Self-Insured Health
Benefit Program

RESOLUTION NO. 913

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF REDMOND, WASHINGTON, ADOPTING THE SELF-INSURED EMPLOYEE HEALTH BENEFITS PROPOSAL

WHEREAS, the City of Redmond's Employee Benefits Committee has developed over a two-year period a proposal to self-insure employee health benefits, including medical, dental, and vision services; and,

WHEREAS, self-insuring employee health benefits has proven to be a successful and cost-effective method of providing these benefits in other cities; and,

WHEREAS, the City Council had previously considered and endorsed self-insurance for health benefits in their March 24 study session; and,

WHEREAS, the Redmond City Hall Employees Association, the Redmond Police Officers Association, the Washington State Council of County and City Employees Local 21-RD, and the Redmond Fire Fighters Union (IAFF Local 2829) have all endorsed the self-insurance proposal; now, therefore,

THE CITY COUNCIL OF THE CITY OF REDMOND, WASHINGTON, HEREBY RESOLVES AS FOLLOWS:

SECTION 1. Chapter 6--"Benefits", Section 6.40(1) "Basic Benefit", shall be amended to read as follows:

> The City provides a self-insured health benefit program, including medical, dental, and vision benefits, to regular employees as outlined in the proposal adopted by Resolution 913 of the Redmond City Council.

SECTION 2. The "Proposal for a Health Benefit Program for City of Redmond Employees" attached hereto as Exhibit 1 and incorporated by this reference as if set forth in whole, shall be adopted as the basic guideline for self-insuring employee health benefits.

SECTION 3. The effective date of self-insured health benefits adopted by this resolution shall be January 1, 1993.

RESOLVED, this 3rd day of November, 1992.

APPROVED:

MAYOR, ROSEMARIE IVES

Resolution No. 913

ATTEST/AUTHENTICATED:

Doris A. Schaible
CITY CLERK, DORIS A. SCHAIBLE

FILED WITH THE CITY CLERK: October 29, 1992
PASSED BY THE CITY COUNCIL: November 3, 1992
RESOLUTION NO. 913

EXHIBIT 1

PROPOSAL

For A

Health Benefit Program For City of Redmond Employees

Developed By

City of Redmond

Employee Benefits Committee

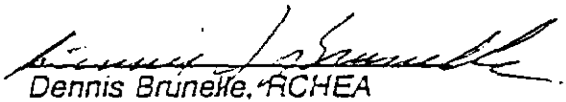
September 17, 1992

Resolution No. 913

Preface

The proposed health benefit program presented here is recommended for adoption by all the City's collective bargaining groups and City administration. The major recommendation includes the development of a self-insured health benefit program for City of Redmond employees and their dependents. This proposal was developed by the Employee Benefits Committee with the help of an outside consultant. The proposal is the result of a thorough assessment of the City's current health plans and an analysis of the most cost-effective and appropriate plan design and administrative features. The Committee believes that the proposal, in its entirety, represents the best possible effort to help contain long term health costs for the benefit of the City and all its employees.

Employee Benefits Committee Members:



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A. Summary of Health Plan Characteristics

It is proposed that City of Redmond will self-insure a high option and low option indemnity plan and offer a Group Health Cooperative option to its employees. A summary comparison of plan options is as follows:

Benefits	High Option	Low Option	GHC☆
Lifetime Maximum	$1,000,000	$1,000,000	Unlimited
Annual Reinstatement	$10,000	$10,000	NA
Annual Per Person Deductible	$100	$500	NA
Annual Family Deductible	$300	$1,500	NA
Co-insurance Rate	20%	20%	NA
Applicable Amount	Next $3,000	Next $3,000	NA
Maximum Out-of-Pocket	$700	$1,100	NA
Maximum Family Liability	$1,400	$2,200	NA
Optional Deductible Waiver	$100	$100	NA
Visit Co-pay	NA	NA	$5.00
Inpatient Hospital Services			
Hospital days (Semi-private)	Unlimited	Unlimited	Unlimited
Room & board	Semi-private*	Semi-private*	Semi-private
Ancillaries	As needed*	As needed*	As needed
Intensive care	As needed*	As needed*	As needed
Other in-patient charges	As needed*	As needed*	As needed
Maternity care	As needed[1]*	As needed[1]*	As needed
Hospital nursery charges	As needed*	As needed*	As needed
Surgical fees(UCR)	As needed*	as needed*	As needed
Physician visits	As needed*	As needed*	As needed
Out-Patient Services			
Emergency Room	$50 Co-pay[2]	$50 co-pay[2]	$25 Co-pay
Physician Services	As needed*	As needed*	As needed
Lab & X-ray	As needed*	As needed*	As needed

Benefits	High Option	Low Option	GHC
Physical Therapy	As needed*	As needed*	As needed
Mental Health			
Inpatient[3]	$10,000 Annual maximum* $20,000 Lifetime maximum	$10,000 Annual maximum* $20,000 Lifetime maximum	As needed
Outpatient	$500 annual maximum 50% co-insurance rate	$500 annual maximum 50% co-insurance	As needed
Alcohol & Substance Abuse			
Inpatient and outpatient[3]	$10,000 Annual maximum* $20,000 Lifetime maximum	$10,000 Annual maximum* $20,000 Lifetime maximum	As needed
Outpatient only[3]	$500 annual maximum 50% co-insurance rate	$500 annual maximum 50% co-insurance	As needed
Other Benefits			
Ambulance	As needed*	As needed*	As needed
Well Physicals	$150 limit[4]	$150 limit[4]	As needed
Prescription Drugs	As needed* Mail order option[5]	As needed* Mail order option[5]	As needed
Chiropractic	$150 annual maximum*	$150 annual maximum*	Not covered
Rehabilitation Services[6] (Inpatient only)	Maximum 30 days per condition	Maximum 30 days per condition	As needed
Vision[7]	$150 annual maximum	$150 annual maximum	As needed
Dental Care[7&8]	$1,000 annual maximum	$1,000 annual maximum	Not covered

☼ = Specific coverage features will depend on the contract entered into with GHC

* = After payment of deductible and co-insurance provisions and usual, customary and reasonable limits up to the 90th percentile for physicians and hospitals will be used.

