



Technical Proposal

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Request for Proposal for Group Health Plan Actuarial and Consulting Services

April 17, 2014

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April 17, 2014

Ms. Cheryl Stockert
North Dakota Public Employees Retirement System
400 E. Broadway, Suite 505
Bismarck, ND 58501

Re: **RFP for Group Health Plan Actuarial and Consulting Services**

Dear Ms. Stockert:

We are pleased to provide Group Health Plan Actuarial and Consulting Services to the North Dakota Public Employees Retirement System (NDPERS) for the period May 2014 through December 31, 2015. In 2012 Segal was pleased to have the opportunity to serve as the Dental Plan RFP manager for NDPERS. Gary L. Petersen, FCA, ASA, MAAA led the assignment in 2012.

For this project, the consulting team includes Gary L. Petersen, FCA, ASA, MAAA, Consulting Actuary, Daljit Johl, PharmD, Pharmacy Benefits Consultant, Mike Macdissi, FLMI, Vice President, and Ethel Tan, Health Benefits Analyst.

Our proposal fully meets the stated requirements of the RFP and our work plan is structured for completion in the timeframe you require.

Sincerely,

A handwritten signature in blue ink that reads "Gary L. Petersen". The signature is written in a cursive style and is positioned above a horizontal line.

Gary L. Petersen, FCA, ASA, MAAA

Table of Contents

Proposal to provide Group Health Plan Actuarial and Consulting Services to NDPERS

April 17, 2014

1. Technical Approach (a-h).....	1
2. Experience (a-o).....	9
Sample Segal State Government Clients.....	12
Prescription Drug Benefits and Cost Control.....	16
1. Proposed Legislation	24
2. Strategic Plan Implementation	24
3. Implementation of Federal and State Health Reform	24
3. Staffing	30
Resumes of Consulting Team	31
4. Additional Information	36
5. Conflicts of Interest	37
6. Company Literature.....	38
Exceptions – Contract and BA Agreement	39

1. Technical Approach (a-h)

a) Generally discuss your understanding of the requested work.

Segal understands that PERS is looking for an experienced consulting to manage the Group Health Plan Services RFP process.

We will use a team approach to meet all of the services requested by the PERS Board. Of particular note, Segal annually drafts, issues and produces analyses for well over 100 bid specifications for clients.

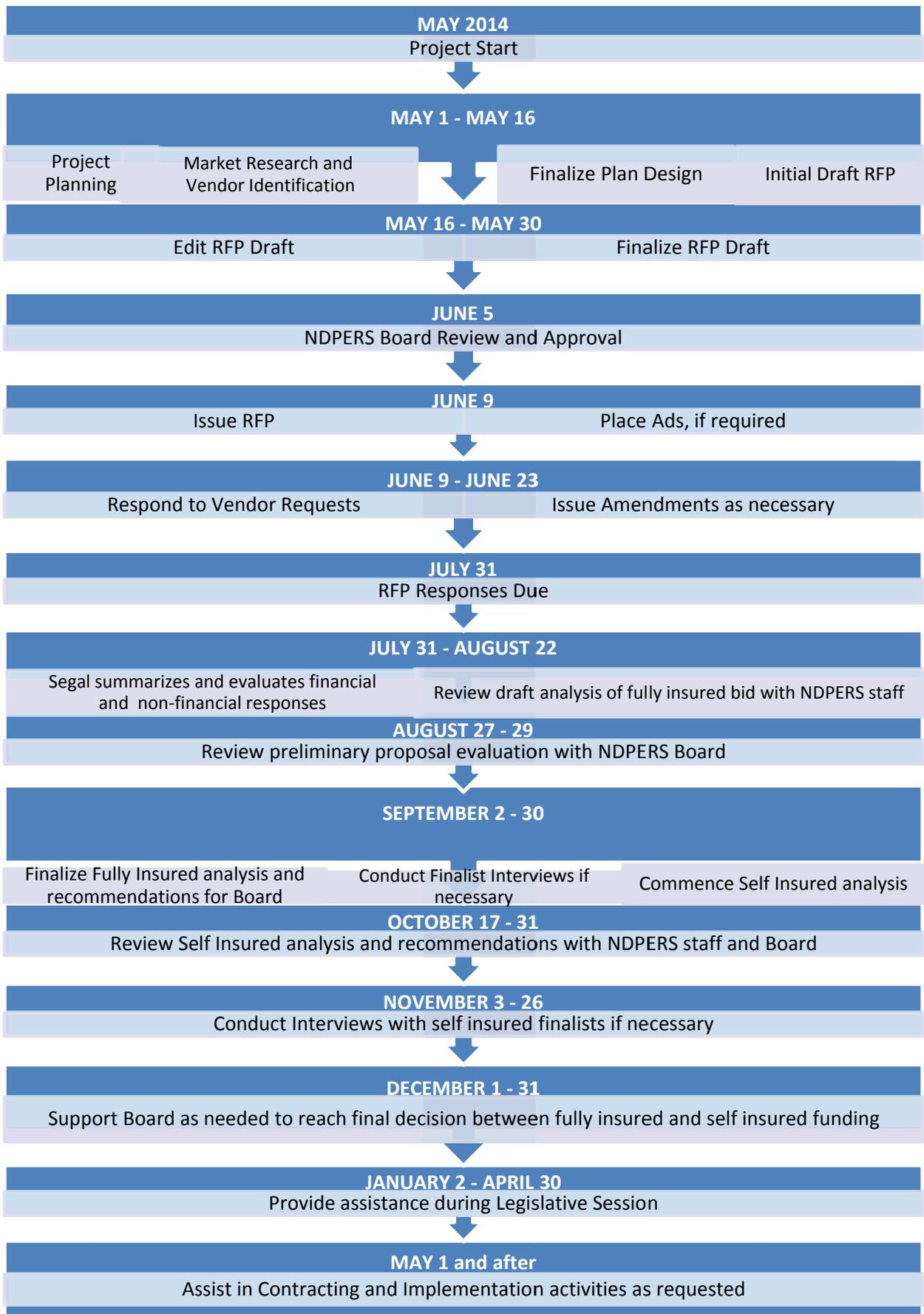
Segal assists many clients with the design, implementation and evaluation of group health plans on a fully insured and self-insured basis. In the evaluation and development of these RFPs, our methodology for each RFP would include the following steps:

Segal will take lead responsibility for:

- Identifying key markets and soliciting participation
- Drafting the Technical Specifications of the RFP
- Evaluating RFP responses
- Assisting in the Finalist Selection and Interview Process

b) Timeline – discuss your understanding of the timeline for this effort and your ability to meet those timelines.

Segal believes NDPERS has outlined a reasonable and attainable timeframe for processing their Dental RFP and we are staffed appropriately to accomplish the timeline set forth. A timeline is shown on the following page.



c) Approach – discuss your project plan for this effort, identify major steps, timeframes and products.

Segal assists many clients with the design, implementation, and evaluation of group health benefits. In the evaluation and development of health benefit plan elements, we take into account current “best practices” among other similarly situated employers. Our methodology would include the following steps:

A. Meet with Staff. Segal will schedule a meeting to determine the scope of the project and then develop a detailed work plan. At that meeting, we will identify the specific objectives for the health program and any initial parameters to be considered in the design, modification, or implementation of the plan. We will create a detailed work plan in collaboration with NDPERS that addresses the specific targets and deadlines for completion of the various tasks and steps.

B. Market Research. Segal will reach out to all major health insurers as well as those nominated by PERS to identify which vendors can provide the level of benefits and services desired by the NDPERS.

We will tap into the accumulated knowledge of our consultants working with similar sized groups across the country, whether public sector, corporate or multiemployer. This pooling of current knowledge can help us better understand which dental plan providers have had the most success meeting employer needs. This research will provide the backbone for the RFP vendor list.

C. Finalize Plan Design. The first step in designing the health plan RFP is to develop the primary plan design elements. These elements include such factors as eligibility requirements, patient cost sharing, and network issues, as well as services to be provided under the health plan umbrella, including medical management, prescription drug management, behavioral health, wellness services, etc.

D. Finalize Technical RFP. Segal has proven RFP templates to solicit and differentiate vendor responses. After including NDPERS plan specific information, we will ask NDPERS to review, edit and approve the final technical RFP specifications.

With respect to self-insurance proposals, one of the most important aspects is an evaluation of expected claims costs. This is discussed further in our response to question d).

E. Evaluation of Top Providers and/or Delivery Systems. Once the technical RFP responses have been received, we will engage in a detailed evaluation of bidder proposals. Our analysis will identify whether the provider meets any Federal, state or local regulatory requirements. We will consider the financial stability and solvency of the provider. In addition, we will look closely at how effectively the provider handles customer service for participants in the plan, including how a participant accesses the vendor through its call center operation. We will look for evidence of superior client service, particular in the vendor's day-to-day interactions with the client's benefits personnel. We will review the proposed systems for handling the health program and look for flexibility in adjusting to the NDPERS' operating systems (payroll, personnel and benefits system). We will assess the vendor's ability to handle claims processing in a timely and accurate manner. We will also evaluate the vendor's ability to provide appropriate management reporting, including the flexibility to produce any special ad hoc reports that may be needed by the NDPERS in the future.

F. Cost Analysis of Top Providers and/or Delivery Systems. We will compare the vendors' proposed costs in detail, focusing specifically on the levels of administrative fees, provider reimbursement

levels, and performance guarantees. We will prepare a side-by-side comparison of the costs along with rankings in each category for review by NDPERS staff.

G. Interviews. Segal will assist in developing the interview questions for finalists and participate in the interview process, including any negotiations that NDPERS might desire.

H. Implementation. Segal will serve in the role designated by NDPERS to support final contract negotiations and the implementation process.

d) Describe the method used by your firm to project expected claims. Also, provide specific details of how your firm decides the appropriate medical trend; what factors are considered; (i.e., historical claims trends, cost shifting, leveraging, intensity, etc.) and how these factors are weighted or allocated in the final decision. Please discuss how this relates to the NDPERS renewal.

Segal performs an annual trend survey of all major carriers in order to identify the consensus opinion on where trends are leading. This survey identifies the primary components of trend. We also believe information about projected local market conditions should be gathered from the local market network managers as an additional consideration, along with case specific trend of the NDPERS benefit plan. We believe that within a range of reasonable trend assumptions, and in consideration of the level of reserves in excess of IBNR, if any, that are available, that the self-insured plan sponsor should participate in the selection of appropriate trend assumptions and can provide sensitivity analysis as requested around the assumptions considered. In the context of a Fully Insured plan, Segal uses the knowledge gained from the research above to advocate for the lowest possible trend rates, or in lieu thereof, for experience sensitive contracts that allow either the deferred payment of a portion of the premium, or a refund, if actual trend comes in significantly below what we have been able to negotiate during our renewal analysis.

With respect to projection of expected claims under alternative self-insured and fully insured networks, Segal maintains a dual focus in network evaluation:

- Member Disruption
- Effective Discount Rate

Depending on the funding method and multi-year rate guarantees provided, these factors may take on varying weights in the final evaluation and selection process. Segal uses our depth of experience to assist our clients in evaluating the relative importance of each to meeting their long term goals.

With respect to self-insurance proposals from competing networks we will work with NDPERS to select the best alternative evaluation criteria based on the specifics of their situation.

Effective Discount Rate evaluation methodology will be selected in preliminary discussions with NDPERS of the pro's and con's of each approach. Examples of valid approaches and some high level pro's and con's are provided below.

UDS Analysis: The four major carriers; Aetna, Blue Cross and Blue Shield, CIGNA and United Healthcare all provide complete semi-annual data files of their actual network claims on a retrospective, adjusted and prospective basis to most major consulting firms. The advantage of providing consistent data to all major consulting firms in a specified format is a major factor weighing in favor of this method and reduces the possibility of subsequent appeals in the RFP process. For employers who expect these

four major carriers to be the primary responders to the RFP, this is the most consistent and accurate approach to comparing projected network claims. It allows the Segal company to perform an independent discount analysis that adjusts for geographic mix and other components in a manner that provides for a true apples to apples comparison of competing vendors.

The downside to UDS analysis is that it may not be possible to get data from vendors who do not currently participate in the UDS process. If NDPERS anticipates strong proposals to be provided by other than the top 4 medical networks, either advance work to solicit participation in the UDS data base should occur, or an alternative pricing methodology should be selected for evaluation purposes.

Repricing: If detailed claim level data is available by member, a file selected from a historical claims period, e.g. 12 months, can be provided to each prospective respondent to reprice. Because the methodology of repricing can vary from respondent to respondent it is important the consultant specify in the RFP instructions the specific manner in which the repricing is to be performed, or the results will be predictably inconsistent. Such approach requires cooperation from the incumbent health plan vendor to provide the detailed claims file to be used as the basis of the repricing exercise.

Target Claims PMPM: This approach requests each vendor to provide a Target Claims PMPM and meaningful guarantees around achievement of the Targets. In general this approach is useful to show the vendors confidence in their ability to perform, but the corridor around the Target Claims PMPM is generally too broad to lead to a high level of confidence in the projection.

Self-Reported Discounts by class: Allowing vendors to provide self-reported discounts by class, or average payments by class relative to Medicare Reimbursement have the advantage of not requiring respondents to participate in UDS or reprice a claims file provided by the incumbent. However, such approaches are generally considered less rigorous and virtually impossible to audit with any degree of certainty, thus requiring a fair degree of trust in the responses of the participating bidders.

As previously discussed, during the RFP planning process Segal will work with NDPERS to identify the best approach to claims projection specific to their objectives and the market environment in which the RFP is conducted.

- e) **Specifically, address how you would approach the review of the NDPERS bidding process, the product we could expect and the range of considerations you may review.**

The Bidding Process

At the outset of the process, we will assist PERS staff in setting parameters for the bid(s), to assure that the offerings received from vendors reflect the desires of the PERS.

The following steps would be included in this procurement:

- **Prepare RFP Specifications** – We will develop detailed specifications for inclusion in a formal request for proposal to comply with PERS’ bid requirements. We will also discuss with PERS staff specific criteria and question areas to be explored and analyzed for each qualified vendor candidate. We will work closely with PERS to include required language in the RFP.

