Memorandum
City of Lawrence

TO: **David L. Corliss, City Manager**

FROM: **Lori Carnahan, Human Resources Manager**
Michelle Spreer, Benefits Specialist

CC: **Diane Stoddard, Assistant City Manager**
Cynthia Wagner, Assistant City Manager
Casey Toomey, Budget Manager
Ryann Pem, Recruiter / Wellness Coordinator

Date: **May 8, 2013**

RE: **2014 Employee Healthcare Plan Budget Memo**

Executive Summary

- Staff and Hays Companies (Hays), the city's independent healthcare consultants, recommends maintaining current vendors for medical, dental and prescription drug coverage for 2014. Contract negotiations are under way with Cigna, Delta Dental and MedTrak.

- Staff recommends increasing the deductible to $1,000 individual/ $2,000 family with the out of pocket maximum going to $1,600 individual/ $3,200 family (including deductible). Additionally, staff recommends increasing Health Reimbursement Account (HRA) maximum balance to $1,600, regardless of coverage level (single or family).

- Staff recommends a 0% increase in city funding for 2014. Funding would remain at $7,691,464.

- Staff recommends employee contributions remain flat for 2014. While this is the recommendation for employee funding, the requirements to receive wellness incentives and/or rewards will be more stringent.

- Retiree contributions are projected to increase approximately 3% in order to maintain the 80% contribution to premium equivalent. This projected increase will be finalized in the fall 2013 when COBRA rates are established.

- 2012 healthcare claims utilization finished under budget for the third year in a row with a .19% increase over 2011. The city was able to add $795,430 to retained earnings at the end of 2012. Overall plan costs increased by 2.06%.

- Beginning July 2013, the plan must begin to comply with Patient Protection and Affordable Care Act (PPACA) regulations which include additional fees to be paid directly to Health and Human Services (HHS) and/or the IRS.

- Healthcare coverage for elected officials was incorporated into our plan in May 2013 for coverage to begin on June 1, 2013.

- Beginning January 1, 2014 the plan will begin providing coverage for certain bariatric surgeries.

- Staff recommends modifying our plan eligibility rules to allow benefits for domestic partners beginning January 2014. An employee survey conducted in April 2013 indicated a number of employees that would utilize the benefits if available.

Request for Proposals (RFP) for Healthcare Plan Vendors

Hays sent out an RFP for healthcare services in February 2013. It was sent to 10 health plan administrative service providers, 3 stand alone dental administrative providers and 7 stand alone pharmacy benefit managers as well as posted on DemandStar. There were 6 respondents for medical, 7 for Dental and 10 for pharmacy benefit managers. Hays compared the results with a focus on operational capabilities, network coverage and discounts as well as pricing for services. It was important that any potential vendor be able to administer our current plan design. This requires the ability to share data and integrate service as much as possible. Not all vendors were able to meet these needs.

After reviewing responses the top two health plan providers were selected. The process resulted in Cigna offering a reduction in their per employee per month (PEPM) administrative fee (from $22.99 to $16.99) and a slightly better discount guarantee for 2014. Cigna has committed to doing a discount guarantee each year. They also agreed to retain the 2014 fees in 2015 with a 3% cap on increased fees for 2016 and 2017. Network discounts were the same or greater than in 2009 and customer service ratings have been high.

Negotiations continue with Delta Dental for a reduction in administrative fees; however we do not expect them to offer a reduction without a reduction in services. Their current fee is competitive. MedTrak submitted the most attractive proposal for pharmacy benefit managers.

Unlike the 2009 RFP process, there appears to be no significant financial or operational improvements resulting from alternative vendor partners in any area.

Staff and Hays recommend renewing contracts with our current vendors for health plan services.

Healthcare Plan Design

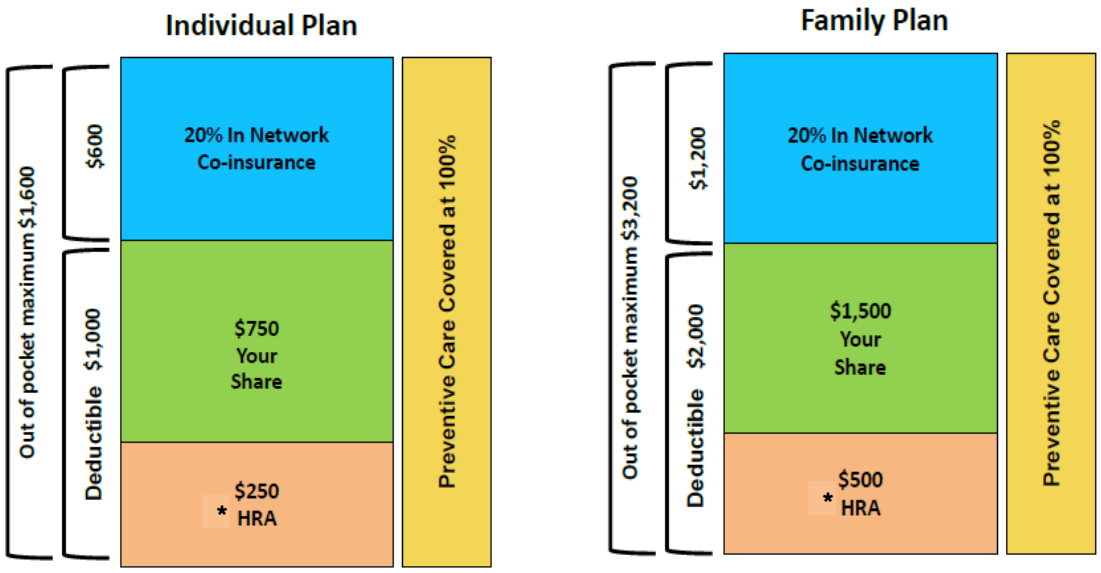
The long term goal of Staff, Hays and the Healthcare Committee (HCC) is to make strategic changes to the healthcare plan that will reduce the upward trend of healthcare costs while providing a comprehensive healthcare program for plan members.

The Health Reimbursement Account (HRA) plan design was implemented in 2012 as part of a bigger initiative to help reduce future trend on the healthcare plan. The HRA design introduced consumerism to our plan. Allowing for first dollar coverage and the ability to roll over unused funds can empower members to make educated decisions about their healthcare services (i.e. going to emergency room or going to an urgent care center/walk in clinic). The WellCare clinic was implemented as a tool in reducing risk factors for chronic conditions in our plan members. Both of these structures can help reduce future trend.