[1] = Short stay maternity incentive of 5 homemaker aide visits if hospital stay is less than 48 hours.

[2] = Co-pay waived if patient is treated for an injury or if patient is subsequently admitted to the hospital.

[3] = Utilization of either mental health or alcoholism/drug abuse benefit maximums precludes coverage under the other benefit.

[4] = Limit applies to age specific periodic physicals, for specific provisions please see the section on health cost management features. Co-insurance feature does not apply.

[5] = For details on the mail order maintenance drug program please see health cost management features.

[6] = Under the care of a physiatrist(i.e., a rehabilitation specialist).

[7] = Deductible does not apply but co-insurance is paid at 80% of actual services performed. The amounts paid by the employee/dependent do not apply to the maximum out-of-pocket provisions of the plan. These coverages would be available as supplemental coverages for those who take the benefit waiver.

[8] = Routine cleanings and fillings would be paid at 100%.

B. Health Benefit Program Objectives

The suggested goals and objectives for the health benefit program for City of Redmond are as follows:

Overall Goals

1. *To ensure that all covered employees and their dependents have a basic level of financial protection from the routine and catastrophic costs associated with diagnosis and treatment of illness and injury.*

2. *To provide a health benefit program that provides reasonable levels of satisfaction and value to employees while remaining competitive within the City's labor market.*

3. *To provide long term stabilization of health benefit costs for both the City and for employees.*

4. *To provide a reasonable set of incentives for prudent use of health services and healthful lifestyle choices.*

5. *To provide the foundation and framework for significant long term improvement in the health status of employees, and dependents of the City of Redmond.*

Specific Objectives

1. *To maintain an average annual rate of total increase in indemnity plan costs of no more than 7% for the next five years.*

2. *To provide a wellness incentive cash payment to a minimum of 75% of employees each year.*

3. *To keep annual administrative costs of the indemnity health plans to no more than 9% of the total premium.*

C. Funding Arrangement

The following recommendations are made in relation to the funding status of the indemnity plans, the premium structure and the rating basis of the plans:

1. *It is proposed that the two indemnity plans be partially self-insured with a $75,000 specific claim excess loss policy.*

2. *The indemnity plans will be rated individually based on an initial estimation of their premium cost and then adjusted annually based on their experience or the minimum level of increase stipulated elsewhere in this document.*

3. *A multi-tiered premium structure will be used based on the following categories:*

   √ *Single employee*
   √ *Spouse*
   √ *First dependent*
   √ *Second & all other dependents*

4. *The City will provide an amount equal to the projected cost of the high option health plan for each premium type.*

5. *Employees may have an option to waive their health plan coverage for a lump sum annual incentive payment of $300. The entire difference between the $300 and the applicable premium amount will be placed in the incentive rebate pool. The employee must provide proof of adequate insured status under another employer's health plan and must agree to notify the city within ten working days of any change in coverage status and be enrolled in the City's health insurance coverage. Any repayment of the incentive amount by the employee will be based on the percentage of the benefit year expended by the time coverage under a City sponsored health plan is completed.*

6. *The possibility of retirees under the age of 65 enrolling in Group Health Cooperative while paying the entire premium themselves will be explored during the coming year.*

7. *Each year the City's total budgeted contribution for employee and dependent health benefit coverage will, at a minimum, be equal to the previous year's estimated actual expenditure determined at the end of the third quarter, plus an amount equal to 1/2 of the percent increase in the medical care component of the Metropolitan Seattle Consumer Price Index.*

8. *LEOFF I employees will be treated the same as all other employees except that their cost sharing will be maintained as legally required. All LEOFF I dependents of active employees will be treated the same as all other dependents. The entire retiree premium for LEOFF I retirees will be paid by the City.*

9. *Regular part-time employees will receive a pro-rated contribution from the City for their health benefit coverage based on the existing schedule. The remainder of the premium will be paid by the individual employee who desires health plan coverage.*

10. *Premium projections for the first year will be established by using the 1992 AWC premium rates for the comparable plans, multiplied by the proportion of the work force enrolled in each of the indemnity plans, and then added together to derive the total cost to the City. Premium levels for the two indemnity plans will then be estimated so that the entire amount of budgeted health plan expense will equal the amount derived from the use of the AWC 1992 rates plus 50% of the medical trend factor projected for 1993 for $100 deductible plans as reported in* ***Health Trend Report****, authored by Howard Johnson Co.*

11. *The City agrees to maintain a separate and distinct fund accounting of the finances involved in the health benefit program and that all savings and incentive amounts will be preserved to directly benefit the health of employees and their family members.*

D. Overall Plan Structure and Options

The health benefit options available to City of Redmond employees include:

Option # 1 — *A "High Option" indemnity plan using a comprehensive style plan structure, meaning that all cost sharing requirements apply similarly to all covered services.*

Option # 2 — *A "Low Option" indemnity plan using a comprehensive style plan structure with a higher deductible and higher out-of-pocket cost levels with identical benefits to the "High Option" plan. Those employees who select this plan will receive 1,000 extra bonus points for the incentive rebate program.*

Option # 3 — *Group Health Cooperative*

Option # 4 — *Waiver of benefits*

For any provisions not specifically addressed in the summary of the plan characteristics for the High and Low option plans, the applicable provisions of the Association of Washington Cities health plan option "A" will apply. Both of the proposed health plans will provide coverage which meets or exceeds the mandated coverage requirements of the Washington Administrative Code for employer health benefit coverage. Please refer to Appendix E for a complete listing of current state mandated benefit coverage requirements.

