City of Franklin
Common Council and Board of Public Works and Safety
Special Joint Meeting Minutes
Saturday March 16, 2013

The special meeting of the Common Council and the Board of Public Works and Safety of the City of Franklin, Indiana came to order at 9:05 a.m. in the Council Chambers located on the first floor of City Hall, 70 E. Monroe Street, with Council President Steve Barnett presiding. Council members Joe Ault, Ken Austin, Rob Henderson and Board of Public Works member Robert Swinehamer were present. The Clerk Treasurer Janet Alexander was also present, In addition to the elected and appointed members both Stephanie Shepherd the Payroll Coordinator, and Senior Planner Joanna Myers were present to assist with the presentation. Some department heads and employees also attended the meeting including: Ron Collins, Deputy Chief Tennell, and Chip Orner.

The purpose of this meeting was to receive and discuss information about the current employee medical and dental benefit program. Mr. Barnett turned the meeting over to Mr. John Auld of Franklin Insurance.

The following documents were presented and discussed:

Group Life & Medical Insurance 2012 Experience Report
Self-Funding Insurance Health Insurance
UMR Summary of Benefits and Coverage
Reinsurance / Stop Loss
Graph – City of Franklin 10 Year Expense Trends
Graph – Franklin Medical / RX Claims / Expenses vs. Aon Hewitt Annual Trend
City of Franklin Total Expense Summary
Report: *Wellness Programs – Are They Worth Their Weight? An Overview of Workplace Wellness Programs; Their Return on Investment; and Current Trends*
UMR – Patient Protection and Affordable Care Act Implementation Timeline (dated 2011)
2013 City of Franklin Group Health / Dental Enrollment Form

A discussion was held however no decisions were made and no action was recommended.

Mayor McGuinness arrived after 11:00 a.m.

The meeting adjourned at 11:50 a.m.

Respectfully submitted,
Janet P. Alexander, Clerk-Treasurer
Enrolled: 4-6-13

Joseph McGuinness, Mayor

Attest:

Janet P. Alexander, Clerk-Treasurer

CITY OF FRANKLIN

Group Life & Medical Insurance

2012 Experience Report

	Enrollment				Adm / PPO		Reinsurance			Attachment	Claims			Accum	% Inc
	Emp	E+Sp	E+Ch	Fam	Pre Cert	Life	Specific	Aggregate	Transplant	Point	Pd Dental	Pd Medical	RX Card	Claims	2011
January	36	33	25	73	$6,957	$798	$15,017	$1,727	$994	$196,651	$11,417	$68,163	$36,901	$116,482	-30%
February	37	34	24	73	$6,999	$803	$15,052	$1,737	$1,000	$393,761	$12,536	$56,339	$30,621	$215,977	-38%
March	37	34	24	73	$6,999	$803	$15,052	$1,737	$1,000	$590,871	$10,674	$121,332	$48,932	$396,915	-21%
April	39	33	24	73	$7,041	$808	$15,018	$1,747	$1,006	$787,525	$8,788	$75,106	$27,802	$508,611	-37%
May	39	33	24	74	$7,082	$813	$15,123	$1,758	$1,012	$985,555	$10,017	$235,397	$29,192	$783,217	-24%
June	39	33	24	73	$7,041	$808	$15,018	$1,747	$1,006	$1,182,209	$10,319	$89,638	$24,309	$907,483	-15%
July	39	33	24	73	$7,041	$808	$15,018	$1,747	$1,006	$1,378,864	$11,761	$86,316	$28,944	$1,034,504	-11%
August	36	38	25	71	$7,082	$813	$15,332	$1,758	$1,012	$1,579,639	$12,051	$126,072	$31,719	$1,204,346	-13%
September	36	38	25	71	$7,082	$813	$15,332	$1,758	$1,012	$1,281,330	$8,021	$33,454	$26,675	$1,272,496	-18%
October	37	37	25	71	$7,082	$813	$15,262	$1,758	$1,012	$1,481,190	$9,800	$150,062	$26,041	$1,458,399	-12%
November	37	37	25	73	$7,166	$822	$15,472	$1,778	$1,023	$1,683,800	$10,739	$68,385	$31,823	$1,569,346	-12%
December	37	37	25	73	$7,166	$822	$15,472	$1,778	$1,023	$1,886,409	$9,427	$100,079	$34,640	$1,713,493	-16%
TOTALS	37	35	25	73	$84,736	$9,723	$182,169	$21,032	$12,102	$1,886,409	$125,550	$1,210,344	$377,599	$1,713,493	

PROJECTED YEAR END COST SUMMARY:	2012 Actual	*Chg '11*	2012 Budget
Administration	$ 84,736	*-12%*	$ 89,017
Reinsurance	$ 215,303	*-3%*	$ 235,970
Life & LTD Insurance	$ 9,723	*-28%*	$ 13,127
Long Term Disability	$ 20,400		$ 20,400
Specific Reimbursement *(Claims Above Specific Deductible: $120,000)*	$ -		$ -
Aggregate Reimbursement *(Claims Above Attachment Point)*	$ -		$ -
Total Claims	$ 1,713,493	*-16%*	$2,171,937
Estimated Total Cost to City: *(Less Employee Contributions)*	$ 1,928,766		$ 2,530,451
Year End Under / Over Budget:	$ (601,685)		

AVERAGE COSTS	
Per Employee / Year	$11,379.15
Per Employee / Hour:	$5.47
Per Employee / Month:	$948.26
Emp Premium Contribution:	$114,888
Emp Contribution/Total Cost:	5.62%

Self Funding Insurance Health Insurance

Self-funding is an arrangement in which an employer funds medical expenses and contracts with a third party administrator (TPA) to provide administrative services and process claims for the group's medical and dental benefit plan. Many factors affect an employer's decision to self-fund, particularly the ability to assume the risk involved. An employer can generally save 10-25% of fully insured premiums for providing employee health insurance.

Self funding your employee benefit plans allow you the flexibility to control risks and the ancillary costs associated with insurance plans. They include:

- Self-funding treats predictable claim costs as expenses rather than as insurable risk items.
- In a self-funded plan model, employers determine the amount of risk that is appropriate for their company.
- Employers purchase stop-loss insurance to protect against catastrophic claims.
- Risk charges, insurance company reserves, and most premium taxes are avoided.
- Self-funded plans are governed by ERISA instead of state insurance law.
- In a self-funded plan, the employer can either fund expenses as they come due or deposit expected or maximum costs into an account each month.
- Unbundling expenses of a employee benefit plan by contracting for services independently, i.e. third party administrators, PPO networks, employee assistance programs, life & disability insurance, stop-loss coverage & large case management.