The specifications sheet would include:

- » purpose for the request
 - » demographic information about the employee population
 - » request for vendors to present a plan that would be most appropriate for the structure and demographics of PERS employee population
 - » request for a financial proposal, including all program costs
 - » request for any design ideas or information on similar products the carrier might suggest
- **Market Research** – If in working through NDPERS objectives and specifications we believe advance market research is helpful prior to finalizing the RFP, we will do so in order to maximize the likelihood of quality/cost effective responses.
 - **Develop Vendor Lists** – We will identify vendors that should be included in the list of potential long term care vendors in addition to those already who have requested to be included on the RFP list.
 - **Issue the RFP and Conduct Pre-proposal Conferences** – We will assist in the pre-proposal conference and will help in responding to vendor questions. If acceptable, we will issue them through eRFP, our web-based proposal management system.
 - **Receive and review submissions** - Segal (or PERS) will receive the vendor submissions. We will then analyze the submissions for plan design.
 - **Analyze Proposals** – Once the competitive proposals have been submitted, we will analyze the proposals against each other and against the initial objective for the program. We will point out relative strengths and weaknesses and will analyze the cost and ease of implementation. We will review a wide range of criteria in making our comparison, including:
 - » administrative fees
 - » benefit levels

- » provider discounts
 - » financial stability
 - » commitment to performance standards and guarantees
- **Draft Recommendations and Present Final Report** – We will prepare and present a summary report of the entire analysis process, including the assumptions used in our comparisons and recommendations.
 - **Assist with Interviews and Negotiation with Finalists** – We will participate in interviews with the finalist vendors and will help to guide the questioning to assure that PERS is receiving all the information it needs to make an informed decision. We will also assist in direct negotiations with selected vendors and will provide additional price and cost analyses as required.
 - **Presentation to PERS** - We will present the results of our report as well as the outcome of negotiations with finalists to PERS.
 - **Assist with Implementation** – We will monitor progress of the selected vendor toward successful implementation and will assist in review of contracts and other documents required to carry out the program.

f) Exceptions – identify any exceptions or variations in your proposal from the work effort identified in this RFP.

Other than contractual exceptions listed later in the RFP as “Exceptions – Contract and BA Agreement” we have no exceptions or variations from the work effort identified in the RFP.

g) Outline the product NDPERS will receive from you.

Segal will provide consulting expertise around RFP development and customized editing to ensure the services and proposals requested in the RFP meets NDPERS objectives and provide appropriate documentation of the differentiation between competing vendors. Segal effectively deals with real life challenges in the RFP process to identify the most competitive contract offerings. Factors include:

- Vendor Stability
- Deviation from Benefit and Service Specifications
- Premium/Fee Analysis
- Projected Claims
- Network Analysis
- Service Capabilities
- Reporting
- Performance Guarantees

Segal will provide a report which identifies key differentiators, and cost projections as the basis of staff and Board evaluation.

Segal will provide draft interview questions and participate as requested in any finalist interviews.

Segal will consult staff and Board members relative to the merits of finalist proposals.

Segal will review contracts and support implementation of awarded contracts as requested.

h) Identify your assumptions concerning the contributions of NDPERS staff toward this effort (i.e. that NDPERS staff will provide the data for projections, timeframes for NDPERS review of material, estimated dates that NDPERS staff need to be available for meetings, etc.)

Based on the preliminary timeframes previously outlined, it appears NDPERS staff will be most engaged during meeting(s) related to the project planning period from May 1 – 16, collecting data during the RFP development phase from May 1 – 30, and meetings the weeks of May 26, June 1, June 18, August 17, August 24 and thereafter based on direction provided by the Executive Director and Board.

Input from the NDPERS staff during the RFP development and market research phase is critical to assuring a positive response from quality cost effective firms. During this process which may include a pre-bid conference, NDPERS staff will:

- Identify key vendors to be considered and review vendor lists proposed by Segal in order to select and identify the proper person to receive the RFP. Ensuring the RFP gets into the right hands at the start of the RFP cycle dramatically increases the chance of competitive proposals.
- Discuss with Segal and identify potential stumbling blocks in services requested and bid requirements. The goal is to eliminate any non-essential requirements that scare off vendors.
- Discuss with Segal, identify and incorporate Mandatory Requirements into the RFP draft. Weeding out less qualified vendors before RFP submission often results in more competitive proposals from the remaining vendors.
- Work with Segal to identify the most appropriate approach to managing the RFP process. If NDPERS permits use of eRFP, our electronic RFP engine, we are able to track system access and progress and encourage all vendors to engage adequate resources throughout the process to effectively respond. The ability of this system to push out RFP amendments and answer vendor questions on a consistent and real time basis improves vendor responses and competitiveness while significantly reducing consulting hours spent during the proposal evaluation process.
- Work with Segal to collect plan documents, enrollment data and claims data from current vendors in support of the RFP effort.

2. Experience (a-o)

a) General firm experience – a brief description of the size, structure and services provided by your organization.

The Segal Group, founded in 1939 by Martin E. Segal as The Segal Company, is an independent, privately held consulting firm. It has been employee-owned by its officers since 1978. There are currently 245 employee owners. An 11-member Board of Directors sets policy and governs the organization. Implementation of policies, development of strategies and day-to-day operations are the responsibilities of the Chief Executive Officer.

As employee benefits, actuarial, compensation and human resources consultants to the public sector, we serve the needs of a wide range of clients, including:

- State and local governments
- Statewide employee retirement systems and health benefit plans
- Public school and higher education institutions
- Federal government agencies and other public organizations and entities
- Special districts: transit, utilities, water, toll and port authorities.

The Public Sector Market of the Company provides benefit consulting services to over 325 clients, representative of 40 states plus the District of Columbia, the U.S. Virgin Islands, the U.S. Government, and Canada. Health consulting services are provided to 193 public sector funds including state, local, transportation, and both primary and secondary education venues. Covered lives vary in size from 60 to over 1.8 million.

Our services include:

Health and Welfare Plan Consulting

- Medical, dental, disability, prescription drug, and vision benefits plan design
- Valuation of retiree health plan liabilities and obligations according to GASB (Governmental Accounting Standards Board)
- Cost management strategies
- Financial forecasting and trend analysis
- Plan trend and industry benchmarking
- Plan administration and compliance strategies
- Vendor selection, contracting and management services
- Quality performance standards

Compensation and Collective Bargaining Consulting

- Employee opinion surveys to support reward system design
- Customized rewards system design and implementation
- Customized compensation surveys and cost modeling
- Classification studies and job descriptions
- Job evaluation and classification analyses
- Collective bargaining support
- Human resources training

Retirement Plan Consulting

- Defined benefit and defined contribution consulting
- Actuarial valuations and audits
- Supplemental savings plans 457, 403(b), 401(k)
- Deferred Retirement Option Plans and Partial Lump Sum Plans

Compliance Consulting

- Preparation and review of plan documents, enrollment information, and participant correspondence
- Internal Revenue Code, state and local law, and GASB compliance
- HIPAA assessment, compliance and training programs
- SPD (Summary Plan Descriptions) review, drafting, and redesign

Claims Audit Consulting

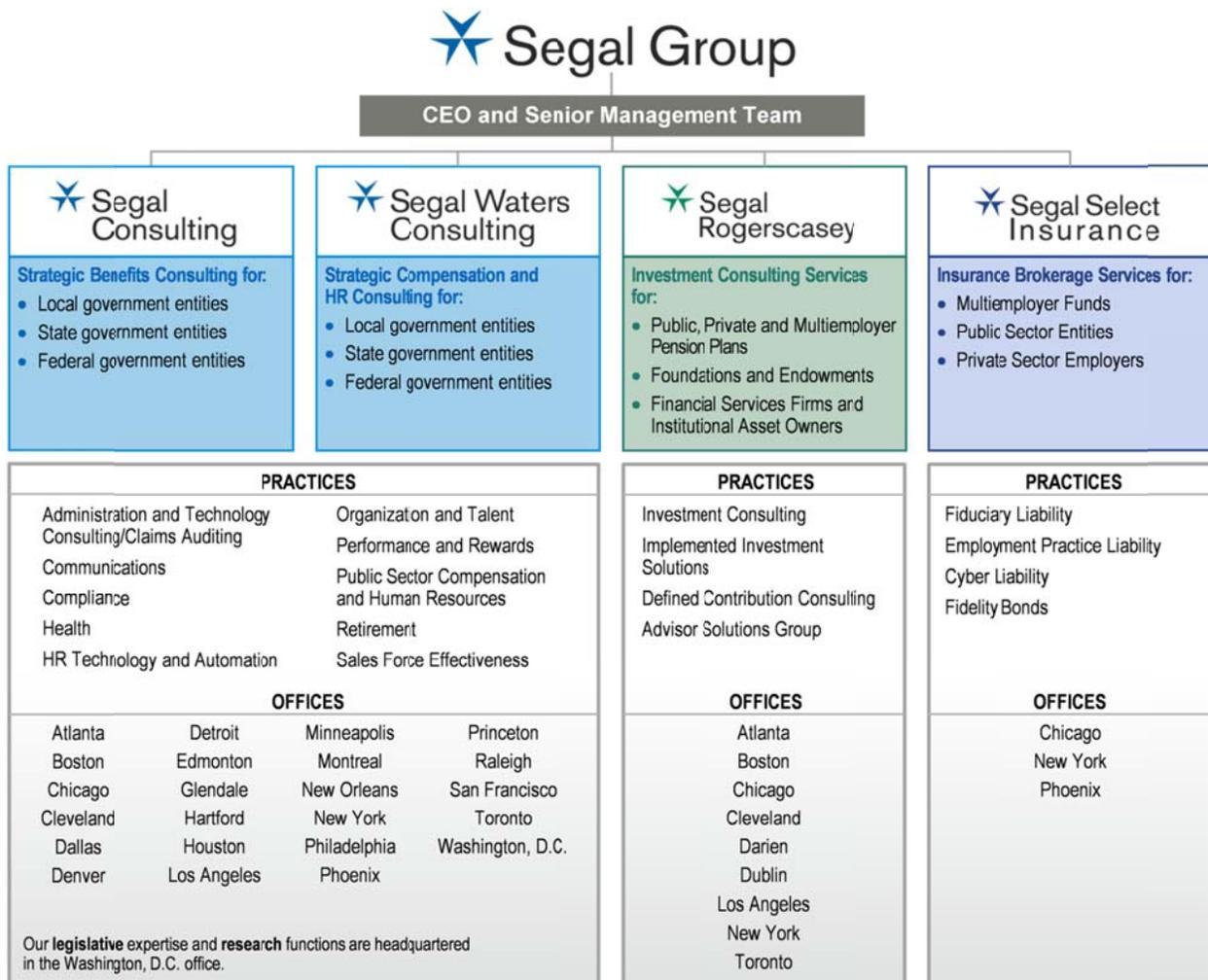
- Analysis of medical, dental, disability, vision, and/or prescription drug claims administration and transaction processes
- Assurance of financial and procedural accuracy in compliance with plan provisions and timeliness of claims adjudication
- Review of insurance carriers, third party administrators, and self-administered plans

Communications Consulting

- Open enrollment communications
- Communications assessments, employee research, strategic planning
- Organizational change communications
- Compensation and performance management communications
- Personalized communications and benefit statements
- Web site content development and design

Administrative and Technology Consulting

- Review of strategic initiatives and business objectives
- Assessment of administrative processes, organizational structure and operational technology
- Feasibility studies of administrative alternatives
- Process re-engineering
- Technology assessment, acquisition and implementation



Consulting and Actuarial Experience with Governmental Entities

Segal has consulted to state and local governments and the federal government on their health benefit and retirement programs for over 60 years. Our experience extends not merely to routine plan design, premium rate renewals, actuarial valuations and rate setting, but also very strongly to the special projects where jurisdictions are exploring new options to meet new challenges. Segal is committed to growing the public sector entity business, as we recognize government clients require an array of specialized expertise. Your Segal actuaries and consultants have assisted clients with:

- Designing health and welfare and retirement plans for government entities that offer innovative private sector solutions to state or local governments;
- Working with States on health care reform;
- Developing innovative financial risk management strategies, incorporating best in class models;
- Providing comprehensive data analytics and clinical support in order to delve deeper into the health cost drivers in order to develop real world action plans for cost savings; and
- Vendor RFPs and contract/renewal negotiations

Segal actuaries have worked with other states and local governments to develop risk-adjusted rates, rate certifications, cost-reduction strategies, forecasting, deficit management, and risk programs.

Segal serves many public sector clients at all levels from local jurisdictions to states to the federal government. The following are selected current and recent clients:

Sample Segal State Government Clients

State of Delaware	Michigan Office of Retirement Systems
Government of the District of Columbia	Missouri Local Government Employees Retirement System
State of Florida	Ohio Public Employees Retirement System
State of Hawaii	Ohio School Employees Retirement System
State of Illinois	Pennsylvania Public School Employees' Retirement System
State of Maryland Comptroller	Illinois Teachers' Retirement System
State of Maryland Dept of Budget & Mgmt.	Maryland Supplemental Retirement Plans
State of New Hampshire	Georgia Municipal Employee Benefits System
State of North Carolina	Illinois Teachers' Retirement System
State of Tennessee	Minnesota State Retirement Systems
State of West Virginia	Nevada Public Employees' Retirement System
State of Wyoming	North Dakota Public Employees Retirement System
Arizona State Retirement Systems	North Dakota Teachers Fund for Retirement
California State Teachers' Retirement System	

District of Columbia Retirement Board	Ohio Public Employees' Retirement System
Georgia Municipal Employees' Retirement System	Rhode Island Employees' Retirement System
Illinois Municipal Retirement Fund	Texas Municipal Retirement System
Retirement System – Health Options Program	University of California Retirement System
	Wisconsin Retirement System

b) Identify and discuss similar projects you have done, for who, when and how they compare to this project in terms of work efforts. Also discuss the outcome of those projects if that information is available.

Segal annually drafts, issues and produces analyses for well over 100 bid specifications for clients. Mr. Gary Petersen will be managing the process for NDPERS. Mr. Petersen has been managing RFP processes for Health and Prescription Benefits, Dental Benefits, Life and Disability and other employee benefit offerings since 1983. During that time, he has worked with numerous States, Counties, Cities and Corporations to achieve their goals and objectives. In the past 5 years his Segal clients have included RFP projects for the State of Colorado, State of New Mexico, State of South Dakota, New Mexico Public Schools Insurance Authority, New Mexico Retiree Health Care Authority, Albuquerque Public Schools, Clark County NV, City of Houston, and he has assisted other consultants on special RFP projects related to their clients as well.

While results vary based on objectives and market, his engagements frequently result in significant cost savings by taking advantage of emerging market opportunities and always focus on achieving best in class financial terms and conditions while balancing member needs.

In addition, Segal works with a number of other large States and institutions and works hard to incorporate the knowledge gained through assignments with groups like the State of Georgia, State of Maryland, Pennsylvania Public Schools Employees' Retirement System and others into our RFP process.

c) Discuss your experience in working with Part D products in general and in the public sector. In particular discuss your experience with products similar to NDPERS product.

Segal works with a number of other large States and institutions in the EGWP and Medicare Advantage PDP market in order to advise them on how to best take advantage of federal funds that are available to support Medicare Retiree Drug programs. Recognizing that the 28% federal Retiree Drug Subsidy did not represent the most cost effective approach available to providing prescription drugs to the plan sponsors Medicare population, Segal actuaries and consultants supported early adopters of Medicare Advantage PDP and self-insured EGWP programs. This issue has continued to evolve with the changes precipitated by ACA and Segal will assign experts in this area to work with NDPERS to develop and maintain a cost effective go forward strategy. Some of our clients include New Mexico Retiree Health Care Authority, Pennsylvania Public Schools Employees' Retirement System and others who have saved millions of dollars by taking advantage of the opportunities available to them.

d) Discuss your experience in doing health premium projections such as that requested in this RFP.

Mr. Petersen and the Phoenix office team perform health premium, claims and IBNR projections for fully insured and self-insured plans for over 80 clients annually. Mr. Petersen's personal clients include the State of Colorado, New Mexico Retiree Health Care Authority, New Mexico Public Schools Insurance Authority, Montana Unified School Trust, Colorado Contractors Health Trust, Northern Arizona Employee Benefits Trust as well as providing consulting support to the other Segal consultants in the office on an as needed basis.

e) Discuss your experience in assessing wellness programs.