Hays introduced staff and the healthcare committee to the term *Member Burden* in 2010. Member burden is described as the employees' cost share when factoring in both contributions and their share of medical expenses, such as deductibles and co-insurance. We have monitored member burden over the past several years which has ranged from 24 to 29%, with 2012 ending at approximately 26%. This is where staff and the HCC anticipate keeping this number for 2013 and 2014. We will continue to monitor this number as we recommend changes to the healthcare plan in future years as well.

Attachment A – Plan Design Recommendations includes current design and proposed 2014. Deductibles and out of pocket maximums remained flat from 2012 to 2013. In order to maintain member burden and keep up with increasing medical costs, staff recommends deductibles of $1,000 individual / $2,000 family (currently $700 and $1,400 respectively) and out of pocket maximums $1,600 individual / $3,200 family (currently 1,200 and $2,400 respectively). The following charts reflect this plan design.

Currently the HRA maximum balance is $800 individual / $1,300 family. For ease of communication and administration, staff recommends changing from a tiered HRA maximum balance to just one maximum balance of $1,600; regardless of individual or family plans.



* Does not include wellness incentives or money rolled over from previous years

Fund Balance (Retained Earnings) and Minimum Retained Earnings (MRE)
Maintaining MRE at 20% of projected plan cost for two years out allows the City to smooth out increases to city funding as well as employee contributions. Having a healthy MRE level allows funding of current and future incentives related to wellness programs.

Retained Earnings also funds the cost of catastrophic claims, the amount determined by our stop loss contract each year. In 2014 it will be set at 120%. The 120% represents the amount of claims the city is responsible for paying over the projected costs before stop loss insurance begins paying claims.

Staff recommends that city funding remain flat for 2014 at $7,691,464. This will be the third consecutive year that city funding has remained flat. Our projected claims continue to come in under budget with claims growth from 2011 to 2012 at only .19% and overall plan costs increasing by 2.06% over 2011. The city has been able to add to retained earnings for the past 3 years as shown in **Attachment B – Internal Financial Summary**.

Attachment C – **Plan Funding Modeling** projects future trend, to include claims, administrative expenses and stop loss insurance. It is desirable to have "Fund Balance EOY" equal to or greater than "Recommended MRE" for at least one year beyond the year for which the budget is being prepared (12/31/2015 as highlighted in attachment).

Plan growth assumptions are at the bottom of the chart. While our fund balance is substantial at this point in time, with no increase in funding and/or plan design changes (cost shifting) and the assumed expense growth, the retained earnings will fall below MRE at the end of 2015 as highlighted in Attachment C. This is the first time in 3 years that fund balance is below MRE just one year beyond the year being budgeted. In past years, fund balance is not projected to go below MRE until at least two years past the year being budgeted.

These projections are done early in the year (April) for the following year. With only a few months of claims data, the projections are typically conservative. The 2014 projections will be updated this fall for stop loss quotes, once Hays has more claims data for 2013. They will be updated again in March of 2014 while preparing for the 2015 plan year. This is the cycle that is followed each year.

Patient Protection & Affordable Care Act – PPACA
In accordance with PPACA regulations the healthcare plan will be required to pay new fees beginning July 1, 2013. Staff will work closely with Hays and Cigna to ensure all fees are calculated correctly and paid on time to HHS and/or IRS. The fees are included in the cost projections.

- Patient Centered Outcomes fee (aka Comparative Effectiveness Research Fee)
    - First payable by 7/31/2013 for the 2012 plan year
    - $1 per average number of covered lives (approximately $2,100)

- In 2014 for the 2013 plan year, fee goes to $2 per participant
- Fee to be determined for future years

- Reinsurance Assessment Fee
  - Funding to lessen impact of high-risk individuals entering the individual market
  - $63 per covered life on the plan (approximately $133,000)
  - Will apply through 2016 (amount for 2015 and 2016 not yet known)

- New eligibility rules
  - Variable hour employees (part-time, temporary) eligible if average 30 hrs/week
  - Staff will test hours on a 12 month look back (October 1 – September 30) each year
  - Staff recommends that the city manage part time temporary hours to less than 30 on a 12 month average

- Early Retiree Reinsurance Program (ERRP)
  - Approved for participation in the program in 2010
  - Total funds received $129,713
  - Funds were used for initial set up and operation of the WellCare Clinic in 2012
  - Staff has documented use of funds and responded to surveys from HHS regarding fund usage

Plan Coverage Changes

Beginning June 1, 2013 the City of Lawrence will amend the plan to allow coverage for elected officials to include health, dental, vision, prescription as well as flexible spending and life insurance.

Effective January 1, 2014 City of Lawrence healthcare plan will begin providing coverage for certain bariatric surgeries. Coverage for these types of surgeries will be based on a rigorous coverage position from Cigna Healthcare as spelled out in **Attachment D – Cigna Medical Coverage Policy; Bariatric Surgery**. The attached coverage position is just a portion of the entire document. The first several pages spell out the strict criteria to be eligible for surgery.

Cigna projects potential impact to claims to be approximately 2.5% for providing coverage for these types of surgeries. This is an actuarial cost factor only, which applies in the initial year – it does not factor in client-specific data, or future potential savings (cost avoidance) in other obesity-related types of claims (i.e. member using less medications, avoiding a heart attack/stroke etc.). Cost impacts in future years will be determined by the overall claims experience of the plan.

Based on the 2012 Mercer National Survey of Employer-Sponsored Health Plans 20% of companies with 500 – 999 employees cover bariatric surgeries as any other medically necessary treatment, 33% cover the surgeries with a behavior modification program participation requirement and 46% do not cover the surgeries. For all government plans, those respective numbers are 24%, 34% and 42%.

Domestic Partner Benefits

Staff recommends modifying plan eligibility rules to allow for domestic partners effective January 1, 2014. IRS does not allow use of a section 125 flexible spending plan for a domestic partner. Cigna does not factor in an increase in stop loss rates or aggregate factors for this change. The biggest impact is administratively due to different tax law considerations. The employee would have imputed income when covering a domestic partner. Hays can provide the city with a worksheet to determine the amount of imputed income.

Human Resources would require proof of partnership by using a verification process similar to the City's Domestic Partner Registry that is currently in place.

Domestic Partnership is defined as a person of the same or opposite sex who:

- Share a common permanent residence;
- Have agreed to be in a relationship of mutual interdependence;
- Both contribute to the maintenance and support of the household;
- Are not married to a third individual or a member of a domestic partnership with a third individual;
- Are 18 years of age or older;
- Have the mental capacity to contract;

- Are not related by blood in a way that would prevent marriage in this State.

