8,406.99 Total = $14,424.91
Town of Mt. Morris	8 actives Town pays 100% of premium for FT employees; PT employees may enroll but pay 100% of premium.	EPO Blue Healthy Choices: Single = $320.81 Two Person = $737.74 Family No Spouse = $807.31 Family = $849.41	4*$320.81=$1,283.24 1*$737.74=$737.74 3*$849.41=$2,548.23 Total = $4,569.21

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of North Dansville	3 actives Town pays 100% of premium	Excellus Blue Choice Select One Person = $1377.93 per quarter/ $459.31 per month Service charge = $12 per quarter / $4 per month	$459.31 * 3 = $1,377.93 plus $12 servicing $459.31*2 =$918.62 (paying single coverage for 2 spouses) plus $20 servicing fee Total - $2,316.55
Town of Nunda	6 actives: 3 Two Person 3 Family Three employees pay 30% of premium; 3 employees have 100% employer paid coverage.	Blue Cross EPO Balance Opt 5 (#011): Single = $279.51 Two Person = $642.82 Family No Spouse = $704.14 Family = $740.93	3*$642.82=$1,928.46 3*$740.93=$$2,222.79 Total = $4,151.25
Town of Ossian	2 actives Highway employees – Single coverage provided at a rate of $815/quarter - DOH after 1/1/08	Excellus Blue Choice Select One Person = $1377.93 per quarter/ $459.31 per month Service charge = $12 per quarter / $4 per month Opportunity One Person = $951.75 per quarter/ $317.25 per month Service charge = $12 per quarter / $4 per month	Excellus Choice Select - single $459.31 service fee = $3.00 Total = $462.31 Opportunity - single $317.25 service fee = $3.00 Total = $320.25 Grand Total = $782.56

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of Portage	3 actives Town pays 100% of premium.	Blue Choice Select (#450): 009 - Sub-Depts - $1,156.57 012 - Single - $459.31 013 - Two person - $1,056.21 014 - Family - $1,217.01 018 - Med Second - $459.31 020 - Fam Medsec - $1,217.01 022 - Fam w/o Med - $757.70 025 - 2 Pers Med Second - $1,056.21	3*$1,217.01=$3,651.03
Town of Sparta	5 employees :4 actives (1 Single, 2 Two Person, 1 Family) 1 retiree Highway employees – FT employees - Town pays 100% of premium for medical coverage.	Blue Choice Select (#450): 012 - Single - $1,377.93 quarterly (459.31/month) 013 - Two person - $3,168.63 quarterly (1,056.21/month) 014 - Family - $3,651.03 quarterly ($1,217.01/month)	1*$459.31=$459.31 2*$1,056.21=$2,112.42 1*$1,217.01=$1,217.01 Total = $3,788.74
Town of Springwater	7 actives: 1 Two Person 4 Family Town pays 100% of premium for FT employees.	Blue Choice Select (#450): 009 - Sub-Depts - $1,156.57 012 - Single - $459.31 013 - Two person - $1,056.21 014 - Family - $1,217.01 018 - Med Second - $459.31 020 - Fam Medsec - $1,217.01 022 - Fam w/o Med - $757.70 025 - 2 Pers Med Second - $1,056.21	1*$1,056.21=$1,056.21 4*$1,217.01=$4,868.04 Total = $5,924.25

Towns/Village	Participants /Eligibility rules and Cost Sharing	Rates (Actives Only)	Aggregate Costs
Town of West Sparta	4 actives: 3 Single 1 Family Town pays 100% of cost of coverage for FT employees; DOH after 1/1/93 – single coverage after probationary period. Additional cost of coverage paid by employee.	Preferred Care Tri-Vantage Active Lifestyle Preferred Care Tri-Vantage Family Focus Preferred Care Tri-Vantage Healthy Alternative: Single = $359.50 Two Person = $808.92 Family = $934.74	3*$359.5=$1,078.50 1*$934.74=$934.74 Total = $2,013.24
Town of York	7 actives: 2 Single 4 Two Person 1 Family Highway Department/Local 264 Buffalo, IBT – Medical cover: DOH prior to 1/1/97 – no cost; DOH between 1/1/97 and 12/31/05: 75%/1st year/80% 2nd year/85% 3rd year/90% 4th year; DOH after 1/1/05: 70%/1st year/75% 2nd year/80% 3rd year/85% 4th year. Town reimburses co-payments for medical and prescription up to $750/family and $500 two person/$400 single per calendar year; Section 125 Plan; Opt-out provision receive a cash payment of 70% of the single coverage premium. Retiree benefits available.	NYS Teamsters Council Health and Hospital Fund: Single = $416.22 Two Person = $782.39 Family = $1,057.11	2*$416.22=$832.44 4*$782.39=$3,129.56 1*$1,057.11=$1,057.11 Total = $5,019.11