While the NDPERS RFP does not address specific objectives relative to Wellness programs, our response considers that such activities could be performed on an hourly basis under the non-fixed fee component of the proposal. Our Sibson consulting division has invested significantly in wellness research and have published the results of their thought leadership in numerous publications, see <http://www.segalco.com/publications/publicsectorletters/nov2013.pdf> for how to measure the effectiveness of your wellness program, <http://www.sibson.com/publications-and-resources/articles/ISCEBS-Benefits-Quarterly.pdf> for our Healthy Enterprise initiative and <http://www.sibson.com/publications-and-resources/articles/workspan-article-10-13.pdf> for an article on Behavioral Economics as it relates to Wellness. These articles are also reprinted in Section b for your convenience.

Segal regularly works with a variety of employer/plan sponsors including corporate, public sector (city/town, county, state and school districts), and multiemployer union funds to help them implement, evaluate and manage both wellness (also called disease prevention or health promotion) and disease management (DM) programs. Because of the uniqueness of these Wellness and Disease Management Programs, no two plan sponsor projects are ever exactly alike...they are highly customized to your unique needs. While our consulting assistance for support of Wellness and Disease Management initiatives can vary significantly from client to client, one approach for those just getting started along the health promotion path can be arranged in phases as follows:

Phase One: Inventory and Organization by Risk Factor. This phase involves finding out exactly what you are wanting to accomplish (your goals), what group of individuals you want to reach (employees only or employees plus dependents, retirees, etc.), your financial resources for these programs, what health/wellness/disease management services are already available either through your own internal sources or through your existing vendor relationships and benefit programs (an inventory/gap analysis), what is working and not working with any current wellness and disease management services and your desired timeframe to implement new/enhanced wellness and/or disease management services.

To do this assessment we use our proprietary Segal Wellness and Disease Management Inventory tools to assist in gathering comprehensive information about your current Wellness and Disease Management services. For example, the Wellness Inventory currently lists 165+ wellness ideas and while you may often only be performing 1/4 or 1/3 of these wellness ideas, the results of the inventory give you numerous new wellness program ideas. Some of these ideas are no cost or low cost while some ideas need to have a fee projection to determine the financial impact of adding that new wellness service.

We then outline for you the wellness and disease management services you already have available/offer and the array of other wellness/disease management options available organized on a chart by health

risk factor using Segal's Wellness Action Plan (and by disease for the disease management Action Plan). This assures that there is no accidental duplication of wellness and disease management services and fees, unless you want such an overlap. You can then see exactly which wellness services you offer to control health risk factors like weight, exercise, stress/depression/anxiety, smoking, etc. and what support you offer to participants who already have a chronic disease like diabetes or heart disease. This Action Plan organizes your wellness program so you can focus future wellness program enhancements on the risk factors you want to help your participants reduce/eliminate. The Disease Management Action Plan organizes your current efforts to assist participants to better control their chronic disease and gives ideas on other ways to assist them.

Incentives/Rewards/Penalties: It is also at this point that you, like most plan sponsors, will want to discuss incentives for encouraging participation in wellness services or for actually changing behavior (stop smoking, lose weight, reduce blood pressure) or incentives for both participation and behavior change. Here Segal discusses your philosophy and budget constraints as relates to incentives/rewards or penalties. Many clients have their own legal counsel review proposed incentive/penalty design before they are implemented.

Phase Two: Employee Communication Material. Some plan sponsors like to take this inventory/outline of existing wellness and disease management services and have Segal create a brochure for distribution to all plan participants letting them know what is available, any out-of-pocket costs and how to access the existing wellness and disease management services/benefits.

Additionally you, like many plan sponsors, may want a formal 12-month strategic communications plan of action to help implement ideas from the Wellness and Disease management inventory projects. Segal's Communications Department prepares this strategic plan along with any brochures, magnets, flyers, posters, videos, website enhancements, etc you want in order to boost interest and enrollment in the wellness program offered (and disease management programs if you want).

Phase Three: RFP Preparation and Analysis. This phase (when desired) includes Segal's creation of a customized request for proposal for either or both Wellness and Disease Management Services. This phase also includes creation of custom vendor bid lists, analysis of bids, coordination of vendor interviews/reference checks and management of the best and final process to allow you to make an appropriate selection of vendors.

Phase Four: Vendor Implementation. This phase (when RFP phase is selected) typically consists of meetings between your staff, the newly selected vendor and Segal to work through all the steps of the implementation process including contract language, performance guarantees, reports style/content and frequency and ongoing vendor management.

Phase Five: Formal Written Wellness Business Plan: This phase is available if you would like to formalize your wellness program. The written business plan is a custom document to outline your wellness program mission, vision, goals, objectives along with the design of an employee wellness committee, short and long term goals, incentives, etc. The Business Plan becomes the framework for the program and guides your month to month wellness program activity.

- f) **Discuss your experience with reviewing Rx programs and proposals in general and for clients similar to NDPERS. Include in the discussion your experience in analyzing clinical programs, specialty drug programs, Rx networks, drug utilization review programs and rebate methodologies.**

Prescription Drug Benefits and Cost Control

Rapidly rising prescription drug costs are driving overall increases in the cost of health coverage, and plan sponsors are struggling to rein in these benefit costs. The Affordable Care Act of 2010 (ACA) has created significant changes in Medicare Part D and has important implications for plan sponsors who provide prescription drug benefits to their Medicare eligible retirees. Segal also offers expertise in addressing the rising cost of specialty drugs- high cost, bio-engineered drugs- used to treat rare and complex conditions. We are experienced with the specialty drug programs and tools available from the major PBMs, including the specialty drug management programs.

The Segal Company's three-step approach to achieving cost savings focuses on plan design, vendor management and individual health management. In addition, we offer an array of services designed to optimize pharmacy benefit management. Segal can help the System manage the cost of prescription drug coverage through a variety of services, including:

- Performing RFP analysis of bundled and carve-out prescription programs
- Performing Prescription Drug Program Analysis (PDPA) that audits the performance of a pharmacy benefit manager (PBM) to assure that all contract provisions are being administered correctly and that a client is receiving the maximum financial benefit from the guaranteed pricing term
- Evaluating and negotiating annual renewals
- Reviewing utilization and cost data to discover ways that a client can more effectively provide prescription drug coverage by making plan design changes
- Providing input and advice regarding changes to the prescription program proposed by the PBM, including addition of Medication Management programs, changes to the formulary, or restrictions/expansions in the network
- Reviewing the contract to evaluate whether the terms are competitive
- Managing specialty pharmacy costs through utilization and cost reviews, data analysis, formulary management through tiered cost sharing, clinical management, monitoring high-risk participants and step therapies
- Reviewing prescription copays and/or coinsurance and targeting copays to encourage individual health management
- Evaluating generic prescription utilization, generic dispensing rates and generic discounts in the current contract, and improving generic dispensing rates through aggressive plan redesign and pricing improvements
- Implementing a tiered plan design using copays or coinsurance

- Reviewing Average Wholesale Pricing (AWP) costs by checking a plan's contractual language on AWP reimbursement and renegotiating to address revised drug pricing
- Evaluating Value Based plan designs
- Analyzing clinical programs to determine the impact and potential advantage for both the plan and its participants.

We have assisted a number of clients improve the management of their specialty drug utilization with a variety of strategies including the optimization of channel distribution, implementation of prior authorization and other guideline management programs, and re-contracting terms with a specialty drug provider. Many plan sponsors can lower their cost for specialty drugs while at the same time improve the quality of care and service received by plan participants.

We are currently working with a large number of clients in determining the potential impact of moving to an EGWP.

We have assisted four of the initial nine Employer Direct-Contract Prescription Drug Plans in becoming qualified with Medicare to receive CMS reimbursements for Medicare prescription drug coverage.

g) Discuss your experience in assessing claim payment systems offered by vendors.

Segal is one of the few major consulting firms still providing Claims Audits using our own professional Audit staff. Part of our Administrative Technology Consulting practice, we are able to call upon these resources both during the RFP process to assess claim payment systems, as well as afterward to provide a post implementation set-up audit, or a stratified Claims Audit once the plan has been in place for a period of time.

This proposal offers to incorporate best practices questions into the RFP questionnaire to ensure proper controls are in place for efficient administration of the Plan and accuracy of benefit plan payments. In addition, if NDPERS wishes to engage us for a post implementation audit to assess the selected vendors initial plan set up we are happy to assist. The scope of services provided can be tailored to meet any additional concerns or objectives NDPERS may have.

Should NDPERS wish to audit the claims processing for contract compliance and accuracy at a later date, Segal stands ready to provide the needed assistance. The unique aspects of administering medical and prescription drug benefits requires individual scopes of services to effectively assess the respective vendor's performance. Medical claims, which include multiple benefit variables and a significant amount of human intervention, are addressed through statistical and target claim samples. Prescriptions that are electronically captured and adjudicated at the point of sale lend themselves to 100% electronic analysis.

h) Provide a list of clients for whom your organization has performed similar tasks and specifically highlight efforts in the public sector.

As previously addressed, Segal annually drafts, issues and produces analyses for well over 100 bid specifications for clients. Mr. Gary Petersen will be managing the process for NDPERS. Mr. Petersen has been managing RFP processes for Health and Prescription Benefits, Dental Benefits, Life and Disability and other employee benefit offerings since 1983. During that time, he has worked with numerous States, Counties, Cities and Corporations to achieve their goals and objectives. In the past 5

years his Segal clients have included RFP projects for the State of Colorado, State of New Mexico, State of South Dakota, New Mexico Public Schools Insurance Authority, New Mexico Retiree Health Care Authority, Albuquerque Public Schools, Clark County NV, City of Houston, and he has assisted other consultants of special RFP projects related to their clients as well.

While results vary based on objectives and market, his engagements frequently result in significant cost savings by taking advantage of emerging market opportunities and always focus on achieving best in class financial terms and conditions while balancing member needs.

In addition, Segal works with a number of other large States and institutions and works hard to incorporate the knowledge gained through assignments with groups like the State of Georgia, State of Maryland, Pennsylvania Public Schools Employees' Retirement System and others into our RFP process.

i) Discuss your experience in reviewing the adequacy and pricing implications of vendor provider networks and comparing networks from one provider to another.

We discussed the importance and selection of the proper techniques for evaluation of network discounts in Section 1, d).

In addition, network access is a critical concern during the RFP process. The availability of primary care physicians, specialists, hospitals and Centers of Excellence is critical to member satisfaction and health. While many plan sponsors will focus on GeoAccess reports as a means of identifying gaps in coverage availability, we also believe member disruption should be measured. By providing a claims file from the existing vendor, we ask competing vendors to indicate the number of visits and the number of claims dollars that would fall within their network if the plan sponsor was to change vendors. While most major networks in a Metropolitan area will show very similar GeoAccess results (this is not always true in a rural area population), there is almost always a measureable level of member disruption caused by participants having to choose new providers in order to receive In-Network benefits. Segal strives to provide comprehensive and meaningful analysis of all issues surrounding network adequacy and member disruption as part of our RFP analysis for NDPERS

j) Indicate your organization's depth of experience in each of the following areas:

Benefit Design (Health)

With health benefit cost increases currently outpacing the Consumer Price Index by a large margin, public employers balance increased subsidies to employees that exceed fiscal year budgets against increased employee contributions that consume the employee's pay increase. This environment calls for a comprehensive approach to formulating plan design strategies that includes data analysis, benchmarking, demographic assessments, vendor management and knowledge of emerging industry trends. Segal is experienced in working with public entities that face these challenges.

Many public sector employers operate benefit plans without overall benefit objectives. Often, this is because plans have evolved over long periods of time and have come to be administered by different departments or agencies under different political oversight. As your consultant, we can help you:

- Identify key decision-making areas;
- Focus attention on making and maintaining a consistent set of objectives;
- Evaluate the demographics of the employee, dependent and retiree populations, plan experience, budget constraints, and the client's benefit philosophy; and
- Develop health care benefits that meet the goals of the client as well as the needs of employees in the most cost-effective manner.

Retiree Health Insurance

The cost of retiree health coverage, which is already a serious concern for sponsors of public sector health plans, has already become the focus of increased attention as the Governmental Accounting Standards Board (GASB) has issued its final standard on reporting liabilities for retiree health and other post-employment benefits. Segal has participated and advised throughout the development process of this standard and is prepared to assist NDPERS in addressing the issues that flow to benefit program design as a result of the reflection of retiree liability on the organization's balance sheet.

Segal can provide the following plan design services to assist in managing retiree health costs:

- Reviewing and revising eligibility rules,
- Setting up purchasing coalitions,
- Negotiating discounts from pharmacy benefit managers (PBMs) and other vendors,
- Developing new ways to coordinate coverage with Medicare, including a supplemental approach, and Assessing features that may encourage retirees to become better health care consumers.

At Segal, we know that costs for retiree's health coverage need to be examined with varying time horizons. A short-term view requires an analysis of current retiree costs over the next two or three years. Recommendations for handling short-term issues may include plan design and participant contribution alternatives. Plan design issues for retiree health coverage are very similar to plan design issues for active coverage but with heavier weight on prescription drug coverage and Medicare integration, the two forces driving health costs for Medicare retirees.

As the horizon moves long-term, the impact of new retirees must be considered. This will typically include preparation of an actuarial valuation of those costs since this analysis will look at costs five to ten years out and consider long-term planning of more than ten years. Areas that may be reviewed include eligibility for retirement and replacement ratios (coordination with pension plan issues and concerns). Long-term funding and reserving may be addressed. Strategies that provide benefits that vary based on age or service can be developed as well as plans that provide caps on costs to the program.

With the publication of the Government Accounting Standards Board (GASB) exposure draft on accounting for other post-employment benefits, public employers must begin reflecting the annual cost and liability for health benefits promised to retirees on their financial statements. Segal can assist in analyzing retiree health liabilities and in designing the retiree benefit program to balance costs.

To take advantage of emerging market opportunities, Segal is also involved in evaluating and negotiating private exchanges for Medicare Retirees and creating strategies to leverage Medicare Advantage opportunities in the market.

Preparation of Plan Documents

We have a dedicated compliance department that is responsible for the development and review of all plan documents for both health and retirement plans. We produce summary plan descriptions (SPDs) that are reader friendly yet compliant with Federal law.

Preparation of Member Booklets

Segal is experienced in creating employee educational material that relates to the benefits being offered including SPDs, open enrollment material, newsletters, etc. In the event customized design and production of plan booklets are needed, Segal has a Communications Practice available to provide these services. Further, we are increasingly working with our clients to integrate Intranet and web-based applications into their overall communications and administrative efforts.

Concurrent with the development of plan documents, we continually are developing employee booklets. We view the member booklets not only as a vehicle to describe the benefits but as an important component of an ongoing communication campaign, as part of a total cost management strategy.