Of the 146 employee survey responses, 30% said they would use the domestic partner benefits if offered. Two thirds of those responding with feedback were highly in favor of offering domestic partner benefits.

At a future date, staff will examine other benefits such as the use of sick time for a domestic partner and recommend implementation if appropriate.

Staff requests approval to amend the plan to allow for domestic partner benefits for the healthcare plan.

CHAMP Wellness
The wellness committee continues to meet once a quarter and implement programs as time and budget allows. **Attachment E – CHAMP Budget** lists the CHAMP wellness programming and the cost associated with these programs.

Other Post-Employment Benefits (OPEB) Obligations under GASB 45
In 2004 the Governmental Accounting Standards Board (GASB) released Statement 45 (GASB 45) which issued a new set of accounting rules concerning health and other non-pension benefits for retired public employees. These benefits, also referred to as "other post-employment benefits" (OPEB), include non-pension benefits such as life insurance, dental coverage and long-term care, as well as retiree health benefits. GASB 45 strongly encourages public sector employers to set aside funds for OPEB benefits, instead of a "pay as you go" funding method. Employers are strongly encouraged to fully fund OPEB benefits in order to show a more favorable financial statement.

The intent of GASB 45 was to bring governmental accounting standards more in line with private company standards. GASB 45 requires that an actuarial valuation be conducted every two years to determine the annual OPEB liability.

The city's net OBEB obligation as of December 31, 2011 was $2,079,000. The annual required contribution to fully fund its obligation was $1,605,000 in 2011. The city's actual contribution in 2012 was $657, 000. Retiree contributions in 2012 were $400,958. There will be a valuation and OPEB obligation under GASB 45 for the 2013/2014 fiscal years required in 2013. The net OPEB obligation will change with each valuation. In the 2013 budget the city assigned $250,000 in the Health Insurance Fund to cover a portion of the current and future retiree health care plan obligations which is reflected in **Attachment C – Plan Funding Modeling** under "Retiree Balance BOY".

Beginning with the 2013 budget, Hays divided out the retiree revenues and expenses from the active employees, also shown in **Attachment C**. This will allow the City to better track the liabilities under OPEB and assist us in determining where the fund balance for OPEB should be set. Based on projected 2013 retiree revenues and expenses, the retiree fund balance at the beginning of 2014 will be approximately $1,024,000.

Projected retiree expenses for 2014 are $898,000 and projected revenues (from both retiree premiums and city funding) are $1,108,000. This will allow the city to add to the retiree fund balance helping to meet the OPEB obligations. Projected fund balance at the end of 2014 is $1,349,000.

Transfers to Healthcare Plan
Each year Staff calculates the breakdown of city funding to the healthcare plan for each department to assist them in developing their budgets. Beginning in 2013 staff began allocating and tracking retiree healthcare expenses separately from active employees. With this change the projected actual retiree expense for healthcare has been allocated to each fund based on where the retiree worked while employed. See **Attachment F – Transfers to Fund Health Plan 2014**.

A 0% increase in city funding translates to $8,656.13 per authorized position, $9,398.75 per new authorized position and $11,929.82 per new retiree. These per person amounts reflect total projected plan expenses.

Attachments:

A – Plan Design Recommendations
B – Internal Financial Summary
C – Plan Funding Modeling
D – Cigna Bariatric Surgery Coverage Position
E – CHAMP Budget
F – Healthcare Fund Transfers
G – Healthcare Committee Goals

Attachment A

2014 Plan Design Recommendations

Medical Plan Information	2013 Current Plan	2014 Proposed
Employer HRA Contribution		
Individual/Family	$250/$500	$250/$500
Wellness Incentive (if earned)	$150	$300
HRA Maximum Balance	$800/$1,400	$1,600/$1,600
Deductible (Individual/Family)		
In-Network	$700/$1,400	$1,000/$2,000
Out-of-Network	$700/$1,400	$1,000/$2,000
Out-of-Pocket (Individual/Family)		
In-Network	$1,200/$2,400	$1,600/$3,200
Out-of-Network	$3,650/$7,300	$3,650/$7,300
Coinsurance Level		
In-Network	20%	20%
Out-of-Network	40%	40%
Prescription Drug		
Generic	20%	20%
Brand - 30 day supply	$25 + 20%	$25 + 20%
Brand - 90 day supply	$50 + 20%	$50 + 20%
Out of Pocket Maximum (Individual/Family)	$1,000/$2,000	$1,000/$2,000
Biweekly Contributions		
Employee	$5	$5
Employee plus Spouse	$77	$77
Employee plus Children	$69	$69
Family	$118	$118
HRA Account Utilization (Total Available)		
Employee Spend Percentage	77%	65%
Plan Funding Impact		
% Change in Projected Plan Cost	n.a.	0.3%
Projected Fund Balance Spend Down	n.a.	$1,484,000
Member Burden Impact		
City Funds	74.3%	74.6%
Employee Funds	25.7%	25.4%

Notes:

Member burden shown as "current" is from 2012 data. In 2011, before the HRA plan design, employee funding was 29.7%. Target range is 25-29%.