E. Health Cost Management Features

The recommended health cost management features of the health benefit program are as follows. Each of the recommendations will be discussed in depth.

1. *Prior-authorization*
2. *Mandatory Case Management*
3. *Mental Health & Substance Abuse Treatment Provision*
4. *Hospital & Medical Bill Correction Incentive*
5. *Short Stay Maternity Incentive*
6. *Well Physicals*
7. *Mail Order Maintenance Drug Program*
8. *Health Advice Line*
9. *Employee Wellness Program*
10. *Wellness Rebate Program*

1. *Prior-authorization*

Prior-authorization is required for all inpatient hospital stays. The failure to make a call at least 72 hours prior to admission or within 48 hours of an emergency hospital admission will result in a $300 compliance penalty. Approval of authorization for admission is valid for a three month period.

The types of issues which the prior-authorization or utilization management vendor will review are as follows:

- √ *a second medical or and/or surgical opinion is advisable*
- √ *hospitalization is medically necessary*
- √ *pre-admission testing is warranted*
- √ *outpatient surgery is warranted*
- √ *a week end admission is scheduled*
- √ *concurrent review or monitoring is necessary*
- √ *expected length of stay*
- √ *discharge planning is needed*
- √ *home health services are needed*
- √ *private duty nursing is advisable*
- √ *a clinical "center of excellence" will be considered*
- √ *a consulting specialist will be involved in the treatment planning*
- √ *the case will be assigned to a case manager and the responsible clinician so notified*
- √ *special provisions for the patients family will be arranged*

To the maximum extent possible the utilization management function will be carried out in a consultative rather than regulatory mode.

2. *Case Management*

All patients with diagnoses that have a clear potential to result in $10,000 or more in health claims will be assessed for possible referral to a case manager. The case manger will have the authority to waive health plan requirements where it results in the provision of higher quality and/or more cost-effective health care for covered beneficiaries.

Those individuals who meet their out-of-pocket maximums will be reviewed for optional use of case management services.

3. *Mental Health & Substance Abuse Treatment Provision*

The following provision apply to the use of mental health and substance abuse treatment benefit coverages.

A. Mental Health Benefits

1. *Provide for short term hospitalization for psychiatric reasons under the same cost sharing provisions which apply to medical reasons for hospitalization. This will provide a basic "safety net" for employees and dependents for short term acute psychiatric episodes.*

2. *The health plan, under its prior-authorization provision, will require advance notification to the utilization management vendor within 72 hours of an elective admission to the hospital. Notification within 72 hours after admission is required in the event of an emergency admission. If notification could have been made and was not, the employee or the employee's family will be required to pay a $300 compliance penalty. Exceptional circumstances can be considered for a waiver of the penalty.*

3. *Provide coverage for partial hospitalization and day treatment programs under this benefit.*

4. *After the 14th day of confinement initiate a case management process through the utilization management vendor.*

5. *Include outpatient mental health services under the deductible provisions of the health plan.*

6. *Provide coverage for an annual maximum of $500 for outpatient mental health services for all individuals covered under the health plan.*

B. Substance Abuse Benefits

In order to provide a cost-effective alcohol and drug abuse benefit, it is necessary to do the following:

1. *Provide for short term hospitalization for detoxification reasons under the same cost sharing provisions which apply to medical reasons for hospitalization. This will provide a basic "safety net" for employees and dependents for short term acute drug toxicity episodes.*

2. *Provide for a maximum of 2 treatment cycles per lifetime with a maximum of $10,000 per year applied to both inpatient and outpatient services. The use of a $20,000 lifetime limit for substance abuse provides an adequate level of resources for treatment. One treatment cycle should be no less than 24 months in length with a minimum of 12 months between the end of one treatment cycle and the beginning of the second. This 12 month "waiting period" can be waived for patients under 18 years of age.*

3. *If City of Redmond, in the future, experiences more than 5 alcohol and/or 5 drug treatment cases total, per year with different employees or family members, it may be appropriate to identify an exclusive provider organization(EPO) which can*

provide treatment to either adults or adolescents or arrange for an EPO for each of the two kinds of treatment situations. EPOs should be selected based on their episode of treatment total costs, emphasis on intensive outpatient therapy, aggressive follow-up, linkage to Alcoholics Anonymous and other "12 step programs" which provide social support, adequacy of staffing patterns and low recidivism or relapse rates for patients who utilize the services of the provider.

4. *Limit all inpatient treatment programs to a maximum of 14 days with a requirement for a minimum of 3 months of intensive out-patient follow-up treatment and strongly encouraged involvement in a "12 step program".*

5. *Under the prior-authorization provision of the two health plans, notification of the utilization management vendor within 72 hours of an elective admission or 72 hours after an emergency admission to the hospital or treatment facility is required. If notification is not made, the employee will be required to pay a $300 penalty.*

6. *Provide coverage for partial hospitalization, day treatment and intensive outpatient therapy programs as part of a plan of treatment.*

4. *Hospital & Medical Bill Correction Incentive*

It is recommended that a hospital bill correction incentive be added to both indemnity plans in order to reduce health plan expenses by having employees detect errors in hospital and medical bills and to increase their cost-sensitivity to health plan expenditures. The program would provide employees with a cash payment of one half of the amount of an error found in their own or their dependent's hospital bill. The minimum size of the incentive payment is $25 and the maximum size is $500. Employees must submit to the Human Resources Department the original bill and the corrected bills highlighting the error.

5. *Short Stay Maternity Incentive*

The short stay maternity incentive provides 5 homemaker aide visits for those maternity patients whose length of hospital stay in routine maternity cases is under 48 hours. The feature is designed to provide an incentive for shorter routine maternity stays. The total per case reimbursement under this provision will not exceed $250 per patient care episode.