Provider Contract Negotiations

Segal has an extensive team of experts fully prepared to coordinate the NDPERS' benefit plan renewals. Our approach is to aggressively negotiate with the providers/vendors limits on subsequent year's increases, generally defined to an acceptable and reliable index. We continue to conduct negotiations and develop contracts on a direct basis with providers, as well as with provider networks. Additionally, performance guarantees that place financial penalties on the vendors will be incorporated in the contracts. Implementation terms and schedules will be negotiated in the best interest of NDPERS for successful transition.

Segal's resources and substantial strength in the marketplace will provide PERS with the best information and credibility within negotiations to achieve the most effective results. Our technical expertise, depth and experience enable us to evaluate design alternatives within program offerings, funding alternatives, services provided, contribution strategy and innovative solutions with an innate understanding of the public and private employer requirements.

The Phoenix office issues RFPs and negotiates well over 100 contracts annually.

PPO Formulation and Development

While traditionally focused on selection of existing PPOs in the commercial marketplace, we recognize that the desire to identify and negotiate special contracts with Onsite Health Clinics, Centers of Excellence or to create a custom network is sometimes in the clients best interest. When such issues are present, we feel that it is critically important to develop such contracts based on solid data analysis and benchmarks. In this case, we believe it is of critical importance to have access to the clients detailed claims data to identify current provider costs, identify variations in provider costs and compare such costs to appropriate comparison benchmarks, e.g. Medicare pricing. While beyond the scope of this proposal,

we are happy to entertain a conversation around those area's we feel may be in NDPERS best interest to explore.

As a recent example, Gary Petersen and Sadnha Paralkar from Segal assisted the State of South Dakota in the development of a customized Health Clinic RFP to identify the best resources and approach to develop the State's pilot program for State sponsored health clinics.

Actuarial Analysis and Reporting

Segal has developed sophisticated claim reserve and funding projection models. We have developed our own proprietary dental pricing software and purchase dental fee data to allow us to perform discount analyses and actuarial projections. We also maintain rate projection and IBNR calculation modules. Finally, we offer clients the opportunity to participate in either Segal's internal data warehouse or an external data warehouse based on the specific needs of the client for sophisticated and actionable claims data analysis.

Preparation of Contracts, Bid Specifications and RFPs

There is no prescription or exact schedule that determines when it is "right" to obtain competitive bids on employee health plans. A decision to market your benefits is a strategic decision that needs to consider the potential gains vs. the time and other costs involved with marketing, as well as your readiness and willingness to make a change. When you have experienced a service failure, have encountered unresolved carrier flexibility, when your needs have outgrown the capabilities of your carrier, when costs are no longer competitive, or when costs are not reflective of your claims, it may be time to consider marketing. Other factors such as, standard purchasing procedures, and influence from your constituents also need to be considered. Competitive marketing "can" address and improve your programs. Segal will gladly assist you in the competitive bidding process. However, we will also seek out and demonstrate other alternatives as your partner in choosing the best solution, which may or may not include competitive bids. We recognize the value of competitive marketing, but it is not always the best way and certainly not the only way to get the best price. It is not a silver bullet in improving costs and service, only one of many tools. When the time is "right" for the county, Segal will be by your side.

Your Segal team has extensive experience in marketing insurance, self-insured, self-funded and partially self-funded benefit programs. We do not have a single preferred vendor where we place all or most of the business of our clients. Instead, we have experience and considerable clout in working with all of the medical, dental, vision, life, disability, and other benefit program vendors nationally.

Our experience covers a broad range of services not always familiar to all consultants, and over the years our consultants have been one of the first to analyze and implement innovative benefit programs, including:

- Implementation of the nation's second and third Point of Service medical plans (City of Phoenix was one of those along with the State of Arizona)
- First to negotiate HMO rate reduction for carve-out of Behavioral Health to independent vendor
- Implementation of Quality Bonus structure in managed care environment
- Design of Flexible Compensation programs under IRC Section 125
- Design of Consumer Driven Health programs

- Our experience includes marketing fully insured, partially self-funded, and self-funded:
- Medical Indemnity, PPO, HMO and Point of Service programs
- Behavioral Health and EAP programs
- Prescription Drug programs
- Disease Management and Wellness programs
- Dental Indemnity, PPO, and Prepaid/DMO programs
- Vision programs
- Basic and Supplemental Life, Accidental Death and Dismemberment, and Travel Accident programs
- Short-Term, Mid-Term, and Long-Term Disability programs
- Long Term Care programs
- Voluntary Benefits including cancer coverages, prepaid legal, etc.
- Third Party Administrators, Network Selection, and other service providers for self-funded employers

COBRA Administration and Interpretation

Segal does not provide administrative services. However, we frequently help our clients find administrative solutions to help them manage their plans including COBRA, FMLA, FSA and full benefits administration. This process typically includes specification development, RFP creation, bid analysis and contract negotiation.

Should you wish to administer these programs in-house, Segal has prepared various manuals for clients, including but not limited to, COBRA administration, HIPAA Certificate of Creditable Coverage administration, HIPAA Privacy and Security Policies and Procedures. The manuals are customized for each client, based on the degree of the client's involvement in the day-to-day administration of these operations. Initially an assessment is performed by our Compliance Specialists to determine an "as-is" state and identify gaps in the administration. Upon completion of the assessment, the manual is then developed.

In addition, our Health Compliance practice is ready and available to respond to regulatory questions that may arise in the course of COBRA administration on a day to day basis.

Disease Management and Wellness Programs

Wellness and disease management programs have become very commonplace among employers, and we believe can add significant value to both the short- and long-term health of your employees and your benefits programs. Segal's Healthy Enterprise research indicated that disease management programs were the most prevalent, but considered the least effective and least important to overall wellness practice effectiveness among the various wellness and disease management practices included in our study.

However, it has been our experience that most employers have taken somewhat of a “scatter-shot” approach to implementing both wellness and disease management programs. Therefore, Segal prefers to develop a wellness and disease management strategy which considers all of your vendors’ offerings, any in-house programs you may have, how to most effectively impact employees who are at very different stages in the health status continuum and addresses the disease states most critical to your population.

Creating a disease management strategy and making it stick is not just about determining your major disease states and implementing a few wellness programs. An effective strategy seeks to create a shared mindset across the organization about the importance of wellness and healthy behavior. It takes advantage of the resources of the organization. It assures that people feel responsible and accountable for the success of the program.

We have extensive experience in helping organizations design and implement disease management programs, from relatively modest ad hoc efforts to full-blown, multi-year, multi-element programs. The scope of any disease management programs depends on how broad the gap is between current conditions and the desired state, as well as the organization’s goals and resources. These factors, among others, would be explored in depth at our initial planning session.

Measuring the effectiveness and impact of disease management programs can be very difficult for a number of reasons. As a starting point, we recommend evaluating participation levels, satisfaction of participants, the impact on gaps in care, changes in lifestyle behaviors and biometrics, rates of hospitalizations and emergency room visits and finally impact on health costs, absence, disability. Depending upon the size of the group, some of these measures will not be reliable and given the higher risk nature of the group in disease management programs, outliers could skew the results.

Rx Carve-out Programs

Recognizing the highly technical and rapidly changing environment in which prescription benefit contracts are administered, Segal has developed a dedicated National Prescription Consulting team that is directly involved in all significant client engagements. While many of our actuaries and consultants are well versed in the prescription practice, we find that our Clinical Pharmacists and Prescription Benefit Financial Analysts enhance the value of our services by leveraging best practices contracting knowledge on a real time basis. For more than a decade it has been true that if you have not renegotiated your prescription contract using a dedicated specialist in the last two years, you are likely leaving money on the table in an increasingly competitive market.

Legal Assistance

Segal maintains a National Health Compliance staff in Washington DC comprised of attorneys who track and analyze emerging legislation and regulations. The National Health Compliance staff works with local Segal staff attorneys and compliance specialists who are pro-actively responsible for informing our clients and consultants as to emerging and problematic issues.

While we do not practice law, we work with many jurisdictions to interpret legislation and regulations and develop action plans to comply. Where an issue does not have a clear interpretation under existing law we always recommend that the client obtain outside counsel or refer the matter to internal counsel. Many of our clients outside counsel turn to Segal to assist them in helping clients educate their staff on compliance issues, maintain their compliance status, develop participant communications, and draft mandatory plan documents.

k) Describe your organization's experience and availability regarding legislative hearings and testimony.

Segal assists our public sector clients in developing and implementing health policies and processes in a number of areas as outlined below. Segal consultants and actuaries have direct experience in giving testimony to legislative committees, public boards, commissions and other governing bodies in both open and closed session.

1. Proposed Legislation

We work closely with our public sector clients to identify the impact of proposed legislation at state and federal level that would change the benefit requirements and cost for the plan. Legislation is often policy based and we assist our clients in determining the rationale of the policy and how it might be implemented or altered to allow smooth plan operation. Often these analyses take the form of fiscal notes that must be reviewed and responded to on a short turnaround basis.

2. Strategic Plan Implementation

As we develop and help our clients implement strategic plans, we are often called upon to analyze changes in health and program policy to achieve the agreed goals. We analyze the financial impact as well as the participant and sponsor impact on the program.

One example is our current work with the University of Virginia to help accomplish its strategic objective of shifting more utilization to its own University Medical Center. We have worked through a number of policy issues and approaches and how they impact the current benefit plans. We are helping them analyze projected cost of plan design changes to encourage employees and retirees to use the Medical Center rather than other hospitals and providers in the community.

Similarly, Mr. Petersen assisted the University of California Human Resources Division last year in peer reviewing and evaluating the projected self insured pricing provided by it's Risk Management Division and Risk Management Consultants in proposing a UC Medical Center Network Plan for use by University System employees.

3. Implementation of Federal and State Health Reform

We know through our frequent policy work with state clients that the Affordable Care Act, particularly the implementation of the Health Insurance Exchanges, significantly changes the future playing field for public sector health benefits. Every state is now having to face the ultimate discussion of whether it will be better in the long term to maintain its own health insurance program or to cede state employees into the state's health insurance exchange.

Most states are already beginning to address this issue and some are also working to identify the potential advantages and disadvantages of integrating the state employee health plan with the state health insurance exchange. Indeed, shifting from an employer based plan to an employer subsidized health insurance exchange is likely to become one of the more formidable issues for discussion at the state level in the coming years.

Our consulting and compliance staff can assist and advise NDPERS on all applicable federal, state and local laws that may affect NDPERS sponsored benefit programs. We can assist NDPERS in identifying

and reviewing fiduciary responsibilities, impact of legislation and pending regulatory changes, and short and long-term costs for required plan changes. At meetings, we will be prepared to present legislative and industry updates or to report on specific issues as requested.

Segal takes a proactive role in keeping its consultants and clients informed on federal legislative, judicial and regulatory changes and issues that may impact benefit plans. We actively bring issues to our clients before the opportunity for change has passed. Our involvement at the highest levels of the legislative and regulatory process allows us to identify emerging issues to our clients when there is still time to influence the outcome.

I) Explain how your organization develops premium rates for health insurance plans.

Development of client specific premium rates is based on an analysis of several key issues including:

- Collection of historic claims and enrollment data
- Determination of actuarial adjustments necessary to normalize past experience to current benefits, network contracts and enrollment
- Determination of actuarial adjustment necessary to reflect future benefit, network, administration and enrollment changes
- Determination of potential impact of member contribution changes on plan enrollment and penetration
- Impact of modifying wellness and health management initiatives on projected costs
- Projection of increases to fixed fees and risk premiums
- Appropriate contribution to IBNR and contingency reserves
- Recognition and negotiation of fixed fees and claims trend for the upcoming renewal

Your Segal consulting team will be available to present premium rates for each program in which we have been involved to NDPERS benefits management. Our senior team members have extensive experience in presenting the results of our work to public governing bodies and are sensitive to the political needs of such meetings. We will work closely with the NDPERS staff to develop presentation formats and key discussion points that fairly present the plan, the process and methodology employed for the rate setting, the results and how they have changed from the previous rate cycle, and any other important considerations for the reviewing body to take into account.

Segal is prepared to assist with the annual renewal process for both fully insured and self-insured benefit plans. The following describes our typical rate renewal process leading to the presentation of rates.

Rate Renewal

Developing annual premium rates is one of the most important tasks assigned to the actuarial consultant, as premium rates are used to determine the participant's share of the cost and therefore, the projected effect on NDPERS budget. We view the rate setting cycle not as a routine process to be carried out each year, but as an opportunity for the client and vendors to make course corrections, adjust inequities, focus on special needs and identify potential improvements to the program prior to the next full procurement

process. This approach allows NDPERS to maintain a high degree of knowledge about, and control over, its health benefit costs.

In order to assure that Segal is providing these services in a manner that adds value, we will initiate a rate projection planning meeting. At this meeting Segal will work with appropriate NDPERS staff and staff from the carriers and PBM to review, understand and suggest improvements to the previous process for collecting data for the rate and budget development process. In its initial review, Segal will review and take into account work already performed by other consultants to avoid duplication of work and make the process more efficient.

Segal anticipates developing a process that is both timely and similar from year to year. By utilizing the same process yearly, we will be able to determine when vendors are doing something different that may require the assistance of Segal, or become familiar enough with the process to make the correction themselves.

Data request letters will be carefully constructed to obtain data needed for analysis. Each carrier and the PBM tracks data differently and it is easy for an actuarial consultant to ask for too much data and details. In some cases a carrier or PBM cannot respond easily. In other cases, they need to be pushed to provide the level of data required for the analysis. The data request letters need to address the peculiarities of each contractor to maximize the usefulness of the data provided.

Segal anticipates that each year the requests will be modified as appropriate to reflect strategies developed during the year. These modifications can be used to test or verify changes and improvements in the NDPERS benefit plan.

Segal will receive and evaluate the data from the vendors. We will review it for completeness, identify where information is missing and obtain clarification or secure the required data from the vendor when necessary.

Segal would incorporate the following steps for annual accounting and renewals:

- **Meet with NDPERS Staff**—Prior to beginning the task, we would like to fully understand the methods of reporting and types of reports that need to be prepared. It is important that the report prepared by Segal is in a format and terms that are familiar and understandable to all parties who use the information.
- **Data Collection**—Segal will analyze and gather data from the vendors. We will carefully construct data request letters to obtain data needed for analysis. Each health benefit contractor tracks data differently and determines its rate request using different methodology. Each year the requests will be modified as appropriate to reflect strategies developed during the year.
- **Estimate Trend**—A key factor in this analysis will be the estimation of medical and prescription drug trend. Due to the timing of the renewal process, costs and rates have to be projected in advance of their effective date. Segal annually estimates trend by examining the increases experienced by its clients as well as estimates from major Managed Care Organizations. We will then validate this estimate against the NDPERS vendors' estimates.
- **Incorporation of Vendor Projections**—We will also ask the health benefit vendors to provide their estimate of costs for the next plan year. Where there is a difference from our projection it will be discussed with the vendor to see if there is an anticipated increase in fee schedules or

discounts. Proposed changes to administrative fees and capitation payments are reviewed and negotiated where needed.