Healthcare Plan Internal Financial Summary

Attachment B

	Actual							
	2005	2006	2007	2008	2009	2010	2011	2012
Revenues								
City - Employee	5,287,932.00	5,678,536.00	6,005,611.00	6,321,793.00	6,369,977.36	7,246,945.96	7,571,408.56	6,801,560.05
City - Retiree								657,000.00
Employee	864,609.54	909,102.23	964,376.20	959,811.04	1,052,992.01	1,090,287.58	1,212,037.98	1,350,438.36
Retiree	252,562.60	285,339.75	265,263.24	269,069.32	334,810.69	390,394.58	400,402.27	400,958.74
Interest - Employee/Retiree	122,696.12	253,552.79	293,838.00	283,002.59	14,936.55	13,421.78	16,714.13	18,623.05
ERRP							129,713.14	
Total Revenues	6,527,800.26	7,126,530.77	7,529,088.44	7,833,675.95	7,772,716.61	8,741,049.90	9,330,276.08	9,228,580.20
Expenses								
Claims - Employees	4,377,650.54	5,024,471.39	6,082,168.73	6,715,784.55	7,371,877.61	7,099,333.91	7,024,139.67	6,551,355.74
Claims - Retirees								486,167.40
Admin Charge - Employee	173,390.69	162,852.15	192,487.90	234,478.51	254,926.83	391,106.95	482,331.17	306,540.96
Stop Loss Premium - Employee	311,057.25	312,202.02	386,141.05	424,221.55	499,666.96	631,270.00	696,000.00	754,906.00
Admin Charge - Retiree								27,801.57
Stop Loss Premium - Retiree								58,470.00
Other Contractual Expenses	0.00	0.00	10,501.36	0.00	81,745.12	48,548.40	60,842.90	50,000.00
Health & Wellness/WellCare Clinic								197,908.32
Total Expenses	4,862,098.48	5,499,525.56	6,671,299.04	7,374,484.61	8,208,216.52	8,170,259.26	8,263,313.74	8,433,149.99
City Authorized FTEs	767.89	798.25	827.67	818.92	809.17	812.67	796.67	796.00
Net Income - Employee	1,665,701.78	1,627,005.21	857,789.40	459,191.34	-435,499.91	570,790.64	1,066,962.34	307,794.52
Net Income - Retiree								487,635.69
Actual ending fund balance - Employee	4,587,423.78	6,214,428.99	7,072,218.39	7,531,409.73	7,095,909.82	7,666,700.46	8,733,662.80	8,791,093.01
Actual ending fund balance - Retiree								737,635.69 *

* This amount includes $250,000 that was allocated to the retiree fund balance at the beginning of 2012

Percent change								
Revenues								
City	9.50%	7.39%	5.76%	5.26%	0.76%	13.77%	4.48%	-1.49%
Employee	1.72%	5.15%	6.08%	-0.47%	9.71%	3.54%	11.17%	11.42%
Retiree	-0.23%	12.98%	-7.04%	1.43%	24.43%	16.60%	2.56%	0.14%
Interest	262.37%	106.65%	15.89%	-3.69%	-94.72%	-10.14%	24.53%	11.42%
ERRP								
Total Revenues	9.42%	9.17%	5.65%	4.05%	-0.78%	12.46%	6.74%	-1.09%
Expenses								
Claims - Employees/Retirees	0.37%	14.78%	21.05%	10.42%	9.77%	-3.70%	-1.06%	0.19%
Admin Charge - Employee/Retiree	-11.47%	-6.08%	18.20%	21.81%	8.72%	53.42%	23.32%	-30.68%
Stop Loss Premium - Employee/Retiree	-35.15%	0.37%	23.68%	9.86%	17.78%	26.34%	10.25%	16.86%
Other Contractual Expenses						-40.61%	25.32%	-17.82%
Health & Wellness/WellCare Clinic								100.00%
Total Expenses	-3.47%	13.11%	21.31%	10.54%	11.31%	-0.46%	1.14%	2.06%
Actual ending fund balance	57.01%	35.47%	13.80%	6.49%	-5.78%	8.04%	13.92%	9.10%

City of Lawrence - Plan Funding Modeling

Category	2013 Budget - done May 2012	2013 Updated* Done Feb 2013	2014 Proposed Plan Design	2015 Proposed Plan Design	2016
Active Expenses					
Medical	5,978,000	5,630,000	6,110,000	6,467,000	6,984,000
Rx	1,627,000	1,527,000	1,672,000	1,831,000	2,005,000
Dental	570,000	564,000	592,000	622,000	653,000
Administration	494,000	494,000	425,000	425,000	425,000
Stop-loss	955,000	858,000	1,073,000	1,341,000	1,676,000
Total	9,624,000	9,073,000	9,872,000	10,686,000	11,743,000
Active Revenues					
City	7,034,000	7,034,000	7,034,000	7,034,000	7,034,000
Employee	1,350,000	1,350,000	1,350,000	1,350,000	1,350,000
Total	8,384,000	8,384,000	8,384,000	8,384,000	8,384,000
Fund Balance BOY	8,144,000	9,529,000	8,791,000	7,303,000	5,001,000
Retiree Balance BOY	250,000	738,000			
Active Fund Balance EOY	7,475,000	8,791,000	7,303,000	5,001,000	1,642,000
Retiree Expenses					
Medical	518,000	518,000	562,000	595,000	643,000
Rx	169,000	169,000	185,000	203,000	222,000
Dental	47,000	47,000	49,000	51,000	54,000
Administration	33,000	33,000	33,000	33,000	33,000
Stop-loss	55,000	55,000	69,000	86,000	108,000
Total	822,000	822,000	898,000	968,000	1,060,000
Retiree Revenues					
City	657,000	657,000	657,000	657,000	657,000
Retiree	437,000	451,000	451,000	451,000	451,000
Total	1,094,000	1,108,000	1,108,000	1,108,000	1,108,000
Fund Balance BOY	250,000	738,000	1,024,000	1,349,000	1,567,000
Fund Balance EOY	522,000	1,024,000	1,349,000	1,567,000	1,649,000
Total Expenses					
Medical	6,537,000	6,148,000	6,672,000	7,062,000	7,627,000
Rx	1,812,000	1,696,000	1,857,000	2,034,000	2,227,000
Dental	619,000	611,000	641,000	673,000	707,000
Administration	528,000	527,000	458,000	458,000	458,000
Additional Wellness Expenses	192,000	192,000	207,000	224,000	242,000
Stop-loss	1,024,000	913,000	1,142,000	1,427,000	1,784,000
Total	10,712,000	10,087,000	10,977,000	11,878,000	13,045,000
Total Revenues					
City	7,691,000	7,691,000	7,691,000	7,691,000	7,691,000
Employee/Retirees	1,787,000	1,801,000	1,801,000	1,801,000	1,801,000
Total	9,478,000	9,492,000	9,492,000	9,492,000	9,492,000
Fund Balance BOY	7,040,000	9,529,000	5,806,000	4,321,000	1,935,000
Fund Balance EOY	5,806,000	8,934,000	4,321,000	1,935,000	(1,618,000)
Recommended MRE	2,814,000	2,634,000	2,851,000	3,131,000	3,448,000
% Increase in Revenues needed to Cover Current Years' Expenses			16%	25%	40%
% Increase in Revenues needed to Maintain Minimum Funding (per City's policy)			0%	38%	91%

*** Updated to Reflect 2012 Claims**

Assumptions / Inputs	
Trend	
- Medical	8%
- Rx	9.5%
- Dental	5%
- Administration	0%
- Stoploss	25%
City Funding Increase (if applicable)	0%
Employee Funding Increase (if applicable)	0%
MRE Level	20%
Catastrophic Load	20%