Stop Loss Insurance

The purpose of stop loss insurance is to provide financial protection to the plan sponsor, by capping financial exposure of claims.

Stop-loss insurance is neither health insurance nor reinsurance. It's more closely resembles a catastrophic coverage that indemnifies a plan sponsor from abnormal claim frequency and / or severity. Stop-loss claim reimbursements can be made for a variety of benefits, including medical, prescription drug, dental, and others. Severe, high-dollar claims such as cancer, organ transplants, and dialysis are considered "shock loss" claims which can give plans the most concern when they consider self-funding.

There are two forms of stop loss insurance: specific and aggregate. Specific stop-loss, protects the plan against catastrophic claims incurred by an individual employee during the plan term. Aggregate stop-loss limits the plan's exposure for the claims generated by the entire group throughout the plan year.

Specific Stop-Loss

Specific stop-loss coverage is purchased to limit the plan's financial exposure on any one individual. The exposure (i.e. specific deductible) should be a function of the company's size, risk tolerance, financial resources, location, plan of benefits, PPO network, and claims experience.

Example: A group purchases specific stop-loss coverage with a $150,000 specific deductible. An individual has claims that exceed $150,000. The stop loss carrier reimburses the plan eligible claims paid out by the plan, in excess the $150,000 specific deductible. Therefore, if the plan paid $500,000 in eligible claims, the stop-loss insurance carrier would reimburse the plan $350,000. With specific coverage, the plan can file a specific claim at the time it incurs the loss. The premium for the specific stop-loss coverage is expressed as a monthly rate (e.g. per employee, single, family, composite, etc.)

Aggregate Stop-Loss

With specific stop-loss, we're protecting the plan from individual catastrophic claims. But what happens when "routine" claims are greater than what the plan had projected? Aggregate stop-loss is the answer to protect against a higher than average frequency of claims. Aggregate stop-loss limits the financial liability of the plan, for all eligible plan members (e.g. the entire group). Eligible claims, below the specific deductible, will accrue and towards an aggregate deductible, also referred to as an "aggregate attachment point," which is determined by the underwriter, and based on the plan's projected claims. An underwriter will also consider the plan's historical claims experience as well as the group's demographic, the current vs. proposed plan design, provider networks, and a number of other factors. Aggregate stop-loss claims are usually made following the conclusion of the aggregate stop loss policy period, and determined by comparing the eligible aggregate stop- loss claims for the period to the annual attachment point. Aggregate claims in excess of the aggregate attachment point are reimbursed to the plan.

Stop-Loss Contract Types

When an employee is covered by a fully-insured plan and incurs a claim during the effective period of the contract, the employee simply submits the claim to the insurance carrier, and either the employee or the provider is paid the benefits due. This is known as "incurred" contract.

A stop loss contract operates differently because it is actually insuring the employer and not the individual employee. It is important to grasp this concept. When a plan is self-funded, the stop-loss contract insures the employer against catastrophic losses under the plan. The medical plan established by the employer accepts the responsibility for paying providers' claims for individuals but limits its risk with stop-loss coverage. Individual employees are not personally insured by the stop-loss carrier.

UMR: CITY OF FRANKLIN: 7670-00-550032 002

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period:01/01/2013 – 12/31/2013
Coverage for: Individual + Family | **Plan Type:**PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.franklin.in.gov or by calling 317-736-3606.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person / **$750** family in-network **$250** person / **$750** family out-of-network Copayments do not apply to the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,000** person / **$3,000** family in-network **$1,000** person / **$3,000** family out-of-network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments for medical services, penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers,** see www.umr.com. If you are unsure which network list to select, please call 317-736-3606	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to	No.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 317-736-3606 or visit us at www.franklin.in.gov.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov** or call 317-736-3606to request a copy.

see a specialist?		
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copay per visit	50% Coinsurance	Deductible Waived In-network
	Specialist visit	$20 Copay per visit	50% Coinsurance	Deductible Waived In-network
	Other practitioner office visit	20% Coinsurance	50% Coinsurance Chiropractic care; Not covered Acupuncture	none
	Preventive care/screening/immunization	No charge	Not covered	Deductible Waived In-network
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	none

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.umr.com.	Generic drugs	$10 Copay per prescription (retail); $20 Copay per prescription (mail order)	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	Covers up to a 30-day supply (retail & specialty); 31-90 day supply (mail order)
	Preferred brand drugs	$30 Copay per prescription (retail); $60 Copay per prescription (mail order)		
	Non-preferred brand drugs	$45 Copay per prescription (retail); $90 Copay per prescription (mail order)		
	Specialty drugs	$10 Copay per prescription (Generic); $30 Copay per prescription (Preferred brand); $45 Copay per prescription (Non-preferred brand)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	none
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	none
If you need immediate medical attention	Emergency room services	20% Coinsurance	20% Coinsurance True ER; 50% Coinsurance Non-true ER	In-network deductible applies to Out-of-network True ER
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	$20 Copay per visit	50% Coinsurance	Deductible Waived In-network

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	50% Coinsurance	Prior authorization is required or benefit reduces by $500 per claim
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 Copay per office visit; 20% Coinsurance other outpatient services	50% Coinsurance	Deductible Waived In-network office visit
	Mental/Behavioral health inpatient services	20% Coinsurance	50% Coinsurance	Prior authorization is required or benefit reduces by $500 per claim
	Substance use disorder outpatient services	$20 Copay per office visit; 20% Coinsurance other outpatient services	50% Coinsurance	Deductible Waived In-network office visit
	Substance use disorder inpatient services	20% Coinsurance	50% Coinsurance	Prior authorization is required or benefit reduces by $500 per claim
If you are pregnant	Prenatal and postnatal care	No charge Prenatal; 20% Coinsurance Postnatal	50% Coinsurance	Deductible Waived In-network Prenatal
	Delivery and all inpatient services	20% Coinsurance	50% Coinsurance	none

Common Medical Event	Services You May Need	Your cost if you use an In-network	Your cost if you use an Out-of-network	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	180 Maximum visits per calendar year; Prior authorization is required or benefit reduces by $500 per claim
	Rehabilitation services	20% Coinsurance	50% Coinsurance	----------none----------
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Prior authorization is required or benefit reduces by $500 per claim
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Prior authorization required for DME in excess of $500 for rentals or $1,500 for purchases or benefit reduces by $500 per claim
	Hospice service	20% Coinsurance	50% Coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----------none----------
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others.)