6. *Well Physicals*

The recommended structure for periodic Well Physicals is as follows:

A. *Identify a separate category of covered services under the two indemnity health plans named "Well Physicals".*

B. *Provide the following categories of preventive services and corresponding coverage guidelines:*

1. ***Well Child Visits and Immunizations*** *(i.e., separate visits from acute care needs)*

 √ Seven visits between birth and 2 years of age
 √ Three visits between 2 and 6 years of age
 √ Two visits between 6 and 18 years of age

2. ***Well Adult Physicals***

 √ One visit every five years for ages 18 - 50
 √ One visit every other year for ages 50 - 64
 √ One visit every year for ages 65+

3. ***Cervical Cancer Screening(PAP Smears)***

 √ Provide coverage for annual PAP smears.

4. ***Breast Cancer Detection***

 √ Provide coverage for one medical visit per year for women 35 or older for an annual clinical breast exam.

 √ Provide coverage for mammography every two years between the ages of 50 and 75.

Note: These preventive screening coverages and guidelines meet or exceed those recommended by the U.S. Preventive Health Services Task Force in their report ***Guide to Clinical Preventive Services****, 1989, pp. 419.*

E. *Place a maximum reimbursement limit of $150 per well adult visit including all laboratory and x-ray procedures with the patient responsible for any of the charge or cost above $150.*

F. *Provide written recommendations concerning preventive medical screening to employees based on the recommendations contained in the publication* ***Guide to Clinical Preventive Services****.*

G. *Include in the employee wellness program selective preventive screening tests to be incorporated into the mini-wellness assessments to be conducted at the work site.*

7. ***Mail Order Maintenance Drug Program***

Provide a mail order maintenance drug program options to all employees and retirees. Provide for up to a ninety day prescription and require a $5 co-payment per prescription for generic drugs and a $10 co-pay for brand name drugs. This program is intended for use only with maintenance drugs. All non-maintenance prescription drugs would be covered under the basic provisions of the health plans.

8. ***Health Advice Line***

Provide the CareWise program from Employee Managed Care Corporation, of Bellevue to all employees and retirees covered under the City's health benefit program. This includes an advice line and periodic workshops for employees, and a periodic newsletter.

9. ***Employee Wellness Program***

The existing employee wellness program will be expanded with a funding level of approximately $50 per employee per year. Appendix E contains a recommended draft version of an expanded wellness program for City of Redmond employees and their family members.

10. ***Wellness Rebate Program***

A wellness rebate program will be established which has the following features:

- √ *Provide cash payments to employees based on their use of health plan benefits and healthy lifestyle choices.*
- √ *Organize the program consistent with the description provided in Appendix C.*
- √ *Offer a "Wellness Bonus Point" option for all employees, including the GHC enrollees and those who utilize the benefit waiver, that provides up to 1500 points for the eight wellness achievements identified in Appendix D.*
- √ *Place in the incentive pool, one half the difference between actual and expected claims expense and the entire difference between the premium amount for those who waive their health benefit coverage minus the incentive amount of $300.*

F. Plan Administrative Features

The following are the major administrative features recommended for both indemnity health plans.

1. *A plan eligibility clause*
2. *A pre-existing condition clause*
3. *A coordination of benefits clause*
4. *A subrogation clause*
5. *A medical necessity clause*
6. *A mediation requirement clause*
7. *A claims appeal and adjudication clause*
8. *A plan conversion and continuation clause*
9. *A claims review & analysis protocol*
10. *A periodic claims audit and restitution agreement*

11. *A non-discriminatory intention clause*
12. *A large hospital bill audit requirement*
13. *On-going review by benefits advisory committee*

1. ***Plan Eligibility Clause:***

The plan eligibility clause will identify the characteristics of the employee who is eligible for coverage under the two self-insured health plans. The effective date of employment or no later than the first day of the following month will be the date of beginning of coverage. An exclusion clause for those on disability at the time of enrollment date will also be included. Family relationships will be detailed as including marital status, residence, source of financial support, student status, mental status and age.

2. ***Pre-Existing Condition Clause:***

Benefits for treatment of pre-existing conditions will be provided only after the patient has been covered under this plan for six consecutive months. Benefits for treatment of tonsils and adenoids will be provided only after the patient has been covered under this plan for six consecutive months. This clause will not apply to the initial conversion to the City's self-insured health plan or to individual conversion from Group Health Cooperative coverage during open enrollment periods in future years.

3. ***Coordination of Benefits Clause:***

The coordination of benefits (COB) provision will mirror the recommended provisions of the National Association of Insurance Commissioners(NAIC) Ideal COB regulations. A provision will also be added that prohibits another health plan from placing primary responsibility for payment in cases where it contravenes the NAIC provisions. The claim form used by the plan will contain a clear disclosure statement with requests for birth dates of plan principles in order to comply with the "birthday rule" aspect of the NAIC recommendations. In the event of coordination of benefits between two health plans, the out-of-pocket cost sharing provisions of this plan will remain in effect.

4. ***Subrogation Clause:***

This clause will provide the legal basis for litigation in the event that other insurance coverage is in effect or where there is collateral responsibility for the health condition or a judgement has been made in relation to the illness or injury involved. This provides a basis for legal recovery of medical expenses for those covered under the health plan.

5. ***Medical Necessity Clause:***

The medical necessity clause will state that health plan benefits will only be provided when it is deemed medically necessary for the diagnosis and treatment of disabilities or conditions arising from illness, injury or pregnancy. This provision provides the basis for medical review of questionable situations and will be conducted through the utilization

management activities of the plans.

6. ***Mediation Requirement:***

In the event of a potential medical malpractice circumstance, all employees and family members are required to first submit to formal independent mediation in the event that an "untoward" medical event occurs that has the potential to result in a liability or malpractice case. The mediation clause will require the conduct of mediation within three months of the notification of the employer. The City will appoint a mediator for each case. This provision is designed to help reduce the potential of liability claims made against providers under the plan's auspices and to help reduce the long term "defensive medicine" practices of providers.