Cigna Medical Coverage Policy

Effective Date **5/15/2012**
Next Review Date **5/15/2013**
Coverage Policy Number **0051**

Subject **Bariatric Surgery**

Table of Contents

Hyperlink to Related Coverage Policies

Panniculectomy and Abdominoplasty
Gastric Pacing/Gastric Electrical Stimulation (GES)
Nutritional Counseling
Obstructive Sleep Apnea Diagnosis and Treatment Services
Vagus Nerve Stimulation (VNS)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna companies including plans formerly administered by Great-West Healthcare, which is now a part of Cigna. Coverage Policies are intended to provide guidance in interpreting certain ***standard*** *Cigna benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document* ***always supercedes*** *the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations. Proprietary information of Cigna. Copyright ©2012 Cigna*

Coverage Policy

Bariatric surgery is specifically excluded under many benefit plans and may be governed by state and/or federal mandates. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

Unless excluded from the benefit plan, this service is covered when the following medical necessity criteria are met.

Cigna covers bariatric surgery using a covered procedure outlined below as medically necessary when ALL of the following criteria are met:

- The individual is ≥ 18 years of age or has reached full expected skeletal growth **AND** has evidence of **EITHER** of the following:
  - a BMI (Body Mass Index) ≥ 40
  - a BMI (Body Mass Index) 35–39.9 with at least one clinically significant obesity-related comorbidity, including but not limited to the following:
    - mechanical arthropathy in a weight-bearing joint
    - type 2 diabetes mellitus
    - poorly controlled hypertension (systolic blood pressure at least 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, despite optimal medical management)

  - hyperlipidemia
  - coronary artery disease
  - lower extremity lymphatic or venous obstruction
  - obstructive sleep apnea
  - pulmonary hypertension
- Medical management including evidence of active participation within the last 12 months in a weight-management program that is supervised either by a physician or a registered dietician for a minimum of three consecutive months. The weight-management program must include monthly documentation of **ALL** of the following components:

  - weight
  - current dietary program
  - physical activity (e.g., exercise program)

  Programs such as Weight Watchers®, Jenny Craig® and Optifast® are acceptable alternatives if done in conjunction with the supervision of a physician or registered dietician and detailed documentation of participation is available for review. However, physician-supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.

- A thorough multidisciplinary evaluation within the previous six months which includes ALL of the following:

  - an evaluation by a bariatric surgeon recommending surgical treatment, including a description of the proposed procedure(s) and all of the associated current CPT codes
  - a separate medical evaluation from a physician other than the requesting surgeon that includes both a recommendation for bariatric surgery as well as a medical clearance for surgery
  - unequivocal clearance for bariatric surgery by a mental health provider
  - a nutritional evaluation by a physician or registered dietician

Bariatric Surgery Procedures:

When the specific medical necessity criteria noted above for bariatric surgery have been met, Cigna covers ANY of the following open or laparoscopic bariatric surgery procedures:

- Roux-en-Y gastric bypass
- adjustable silicone gastric banding (e.g., LAP-BAND®, REALIZE™)
- biliopancreatic diversion with duodenal switch (BPD/DS) for individuals with a BMI (Body Mass Index) > 50
- sleeve gastrectomy (SG)
- vertical banded gastroplasty

Cigna covers adjustment of a silicone gastric banding as medically necessary to control the rate of weight loss and/or treat symptoms secondary to gastric restriction following a medically necessary adjustable silicone gastric banding procedure.

Cigna does not cover the following bariatric surgery procedures, because each is considered experimental, investigational or unproven (this list may not be all-inclusive):

- Roux-en-Y gastric bypass combined with simultaneous gastric banding
- biliopancreatic diversion (BPD) without duodenal switch (DS)
- Fobi-Pouch (limiting proximal gastric pouch)
- gastric electrical stimulation (GES) or gastric pacing
- gastroplasty (stomach stapling)
- intestinal bypass (jejunoileal bypass)
- intragastric balloon
- loop gastric bypass
- mini-gastric bypass

- Natural Orifice Transluminal Endoscopic Surgery (NOTES)/endoscopic oral-assisted bariatric surgery procedures, including but not limited to the following:
    - restorative obesity surgery, endoluminal (ROSE)
    - StomaphyX™,
    - duodenojejunal bypass liner (e.g., Endobarrier™)
    - transoral gastroplasty (e.g., TOGA®)
- vagus nerve blocking
- vagus nerve stimulation

Reoperation and Repeat Bariatric Surgery:

Cigna covers surgical reversal (i.e., takedown) of bariatric surgery as medically necessary when the individual develops complications from the original surgery such as stricture or obstruction.

Cigna covers revision of a previous bariatric surgical procedure or conversion to another medically necessary procedure due to inadequate weight loss as medically necessary when ALL of the following are met:

- Coverage for bariatric surgery is available under the individual's current health benefit plan.
- There is evidence of full compliance with the previously prescribed postoperative dietary and exercise program.
- Due to a technical failure of the original bariatric surgical procedure (e.g., pouch dilatation) documented on either upper gastrointestinal (UGI) series or esophagogastroduodenoscopy (EGD), the individual has failed to achieve adequate weight loss, which is defined as failure to lose at least 50% of excess body weight or failure to achieve body weight to within 30% of ideal body weight at least two years following the original surgery.
- The requested procedure is a regularly covered bariatric surgery (see above for specific procedures).

NOTE: Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a medically necessary indication for revision or conversion surgery and is not covered by Cigna.

Bariatric Surgery for the Treatment of Type 2 Diabetes Mellitus

Cigna does not cover ANY bariatric surgical procedure when performed solely for the treatment of type 2 diabetes mellitus because it is considered experimental, investigational or unproven for this indication.

Cholecystectomy, Liver Biopsy, Herniorrhaphy, Prophylactic Vena Cava Filter Placement, or Upper Endoscopy:

Cigna covers prophylactic vena cava filter placement at the time of bariatric surgery as medically necessary for individuals who are considered to be high risk for venous thromboembolism (VTE) due to a history of ANY of the following conditions:

- deep vein thrombosis (DVT)
- hypercoagulable state
- increased right-sided heart pressures
- pulmonary embolus (PE)

Cigna does not cover ANY of the following performed in conjunction with a bariatric surgery because each is considered not medically necessary:

- cholecystectomy in the absence of signs or symptoms of gallbladder disease

- liver biopsy in the absence of signs or symptoms of liver disease (e.g., elevated liver enzymes, enlarged liver)
- herniorrhaphy for an asymptomatic hiatal hernia
- routine vena cava filter placement for individuals not at high risk for venous thromboembolism (VTE)

Cigna considers upper gastrointestinal endoscopy performed concurrent with a bariatric surgery procedure to confirm a surgical anastomosis or to establish anatomical landmarks to be an integral part of the more comprehensive surgical procedure and not separately reimbursable.