- **Analysis**—The data would be analyzed for trends and unusual patterns. As an example, many of our clients have seen very large increases in the cost and utilization of outpatient services in the last year. Segal will discuss these types of findings with the appropriate vendor and XX staff to determine if actions could be taken to curb these increases, whether or not they are likely to continue, and then factor the information into the overall projected costs. In a self-insured plan like the NDPERS, an underwriter must develop the premium rate equivalents based on historical claims data, administrative fees and any capitation payments that may be in place (like stop loss premium). Rate development involves an analysis of utilization, participation levels and trends for the trailing 12 to 24 months to project the likely experience for the next 12 months.

Adjustments for population shifts, plan changes (including mandated benefits) and demographic differences need to be included. Based on historical cost and utilization trends as well as general health trend patterns, these costs are projected to the applicable calendar year. To the extent that the plan designs are changing from year to year, we will apply expected migration factors between benefit levels to determine the anticipated participation levels in each plan option.

Calculation of Incurred But Not Reported (IBNR) Claims—As part of the annual rate renewal process, Segal's actuarial and benefit analysts staff can perform reserve computations for the NDPERS self-funded health plan to be reported to the plan's auditor. Critical to the success of a self-funded program is the proper provision of reserves for incurred but not reported (IBNR) claims. We will review the NDPERS self-funded health plan's experience data and perform risk analysis to estimate the liability of the programs, while identifying the risk factors involved with each plan. Our health actuaries will calculate estimates of the IBNR claims amounts and report them as one component of the overall cost.

Meet with NDPERS Staff—Segal will meet with staff to review our results and make modifications as necessary. Calculations will be completed in conjunction with appropriate staff and other stakeholders. Ongoing discussions allow for better strategic planning in light of budgetary requirements. Based on these discussions, Segal will develop various rate scenarios to be presented.

We view the rate setting cycle not as a routine process to be carried out each year, but as an opportunity to make course corrections, adjust inequities, focus on special needs and identify potential improvements to the program without automatically rebidding the program on a frequent basis. This approach allows the NDPERS to maintain a high degree of knowledge about, and control over, its health benefit costs.

We will prepare a written report, outlining our review methodology, observations and findings from the analysis. We will make concise recommendations for changes or enhancements to the programs and outline the steps necessary to effect the changes. We understand that the NDPERS needs may change over time, but with careful annual planning we are able to anticipate most events and plan accordingly. A part of our ongoing strategic planning, we will help to reinforce existing strategies or develop new aspects as needed, identifying programs that must or should be taken to market for competitive bids.

m) What new cost containment programs does your organization foresee being implemented in the next 2-3 years and how are you positioned to provide assistance.

In metropolitan areas, Accountable Care Organizations and Patient Centered Medical Homes will increasingly be relied on to ensure that health care is delivered in accordance with evidence based medicine and that patient care is coordinated, monitored and effective in improving the health of the covered population. In addition the cost of care is expected to be reduced by these efforts as a result of reduction in redundant testing, increased compliance with recommended drug treatment plans and after care visits, increased use of preventive screenings, reduced emergency room utilization, and reduced admission and readmission rates.

In rural areas, increased utilization of telemedicine, cost transparency tools, reference based pricing and participant incentives will encourage cost reduction by redirecting care to more cost efficient metropolitan providers for major health care expenses, or by encouraging rural health providers to re-examine their cost delivery structures and patterns.

Health Clinics sponsored by plan sponsors will continue to change the competitive cost of delivering routine and preventive care.

Value based purchasing and benefit design will continue to emphasize reliance on care plans that emphasize evidence based medical practice guidelines and maintenance of employee health.

Wellness and Disease Management will continue to be relied on as a means to keep healthy people healthy and those with chronic diseases from advancing to later stages of their disease and comorbidities.

In each of these areas, your Segal consultants are investing significant time and energy in staying up with the state of the art, tracking emerging vendor developments, tracking results, modeling outcomes, and implementing creative and pro-active strategies.

n) Identify and discuss your experience with reviewing self-insured plans the adequacy of the stop loss coverage offered.

The optimum efficiency horizon for stop loss coverage combines knowledge of the past claims history of the covered participants, knowledge of the funding adequacy and risk tolerance/ funding policy of the plan sponsor, combined with up to date knowledge of the stop loss market and potential costs of large claimants to identify the best stop loss level and structure for the individual plan sponsor.

Generally plans with almost 28,000 employees/retirees will only participate in stop loss during the initial years of a self-insured plan, as they tend to be highly credible. The Stop Loss industry uses a target loss ratio of 60 – 70 percent to set its ongoing renewal premiums and even with aggressive renewal negotiations will generally make a significant profit on a large group over time. However, the experience and ability to negotiate special risk sharing arrangements can significantly impact the net cost of stop loss insurance where there is a desire to achieve a meaningful level of risk protection at a reasonable price.

- o) In terms of implementation efforts, discuss the services you have offered other clients and in particular, if NDPERS went self-insured, the services you could offer.**

Segal implementation services could include, but are not limited to:

- Determine appropriate starting reserves
- Negotiation and review of final vendor contract terms and conditions
- Participation in vendor implementation meetings
- Post implementation audits
- Creation of Policy and Procedure Manuals for COBRA, HIPAA Privacy, Plan administration, Appeals, etc.
- Creation of Plan Documents, Summary Plan Descriptions and SBCs
- Assistance with plan interpretation and problem claims
- Identification of specialty service vendors to enhance cost management of emerging out of network and high cost claims
- Ongoing claims and administrative auditing
- Prescription Drug audits
- Data warehousing and claims data analysis
- Employee open enrollment and health plan communications
- Ongoing financial monitoring
- Compliance consulting
- Ongoing plan design consulting
- Actuarial support for pricing plan changes, contribution changes and multi-year projections and budgeting
- Recommendation of wellness, disease management and cost containment strategies to improve participant health and control future costs

3. Staffing

The following grid will outline your consulting team.

HEALTH CONSULTING AND ANALYSIS		
Team Member	Classification	Role
Gary L. Petersen, FCA, ASA, MAAA <i>Vice President and Consulting Actuary</i>	Lead Consultant and Client Relationship Manager	Gary Petersen will be the lead consultant and will work closely with NDPERS to develop a project plan. He will also be involved in all actuarial and strategic planning. Gary has over 35 years' experience consulting to public sector clients. His recent clients include New Mexico Retiree Health Care Authority, New Mexico Public Schools Insurance Authority, Montana Unified School Trust, Colorado Contractors Health Trust, State of South Dakota, the State of Colorado, and the City of Albuquerque.
Mike Macdissi <i>Health Consultant</i>	Health Consultant	Mr. Macdissi will provides oversight and direction on complex financial projections and contractual issues as well as provide a focal point for our quality assurance initiatives. Mike has worked with several public sector clients including the State of Colorado, Pima County Community College District, Washington School District, and Pueblo County.
Ethel Tan <i>Health Benefits Analyst</i>	Health Benefit Analyst	Ethel will be responsible for analyzing all health and welfare related financial matters associated with NDPERS. She is currently providing her expertise to several public sector clients including the Montana Unified School Trust, State of Colorado, and Arizona Public Employees Health Trust.
Nancy R. Hakes, RN, MSN <i>Vice President/Health Care Consultant and Compliance Manager</i>	Senior Consultant	Ms. Hakes will be available to consult on health care clinical and operational issues as well as health compliance issues. Nancy consults with all of Segal's clients, many of whom are public sector.
Daljit Johl, PharmD <i>Pharmacy Benefit Consultant</i>	Pharmacy Consultant	Daljit is a member of our National Prescription Benefit Consulting team and will provide technical and analytic support for all pharmacy consulting services.



Expertise

Mr. Petersen is a Vice President and Actuary in Segal's Phoenix office with over 30 years of benefits consulting experience. He served as West Region Health Practice leader for the firm for five years.

Mr. Petersen helps public and private sector clients manage a variety of benefits issues, including the development of new health and welfare and total compensation strategies. He assists in the creation of innovative benefits programs based on in-depth health care data analysis, benchmarking and vendor negotiation.

Mr. Petersen's expertise spans a wide array of benefits practices and topics, including cafeteria plans, experience-rated and self-funded benefits programs, managed health care, consumer-driven health care, employee communications and surveys, and all types of employee benefits products.

Professional Background

Prior to joining Segal, Mr. Petersen served as Vice President and Managing Director of public sector and actuarial consulting for Willis. Previous positions also include Managing Principal and Benefits Practice Leader for Mellon/Buck Consultants, and Benefits Practice Leader, Consulting Actuary, and Chairman of North American benefits consulting peer review for Watson Wyatt. Mr. Petersen is a past President of the Phoenix Chapter of the Western Pension and Benefits Conference.

Education/Professional Designations

Mr. Petersen received a BS in Business Administration, specializing in Insurance and Mathematics, from the University of Nebraska at Omaha. He is an Associate of the Society of Actuaries, a Fellow of the Conference of Consulting Actuaries and a Member of the American Academy of Actuaries.

Published Work/Speeches

Mr. Petersen has spoken on topics related to benefits design, strategy, and delivery at organizations such as the Western Pension and Benefits Conference, WEB, WorldatWork, and CUPA-HR.

Expertise

Mr. Macdissi is a Vice President and Health Benefits Manager for the West Region Health Practice in Segal's Phoenix office with over 20 years of experience in the healthcare industry. He consults to clients on a wide variety of complex financial projections and contractual issues and also provides oversight and serves as an internal resource to a staff of Health Benefits Analysts.

Mr. Macdissi's expertise includes the development and management of health care benefits programs, as well as broad product expertise in indemnity and managed care medical, dental and life insurance. He has deep knowledge in all types of funding arrangements, including self-funded, minimum premium and conventionally insured arrangements. Mr. Macdissi also has extensive experience in various underwriting capacities.

Professional Background

Mr. Macdissi joined Segal as a Health Benefits Manager in 2006. Prior to joining the firm, he was a Health and Benefits Consultant for another major consulting firm.

Professional Designations

Mr. Macdissi received a BS degree from the University of Nebraska and an MA degree from Creighton University – both in Business Administration. He has a State of Arizona Producer License in Accident/Health and Life, is a Fellow of the Life Office Management Association (FLMI) and a member of the Health Insurance Association of America (HIAA).

Expertise

As a Health Benefits Analyst with The Segal Company, Ms. Tan provides in-depth financial analysis for insured and self-insured public sector employee health benefit plans. She performs analyses of claims experience; prepares budget projections, IBNR estimates, and financial reports. Ms. Tan's responsibilities also include the preparation of request for proposals (RFPs), the analysis of the resulting proposals, and insurance carrier renewals and rate negotiations.

Education/Professional Designations

Ms. Tan holds a BS in Mathematics from Arizona State University. She has a State of Arizona Producer License in Accident/Health and Life and non-resident licenses in states she works in outside of Arizona.

Expertise

Ms. Hakes is a Vice President and Health Care Benefits Consultant in Segal's Phoenix office. She is the Company's technical expert on operational issues regarding managed care. Ms. Hakes provides detailed research on specific health care issues pertinent to medical coverage, plan design, and quality of care, including disability; workers' compensation; wellness and associated incentive programs; EAP and behavioral health; prescription drugs; disease management; telephonic nurse triage programs; and utilization management. She is skilled in analyzing the effectiveness of health care delivery systems that guide managed care organizations. Ms. Hakes leads the development and maintenance of a proprietary Segal program, Q-ValSM, which allows plan sponsors to assess the extent to which managed care organizations (such as PPOs, POS and HMO plans) oversee and assure the delivery of quality health care to their plan participants.

Ms. Hakes assists employers in the creation and interpretation of technical medical health care coverage language, the design of employee educational information, and the implementation of specific managed care techniques engineered to control health care costs. Additionally, as Health Compliance Manager for the West Region, she researches employee benefit laws and their impact on clients, creates plan amendments and writes plan documents. Ms. Hakes was instrumental in designing the medical text of the Segal Master Plan Document/Summary Plan Description for use with self-funded clients nationwide. Using her past experience as Chief Operating Officer of a nationwide managed health care review organization, she has developed techniques for assessing the comprehensiveness, effectiveness, progressiveness and quality of medical management organizations.

Ms. Hakes performs analyses of medical records as part of her research of complex claims appeals. She additionally conducts assessments of operations and savings assumptions by medical management organizations nationwide, and reviews health records for issues involving cost and quality of care. Ms. Hakes has also customized return-to-work programs and performance guarantees for clients. She is experienced in complex case management and in designing reports that help detail the effectiveness of managed care organizations.

Professional Background

Prior to her 20 years with Segal, Ms. Hakes' background as Director of Health Services and Quality Control for the Arizona division of a national HMO provided her with the expertise to assist Segal clients in the design, implementation, and analysis of unique risk-sharing arrangements for control of medical costs.

Education/Professional Designations

After graduating from the University of Arizona with a BS in Nursing and with an MS from the University of San Diego, Ms. Hakes spent over 10 years providing direct patient care as well as overall nursing unit management in a 650-bed teaching hospital in Southern California. She maintains licensure as a Registered Nurse in Arizona and, until 2004, worked in an urgent care center on weekends.

Published Work/Speeches

Recent articles by Ms. Hakes include::

- “Thank You for Not Smoking,” Christopher Calvert and Nancy R. Hakes, Compensation & Benefits, December 2009
- “Is Your Wellness Program a Scattershot Effort...or on Target to Serve Employees and the Organization?” Chris Calvert and Nancy R. Hakes, Perspectives, Volume 16, Issue 3, June 2008



DALJIT JOHL, PHARM.D

Pharmacy Benefits Consultant, San Francisco

Expertise

Dr. Johl is a Pharmacy Benefits Consultant in Segal's San Francisco office, supporting the West Region. She has more than 20 years of experience in pharmacy benefits. Dr. Johl is a member of Segal's National Pharmacy Consulting Practice and assists clients in optimizing benefit design and formularies. She also serves as an expert in client management, strategic planning, PBM clinical programs, product and formulary strategies and analysis of prescription data. Dr. Johl provides clinical consulting, analysis, support and strategic direction for clients nationally. She focuses on assisting Segal clients in vendor selection and implementation, contract negotiation, and clinical program development.

Professional Background

Prior to joining Segal, Dr. Johl served as a Clinical Program Manager for a PBM, where she utilized her clinical expertise to develop strategies for employers to optimize their prescription drug benefits. Prior to that, she worked as a benefits specialist at Blue Shield of California. Dr. Johl also worked as a manager at Statscript pharmacy, specializing in drug management and education in the HIV community.

Education/Professional Designations

Dr. Johl holds a Doctor of Pharmacy degree from the University of California, San Francisco, and a BS in Biology from California State University (Chico, CA). She is a registered Pharmacist and an active member of the Academy of Managed Care Pharmacy (AMCP), where she serves on the Community Pharmacy Outreach Advisory Council.

4. Additional Information

Mr. Petersen has over 35 years of actuarial and consulting experience serving the needs of large public sector clients. He has worked at Segal for ten years and served a five year term as Segal's West Region Health Practice Leader. Prior to joining Segal, he served as Buck Consultants Managing Principal in charge of the Phoenix office, and Watson Wyatt's Phoenix office Health Practice Leader and Chairman of Watson Wyatt's North American Health and Welfare Benefits Peer Review Committee for many years.