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 317-736-3606. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa/, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: UMR at 800-826-9781. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

欲将该文件翻译成中文，请联系您的雇主。

Díí naaltsos Diné k'eh saadjį́'go háádídool nílgo, éí t'ááshǫǫ́dí bá nalnishígíí bíí hodoínih.

Si necesita este documento traducido al español, comuníquese con su empleador.

Upang ipa-translate ang dokumentong ito sa Tagalog, mangyaring makipag-ugnay sa inyong employer.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays $6,540
- Patient pays $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$70
Coinsurance	$630
Limits or exclusions	$0
Total	**$1,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $4,300
- Patient pays $1,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$900
Coinsurance	$200
Limits or exclusions	$100
Total	**$1,100**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Prescription drug costs (Prescriptions) shown in the Coverage Examples reflect information provided by the Plan's Prescription Benefits Manager.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

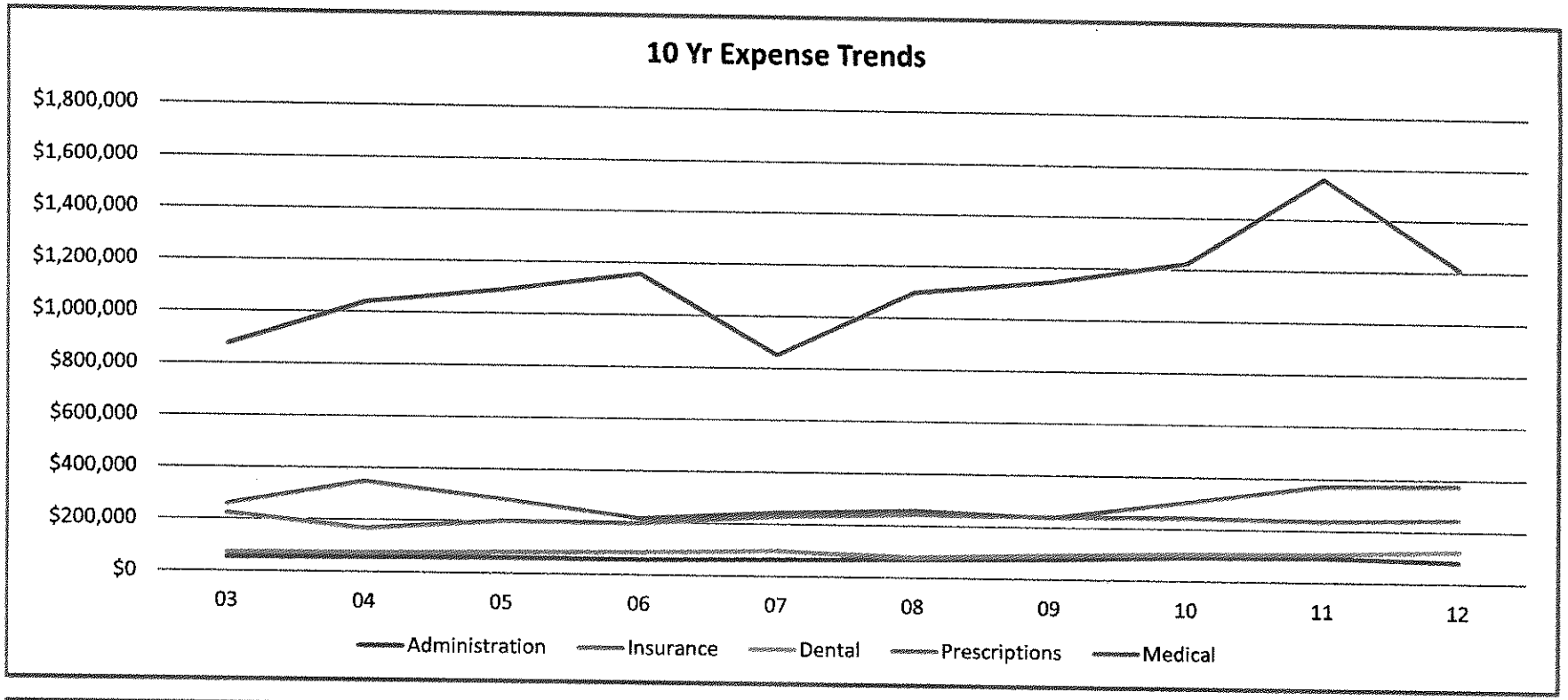
✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