General Background

Obesity and overweight are defined clinically using the body mass index (BMI). BMI is an objective measurement and is currently considered the most reproducible measurement of total body fat. In adults, excess body weight (EBW) is defined as having a BMI ≥25 kg/m^2 (World Health Organization [WHO], 2000).

The National Heart, Lung and Blood Institute (NHLBI) (1998) defines the following classifications based on BMI. The NHLBI recommends that the BMI should be used to classify overweight and obesity and to estimate relative risk for disease compared to normal weight:

Classification	BMI
Underweight	< 18.5 kg/m^2
Normal weight	18.5–24.9 kg/m^2
Overweight	25–29.9 kg/m^2
Obesity (Class 1)	30–34.9 kg/m^2
Obesity (Class 2)	35–39.9 kg/m^2
Extreme Obesity (Class 3)	≥ 40 kg/m^2

BMI is a direct calculation based on height and weight, regardless of gender:

$$\textbf{BMI} = \frac{weight\ (kg)}{height\ (m^2)}\ \textbf{OR}\ \left[\frac{weight\ (lb)}{height\ (in)^2}\right] x\ 703$$

Clinically severe or morbid obesity is defined as a BMI greater than or equal to 40 or a BMI 35–39.9 with comorbid conditions. Comorbidities of morbid obesity that may be considered include any of the following:

- mechanical arthropathy (weight-related degenerative joint disease)
- type 2 diabetes
- clinically unmanageable hypertension (systolic blood pressure at least 140 mm Hg or diastolic blood pressure 90 mm Hg or greater, or if individual is taking antihypertensive agents)
- hyperlipidemia
- coronary artery disease
- lower extremity lymphatic or venous obstruction
- severe obstructive sleep apnea
- obesity-related pulmonary hypertension

Another group of individuals who have been identified are the super-obese. Super-obesity has been defined in the literature as a BMI greater than 50.

Treatment of obesity is generally described as a two-part process:

1. assessment, including BMI measurement and risk factor identification; and
2. treatment/management

Obesity management includes primary weight loss, prevention of weight regain and the management of associated risk. During the assessment phase, the individual needs to be prepared for the comprehensive nature of the program, including realistic timelines and goals.

Strategies for Weight Loss
General recommendations for an overall weight-loss strategy include the following (Gorroll and Mulley, 2009):

- For overweight or obese patients not ready to lose weight, the best approach is to educate them about health risks, address other cardiovascular risk factors, and encourage the maintenance of their current weight.
- For motivated persons who are overweight (BMI 25 to 29.9 kg/m^2) and have two or more obesity-related medical conditions or are frankly obese (BMI >30 kg/m^2), a six-month goal of a 10% weight loss can be set (1 to 2 lb/wk) and a program of diet, exercise, and behavioral therapy prescribed. If, after six months, the target weight is not achieved, one can consider adding pharmacologic therapy for those at greatest risk (BMI >27 kg/m^2 plus two or more cardiovascular risk factors, or BMI >30 kg/m^2).
- For markedly obese persons at greatest risk (BMI >35 kg/m^2 with two or more obesity-related medical conditions or BMI >40 kg/m^2), consider a surgical approach if serious and repeated attempts using the foregoing measures have been unsuccessful.

The NHLBI guidelines (1998) make the following recommendations regarding nonsurgical strategies for achieving weight loss and weight maintenance:

- Dietary Therapy:
  - Low-calorie diets are recommended for weight loss in overweight and obese persons. Reducing fat as part of a low-calorie diet is a practical way to reduce calories.
  - Optimally, dietary therapy should last at least six months, as many studies suggest that the rate of weight loss decreases after about six months. Shorter periods of dietary therapy typically result in lesser weight reductions.
  - The literature suggests that weight-loss and weight-maintenance therapies that provide a greater frequency of contacts between the individual and the practitioner and are provided over the long term should be put in place. This can lead to more successful weight loss and weight maintenance.

- Increased Physical Activity/Exercise is recommended as part of a comprehensive, weight-loss therapy and weight-maintenance program because it:
  - modestly contributes to weight loss in overweight and obese adults
  - may decrease abdominal fat
  - increases cardiorespiratory fitness
  - may help with maintenance of weight loss

- Combined Therapy: The combination of a reduced-calorie diet and increased physical activity is recommended, since it produces weight loss, decreases abdominal fat and increases cardiorespiratory fitness.

- Behavior Therapy: Is a useful adjunct when incorporated into treatment for weight loss and weight maintenance.

In addition, the NHLBI recommends that weight-loss drugs approved by the U.S. Food and Drug Administration (FDA) only be used as part of a comprehensive weight-loss program, including diet and physical activity for individuals with a BMI greater than or equal to 30 with no concomitant obesity-related risk factors or diseases, or for individuals with a BMI greater than or equal to 27 with concomitant obesity-related risk factors or diseases.

Clinical supervision is an essential component of dietary management. According to the NHLBI, "frequent clinical encounters during the initial six months of weight reduction appear to facilitate reaching the goals of therapy. During the period of active weight loss, regular visits of at least once per month and preferably more often with a health professional for the purposes of reinforcement, encouragement, and monitoring will facilitate weight reduction" (NHLBI, 1998). Physicians can also provide clinical oversight and monitoring of what are often complex comorbid conditions and can select the optimal and most medically appropriate weight management, nutritional and exercise strategies. Some commercially available diet programs do not consistently provide counselors who are trained and certified as registered dieticians or with other equivalent clinical training. However, diet programs/plans, such as Weight Watchers®, Jenny Craig® or similar plans are acceptable methods of dietary management if there is concurrent documentation of at least monthly clinical encounters with a physician.

Surgical Intervention
The NHLBI recommends weight-loss surgery as an option for carefully-selected adult patients with clinically severe obesity (BMI of 40 or greater; or BMI of 35 or greater with serious comorbid conditions) when less-invasive methods of weight loss have failed and the patient is at high risk for obesity-associated morbidity or mortality. Surgical therapy for morbid obesity is not only effective in producing weight loss but is also effective in improving several significant complications of obesity, including diabetes, hypertension, dyslipidemia, and sleep apnea. The degree of benefit and the rates of morbidity and mortality of the various surgical procedures vary according to the procedure (Bouldin, et al., 2006).