County	Participants	Rates	Aggregate Costs
Livingston County	626 Active: 198 Single 195 2-person 25 Dependent 208 Family	BluePoint 2 Option B Single: $331.46 2 Person: $762.42 Dependent: $827.49 Family: $870.61 BluePoint 2 Option D Single: $355.75 2 Person: $818.20 Dependent: $887.99 Family: $934.38	20*$331.46=$6,629.20 15*$762.42 =$11,436.30 6*$827.49 =$4,964.94 21*$870.61 = $18,282.81 Total = $41,313.25 178*$331.46=$63,323.50 180*$762.42 =$147,276.00 19*$827.49 =$16,871.81 187*$934.38 = $174,729.10 Total = $402,200.37 Total = 443,513.62

Tab 3 – Summary of Demographics

County (All Adults/ Employees and Spouse)

Age Group	Sex		Grand Total	Percentage
	F	M		
20-24	13	5	18	1.60%
25-29	34	19	53	4.72%
30-34	45	28	73	6.50%
35-39	64	53	117	10.42%
40-44	74	70	144	12.82%
45-49	103	64	167	14.87%
50-54	117	64	181	16.12%
55-59	79	70	149	13.27%
60-64	63	47	110	9.80%
65-69	14	25	39	3.47%
70-74	19	17	36	3.21%
75-79	10	11	21	1.87%
80 Plus	8	7	15	1.34%
Grand Total	643	480	1,123	

Median age: 48.7

Villages and Towns (All Adults/Employees and Spouse)

Age Group	Sex		Grand Total	Percentage
	F	M		
20-24		2	2	0.60%
25-29	9	14	23	7.20%
30-34	11	17	28	8.80%
35-39	16	9	25	7.90%
40-44	21	21	42	13.20%
45-49	27	26	53	16.70%
50-54	25	48	73	23.10%
55-59	14	19	33	10.40%
60-64	8	13	21	6.60%
65-69	3	3	6	1.90%
70-74	3	5	8	2.50%
75-79	0	0	0	0.00%
80 Plus	1	2	3	0.90%
Grand Total	138	179	317	

68 Individuals with unknown birth date
Median age: 47.7

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 knows 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:** • Flexible sigmoidoscopy every 5 years • Colonoscopy every 10 years • Double contrast barium enema every 5 years • CT colonography (virtual colonoscopy) every 5 years

Wellness/Preventive Services/Benefits	Purpose
Screening Abdominal Ultrasound (once for men ages 65 to 75 years who have ever smoked)	3/2005 US Preventive Services Task Force recommends a one-time **screening for 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: • Annual Influenza (flu) shot • MMR • Meningitis • Polio • Hepatitis A • Hepatitis B • Pneumoccocal (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 other than 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**

Wellness/Preventive Services/Benefits	Purpose
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 testing?	
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?	
Blood glucose screening lab work	**Diabetes screening**
Hearing Screening Exam (also called an audiometry exam)	**Hearing loss screening**
Vision Screening Exam	**Screening for glaucoma, retinal exam for diabetics**
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 OTHER than 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**

Wellness/Preventive Services/Benefits	Purpose
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 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**
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**
Health Risk Appraisal (HRA) questionnaire	**Awareness of risks using self-reported information. Alerts individuals to risks.**
Misc. biometric screening laboratory tests for <u>other than</u> 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 (e.g. total body skin examination typically performed as part of an office visit)?	**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**

Wellness/Preventive Services/Benefits	Purpose
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/Diabetics	
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 their feet?	**Promote foot health in people unable to adequately feel when foot problems are developing.**
Directive written to the medical plan claims administrator(s) to **process claims under the medical plan that are 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**
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**
Education specific to **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	
• **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 to 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**

Wellness/Preventive Services/Benefits	Purpose
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 or people who need guidance and support in modifying a health risk factor?	**Facilitates changing behavior through education**
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: • **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 service**s? 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.**

Wellness/Preventive Services/Benefits	Purpose
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**
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 emergency 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**

Wellness/Preventive Services/Benefits	Purpose
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)?	**Promotes 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 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.**

Worksite Considerations

Wellness/Preventive Services/Benefits	Purpose
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 before conceiving, HIV screening test, manage any chronic diseases)	**Encourage optimal maternal health BEFORE a pregnancy occurs to help 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**

Wellness/Preventive Services/Benefits	Purpose
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?	**Promote exercise.**
Walking path at worksites?	**Promote exercise.**
Employer **sets aside workday time to have employees stretch/exercise**?	**Promote exercise**
Walking distances mapped and advertised (such as distance between buildings, distance from desk to copier, etc.?)	**Promote exercise**
Formal **policy on employees taking the stairs instead of elevator**?	**Promote exercise.**
Worksite vending machines: • filled with only healthy foods or • healthy food plus candy/chips or • cost of healthy food signif. less than cost to buy **un**healthy food	**Promotes healthy eating**
Worksite vending machine lists calories, fat, sugar, salt on items? Healthy snacks easily identifiable?	**Promoted healthy eating**
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 to **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	

Wellness/Preventive Services/Benefits	Purpose
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: • **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 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.**
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Wellness/Preventive Services/Benefits	Purpose
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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.**
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.**
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