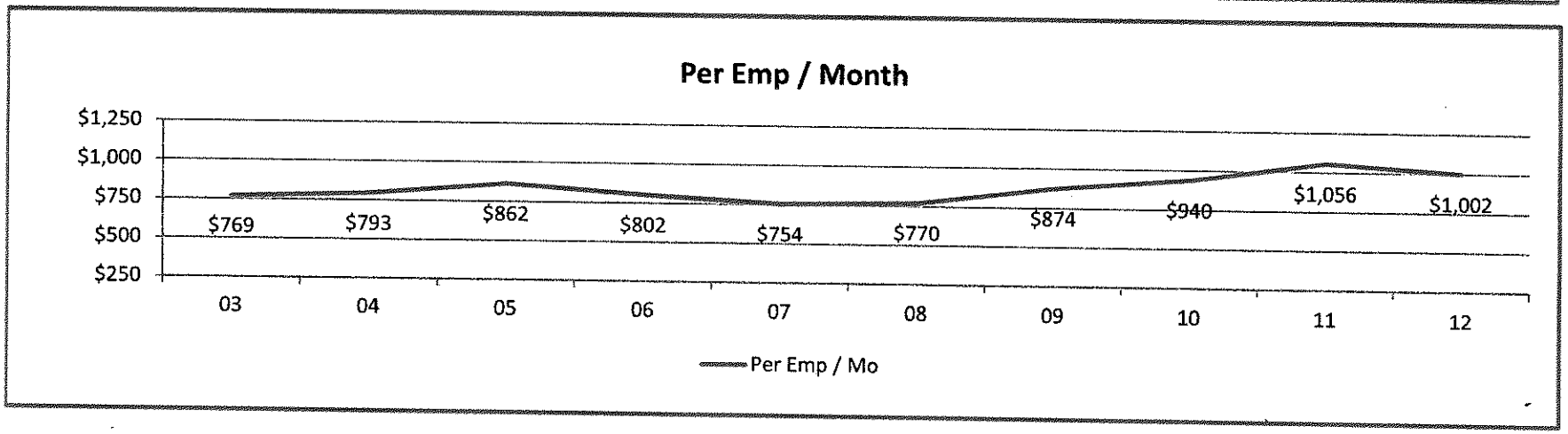
Re-insurance / Stop Loss

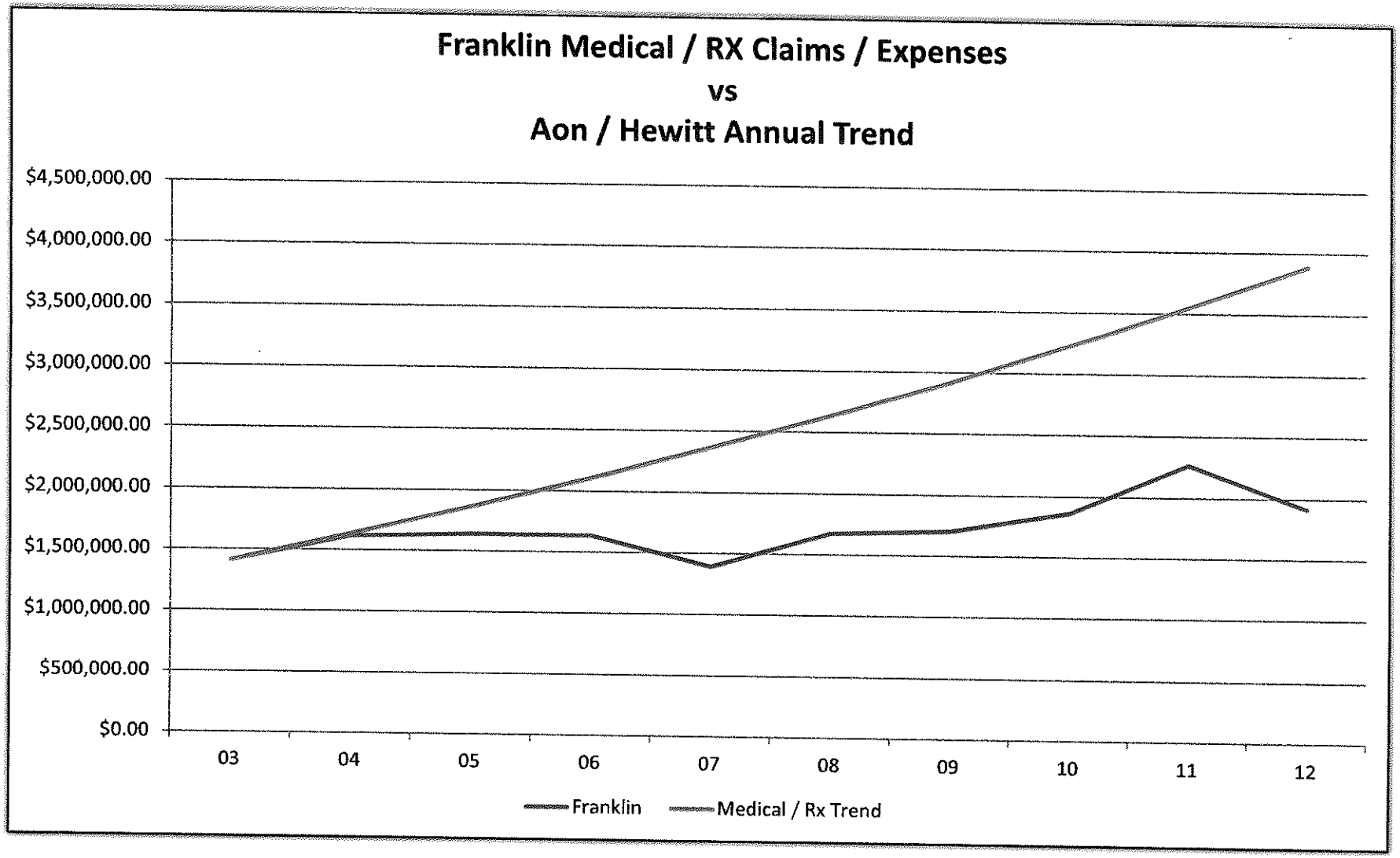
CITY OF FRANKLIN (1/1/2013 - 14)

		CURRENT Symetra Unlimited Lifetime Max				RENEWAL Symetra Unlimited Lifetime Max		ALTERNATIVE #4 Symetra Unlimited Lifetime Max	
SPECIFIC PREMIUM		($120,000 w/ $40,000 Corridor)				($120,000 w/ $40,000 Corridor)		($150,000 w/ $40,000 Corridor)	
Employee	39	$41.33	$19,342	Employee	39	$56.17	$26,288	$43.15	$20,194
Emp / Sp	37	$90.12	$40,013	Family	131	$126.50	$198,858	$99.78	$156,854
Emp / Chd	26	$67.79	$21,150	Composite	170	$110.36	$225,134	$86.79	$177,052
Emp / Fam	71	$123.60	$105,307						
	173		**$185,813**				**$225,146**		**$177,048**
ATTACHMENT FACTORS									
Emp	39	$542.11	$253,707	Emp	39	$523.79	$245,134	$533.47	$249,664
Emp / Sp	37	$1,181.79	$524,715	Family	131	$1,333.39	$2,096,089	$1,358.03	$2,134,823
Emp / Chd	26	$889.06	$277,387	Composite	170	$1,147.66	$2,341,226	$1,168.87	$2,384,495
Emp / Fam	71	$1,620.91	$1,381,015						
	173		**$2,436,824**				**$2,341,223**		**$2,384,487**
AGGREGATE PREMIUM									
	173	$10.47	**$21,736**		170	$10.59	**$21,604**	$12.34	**$25,174**
TOTAL FIXED PREMIUM COST			**$207,549**				**$253,257**		**$202,222**
MAXIMUM COST			**$2,644,373**				**$2,645,546**		**$2,586,709**