Access to a multidisciplinary team approach, involving a physician with a special interest in obesity; a surgeon with extensive experience in bariatric procedures, a dietitian or nutritionist; and a psychologist, psychiatrist or licensed mental health care provider interested in behavior modification and eating disorders, is optimal. A mental health evaluation should specifically address any mental health or substance abuse diagnoses, the emotional readiness and ability of the patient to make and sustain lifestyle changes, and the adequacy of their support system. Realistic expectations about the degree of weight loss, the compromises required by the patient and the positive effect on associated weight-related comorbidities and quality of life should be discussed and contrasted with the potential morbidity and operative mortality of bariatric surgery.

With bariatric surgery procedures, patients lose an average of 50–60% of excess body weight and have a decrease in BMI of about 10kg/m^2 during the first 12–24 postoperative months. Many long-term studies show a tendency for a modest weight gain (5–7 kg) after the initial postoperative years; long-term maintenance of an overall mean weight loss of about 50% of excess body weight can be expected.

BMI Requirement: Selection criteria for studies have uniformly included BMI ranges for clinically severe or morbid obesity, as outlined by the NHLBI. The use of bariatric procedures in patients with lower BMI measurements, with or without comorbidities, has been evaluated primarily in case series with small patient populations with short-term follow-up. Cohen et al. (2006) reported an excess weight loss (EWL) rate of 81% for patients (n=37) with uncontrolled co-morbidities who underwent laparoscopic Roux-en-Y gastric bypass. The mean preoperative BMI for these patients was 32.5 kg/m^2. The follow-up range was 6—48 months. A case series (n=93) by Parikh et al. (2006) examined the effectiveness of laparoscopic adjustable gastric banding with the LAP-BAND in patients with a BMI of 30-35 kg/m^2. Of the 93 patients, 42 (45%) had co-morbidities, including asthma, diabetes, hypertension, and sleep apnea. At three years of follow-up, the BMI was 18-24 kg/m^2 in 34%, 25-29 kg/m^2 in 51%, and 30-35 kg/m^2 in 10%.

A randomized controlled trial conducted (RCT) by O'Brien et al. (2006) assigned 80 patients with mild to moderate obesity (i.e., BMI 30 kg/m^2 to 35 kg/m^2) to a program of very-low-calorie diets, pharmacotherapy, and lifestyle change for 24 months (nonsurgical group) or to a laparoscopic adjustable gastric band placement. The surgical group was found to have significantly greater weight loss (87.2% EWL) compared to the nonsurgical group (21.8% EWL) ($p<0.001$) at two-year follow-up. Limitations of this RCT include small sample size, short-term follow-up, and the fact that the study was not powered for comparison of adverse events.

The International Diabetes Federation (IDF) position statement on the treatment and prevention of obesity and type 2 diabetes states that bariatric surgery is an appropriate treatment for people with type 2 diabetes and obesity (BMI ≥ 35) not achieving recommended treatment targets with medical therapies, especially where there are other obesity related co-morbidities. Under some circumstances people with a BMI 30-35 should be eligible

for surgery. It is further stated that studies are needed to establish the benefit of surgery for persons with diabetes and BMI < 35 (IDF, 2011).

Some study results suggest that bariatric surgery may be effective for weight loss in obese patients (i.e., BMI 30–35), with or without comorbidities. However, larger well designed studies with long-term follow-up are needed to further define the role of bariatric procedures for this subset of individuals.

Preoperative Weight Loss Requirement: According to the NHLBI Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (1998), the initial goal of weight-loss therapy should be to reduce body weight by approximately 10% from baseline. With success, further weight loss can be attempted, if indicated, through additional assessment. The NHLBI guidelines further state that:

- Bariatric surgery is not considered a first-line treatment.
- Even the most severely obese individuals (i.e., super-obese with BMI over 50) can be helped by a preoperative weight loss through a program of reduced-calorie diet and exercise therapy.
- Optimally, dietary therapy should last at least six months.
- Moderate weight loss (i.e., 10% of initial body weight) can significantly decrease the severity of obesity-associated risk factors. It can also set the stage for further weight loss, if indicated.

Bariatric surgeons and centers have advocated for preoperative weight loss, as it is believed that patients who are able to achieve this weight loss are most likely to have successful outcomes after surgery. The benefits of a preoperative weight-loss program include all of the following:

- reduction of the severity of obesity-associated risk factors, such as blood pressure, glucose intolerance, cardiorespiratory function and pulmonary function
- reduction of operative morbidity and surgical risk
- improvement in surgical access with weight loss
- identification of those individuals who will be committed to and compliant with the short-term, long-term and lifelong medical management follow-up, behavioral changes, lifestyle changes, and diet and physical exercise regimen required to ensure the long-term success of this surgery

Attachment E

WellCare Clinic	2014 Budget
WellCare Clinic	$179,000.00
Biometrics & PHA	$21,400.00
Flu Shots	$8,300.00
TOTAL	**$208,700**

CHAMP Wellness Programing	2014 Budget
TriaHealth	$16,000.00
Parks & Recreation Discounts	$5,200.00
Internal Wellness Programming	$100,212.00
Walk Kansas	
Run/Walk events	
Peer Fitness Program	
Police fitness program	
Bike to work program	
Equipment Subsidy	
Parks & Recreation classes	
Golf Tournament	
Annual Employee Picnic	
Community Supported Agriculture CSA Program	
Cooking classes	
Nutritional classes	
Weight Watchers	
Healthy Vending Machines	
Food Pilot Program	
Ergonomic program	
Educational Material	
Drawing Prizes	
TOTAL	**$121,412**

Transfers to fund health plan 2014 - Revised

Budget $8,684.52 per current authorized position, $9,429.58 per new authorized position and $11,526.32 per new retiree.