He has been a frequent speaker on emerging plan design, funding, benchmarking, and claims auditing throughout his career and has a special interest in alternative claims reimbursement methodologies as exemplified in the recent movement towards Accountable Care Organizations, Patient Centered Medical Homes, Global Case Rates and Onsite Clinics.

Over his 35 year career he has managed numerous RFP evaluation projects for large public sector clients including the State of Arizona, Arizona State Retirement System, State of Colorado, State of Kansas, State of New Mexico, State of South Dakota, Maricopa County, Pima County, City of Houston, City of Phoenix, City of Tucson, etc.

Drawing on his personal experience as well of that of his public sector consulting peers throughout Segal, the State of North Dakota can be assured of highly qualified, thoughtful and practical advice delivered on time and on budget. In addition, Segal has invested in state of the art tools and processes to efficiently and effectively help the State identify and award "Best in Class" contracts using proven value based purchasing techniques.

Mr. Petersen worked with the NDPERS staff and Board during their 2012 Dental RFP and looks forward to the opportunity to bring his broad health care and RFP experience to the management of the upcoming Health Plan Consulting assignment.

5. Conflicts of Interest

No Conflict of Interest exists relative to our proposal to NDPERS.

As a fee-based consulting firm with full transparency of any commissions received, The Segal Group (“Segal”) is committed to providing unbiased advice that will ultimately generate the best value for its client. We fully disclose any commissions on a dollar for dollar basis. **With respect to the proposed NDPERS Group Health Plan Actuarial and Consulting Services, Segal will not receive any commissions unless requested to do so by both NDPERS Board of Directors and Executive Director.**

Insurer incentive compensation/supplemental commission payments are used to finance national investments in research, technology, database development and client education to improve overall client services. Generally, any insurer incentive payments derived are based on Segal book of business activity and are limited to less than 1% of total Segal revenue. **However, Segal has the ability to direct all vendors to exclude specific clients from the determination of incentive compensation/supplemental commission payments and will not allow any contracts issued to NDPERS to be used in the calculation of such payments unless requested to do so by both the NDPERS Board of Directors and Executive Director.**

The approach that our staff takes in analyzing insurance proposals and making recommendations regarding types and levels of coverage is objective and is free from any influence by commissions or supplemental payments. Objective analysis and neutrality are core values of Segal, and the insurance industry recognizes it. We base our recommendations solely on client requirements and objectives. All of this ensures that we have only the best interests of our clients in mind when we approach our work. For more information, please read our “Compensation for Life and Health Benefit Services” disclosure at <http://www.segalco.com/uploads/life-and-health-benefit-services.pdf>.

6. Company Literature

These publications are shown on the following pages:

- Segal Consulting Public Sector Letter November 2013
- Benefits Quarterly, First Quarter 2012
- Workspan, October 2013

Expanding Wellness Programs Beyond Information: Why It's Time and How to Measure the Return on Investment

Wellness programs aim to prevent or reduce health risk factors in order to help eliminate future chronic diseases by keeping healthy people healthy and teaching unhealthy, at-risk people how to reduce or eliminate those risk factors. In addition to managing claims costs, wellness programs can help reduce absenteeism and improve employee engagement. A majority (71 percent) of state and local governments offer at least one wellness program to their employees, according to the 2013 Employer Health Benefits Survey, but the offerings vary widely (as shown in the graph below). Moreover, between state and

local government employers there is a significant difference in whether wellness programs are offered. The Bureau of Labor Statistics' *National Compensation Survey: Employee Benefits in the United States* found that while 70 percent of state workers had access to wellness benefits, only 46 percent of local government workers did.¹

In Segal Consulting's experience, providing information is the most prevalent type of wellness program in the public sector because insurers often provide that service at little or no additional cost as part of the

¹ As defined by the survey, wellness programs offer employees two or more of the following benefits: smoking-cessation clinics, exercise/physical-fitness programs, weight-control programs, nutrition education, hypertension tests, periodic physical examinations, stress-management courses and back-care courses. The survey's public sector data on wellness programs, which was published in March 2010, is available on the following page of the BLS website: <http://www.bls.gov/ncs/ces/benefits/2010/ownership/govt/table24a.pdf>

IN THIS ISSUE:

- **The Affordable Care Act Emphasizes Preventive Care**
- **To Decide Where to Invest, Look at the Drivers of Health Care Costs**
- **Measuring Wellness ROI**
- **Conclusion**

cost of coverage. Public sector employers continue to face acute fiscal challenges that, understandably, make them reluctant to consider investing in more intensive wellness programs, which may require the assistance of a wellness vendor.² This *Public Sector Letter* explains why the new preventive care mandates introduced by the Affordable Care Act³ mean now is a logical time for public sector employers to revisit their wellness-program offerings. It also discusses making additional incremental investments in wellness programs and measuring the return on those investments, with a focus on health plan costs.⁴

"Now is a logical time for public sector employers to revisit their wellness-program offerings."

Percentage of State and Local Governments Offering Various Wellness Programs to Their Employees, 2013



* Biometric screening is a health examination that measures an employee's risk factors such as cholesterol, blood pressure, stress, and nutrition.

Source: Kaiser Family Foundation/Health Research & Educational Trust (HRET) 2013 Employer Health Benefits Survey (<http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf>)

² The cost of using a wellness vendor varies widely depending on the services provided. The Wellness Council of America estimated the cost per employee to be between \$100 and \$150 per year in 2011 for an effective wellness program that produces a return on investment (ROI) of \$300 to \$450.

³ The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

⁴ Additional ROI measures related to absenteeism and/or employee engagement can be made.

“To make the most of an incremental approach to wellness, an entity should focus on programs that target high-utilization areas.”

THE AFFORDABLE CARE ACT EMPHASIZES PREVENTIVE CARE

The Affordable Care Act requires “non-grandfathered”⁵ group health plans to provide in-network coverage for certain mandated preventive care services and immunizations at no cost to participants (*i.e.*, no copayments, coinsurance or deductibles). Examples of preventive services that must be provided free of charge include screening for colorectal cancer, cervical cancer, osteoporosis, cholesterol abnormalities, high blood pressure, diabetes, sexually transmitted diseases, depression, obesity and tobacco use. Plans must provide additional preventive services for women (including well-woman visits), children until age 21 and newborns. The federal government’s lists of preventive services that must be covered will be changed and updated regularly.⁶ Many public sector plans already offer some of the Affordable Care Act’s required preventive care benefits. As more public sector plans choose to lose their grandfathered status, these preventive services can become a base for building a more intense wellness program that encourages use of the preventive benefits.

⁵ Group health plans in existence as of March 23, 2010, when the Affordable Care Act was signed into law, are “grandfathered,” meaning that they do not have to comply with many of the law’s requirements applicable to them. A plan will remain grandfathered as long as the plan’s benefit design does not change in particular ways. Most group health plans are not grandfathered and the number is declining every year. For example, a survey conducted by the International Foundation of Employee Benefit Plans (IFEBCP) since 2011 found that just over 27 percent of plans were grandfathered in 2013, down from almost 45 percent in 2011. The 2013 survey results are available on the following page of the IFEBCP’s website: <http://www.ifebcp.org/pdf/research/2103ACAImpactSurvey.pdf>

⁶ The lists are available on the following page of the HealthCare.gov website: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. All Segal publications on the Affordable Care Act, including several that focus on preventive care mandates for non-grandfathered plans, can be accessed from the following web page: <http://www.segalco.com/publications-and-resources/health-care-reform/>

TO DECIDE WHERE TO INVEST, LOOK AT THE DRIVERS OF HEALTH CARE COSTS

Although a comprehensive approach to wellness may be ideal, many public sector employers do not have the resources to introduce and maintain multiple programs at once. To make the most of an incremental approach to wellness, an entity should focus on programs that target high-utilization areas.

Health care plan costs are a function of two factors: unit costs (*e.g.*, the *price* of an office visit to a doctor or an MRI scan) and utilization (*i.e.*, the *number of times* a health service is used). The unit cost has been increasing faster than general inflation as innovative, new, and more expensive procedures are developed. Research suggests that medical innovation, which includes new drugs and technology, is now responsible for 50 percent of the growth in health care expenditures.⁷ These advances in medical technology are likely to continue. Utilization is a function of the volume, intensity and frequency of people using health care services and treatments, which is related to the severity of illness of the population. The sicker the population, the higher the utilization of health care services. Also, as the population ages, participants become more chronically ill and use more medical services.

Reducing future utilization of health care services by achieving the right behavioral changes is where wellness programs can play a pivotal role. Wellness programs aim to change the

behavior of currently healthy and at-risk participants and encourage the use of preventive care, thereby preventing them from becoming chronically ill, the point at which the emphasis shifts to disease and case management strategies.⁸

When deciding which wellness programs to focus on and how to design them, plan sponsors should get input from multiple sources. That step can help ensure that the final decisions represent a careful consideration of all the options: those that can be provided by currently contracted vendors as well as those that extend beyond current vendor capabilities.

Some public sector employers are beginning to tie the employee’s contribution requirement to participation in wellness programs. For example, if a participant completes certain required wellness tasks or assignments for the year, he or she pays a lower premium. As soon as these programs are implemented, the sponsors need to begin exploring how to progressively tighten premium-discount requirements so the lifestyle changes begun with initial participation are continued and ramped up over time. A final rule on wellness programs that was released in June 2013 increases the rewards that may be provided through wellness programs. More precisely, it defines the term “health-contingent wellness program” and changes the requirements that apply to health-contingent programs, especially outcome-based programs.⁹ Plan sponsors will want to pay close attention to those new rules as they develop their programs.

⁸ An illustration showing the health/disease continuum and the care/cost management efforts used is available as an online supplement to this *Public Sector Letter*: <http://www.segalco.com/publications/publicsectorletters/wellsupp1.pdf>

⁹ This guidance summarized in Segal’s July 11, 2013 *Capital Checkup*, “New Rules for Wellness Programs”: <http://www.segalco.com/publications-and-resources/public-sector-publications/capital-checkup/archives/?id=2386>

⁷ Cutler, D.M. “Technology, Health Costs, and the NIH” (Paper presented at the National Institutes of Health Economic Roundtable on Biomedical Research, Bethesda, Maryland, November 1995).

MEASURING WELLNESS ROI

Some health care industry experts have expressed skepticism that there is an ROI associated with wellness programs. An example of that point of view is a recent RAND report of a study that found “participation in a wellness program over five years is associated with a trend toward lower health care costs and decreasing health care use.”¹⁰ However, the change is not statistically significant. It is important to note that RAND’s findings reflect the average results of a random sample of wellness programs, including a number of different types and intensities. Segal Consulting believes that well-designed, diligently implemented and carefully targeted wellness programs can generate substantial ROI — often in less than five years.

Traditionally, a health benefit plan would measure its success by looking solely at total health care costs: the year-to-year cost increases and trend. While measuring these financial factors remains vitally important, evaluating the success of wellness programs within those health benefit plans requires a different approach: the metrics by which wellness programs are measured should capture whether the “population health” is getting better overall. In the long run, if wellness programs are truly working, they should keep healthy people healthy and reduce modifiable risk factors to slow down the onset and progression of chronic disease, thereby reducing *demand for services*, which helps to hold down costs. This, in turn, will reduce *future* health care costs. Because wellness programs alone can do very little to directly impact the unit costs of care, the expectation for *instant* reduction in overall medical claim costs by instituting wellness programs,

or expecting wellness programs to “bend the cost curve” *immediately*, is not realistic.

Physicians do not begin by telling a patient “you’re cured.” Instead, they study clinical markers that indicate the extent to which treatment is working. Similarly, while it is reasonable for plan sponsors to desire a hard-dollar ROI made in wellness programs, they should also track and study the clinical and behavioral progress of the population. The metrics for measuring the performance of wellness programs must capture the value of multiple interventions in delivering various wellness services. The end result could be an estimation of the amount by which clinical interventions were able to control costs by reducing future health care utilization.

For example, Geisinger Health Systems has a long-standing care management program called “Proven Health.” This comprehensive program includes intensive primary care interventions and tracking of patients with diabetes. According to Geisinger’s 2010 annual report, 52 percent of diabetics in the program had reached their HbA1c¹¹ goals in 2010 compared to just 33 percent of a control group of diabetic patients not in the program. Patients with well-controlled blood-sugar levels, which are typically tracked using HbA1c results, will have improved quality of life and can avoid many of the complications and much of the cost that can come from sustained high blood-sugar levels. This improved participant quality of life also translates into long-term value and reduced claim costs for the employer’s health plan.

Similarly, in a two-year United Health Plan study of diabetes management, 21 percent of participants in the program saw a reduction in their health

risk scores and health plan costs grew at a 4 percent lower rate for that group than for those not in the diabetes management program.¹²

Plan sponsors of wellness programs should set clinical goals against which their wellness program performance can be monitored and measured. Baselines can be established and criteria and targets customized to each plan’s programs and can be drawn from plan-specific performance, national averages and ideal targets. All these measures can provide a meaningful impact on future direct and indirect cost and quality indicators. Comparing the clinical programs against the established targets is a practical and comprehensive way for plan sponsors to assess existing wellness programs. If a plan uses one or more wellness providers, it is important to work with the vendor to set the measures and to implement appropriate performance guarantees for the clinical goals.¹³

To help plan sponsors track the effectiveness of their wellness programs, Segal Consulting has built a tool that defines and takes a snapshot of the most important metrics that need to be monitored. This “dashboard” provides plan sponsors with useful information regarding the direction of important cost and clinical outcomes, such as medication compliance, program participation rates, quit rates and the quality and intensity of participant engagement. The metrics can be divided into process metrics and outcome metrics. The outcome metrics are broken down further into three important categories: (1) clinical improvements; (2) impact on utilization; and (3) financial metrics.

¹⁰ This final report of the *Workplace Wellness Programs Study* is available on the following page of RAND’s website: http://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.pdf

¹¹ HbA1c is a measure of average blood-sugar levels for a 90-day period.

¹² “UnitedHealthcare reports success with diabetes program”; <http://cbn.benefitnews.com/news/unitedhealthcare-reports-success-with-diabetes-program-2732654-1.html>

¹³ Another online supplement to this *Public Sector Letter* lists wellness programs and clinical goals: <http://www.segalco.com/publications/publicsectorletters/wellsupp2.pdf>

Public Sector Letter

Plan-specific results are derived by creating a baseline to which experience and trends are compared. The table below shows a snapshot of how the dashboard was used to effectively measure and monitor the component progress of one wellness program over time. Although the sample plan experienced an increase in the percentage of obese employees, its wellness program managed to reduce utilization of ER visits, the incidence of Type 2 diabetes and costs associated with that disease, which is notable in an environment where overall health plan cost trends continue to increase. Yearly or more frequent updates help determine where programs can be improved and refined.

To achieve greater confidence in the financial impact of a wellness program on the participant population, the plan sponsor can also track a control group of similar participants with similar illnesses who are not participating in the wellness program activities or allowing active case management.

Once health plan sponsors properly set targets and measure wellness program performance, they may need to change tactics to get desired results. If the dashboard points to low participation rates or no improvements in key clinical metrics (e.g., HbA1c test results), some combination of plan design changes, incentives and new communications may be needed to encourage or motivate the participation or improvements. If using a wellness vendor, it is important to work with them to define success and the needed reporting to support measuring progress. Working with a vendor that has knowledge about behavior modification and new technologies to support change is crucial to enabling plan sponsors to develop the right courses of action to get the desired results.