City of Franklin






Franklin Medical / RX Claims / Expenses
vs
Aon / Hewitt Annual Trend
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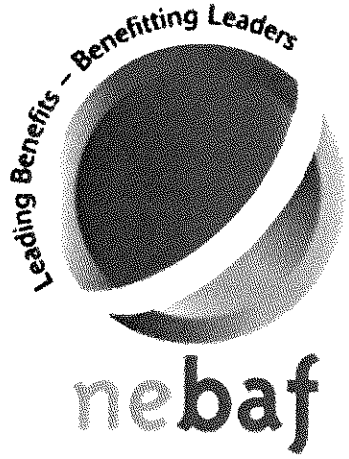
Franklin
Medical / Rx Trend

City of Franklin: *Total Expense Summary*

Year	Average Enrollment Emp	Fam	Admin	Insurance		Re-Insurance Reimburse	Paid Claims	Total Expense	Emp/Mo	% Inc
2012	40	130	$84,736	$245,425	**	$0	$1,713,493	$2,043,654	$1,002	-5%
2011	39	134	$95,828	$236,476	$	(184,895)	$2,044,147	$2,191,556	$1,056	12%
2010	44	131	$91,929	$243,258		$0	$1,633,888	$1,969,074	$940	7%
2009	46	124	$78,324	$240,723	$	(14,891)	$1,477,124	$1,781,280	$874	13%
2008	53	114	$71,384	$243,638		($211,418)	$1,436,542	$1,540,146	$770	2%
2007	48	115	$64,599	$230,447		($14,177)	$1,193,138	$1,474,008	$754	-6%
2006	44	118	$59,935	$197,879		($165,230)	$1,463,459	$1,556,043	$805	-7%
2005	33	133	$60,986	$201,401		$0	$1,456,253	$1,718,640	$862	9%
2004	37	127	$58,479	$168,967		($129,592)	$1,462,766	$1,560,621	$793	3%
2003	34	127	$55,458	$223,455		$0	$1,207,173	$1,486,086	$769	2%



Wellness Programs - Are They Worth Their Weight?

An overview of Workplace Wellness Programs; their return on investment; and current trends

National Employee Benefits Advisory Forum (NEBAF)

Methodology

The information presented in this paper has been compiled from multiple sources, including thought leadership studies and other material offered by and available on various stakeholder and industry websites.

Sources used are listed at the end.

Executive Summary

Workplace wellness programs present employers with one strategy for counteracting rising health care costs. Yet, over the years employers have not been quick to offer these programs; their rise in popularity has been a slow one. Many employers still seem to be questioning whether or not wellness programs are worth the investment.

This report discusses what wellness programs are, why employers utilize them, and what some of the challenges are.

- Workplace wellness programs can be any number of activities such as flu shots and health fairs offered by employers designed to promote healthy behavior in employees and their families.
- These programs aim to influence employee behavior – educating and motivating them to make healthy lifestyle choices. Healthier employees will in turn help employers lower health care premiums and decrease productivity losses.
- As with anything, wellness programs present challenges:
    - The success of a wellness program is heavily dependent on employees and their behavior. To reap the benefits of a wellness program, employers must achieve employee participation.
    - Measuring the success (or ROI) of these programs is difficult to do accurately and comprehensively.

This report also examines the topic of return on investment of wellness programs.

- Over the past two decades, research has been undertaken on the topic of ROI; most industry literature and research agrees that the typical return on a wellness program is $3 - $6 for every $1 invested, with savings realized 2+ years after implementation.

And, finally, this report presents current marketplace trends.

- The incidence of wellness programs has been growing over the past few decades – slowly but steadily. Not surprisingly, more large employers are offering wellness programs than small employers.

A Healthier State of Mind

First introduced in the mid-1970s, workplace wellness programs grew up as a result of various factors during that decade, such as an increasing cultural interest in fitness, the occupational health and safety movement, the growth and emergence of health promotion groups, and the industrial health care burden.

With the current national healthcare crisis and ever-rising health care costs, workplace wellness programs have become more and more mainstream in recent years as a business strategy to combat escalating healthcare costs.

What are Wellness Programs?

Wikipedia defines a workplace wellness program as a combination of educational, organizational, and environmental activities designed to support behavior conducive to the health of employees in a business and their families. Workplace wellness programs can take many shapes and size. Some examples of elements/activities of such programs include:

- Flu shots
- Wellness newsletters
- Health fairs or nutrition classes
- Cancer screenings
- Weight management programs
- Gym memberships
- Smoking cessation programs

Often employers evaluate the health profile of their employees and design wellness programs based on known diseases and/or characteristics of a certain population.

The Whys Behind Wellness

On the surface, it is fairly obvious that healthier employees will benefit employers (as well as society in general). When employees or their family members become sick, or chronically ill, employers are impacted in many ways, both directly and indirectly. Poor employee health affects a company's bottom line directly through its health care costs. Yet, it also impacts the bottom line indirectly through lower or lost productivity due to absenteeism (missing days of work) and presenteeism (not working or being productive while at work due to poor health, sleep deprivation, etc.). Turnover also becomes a cost if the employee is no longer able to work.

Both health care costs and productivity losses are very costly for employers, particularly during this recent economic downturn. Over the last decade, employer-sponsored health insurance premiums have increased 131 percent, and the average employer-sponsored

Resources for Wellness

Many resources are available and much information exists on the topic of Wellness and Wellness programs. Some of the most popular and widely used websites include:

The National Wellness Institute, Inc.: www.nationalwellness.org

Partnership for Prevention: www.prevent.org

U.S. Centers for Disease Control and Prevention (CDC): www.cdc.gov

The Wellness Council of America: www.welcoa.org

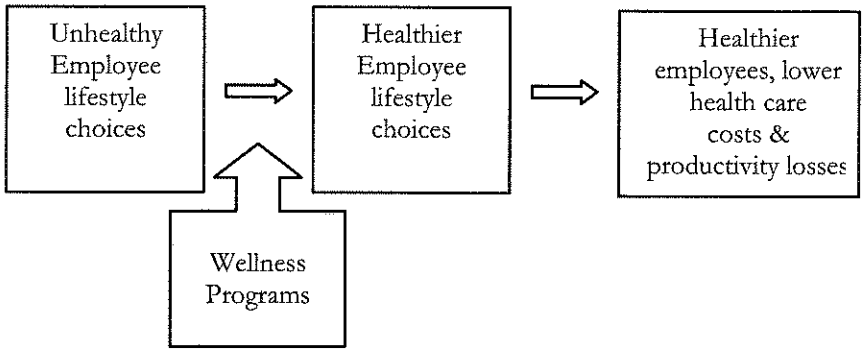
The Whys Behind Wellness (cont.)

premium for a family of four costs close to $13,400 a year[1]. According to the Partnership for Prevention, in 2008, U.S. employers spent nearly $26 billion per year or $1,685 per employee per year on productivity losses due to employee and family health problems.