Fund	Description	Authorized Positions	Increases/ Decreases	Retirees	Total	Rec. Xfers	% of Total Funding
1068	General Fund 001 (Retirees)	0.00	0.00	47.00	47.00	$541,736.84	7.0%
1068	General Fund 001	**464.28**	0.00	0.00	464.28	$4,032,050.55	52.4%
1068	General Fund 213	3.00	0.00	0.00	3.00	$26,053.57	0.3%
210	Public Transportation	0.82	0.00	0.00	0.82	$7,121.31	0.1%
211	Recreation	30.50	0.00	2.00	32.50	$287,930.60	3.7%
214	Special Gas Tax	25.50	0.00	0.00	25.50	$221,455.35	2.9%
501	Finance-Utility Billing	23.50	0.00	0.00	23.50	$204,086.30	2.7%
501	Utilities-Administration	12.00	0.00	1.00	13.00	$115,740.60	1.5%
501	Utilities-Engineering	9.00	0.00	1.00	10.00	$89,687.03	1.2%
501	Utilities-Clinton Plant	12.60	0.00	0.00	12.60	$109,425.00	1.4%
501	Utilities-Kaw Plant	12.60	0.00	0.00	12.60	$109,425.00	1.4%
501	Utilities-WWTP	18.60	0.00	0.00	18.60	$161,532.14	2.1%
501	Utilities-Sanitary Sewer Coll Sys	13.60	0.00	0.00	13.60	$118,109.52	1.5%
501	Utilities-Water Quality	5.00	0.00	0.00	5.00	$43,422.62	0.6%
501	Utilities-Water Distribution	23.60	0.00	0.00	23.60	$204,954.75	2.7%
502	Sanitation	96.34	0.00	4.00	100.34	$882,772.25	11.5%
503	Public Parking	15.00	0.00	0.00	15.00	$130,267.85	1.7%
504	Vehicle Maintenance	17.25	0.00	2.00	19.25	$172,860.66	2.2%
505	Stormwater Utility	10.50	0.00	0.00	10.50	$91,187.50	1.2%
506	Public Golf Course	5.75	0.00	0.00	5.75	$49,936.01	0.6%
604	Farmland	1.00	0.00	0.00	1.00	$8,684.52	0.1%
611	Outside Agency Grant-Transit	3.18	0.00	0.00	3.18	$27,616.78	0.4%
611	Outside Agency Grant-Cops in Schools	0.00	0.00	0.00	0.00	$0.00	0.0%
611	Outside Agency Grant-Traffic	0.00	0.00	0.00	0.00	$0.00	0.0%
621	Fair Housing Grant	0.10	0.00	0.00	0.10	$868.45	0.0%
631	CDBG	4.55	0.00	0.00	4.55	$39,514.58	0.5%
633		0.13	0.00	0.00	0.13	$1,128.99	0.0%
641	Transportation Grant	1.60	0.00	0.00	1.60	$13,895.24	0.2%
		810.00	0.00	57.00	**867.00**	**$7,691,464.00**	**100.0%**

Health Care Committee Ongoing Goals and Objectives
Revised 1/1/2011

Mission

The City of Lawrence Health Care Committee is devoted to balancing the best interest of the City of Lawrence and the best interest of the City employees in order to establish and maintain a high quality, cost effective health care plan that offers meaningful benefits to its employees and retirees.

The largest component of the City of Lawrence employee benefit package is the health care plan. It serves as a recruitment and retention tool. To attract potential employees, and keep current ones, the health care plan must be market competitive in terms of employee cost (i.e. premiums, deductibles, coinsurance, and out of pocket maximums) and the level of benefit provided (scope of covered services).

Background

The City of Lawrence Health Care Committee was formed in 1998 to develop guidelines regarding annual funding and plan design. Since 1998, on an annual basis, the Health Care Committee has devoted time to review, revise, and refine those guidelines according to City Commission directives and input from City management and employees.

The City of Lawrence Health Care Committee is chaired by the Human Resources Manager and consists of City employees from each department. The objectives of the Health Care Committee are:

1. To submit annual budget recommendations to the City Commission regarding funding for the health care plan;
2. To review, evaluate, and determine plan design;
3. To identify, review, and address utilization trends;
4. To monitor current national health care trends;
5. Through partnership with the Wellness Committee (CHAMP), provide health education and wellness interventions to employees and their immediate family members so that they might fulfill their responsibilities as covered plan participants.

Statement of Plan Participant Responsibilities

While it is the right of plan participants to use the Plan to the fullest, and to take advantage of everything it offers, it is also their responsibility to maximize healthy habits, to become knowledgeable about his or her health plan coverage, and to consume health care services in a responsible manner in order to reduce his or her lifetime cost for health care coverage.

Annual Funding Guidelines

Annual budget recommendations will be submitted to City management in May for the next plan year using the most current national industry cost trend projections available at the time.

City funding means annual funding. Employee contributions mean payroll deductions for health care premiums. The City will fund health care for current employees on a per FTE basis and new positions on a per contract basis.

Recommended levels of 16% of projected costs will be maintained in retained earnings for at least one year beyond the year for which the budget is being prepared. Retained earnings fund the cost of catastrophic

claims, which is defined by the claims administrator each year not to exceed 120% of projected expenses. Interest earned on retained earnings will be used to offset the budget request to fund retained earnings.

The City will partially fund the monthly premium equivalent of employee and dependent coverage. The cost to cover eligible dependents under the health care plan is the difference between the monthly premium equivalent for a family membership and the monthly premium equivalent for a single membership.

To keep revenues proportional between City funding and employee contributions, the City will contribute 55-75% of the funding necessary to generate revenue toward the cost of dependent coverage; the employee will contribute 25-45%. Ideally, revenues will be split 65/35 between the City and employees toward the cost of dependent coverage.

Eligible employees receiving a retirement or disability benefit through KPERS will pay 80% of the monthly premium equivalent for their health care membership. The City will fund the remaining 20%.

COBRA participants will pay 102% of the monthly premium equivalent for their health care membership.

The Health Care Committee will work to moderate increases in City funding and employee contributions in order to smooth out the peaks and valleys of actual health care consumption. When increases in health care utilization have depleted retained earnings for future years below recommended levels, changes regarding retained earnings funding parameters will be implemented. When decreases in health care utilization are maintained for multiple years, the health care committee will recommend plan design enhancements.

Plan Design Guidelines

Covered services under the health care plan should satisfy the needs of the majority of employees, which can be identified by annually collecting aggregate data through:

1. Wellness tools;
2. Health care plan utilization reports;
3. Disability and worker's compensation claims; and
4. Periodic employee surveys.

Ideally, the plan design should enable plan expenses to be at or below national industry cost trends. This will be accomplished in part by:

1. Maintaining a plan design that enables and encourages plan participants to make wise consumer choices;
2. Maintaining a plan design that enables and encourages plan participants to utilize preventative services;
3. Educating plan participants on how to be wise consumers of health care services; and
4. Through the Wellness Committee, utilizing intervention programs for employees to use in order to individually examine and improve their overall lifestyle.