CONCLUSION

While it is difficult to measure monetary savings from wellness programs that by their nature are intended to hold down future costs, it is possible to both measure their

effectiveness and their success over time and to hold wellness vendors accountable for results. When plan sponsors see year-over-year improvement, this is an indication that the health of participants and their dependents is improving, easing the cost burden to the plan by reducing demand for health care services. ROI, a clear measurement of success, can help entities make a case for progressively expanding wellness programs to take on more difficult conditions and health expenditures.



For more information about or assistance with measuring the success of wellness programs, including identifying the measurement(s) that will be most meaningful to your jurisdiction, contact your Segal benefits consultant or one of the following experts:

- *Sadhna Paralkar, MD*
312.933.7808
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- *Ed Kaplan*
212.251.5212
ekaplan@segalco.com
- *Rick Johnson*
202.833.6470
rjohnson@segalco.com

Segal Consulting's Dashboard for Measuring the Success of One Wellness Program (a Weight-Management Program) Using Data from a Sample Plan

Metric	Process Metrics**	Outcome Metrics***			
		Utilization	Clinical	Financial	
Baseline Data	N/A	143	8.4%	\$11,700	
Year(s) from Baseline	One	40%	143	8.5%	\$11,800
	Two	43%	137	8.0%	\$11,000
	Three	47%	133	7.8%	\$10,200

* All process metrics should be tracked every month. In this dashboard, the baseline data shown in the first row reflects experience at first measurement and the data in the subsequent rows reflects the average for the year.

** Outcome metrics should be tracked annually.

Source: Segal Consulting

 Segal Consulting

To receive *Public Sector Letters* and other Segal Consulting publications of interest to state and local government employers as soon as they are available online, register your e-mail address via Segal's website: www.segalco.com

For a list of Segal's offices, visit www.segalco.com/about-us/contact-us-locations/

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Making the Case:

New Study Shows It Does, Indeed, Pay to Become a Healthy Enterprise

by Steven F. Cyboran, CEBS and Christopher Goldsmith, CEBS

It may be “common knowledge” that healthy employees with healthy dependents working in an effective work environment make better workers and save their employers money in the long run. But until now, data to document the relative importance of various initiatives in achieving an impact on workforce performance has been lacking. This article presents findings from a recent study to fill that gap, examining the business case for being a healthy enterprise and exploring whether employers’ healthy enterprise efforts make a difference to their return on investment. The authors outline a strategy employers can take to become a healthy enterprise through dedicated leadership, a more effective workplace, greater employee and dependent involvement, and measured outcomes.



As organizations struggle to control costs, those costs associated with being a healthy enterprise tend to be subject to particular scrutiny. Research indicates that an individual’s environment^{1,2} and the effectiveness of the workforce³ have a significant impact on the health of employees⁴ and that the communities in which people live affect the quality and longevity of their lives.⁵ At the same time, the actions employers are forced to take in challenging times (i.e., downsizing, budget cuts) have a direct impact on the health of employees and the health of the overall culture.^{6,7} In this environment, Sibson Consulting conducted a *Healthy Enterprise Study* to both examine the business case for being a healthy enterprise and explore whether the nature and scope of employers’ healthy enterprise efforts make a difference to their return on investment.

Beginning in the latter part of 2009 through early 2010, Sibson sent invitations to participate in the *Healthy Enterprise Study*. In addition, several professional business organizations, including the Interna-

tional Foundation of Employee Benefit Plans and the International Society of Certified Employee Benefit Specialists, asked their corporate members to participate. Nearly 300 employers participated in the study. As a group, they represent more than two million employees, a range of industries and headquarters in 44 states, the District of Columbia and Canada.⁸ (See the sidebar, “Methodology and Participants.”) This article summarizes the study findings, including the prevalence, duration and perceived effectiveness of programs associated with a healthy culture, and the relative importance of different initiatives on the key outcomes, such as health costs and turnover.

KEY FINDINGS AND IMPLICATIONS

The following are among the key findings of the *Healthy Enterprise Study*:

- **Strategic focus is important to program effectiveness.** Program leadership, a strategic health plan and shared vision and collaboration among vendors correlated most with overall reported wellness effectiveness.
- **Metrics matter.** The benefits of investing in a

METHODOLOGY AND PARTICIPANTS

Sibson conducted the latest *Healthy Enterprise Study* from late 2009 through early 2010. Nearly 300 employers* participated by completing a Web-based questionnaire that captured more than 100 data items. Respondents were guaranteed anonymity. This supplement summarizes the survey instrument, the methodology for developing a Healthy Enterprise Index, the analysis of relationships among various practices and outcomes, and the participants in the survey.

Survey Instrument

The survey instrument consisted of 51 questions. Several questions contained multiple items, so in total the survey captured approximately 100 data items. The major categories of the questionnaire were the following:

- **Organization overview.** This category consisted of 14 questions that captured organization name, number of benefit-eligible and enrolled employees, employee demographics, headquarters location, industry, profit status, percentage of unionized workforce, the level of collaboration in collective bargaining, source for learning about the survey and contact information.
- **Specific wellness practices.** This category consisted of 23 questions that captured 40 data items, including the duration and perceived effectiveness or extent the practices are in place, funding sources, budget information, program oversight, types and levels of incentives, participation in health assessments and biometric screenings and duration of the initiative, frequency of progress reviews and unique characteristics.
- **Healthy enterprise initiative effectiveness.** This category consisted of seven questions that captured 34 data items, including the perceived effectiveness of various strategies along the healthy enterprise continuum in each of the seven characteristics and along each of the stages on the continuum of maturity.
- **Outcomes.** This category consisted of seven questions that captured eight data items, including the medical, prescription drugs, wellness, disease management costs per employee, the percentage increase in health care cost expenses, voluntary turnover rate, unscheduled absence, rate of extended absence, workers' compensation and any documented outcomes.

Healthy Enterprise Index Methodology

To develop a Healthy Enterprise Index, Sibson converted all responses to a scale from zero to one, categorized the 100 data items in the *Healthy Enterprise Study* into the following 12 index elements and averaged the values: health plans, wellness practices, institution support, time off, behavioral health, on-site health, employee involvement, communication, shaping behavior, management, metrics and initiative duration.

The index elements were then aggregated into the Healthy Enterprise Index by averaging all 12 elements. The index ranges from zero to 100%. The outcome metrics were not included in the calculation of the index.

Relationships to Outcomes

Sibson evaluated the relationship of the various elements and overall index relative to the adjusted outcomes for industry, age, family size and levels of participation. Sibson measured the index to adjusted outcomes, which included the adjustments shown in Table I:

TABLE I
RELATIONSHIPS TO OUTCOMES

	Health Costs	Health Increases	Turnover	Absence	Workers' Compensation
Industry Adjustment	√	√	√	√	√
Age Adjustment	√	√		√	
Family Size	√	√			
Health Plan Participation	√	√			

Participants

As shown by Figure 1, the largest percentage of employers in the study (31%) have between 1,000 and 4,999 full-time employees. Just over half of the employers in the study are headquartered in the Midwest, as shown by Figure 2. Figure 3 shows average age range, which has a significant influence on the health issues faced by the workforce. According to typical standard actuarial tables, health care costs increase approximately 2% to 4% for each additional year of age.

FIGURE 1
SIZE OF WORKFORCE BY NUMBER OF FULL-TIME EMPLOYEES

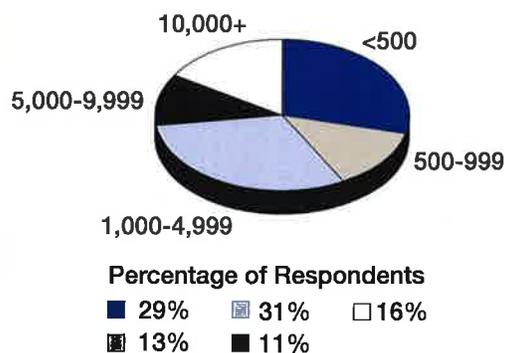
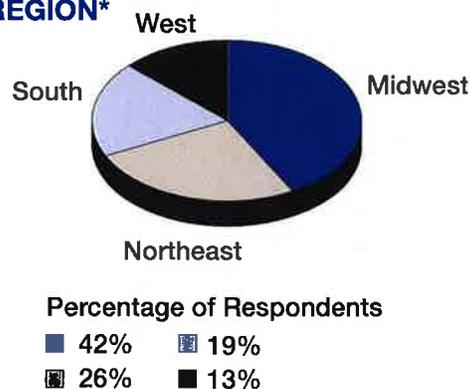
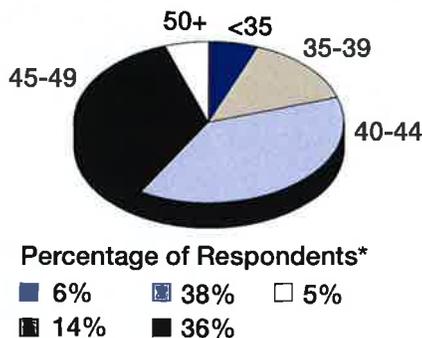


FIGURE 2
REGION*



*Organizations are grouped into four regions that follow the U.S. Census Bureau's divisions: <http://www.census.gov/geo/www/us/regdiv.pdf>.

FIGURE 3
AVERAGE EMPLOYEE AGE RANGE



*Total does not equal 100% due to rounding.

The two largest industry groups represented in the study are colleges/universities (25%) and hospitals/health systems (18%). Table II shows the industry breakdown of the employers in the study.

In analyzing the study results, Sibson did not adjust for differences in employer size or region of headquarters.

*The following organizations kindly gave Sibson permission to note that they participated in the *Healthy Enterprise Study*: Abbott; ABM Industries, Inc.; Advocate Health Care; Akron Children's Hospital; AlphaStaff Inc.; Alverno College; American Chartered Bank; American Institute for Preventive Medicine; American Tower Corporation; Amtrak; Aon Corporation; Apollo Gold; Aptuit (Kansas City);

LLC; Archstone Communities, LLC; AREVA NP; Ascension Health; Avid Technology, Inc.; Avon Lake City Schools; Avon Old Farms School; Babcock Power, Inc.; Baxter International; Beacon Orthopaedics; Belmont University; Ben Venue Laboratories, Inc.; Bendix Commercial Vehicle Systems, LLC; Berkshire Medical Center; BlueCross BlueShield of Massachusetts; BlueCross BlueShield of Michigan; Brambles/CHEP; Brattleboro Memorial Hospital; Bryant University; Bull HN Information Systems, Inc.; Burke, Inc.; CA, Inc.; CACI; California State University Fresno; Calista Corporation; CareFirst BlueCross BlueShield; Carnegie Mellon University; Centenary College of Louisiana; CentraState Healthcare System; CF Industries, Inc.; CFA Institute; Chilton Memorial Hospital; Chr. Hansen, Inc.; CIT Group, Inc.; City of Arlington (Texas); City of Cleveland; City of Parma; Cleveland Clinic; The Cleveland Foundation; Cleveland Indians Baseball Company; Collective Brands, Inc.; College of Wooster; Cytec Industries, Inc.; Dakota County; Dalhousie University; Dana-Farber Cancer Institute; Dearborn County Hospital; Delta College; Denver Health Hospital and Authority; Des Moines University; Diocese of Phoenix; Donley's, Inc.; DynaVox Systems, LLC; East Carolina University; Educational Commission for Foreign Medical Graduates; Ed-

TABLE II
INDUSTRY GROUPS IN STUDY

Industry	Percentage of Respondents
College/University	25%
Hospitals/Health Systems	18
Manufacturing	9
Consumer Products	6
Financial Services	6
Information Technology and Telecommunications	6
Professional Services	6
Health Plan/Insurance	5
Wholesale and Retail	4
Government	3
Not-for-Profit	3
Pharmaceutical and Biotech	2
Utilities/Energy	2
Other*	5

*Other includes agriculture, construction, communications and publishing, entertainment, hospitality, and transportation and logistics.

ward, Elk & Elk Co., Ltd.; Engineering PLUS, LLC; Exeter Health Resources, Inc.; Famous Enterprises; Farm Credit Foundations; FF Thompson; Fletcher Allen Health Care; Frances Mahon Deaconess Hospital; Gardner Denver, Inc.; Generac Power Systems; General Growth Properties; Genesis Health System; The George Washington University; Gold Eagle Co.; The Golden 1 Credit Union; Grand River Hospital District; Gustavus Adolphus College; Hess; Hilltop National Bank; HomeAway.com, Inc.; Hormel Foods Corporation; Hurley Medical Center; Hyatt Hotels Corp.; Illinois State University; Illinois Wesleyan University; The IMT Group; Infinity Property & Casualty Corporation; Independence Excavating, Inc.; Intrepid Potash; Iowa State University; Irwin Financial Corporation; Ithaca College; Itron, Inc.; The James B. Oswald Company; Joe's Crab Shack; John Carroll University; John D. and Catherine T. MacArthur Foundation; JPMorgan Chase; Kforce, Inc.; Kindred Healthcare; Kohrman Jackson & Krantz P.L.L.; Komatsu America Corp.; Kronos, Inc.; Kurtz Bros., Inc.; Lake County Commissioners; Lake Health; Lawson Products; Lee University; Life Line Screening; Limited Stores, LLC; Link Snacks, Inc.; Livingston HealthCare; Longmont United Hospital; LSI Industries, Inc.; MAG Industrial Automation Systems; Main Street Gourmet; Maine Medical Center; MARC USA; Marywood University; McHenry County College; Medline Industries, Inc.; Memorial Hermann Healthcare System; MemorialCare; MiddleOak; Middlesex Hospital; Miniature Precision Components, Inc.; Ministry Health Care; MRA—The Management Association, Inc.; National Association of College Stores; National Futures Association; Nestle; Nichols College; Nintendo of America, Inc.; North Dakota State University; Northeast Ohio Regional Sewer District; Northwestern Medical Center; Northwestern University; NSF International; Oak Ridge National Laboratory; The Ohio University; Oklahoma City University; Olympus Corporation of the Americas; Oracle Corporation; Otterbein College; Pactiv Corporation; Partnership for Prevention; Penn National Insurance; Penn State; Phillips-Van Heusen Corp.; Precept; Purdue University; Quaker Chemical Corporation; Rensselaer Polytechnic Institute; Rhode Island School of Design; Rice University; Riverview Hospital Association; Rochester General Hospital; Rochester Institute of Technology; Rollins College; Rose and Kiernan, Inc.; Roush Fenway Racing; Ryder System, Inc.; Safeguard Properties; Saint Barnabas Health Care System; St. Catherine University; St. Elizabeth Healthcare; Saint Francis Hospital and Medical Center; St. Jude Children's Research Hospital; St. Lawrence University; San Francisco Art Institute; Schneider National, Inc.; Schreiber Foods; Severn Trent Services, Inc.; The Sherwin-Williams Company; Solaris Health System; Solix, Inc.; Southern California Edison; Southern Ohio Medical Center; Suburban Hospital; The Sun Products Corporation; TCP; Texas Chiropractic College; Texas Christian University; Toys "R" Us, Inc.; Transylvania University; Trocaire College; Tyco International; Underwriters Laboratories, Inc.; UNIFI Companies; University at Buffalo; University Health System, Inc.; University of Alaska; University of Colorado Hospital; University of Denver; University of Iowa; The University of Kansas Hospital; University of Kentucky; University of Medicine and Dentistry of New Jersey; University of Michigan; University of Minnesota; University of Nebraska Medical Center; University of New Mexico; University of Oklahoma; University of Oregon; University of Pittsburgh; University of Richmond; University of South Dakota; University of Virginia; UNM Hospitals; Utah State University; VA Healthcare—VISN 4; Valmont Industries, Inc.; Vermont Law School; Wabash National; Wake Forest University; Weeks Medical Center; Western Technical College; Westfield Group; Wilamette University; Wiss, Janney, Elstner Associates, Inc.; Wm. Wrigley Jr. Company; The Woodbridge Group; World Relief Corporation; Worthington Industries; Xavier University; Yeshiva University; York College CUNY; York College of PA; Zel Technologies, LLC.; and Zeon Chemicals L.P.

healthy culture can be measured in terms of lower health care costs, turnover, absence and workers' compensation.