7. ***Claims Appeal & Adjudication Process:***

Covered beneficiaries under the health plan will have an appeal process that can be utilized in the event that there is a major disagreement between the beneficiary and the claims payor concerning payment of covered plan benefits. The process will be conducted within 45 days of the employer's receipt of the request for a reconsideration of the TPAs decision. The minimum amount that can be appealed will be $100.

8. ***Plan Conversion and Continuation:***

In accord with conventional practice and with requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA) this clause identifies who is eligible for conversion and/or continuation of medical benefit coverage in a post-employment status, the circumstances under which they are eligible and the period of time, actions and financial requirements for such conversion and/or continuation. The COBRA provisions will meet all current legal requirements.

9. ***Claims Review & Analysis Protocol:***

This protocol will lay out the parameters of the claims review process, the timing of the review process, the procedures for adjudication of inappropriate claims and the rights of recovery for the claims administrator on behalf of the interests of the City. Included in the claims reviews review process will be such things as: eligibility of beneficiary, dates of care, pre-existing condition nature, appropriateness of coding and procedures, errors in calculations, completeness of information provided, prevention of duplicate payments and several other issues in order to ensure the appropriate adjudication of each claim.

10. ***Claims Audit & Restitution Agreement:***

This agreement identifies the timing, focus and procedures to be used in auditing the claims payor. Recovery or restitution of amounts found in error is also addressed in this

agreement. Typically this will include the timing, sampling methodology, review criteria and process for determining restitution and conditions of recovery at a minimum.

11. ***Non-discriminatory Intention:***

This clause makes a formal statement as to the intention that the health plan has been designed and is being implemented in a manner that does not discriminate against any individual or group of individuals. This statement is intended to help meet the Internal Revenue Service Code requirements regarding the non-discriminatory basis of applicable employee health benefit programs and any Americans with Disabilities Act (ADA) requirements.

12. ***Large Hospital Bill Audit Requirement:***

All hospital bills over $5,000 will be routinely reviewed by the third party administrator for computational errors, errors in billing for services and supplies, inappropriate charges based on the clinical needs of the patient, non-covered services and over-charges.

13. ***On-Going Review By Benefits Advisory Committee***

The Benefits Advisory Committee will met at least quarterly to review the status of the health benefit program and to make advisory recommendations to the City concerning the structure, characteristics and administration of the City's employee benefit programs.

G. Exclusions and Limitations

The general exclusions and limitations contained in the Guardian Medical Plan offered by the Association of Washington (AWC) Cities Employee Benefit Trust will be incorporated in both health plan indemnity options offered by the City with three modifications as follows:

1. *Hospice care may be included under case management for individuals whose medical conditions are judged to be terminal within a six month period.*
2. *Hearing aids will be covered under the two health plans if all of the following are requirements are met:*
   a. *Referral must be from a physician;*
   b. *Up to a maximum of $900 per ear within a four year period;*
   c. *No maintenance fees are eligible for payment;*
   d. *No batteries are included;*
   e. *On-the-job injuries are not subject to the limitations above, but will be reviewed on a case by case basis.*
3. *No coverage will be provided for vitamin and food supplements prescribed for the treatment of obesity and related disorders.*

Appendix A

Proposed Self-Insurance Fund Structure

The City will establish a Health Fund to account for the revenues and expenditures of the health benefit program described in this proposal.

Health Fund

Revenues — *Revenues for this dedicated fund will include the following:*

- √ *Premium income for both the high option and low option plans, including premiums for employees who have waived health benefit coverage.*
- √ *Premium deductions withheld from Group Health Cooperative participants and part-time employees.*
- √ *Interest earnings*

Expenses — *Expenditures from the health fund will include:*

- √ *Employee waiver payments*
- √ *Claims payments*
- √ *Group Health Cooperative premiums*
- √ *Administrative expenses including:*
  - *Third party administrator (TPA) fees*
  - *Stop-loss insurance premiums*
  - *Broker/consultant fees*
  - *Informational materials*
- √ *Utilization management review services*
- √ *Health advice line fees*
- √ *Wellness program activities*
- √ *Employee assistance program (EAP) payments*
- √ *Other expenses as necessary to administer the health plans*
- √ *1 1/2 % of premium will be placed in the General Reserve Fund each month the first year and 1 % of premium in subsequent years.*

General Reserve *The General Reserve will be used for two purposes:*

- √ *To provide for incurred but not reported(IBNR) claims should the City decide to convert to an insured status for indemnity health plans.*
- √ *To pay claims if there are insufficient revenues in the Health Fund.*

Additionally, in 1993 only, the General Reserve may be used if necessary to supplement the employee incentive rebate payments to assure that such payments, when combined with the Fall Back Reserve, will average $50.

Contributions to the General Reserve will be made in two ways. First, from the Health Fund. Second, by appropriating the City's portion of one half the difference between actual and expected claims experience from the health plans.

The General Reserve funding level objectives are to have the equivalent of 25% of total premiums in reserve by the end of the first year, and 50% of total premiums in reserve by the end of the fourth year of operation.

Fall Back Reserve *This reserve account will contain $10,000 of specialized reserves that will only be used if the actual claims and administrative costs under the self-insured plans are greater than available revenues. This amount will provide incentive rebates in the event that claims expenses are inordinately high.*

Appendix B

Description of Wellness Rebate Program

Overall Description

This incentive rebate program will provide a cash based incentive payment to City of Redmond employees based on their health claims experience and is intended to help re-orient incentives around the use of health services and to strengthen the City's employee wellness program. In incentive rebates such as the one recommended here, the particular target behaviors include encouraging wiser use of health services and through the use of a wellness incentive option, the adoption and maintenance of more healthy lifestyle behaviors and participation in City sponsored wellness program activity. The rebate component of this formal incentive system involves an annual cash payment to participants based on both the overall group and their own individual health claims performance and wellness choices. This incentive program is proposed to be used each year for an indefinite period of time. The major components of the incentive rebate program include:

- A. *Advantages and disadvantages*
- B. *Recommended objectives for the program*
- C. *The incentive pool*
- D. *Employee account structure*
- E. *Accrual and depletion rules*
- F. *Recommended payback strategy*
- G. *Recommended design refinements*
- H. *Communications plan and implementing documents*
- I. *Strategies for reducing potential adverse effects*
- J. *Evaluation recommendations*
- K. *Summary*

A. Advantages and Disadvantages

The advantages and disadvantages of the wellness incentive program proposed here are summarized as follows:

Disadvantages

- √ *It's a new approach that requires risk taking and a break with convention.*
- √ *If not designed and communicated well, it has the potential of adversely affecting health by causing a delay in seeking medical advice.*
- √ *It requires additional administrative capability.*

Advantages

- √ *It ties together health status, health care use, health benefits use, lifestyle choices, and employee salary/wages and employee attitudes.*
- √ *It is flexible.*
- √ *It shifts employee attitudes toward their benefits from consuming to conserving.*
- √ *It provides a strong incentive to adopt and maintain healthy lifestyle choices.*
- √ *It simplifies the administration of multiple incentives into one core incentive plan.*
- √ *It is financially self-sufficient because it rebates savings and therefore pays for itself.*
- √ *It provides an opportunity for an upbeat improvement in human resources management.*
- √ *It allows employees to be paid for being well.*

B. Recommended Objectives for the Program

The recommended objectives for the Wellness Rebate are as follows:

1. *To be implemented fully during the next plan year.*
2. *To distribute flyers describing the program during the first month of the new plan year.*
3. *To provide quarterly status reports to all employees within 3 weeks of the end of each quarter.*
4. *To have a minimum of 55% of employees request optional wellness bonus points during the first year of the program.*
5. *To provide wellness bonus checks to no less than 80% of the employee work force during the first program year.*
6. *To provide an average wellness bonus of $150 to $250 to those who receive checks.*

C. The Incentive Pool

In establishing a financial incentive pool for distribution to employees, it is recommended that one half of the difference between actual and expected claims be used. The other half should be retained by the City and kept in a reserve account to provide investment income for funding the employee wellness program in future years. In terms of the probable size of the incentive pool, ideally, it should be large enough to provide an average payment of $200-$300 for those who

receive a cash payment. The recommended form for the basic incentive includes providing a point to each employee for each dollar put aside to cover their or their family's health plan expense. A point is then subtracted from their wellness account for each claim dollar paid under their health plan coverage for themselves or for a covered family member. Wellness bonus points are optional and may add points to their account. At the end of the benefit year, all the points in all the employee wellness accounts are totaled and divided into the amount of dollars in the incentive pool. Each point then takes on a monetary value and the amount to be rebated is determined by multiplying the number of points in an individual's account times the value of each point. This produces the amount of the individual employee's wellness bonus check. In order to be conservative it is recommended that the City seek legal counsel as to the tax status of the cash incentive amount.

D. Employee Wellness Account Structure

An individual employee Wellness Account should be maintained for each eligible employee regardless of his/her family structure or plan enrollment. The individual employee accounts will be used to relate the overall group claim performance to the individual employee's claim experience. For those who have chosen to waiver their medical plan coverage, they will not receive any points in, or points out, due to claims use but they may qualify for wellness bonus points. These employees will be able to apply for the Wellness Bonus points and receive a wellness bonus check based on the number of points they qualify to receive. The same is suggested for those who elect Group Health Cooperative coverage.

Again, at the end of the benefit year, the amount in the incentive pool is divided into the sum total of all the points contained in all the employee wellness accounts. This will establish a "cents per point" value for each point. This amount is then multiplied times the number of points in the account in order to determine the amount of the cash rebate.

E. Accrual and Depletion Rules

Each individual employee receives one point in his/her account for each premium dollar set aside to cover his or her potential health claims cost under the two self-insured health benefit plans. If the City decides to move to a mini-flex or maxi-flex , the premium amounts will be established each year based on the amount of benefit credits available to cover the cost of the premium under any future flex plan arrangements.

For each dollar of health claims paid on behalf of employees or covered dependents by the City for care provided to the employee or an eligible family member, a point is withdrawn from their account. Employees with larger families get more points from the higher family premiums under the recommended multiple tiered premium structure, but also have more potential liability for health service use due to the larger number of family members under the health plan. This design feature therefore provides an incentive for wise use of health services by dependents as well as employees. If total annual claims costs for a particular employee exceeds the premium set aside for that individual, and there are no wellness bonus points requested and awarded, his/her account is zeroed out and no rebate payment is provided for that year. If wellness bonus points are requested and awarded, the individual will receive the proscribed size of cash reward based on the number of wellness points awarded times the value of each wellness point.

F. *Recommended Payback Strategy*

It is recommended that the following payback strategies be implemented:

1. *That quarterly reminders with individual account status be provided to each employee by the third part payer.*
2. *That the wellness bonus checks be provided on separate check stock that is a different color than the regular warrants used by the City.*
3. *That the plan year be changed to end on December 31, so that the incentive checks can be given out during the first quarter of the following year.*
4. *That any employee that requests and is awarded wellness bonus point will receive a check.*
5. *That wellness bonus points will not be reduced by health claims expenses.*

G. *Design Refinements*

The following incentive design refinements are recommended for the City of Redmond's wellness incentive program:

1. *It is recommended that all identifiable preventive services not be excluded from the wellness account point totals of employees, including: such services as, periodic physical exams, well child care, immunizations, mammography and pap smear claims costs. The International Classification of Disease (ICD) codes and Current Procedural Terminology (CPT) codes that would clearly be defined as preventive care are as follows:*

   International Classification of Disease(ICD):

89.7	*General Physical Examination*
99.31-99.54	*Immunizations*

   Current Procedural Terminology(CPT)1992:

   Preventive Visits

   New Patients

99381	*New Patient Preventive Visit (age under 1 year*
99382	*New Patient Preventive Visit (age 1 through 4 years)*
99383	*New Patient Preventive Visit (age 5 through 11 years)*
99384	*New Patient Preventive Visit (age 12 through 17 years)*
99385	*New Patient Preventive Visit (age 18 through 39 years)*

99386	*New Patient Preventive Visit (age 40 through 64 years)*
99387	*New Patient Preventive Visit (age 65 years and over)*

Established Patients

99391	*Established Preventive Visit (age under 1 year*
99392	*Established Preventive Visit (age 1 through 4 years)*
99393	*Established Preventive Visit (age 5 through 11 years)*
99394	*Established Preventive Visit (age 12 through 17 years)*
99395	*Established Preventive Visit (age 18 through 39 years)*
99396	*Established Preventive Visit (age 40 through 64 years)*
99397	*Established Preventive Visit (age 65 years and over)*

Individual Counselling

99401	*Individual counselling on risk factor reduction (15 minutes)*
99402	*Individual counselling on risk factor reduction (30 minutes)*
99403	*Individual counselling on risk factor reduction (45 minutes)*
99404	*Individual counselling on risk factor reduction (60 minutes)*

Other Preventive Medicine Services

99420	*Administration and interpretation of an HRA (e.g. health risk apprisal)*

Mammography

76090	*Mammography (Unilateral)*
76091	*Mammography (Bilateral)*
76092	*Screening mammography (Two view film study of each breast)*

PAP Smears (e.g. Papanicolaou)

88150	*PAP Smear (Requiring technician only)*
88151	*PAP Smear (Requiring physician interpretation)*

90701-90742 *Immunizations*

These are the only codes recommended for exemption from being deducted from the employee's wellness account.

2. *In future years, it is recommended that the City seek to expand the incentive rebate program by adding other self-funded and modifiable budget items such as worker compensation expense, disability coverage, and/or sick leave absenteeism. If these can be added over time to the pool, it will strengthen the incentive effect for healthy lifestyles and help shift the incentives around the use of these programs.*

3. *It is recommended that the City modify some of the wellness bonus points attached to each activity/behavior according to each year's health and wellness priorities.*

H. Communications Plan and Implementing Documents

The following is the recommended communications plan and implementing documents for the incentive rebate program for City of Redmond.

Document Name		***Function and Timing***
Employee Flyer/Brochure	√	*Describe the incentive program and distribute to each employee during the first month of the plan or at employee orientation meetings for the health benefit plan changes. Also place this brochure in the orientation packages given to new employees.*
Employee Quarterly Statement Format	√	*Report current status of employee's wellness account to the employee on a quarterly basis. The TPA should provide these reports and distribute them through inter-office mail.*
Wellness Bonus Points Declaration Page	√	*Formal request for Wellness Bonus Points a copy of which is included in the following Appendix. This should be distributed two months before the end of the benefit year.*
Employee Poster Reminder	√	*To remind employees of the incentive program and to catch their eye by using bright colors while rotating the posters.*
Employee Payroll Stuffer and Claims Insert	√	*To remind employees of incentive program by inserting this 1/3 page size reminder into payroll envelopes a month before the wellness bonus point options become possible to request.*
Employee Education Visuals	√	*For making presentations on the incentive program to employees at orientation meetings and briefings.*
Evaluation Plan for Incentive Program	√	*To evaluate employee reactions and the impact of the incentive program.*

I. Strategies for Reducing Potential Adverse Health Effects of Wellness Rebate Systems

Even though no report of adverse health effects have ever been associated with incentive rebate programs, it is appropriate that some precautions be taken. In order to minimize any potential untimely delay in seeking medical attention due to the presence of a financial incentive, it is recommended that the following steps be taken to help eliminate any potential adverse effects:

1. *Keep the size of the average rebate payment at a moderate level. A rough approximation for the average sized rebate would be between $150 to $250. This would tend to keep the stakes low enough not to discourage seeking medical attention when appropriate.*

2. *Educate and remind employees of key symptoms which are often associated with more serious medical conditions, such as, early cancer signs, kidney disease, neurological problems, or endocrine system disorders. A series of key symptoms to watch can be provided to employees along with some of the recommended preventive screening services that are appropriate for their age, sex and risks.*

3. *Conduct annual training for employees in medical self-care and provide some a basic self-care references to employees such as that distributed to employees at the October 31, 1991 Medical Self-Care workshop.*

4. *Establish an employee health lending library which contains a variety of medical reference books and continue to promote its use by employees.*

5. *Periodically screen employees for some of the medical conditions that clearly benefit from early detection and those that employees would tend to ignore, such as, hypertension, colo-rectal cancer screening, and cholesterol levels.*

6. *Monitor claims data for indications of late stage diagnoses that can be correlated with delays in seeking medical attention.*

7. *Exclude claims for preventive services from the reduction of employee account point totals.*

8. *Concentrate some of the employee communications on medical conditions where early intervention makes a significant difference in the course of the disease.*

9. *Provide a health consultation opportunity through the CareWise Program, to assist employees in determining when it is appropriate to seek medical attention.*

J. Recommendations for Evaluation

In order to evaluate the Wellness Rebate program the following evaluation efforts will be conducted:

1. *A formal review of the status of the program's objectives will be made on a quarterly basis and the summary will be circulated to key managerial staff. An annual summary of the status of program objectives will also be prepared and circulated.*

2. *A set of summary statistics will be prepared including numbers of individuals receiving wellness bonus checks, the distribution of recipients by check size, and the frequency of individuals receiving points for specific wellness achievements will be prepared within two months of the distribution of the wellness bonus checks.*

3. *Two separate end-of-year evaluation surveys will be sent to a random sample of 50 non-participants in the wellness bonus points option and 50 participants (i.e., those who requested and received wellness bonus points from the program) within two months of the end of the*

benefit year. The results will be tabulated into averages and frequency distributions for each response. Open-ended questions will also be placed in a frequency distribution.