The CDC estimates that more than 75% of employers' health care costs and productivity losses are related to employee lifestyle choices.

Excerpt from What's Holding You Back: Why Should (or Shouldn't) Employers Invest in Health Promotion Programs for Their Workers?: *"A large body of medical and epidemiological evidence shows the links between common, modifiable, behavioral risk factors and chronic disease. Employees with seven risk factors – tobacco use, high blood pressure, high cholesterol, overweight or obesity, high blood sugar, high stress and physical inactivity – cost employers 228 percent more than those lacking those risk factors."*[2]

Therefore, the logic is if employers can impact employee lifestyle choices, they can impact their company's health care and productivity costs. So, employers are proactively using wellness programs to help employees to be healthier and make healthier lifestyle choices.



The Challenges of Wellness Programs

Two areas present significant challenges for employers when undertaking these programs.

- **Employee participation:** The success of these programs are dependent on factors outside employers' control: employee adoption and maintenance of the healthy behaviors, employees keeping health risks low, employees not getting chronic diseases, and employees not leaving the company. A very important first step in workplace wellness programs is employee participation.

Spotlight: IBM's Global Wellness Initiatives

As the company states on its website: *"At IBM, we have long understood that investing in prevention and well-being makes sense for both our employees and our business. The company has identified employee health risk reduction and maintenance of low health risk as a key requirement under IBM's Well-being Management System. Wellness and healthy living are considered a company norm and employees are supported in this endeavor through IBM's wellness programs."*

The company introduced its reward-based wellness program 5 years ago. Today, the program is very well developed with an extensive portfolio of wellness offerings around the world. The use of technology is important for reaching the global, mobile workforce and also in allowing for customized country-specific programs.

IBM offers employees up to two $150 payments a year if they complete Internet-based assessments organized around healthy eating, exercise, overall health, and children's health. To earn payments, employees must meet specific requirements such as weight loss, diet change, or attainment of physical fitness goals, with each option.

Examples include: a $150 rebate available for workers who promise to engage in 30 minutes of physical activity three times a week for 12 weeks; and a $150 rebate for weight management and nutrition including keeping food diaries to increase consumption of fruits and vegetables.

[1] The Henry J. Kaiser Family Foundation. Employee Health Benefits: 2009 Annual Survey. September 2009.

[2] Goetzel, Ron Z., and Ozminkowski, Ronald J., "What's Holding You Back: Why Should (or Shouldn't) Employers Invest in Health Promotion for Their Workers?" North Carolina Medical Journal, December 2006, p. 429.

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Website of Healthy Government 2010: *www.healthypeople.gov*

Website of the National Wellness Institute, Inc.:
www.nationalwellness.org

Website of the U.S. Centers for Disease Control and Prevention (CDC): *www.cdc.gov*

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Wellness Council of America (WELCOA), May 2004

What's Holding You Back: Why Should (or Shouldn't) Employers Invest in Health Promotion for Their Workers? by Ron Z. Goetzel and Ronald J. Ozminkowski
North Carolina Medical Journal
Nov/Dec 2006, vol. 67, number 6

What's the ROI on Wellness? by John Carroll
Managed Care Magazine, February 2008

Worksite Health Promotion and Wellness: Affecting the Bottom Line
North Carolina Medical Journal
Nov/Dec 2006, vol. 67, number 6.

- **Employee participation (cont.):** Will employees participate in the wellness activities and will they take them seriously enough to modify their lifestyle choices? This is a significant challenge facing employers. PricewaterhouseCoopers conducted a recent study of 694 U.S. companies in a wide variety of industries and found that fewer than 40 percent of eligible employees actually enroll in their workplace wellness programs.
- **Measuring ROI:** As mentioned above, since there are both direct costs and indirect costs associated with wellness programs, return on investment (ROI) of such programs can be difficult to accurately and comprehensively measure. Also, every program and level of investment is unique to the employer; participation levels are unique; employee health and health outcomes are also unique. Many employers do not even attempt to measure program ROI. According to Hewitt's 2008 Investing in Health Survey, few employers have programs that include comprehensive reporting and accurate ROI assessment. Without measuring return, a program has no measure for success.

Tip- Health Insurance Portability and Accountability Act (HIPAA)

When creating and implementing Wellness programs, employers need to be sure that they fit within a number of legal boundaries; probably the most important of these are the nondiscrimination rules under HIPAA.

Very generally, HIPAA's nondiscrimination rules prohibit:

1) group health plans from denying an individual eligibility for benefits based on a health factor, and

2) group health plans from charging similarly situated individuals different premiums or contributions or imposing different deductible, co-payment or other cost sharing requirements based on a health factor.

However, there is an exception that allows plans to offer wellness programs (including varying deductibles, co-payments, etc.) if they meet some specific standards and criteria. To help employers navigate these legal waters, the Department of Labor (DOL) provides answers to frequently asked questions as well as a checklist of the rules and restrictions on its website.

What is the ROI on Wellness?

It's the big question on employers' minds: What is the ROI on workplace wellness programs? While employers realize that wellness programs are socially responsible, many are left wondering – are they worth the cost and/or investment to my organization?

Research has been conducted by various organizations and groups trying to answer exactly this question. It is commonly reported in the marketplace that for each $1 investment by an employer, a $3 - $6 return (in the form of cost savings) is realized 2 - 3 years after implementation.

In 2001, a review of more than 73 published studies found that employers saved an average $3.50 (due to reduced health care costs and absenteeism) for every $1 spent on work-based wellness programs.[3] In 2003, another literature review that analyzed 42 studies found that worksite wellness programs lead to a more than 25% reduction in absenteeism, health care costs, and disability/workers' compensation claims costs.[4]

These programs, for the most part, are still in their infancy for the mainstream, average employer, and more data and research are still needed on this issue. Yet, with health care costs predicted to continue to rise in the years ahead, these numbers are very encouraging.

[3] Aldana S.G., "Financial impact of Health Promotion Programs: A Comprehensive Review of the Literature," American Journal of Health Promotion, 2001: 15(5): 296-230.

[4] Chapman L. Meta-evaluation of worksite health promotion economic return studies. Art of Health Promotion Newsletter. 2003 Jan/Feb; 6(6): 1-10.

Slow & Steady Growth – With Large Employers Leading the Way

Although estimates vary, recent research suggests that workplace wellness programs are becoming more and more common, particularly among larger employers. Workplace wellness programs are growing at a slow but steady rate. Three recent studies report an increasing trend in wellness programs over the past few years:

- *Kaiser/HRET's 2009 Annual Employer Health Benefits Survey* reported that 58% of employers offering health benefits offer at least one wellness program, up from 27% in 2006.
- *MetLife's Seventh Annual Employee Benefits Trends Study* 2009 cited that 33% of employers are offering wellness programs, up from 27% in 2005.
- *PricewaterhouseCoopers' 2009 Health & Well-being Touchstone Survey* reported that 71% of employers offer wellness programs, up from 69% in 2008.

It's not surprising to find that large employers are largely driving this trend. All three studies report that more large employers are utilizing wellness programs than small employers are (see the table below). Please note each study defines large employers slightly differently.

Study	% Currently Offering	
	Large Employers	Small Employers
Kaiser/HRET's	93%	57%
MetLife's	61%	13%
PricewaterhouseCoopers'	78%	N/A

The Use of Incentives

Employers often offer incentives - both monetary rewards (e.g. cash bonuses) and non-monetary rewards (e.g. days off from work) - to employees. Incentives can be used to motivate participation in, completion of, and/or enrollment in the program or a certain aspect of the program.

The most commonly used incentives are: gift cards, premium deductions, cash bonuses, merchandise (t-shirts or movie tickets), and gym discounts. Incentive amounts usually range anywhere from $50 to $300 per employee.

Did you know?

Healthy People 2010 is a national health promotion and disease prevention initiative. The overall objectives of the program are to improve individual health and quality of life and also to eliminate health disparities between segments of the population.

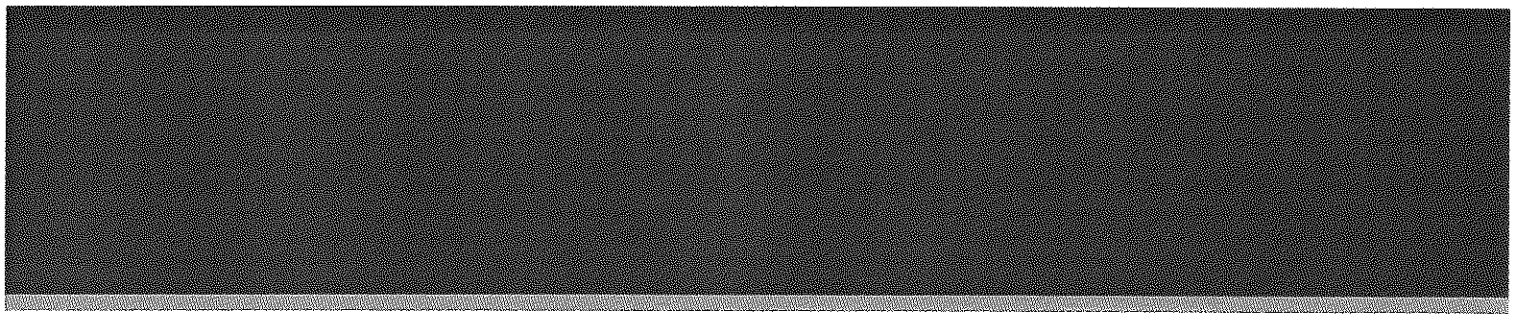
Two of the program's goals are specifically related to workplace wellness programs:

- Increase the proportion of all worksites that offer a comprehensive employee health promotion programs to their employees to 75%.
- Increase the proportion of employees who participate in employer-sponsored promotion activities to 75%.

What do Employees think?

According to the Employee Benefit Research Institute's *2007 Health Confidence Survey*, employees feel favorably about workplace wellness programs. The majority (82%) of employees surveyed report being strongly or somewhat positive about employer sponsored wellness programs overall.

The study results also reported that about three-quarters of employees think employers show concern for their workers when offering wellness programs, but about two-thirds feel employers are only concerned about their bottom line and nearly half say these programs intrude on worker privacy.



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We are continuing to invite Human Resource executives, Finance executives, Brokers, and Consultants to join the **National Employee Benefits Advisory Forum.** If you or someone you know is interested in joining, please visit www.NEBAF.org and click Join Us. Or, email us at nebaf @csr-bos.com for more information on how to join.

Patient Protection and Affordable Care Act Implementation Timeline

UMR
A UnitedHealthcare Company

2010

- Temporary high risk pool
- ERRP
- Small business tax credit
- Adult child coverage until age 26
- No pre-existing conditions for kids until age 19
- Rescissions prohibited except for fraud or non-payment
- Lifetime dollar limits prohibited
- Annual dollar limits restricted
- Preventive services with no cost sharing
- Pediatricians as PCPs, direct access to OB/GYNs
- ER coverage as in-network, no prior authorization
- Initial appeals review standards
- Part D rebate for beneficiaries in gap
- Online consumer information at healthcare.gov

2011

- Annual rate review
- Appeals ombudsmen and process documentation
- Increase penalty for non-qualified HSA withdrawals
- Small business wellness grants
- Annual fee on pharmaceutical manufacturers begins
- Discounts in Part D donut hole
- Non discrimination rules apply to insured plans (implementation delayed until regulations are released)
- Auto-enrollment for groups with 200+ FTEs implementation delayed until regulations released

2012

- Appeals provision fully implemented
- Uniform explanation of coverage and standard definitions
- 60 day advance notice of material modification
- Accountable Care Organization requirements
- Quality bonus begins for Medicare Advantage plans
- Comparative effectiveness fee imposed ($1 per member/year)
- Administrative simplification begins

2013

- Employee notification of access to Exchanges
- Employers to report value of employer-sponsored health benefits on W2s
- FSA contributions limited to $2,500
- High earner tax begins
- Annual fee on medical device sales begins
- Deduction for expenses allocable to Part D subsidy for qualified prescription drug plans eliminated
- Comparative effectiveness fee increases to $2 per member/year
- ICD-10 code adoption