4. *A 7 to 15 page evaluation report will be completed by three months from the end of the benefit year, summarizing the status of achievement of the program's objectives and the findings and conclusions from the evaluation questionnaires.*

K. Summary

This proposed incentive rebate program is designed to introduce a major change in the incentives that guide consumer decision-making in the use of health services and the adoption and maintenance of healthy lifestyle choices for employees and their family members. The program will be reviewed periodically by the Benefits Advisory Committee.

Appendix C

Description of Wellness Incentive

In order to create an incentive for healthy lifestyle behavior and choices in addition to the wise use of health service objective of the incentive rebate program, it is recommended that the City offer employees an opportunity to receive additional wellness bonus points for specific healthy lifestyle choices. The optional activities or behaviors to be incorporated into the wellness bonus point option and their suggested point values are as follows:

Activity/Behavior	Possible Points
☞ Participate in the mini-wellness assessments	200
☞ Attended a Medical Self-Care workshop put on by City within the last year.	200
☞ Attended a stress management workshop conducted or endorsed by the City within the last year.	200
☞ Agree to wear a seat belt 100% of the time while riding in or driving a motor vehicle.	200
☞ Had a total cholesterol level below 200 mg/dl or LDL level less than 130 mg/dl	200
☞ Had a diastolic blood pressure less than 90 mm Hg.	200
☞ Had not smoked a cigarette, pipe or cigar or used smokeless tobacco in the last six months.	200
☞ Routinely exercise at least three times a week for a minimum of 30 continuous minutes each time.	200
Maximum Possible Wellness Bonus Points =	1,600 points

The wellness bonus points are compiled by filling out an optional one page application during the last two months of the benefit year and having Human Resource staff process the application and notify the TPA of the additional wellness bonus points to be added to the employee's wellness account prior to calculation of the monetary value of a point. The wellness bonus points are then used to distribute a higher proportion of the incentive pool to those who adopt and maintain healthy lifestyle behaviors.

Appendix D

Draft of Proposed Wellness Program

The following is a draft proposal for an employee wellness program for City of Redmond employees and their family members.

Program Component	Proposed Activity
Administrative Structure	√ Program Theme: "Its For You!" √ Wellness Program Coordinator - Part time √ Wellness Advisory Committee √ Ad Hoc Wellness Action Groups as needed √ Wellness Contact Point in each site √ Program Evaluation Plan
Wellness Communications	√ Monthly Wellness Newsletter √ Use of an annual Mail Request Card √ Wellness Articles and Wellness Tips in employee newsletter √ Consistent Program Notice Series
Health & Fitness Testing	√ On-Site Mini-Wellness Assessments √ Wellness Fair follow-up testing
Group Activities	√ Provide Free & Clear stop smoking kits with calls and resource information √ Organize walking clubs and events √ Spring and Fall Wellness Games √ Provide stress management classes √ Provide medical self-care workshops
Supportive Environment	√ Adopt a set of formal Wellness Policies √ Encourage the designation of quiet space where feasible √ Establish all smoke-free facilities and vehicles

Appendix D

Listing of Washington State Mandated Benefits

The following listing is a summary of the highlights of the current Washington State requirements for mandated benefit coverages for insured health plans offered to employee groups.

A. ***Required Coverage***

These required provisions must be part of the plan coverage.

1. *Podiatrists:*

   Must be covered for services within scope of license if same service would have been covered when provided by a physician.

2. *Registered Nurses:*

   Must be covered for services within the scope of their license if the same service would be covered when provided by a physician.

3. *Reconstructive Breast Surgery:*

   Must be covered following mastectomy, including prosthesis; and one reconstructive breast reduction on non-diseased breast following reconstructive surgery on diseased breast.

4. *Chemical Dependency:*

   Must be covered in state-approved treatment facilities for alcohol treatment and/or drug abuse treatment: minimum benefit is $5,000 per 24 months up to $10,000 lifetime maximum. Deductibles, co-insurance and other contract parameters may be applied.

5. *Mammograms:*

   Routine screening or diagnostic mammograms must be covered when recommended by patient's physician.

6. *Disabled Child:*

   Coverage must be continued for a developmentally disabled or physically handicapped child after attaining age limit and if he or she is unable to support himself or herself.

7. *Newborn Child:*

   Coverage for the subscriber's natural newborn child must be provided from birth, and must include plan benefits for congenital anomalies.

8. *PKU Formulas:*

   Food formulas for treatment of phenylketonuria must be provided.

9. *Adopted Children:*

   Must be covered from the date of placement for adoption if the insurance contract covers dependent children.

10. *Prenatal Testing:*

    Coverage for screening and diagnostic procedures to determine congenital disorders of the fetus must be included if the contract covers maternity benefits.

11. *Neurodevelopmental Therapy:*

    Coverage must be included for physical, speech, and occupational therapy services for neurodevelopmental therapies for covered individuals age six and under.

12. *Handicap:*

    Coverage may not be denied solely on the basis of sensory, mental or physical handicap. Also, benefits may not be restricted,refused or cancelled because of a mastectomy or lumpectomy performed more than 5 years previously.

B. Required Offerings of Coverage

These required items must be made available to all groups of employers by an insurer, even if they are not required to purchase them or do not elect to do so.

1. *Mental Health Treatment:*

   Minimum benefit must include outpatient services, and must cover psychiatrists, psychologists, licensed community mental health agencies and state mental hospitals.

2. *Home Health and Hospice:*

   Benefits must be provided if contract covers hospital care. Minimum benefit is 130 visits for home health care; six months for hospice care.

3. *TMJ:*

   Benefits can be limited but must be provided under both medical and dental coverages.

4. *Chiropractors:*

   Contract benefits must be offered for services within scope of license if same service would be covered when provided by physician.

Note: For more detailed information on mandated benefits please consult the applicable sections of the Washington Administrative Code (WAC).

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