2014

- Health benefit exchanges
- Guarantee issue and renewal rules
- No annual limits
- No pre-existing condition exclusions
- Rating restrictions
- Individual & employer mandates
- Tax credits and subsidies for individuals and small employers
- Standardized essential health benefits
- Waiting period limits
- Mandatory coverage for clinical trials
- Annual insurance industry tax
- OOP limits must comply with OOP limits for HSA qualified plans
- Deductible caps cannot exceed 2k for individual /$4k for family
- Coverage for all adult children until age 26, including those who have employer coverage (formerly not covered for grandfathered plans)

2015 & beyond

- States can open Exchange to all employers (2017) and CHIP eligibles (2015)
- High-value plan excise tax begins (2018)
- Insurance industry tax through 2018
- Medicare Part D Donut hole closed by 2020

2013

City of Franklin Group Health/Dental Enrollment Form

☐ New Enrollment ☐ Re-Enrollment ☐ Change

GENERAL INFORMATION

Employee Last Name	Middle Initial	First Name	☐ Male ☐ Female	Date of Birth	Marital Status
					☐ Single ☐ Divorced
Address Number and Street Including City, State and Zip			Phone Number	Social Security #	☐ Married ☐ Widow

OPT OUT ELECTION

I have other medical and dental insurance and want to "Opt Out" of the City of Franklin Group Benefit Program. I understand that I will receive additional compensation as long as as I qualify for the "Opt Out" Program ☐ I elect to Cash Opt Out of medical/dental coverage: $5.00 employer contribution per pay period to my Flexible Spending Account

You must attach proof of other medical insurance (copy of insurance card) Carrier/Policy #: ______________________

I attest that I am declining group health/dental coverage because I am currently enrolled in another group health or insurance coverage

Certification: I freely and voluntarily waive all coverage noted above: EE Signature: ______________________ Date: __________

Plan #1 ($500 Deductible)	Per Pay Period		Plan #2 ($250 Deductible)	Per Pay Period
☐ Employee Only	$15.00	**(26 pays)**	☐ Employee Only	$25.00
☐ Employee & Spouse	$20.00		☐ Employee & Spouse	$40.00
☐ Employee & Child/Children	$17.00		☐ Employee & Child/Children	$35.00
☐ Family	$26.00		☐ Family	$54.00

FAMILY MEMBERS TO BE COVERED – This Plan Allows Dependents Under Age 26 to Participate — Check Y or N for each member

Last Name First MI	Social Security #	Date of Birth Mo. Day. Yr.	Sex		Relationship		Full-Time Student		Enrolled in other health plan?	
			☐ M	☐ F	☐ Spouse		☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N
			☐ M	☐ F	☐ Child	☐ Step	☐ Y	☐ N	☐ Y	☐ N

Complete this section only if you checked yes that your dependant children above are enrolled in another health plan:

Name of Person Insured	DOB of Person Insured	Employer or Plan Sponsor	Other Insurance Company Name & Address

Tobacco-Free Credit: (only for employees enrolling in medical plan) ☐ Employee ☐ Spouse

$5.00 medical premium reduction if employee and spouse (if covered) have been tobacco-free for 6 months prior to enrollment and will remain tobacco-free for 12 months after enrollment. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reduction under this program, or it is medically inadvisable for you to attempt to achieve the reduction under this program, call us at 736-3609 and we will work with you to develop another way to qualify.

Signature (Only Sign if both you and your covered spouse are BOTH Tobacco-Free) Date:

2013

City of Franklin Group Health/Dental Enrollment Form

Spouse – Other Health Information

Spouse Currently Employed Full-Time

If your spouse is employed full-time and is eligible for health coverage at their employer, they MUST enroll, and that health plan will provide primary coverage. The may remain on City of Franklin's plan by the City plan will only apply as secondary coverage.

Spouse NOT Currently Employed Full-Time

If your spouse is not currently employed full-time but that status changes in the future and they become eligible for health coverage at their place of enrollment, they MUST enroll, and that health plan will provide primary coverage. In this event, you must notify the City of Franklin of this change within 30 days. They may choose to remain on the City of Franklin plan, but the City of Franklin plan will only apply as secondary coverage.

Currently No Spouse

If you currently have no spouse, but get married in the future, the above rules apply. In this event, you must notify the City of Franklin of this change within 30 days.

I understand the above rules of spouse eligibility for participation, and acknowledge that my failure to follow these rules may result in the loss of coverage for my spouse on the City of Franklin group benefit plan.

Signature (please sign, do not print or type) _____

Date Completed: _____ Employee name (please print): _____

- ❑ I am not married
- ❑ I am married – my spouse works full-time and is eligible for benefits at his/her place of employment
  Currently enrolled: ❑ Yes ❑ No
- ❑ I am married – my spouse works full-time and is NOT eligible for benefits at his/her place of employment
- ❑ I am married – my spouse is self-employed
- ❑ I am married – my spouse is not employed full-time or is not employed outside of the home

If applicable, please indicate name, address and phone number of spouse's employer:

Employer: _____

Address: _____

Phone _____

Insurance Co.: _____

Insurance Phone: _____

UTILIZATION REVIEW AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, or other provider of medical services or supplies and any insurer or reinsurer which has records or other information regarding any physical, mental, drug or alcohol condition or treatment of myself or of my dependents to release and provide such records or other information to UMR. I understand that UMR will use these records and other information for purposes of utilization review, pre-certification of hospital admissions, by my employer ("Plan"). These records will not be further released to the Plan sponsor, and to the insurer or reinsurer of the Plan or Plan sponsor as may be necessary for Plan administration or as otherwise required by law. I agree that a photographic copy of this authorization shall be as valid as the original. This authorization shall remain in effect until I revoke it. Unless revoked, this authorization shall remain in effect so long as I am covered under the Plan or make any claim there under.

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover my contribution for coverage.

Employee Signature: _____ Date: _____

****

To Be Completed by Employer

Hire Date: _____

Effective Date: _____

❑ New Enrollment ❑ Re-Enrollment ❑ Open Enrollment

❑ Reinstatement ❑ Cancellation

Change Reason

Date of Change: _____

❑ Name Change Formerly: _____

❑ Change Dependant Reason: _____

❑ Other Reason: _____