- **Most employers focus narrowly on health issues after they occur, a focus that tends to be correlated with only one outcome.** In contrast, strategies that focus on optimal behavior are most strongly correlated with more outcomes, the rate of health care cost increases and turnover.

Based on the study data on program offerings and reported effectiveness, Sibson created a Healthy Enterprise Index to compare organizations to one another. (See "The Healthy Enterprise Index" section.) Sibson found that a higher index was associated with lower health care costs, health care cost increases, turnover, extended absences and workers' compensation costs.

The results of Sibson's *Healthy Enterprise Study* suggest that employers that want to become a healthy enterprise should consider developing a healthy enterprise strategy with dedicated leadership, a more effective workplace, greater employee and dependent involvement and measured outcomes.

PREVALENCE, DURATION AND EFFECTIVENESS OF WELLNESS PRACTICES

Figure 1 summarizes what the study found about wellness practices. The practices are listed in order of their correlation with a combined metric of overall effectiveness. The practices naturally fell into three different types: strategic drivers, behavior change support and environmental support. Interestingly, the top three most-correlated wellness practices are all strategic drivers given their focus on leadership, strategy and shared vision.

As the pie charts in Figure 1 show, almost all wellness practices are fairly prevalent. The exception is worksite healthy eating policies, which just over one-third of respondents have in place.

The first set of bars in Figure 1 shows for how long the respondents have had each practice in place. Most of the respondents' practices have been in place for at least three years. Research indicates that it generally takes three to five years for the full impact of wellness programs to be realized.⁹ Similarly, Sibson's study found that the breadth and reported effectiveness of initiatives increased over time with somewhat of a plateau at five years.

The second set of bars in Figure 1 shows the study data on perceived effectiveness of programs and initiatives. While most respondents reported each practice is effective, from 5% to 15% of respondents reported that each practice is ineffective.

This analysis yields a few interesting observations:

- As a group, the strategic drivers are the most critical to an effective program, but they are least prevalent.
- Program leadership and oversight was most correlated with overall wellness program effectiveness.
- Disease management was perceived as the least effective and is least important to overall effectiveness, even though it is the most prevalent.
- A smoke-free worksite policy was perceived by respondents to be the most effective practice by a good margin, yet the study found it is not highly correlated with overall wellness effectiveness. This suggests that a smoke-free worksite provides good support, but other elements are more important to an effective initiative.

INCENTIVES AND PARTICIPATION

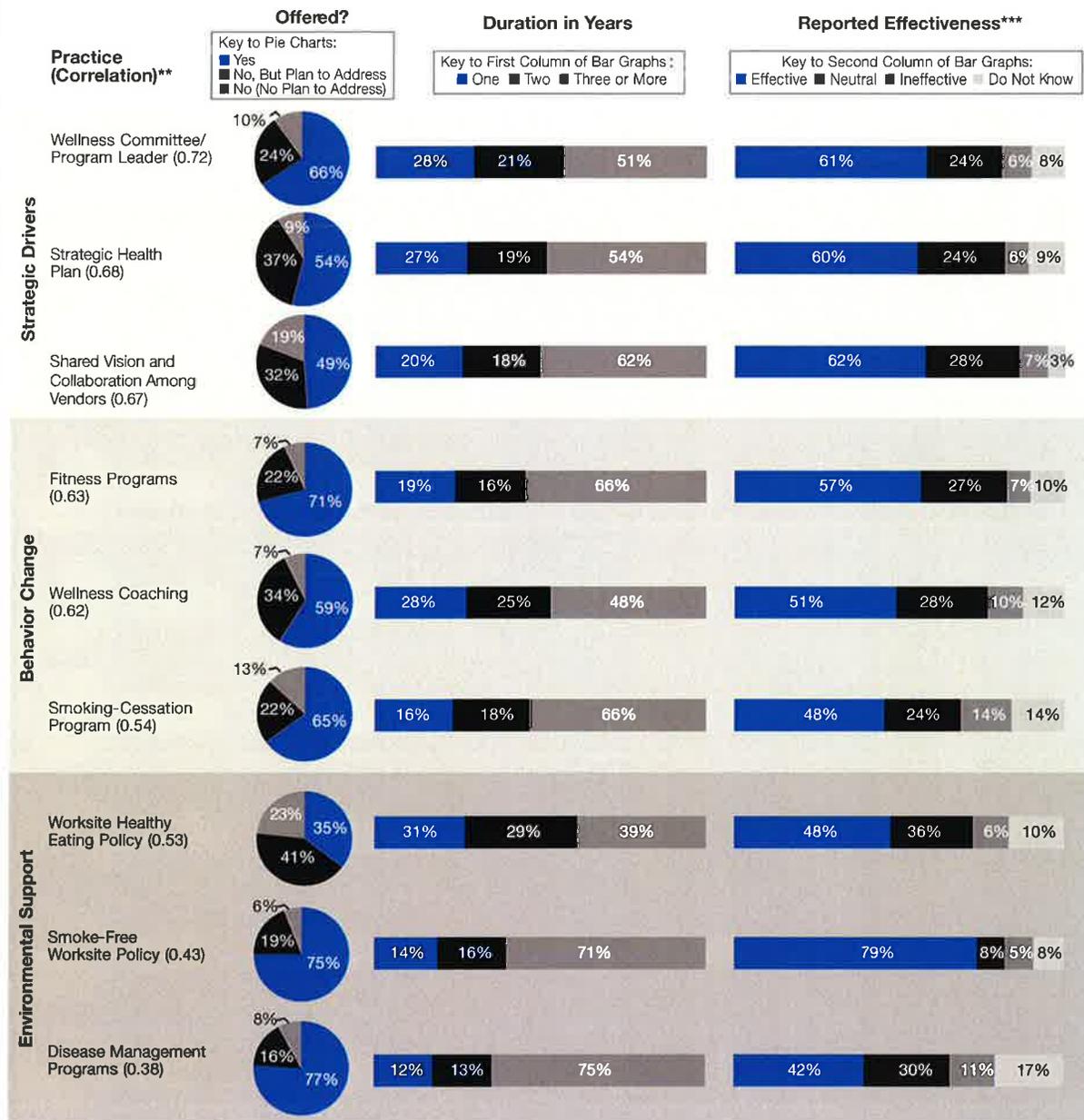
Participation in health risk assessments and biometric screenings is important because those tools provide the employer and employees with a snapshot of employee health status and serve as a measure of the extent to which employees embrace the overall initiative. Employers use incentives to drive participation in assessments and screenings. At first glance, the analysis summarized in Figure 2 appears to support the fact that incentives increase participation in health risk assessments (HRAs). More than half (63%) of employers that do not offer incentives have a participation rate in HRAs of 25% or less. Conversely, more than half (61%) of employers that offer incentives of \$250 or more, have participation rates in HRAs of 50% or more.

Upon further review, the study results suggest that other factors are also important to increase participation. For example, 13% of employers that do not offer incentives had participation in HRAs of 75% or more. Conversely, high incentives do not guarantee high participation. Among employers that offer incentives of \$250 or more, 13% have participation in HRAs of 25% or less. The study revealed more than a dozen items that were well-correlated with increased participation. As such, employers need to employ a broader strategy if they want employees to embrace their initiatives.

BUDGETS AND FUNDING

Organizations make substantial investments in their people, yet most organizations allocate only less than one-half of 1% of this investment to sustaining the health and well-being of their people (excluding the cost of medical coverage). On average, the organizations spend nearly \$80,000 annually on their employees' wages, health care and time off combined, but only 0.16% of that amount is spent on wellness

FIGURE 1
PREVALENCE, DURATION AND EFFECTIVENESS OF WELLNESS PRACTICES*



* Some totals do not equal 100% due to rounding.
 ** The programs are listed in order of correlation with overall wellness practice effectiveness (average reported effectiveness across all the listed wellness practices).
 *** Respondents were asked to rate the effectiveness of the wellness programs and initiatives at their organization on a five-point scale, with one being very ineffective, two being ineffective, three being neutral, four being effective and five being very effective. The segments in these bars indicate what percentage of respondents practice was "effective" (a score of 4 to 5), "neutral" (a score of 3) and "ineffective" (a score of 2 or less), as well as those that did not know a practice's effectiveness.

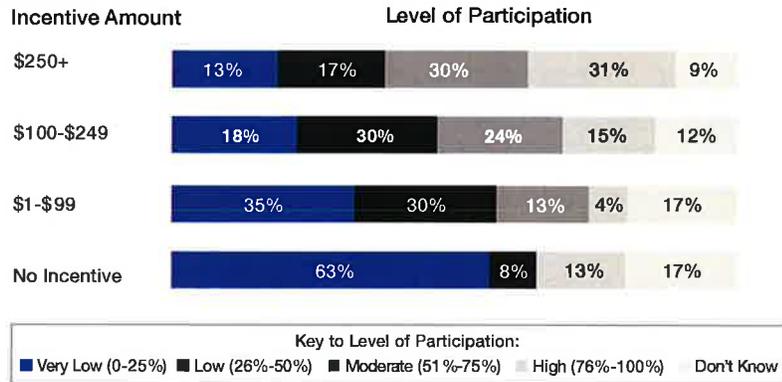
(\$126 average for those reporting a wellness budget). Many employers* may also include preventive services as part of their health plan (now required for nongrandfathered health plans under the Patient Protection and Affordable Care Act), which gener-

ally amounts to no more than 3% of the aggregate cost of the health plans.

More than half of the organizations in the study (58%) fund their initiatives from the benefits budget, and almost one-third (31%) fund them from the general

FIGURE 2

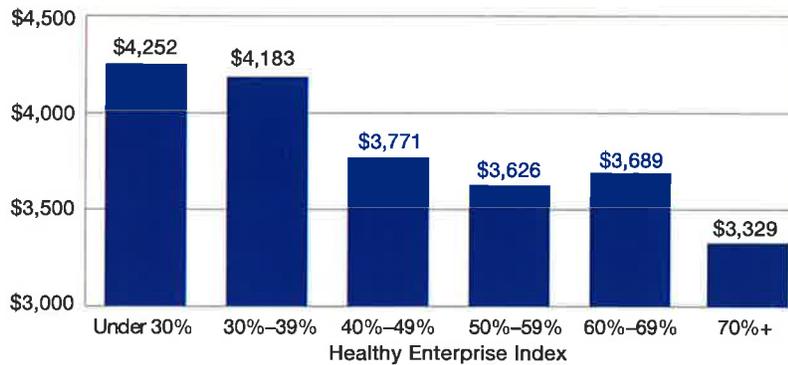
PERCENTAGE OF EMPLOYEES COMPLETING A HEALTH RISK ASSESSMENT BY INCENTIVES TO PARTICIPATE*



*For all respondents providing incentives (77%) the median total value of incentives an employee and dependent can earn each year is \$245 and \$200, respectively. Some bar totals do not equal 100% due to rounding.

FIGURE 3

AVERAGE ADJUSTED* HEALTH CARE COST PER PARTICIPANT ACCORDING TO HEALTHY ENTERPRISE INDEX



N = 205, correlation = -.17, statistical significance = .01

* Sibson adjusted the per-participant cost (inclusive of wellness investments) by industry and demographic (i.e., age and average family size).

human resources (HR) budget. A notable percentage (29%) rely on employee contributions. (Respondents could select multiple funding sources.) Two of the top three funding sources for wellness/health and productivity initiatives came from trade-offs with other benefits or employee contributions. This suggests that money does not need to be found, but rather redeployed.

OUTCOMES

The study found significant variance in each of the outcome metrics reported. Table I summarizes the degree of variance in health care costs, health cost in-

creases, voluntary turnover, extended absences and workers' compensation costs. The 90th percentile was always more than double the tenth percentile. This relationship was also consistent even after adjusting for industry and demographics. Sibson's study seeks to understand some of the organizational drivers that may have an impact on this variation.

THE HEALTHY ENTERPRISE INDEX

Sibson's Healthy Enterprise Index ranges from zero to 100%. The average organization's Healthy Enterprise Index was 57%. Although not every organiza-

TABLE I**DIFFERENCES IN OUTCOME METRICS BY PERCENTILES OF RESPONDENTS***

Metric	Percentiles					Difference Between 90th and 10th Percentiles
	10th	25th	50th	75th	90th	
Health Cost per Employee	\$5,000	\$6,826	\$8,403	\$10,393	\$12,712	\$7,712
Health Cost Increase per Employee	\$0	\$286	\$612	\$975	\$1,469	\$1,469
Turnover	3.0%	5.5%	10.0%	15.0%	20.0%	17 Percentage Points
Extended Absence	1.0%	1.4%	3.0%	8.0%	15.0%	14 Percentage Points
Workers' Compensation as a Percent of Payroll	0.11%	0.29%	0.60%	1.00%	1.98%	1.87 Percentage Points

*For each metric, the percentiles of respondents reflect the lowest to highest dollar amounts or percentages.

Source: Sibson Consulting's *Healthy Enterprise Study*.

TABLE II**COMPARISON OF AVERAGE ADJUSTED* OUTCOME METRICS FOR THE TOP QUARTILE COMPARED TO ALL OTHERS**

	Top Quartile	All Others	Percentage Difference
Healthy Enterprise Index	78%	50%	56%
Annual Health Cost per Participant	\$3,431	\$3,769	-9%
Annual Health Cost Increase per Participant	\$235	\$302	-22%
Turnover	8.1%	12.1%	-33%
Extended Absence	3.9%	6.1%	-36%
Workers' Compensation Cost as a Percentage of Payroll	0.74%	0.89%	-17%

*Sibson adjusted each outcome metric for various factors, such as industry and demographic (i.e., age and average family size). For information about which adjustments were applied to each metric, refer to the online supplement to this article that discusses the study methodology, which is available at www.sibson.com/publications/surveysandstudies/HESsupp2.pdf.

Source: Sibson Consulting's *Healthy Enterprise Study*.

tion will aim for an index of 100%, employers may want to determine their index and, if it is low, develop strategies to improve it. Sibson found that a higher Healthy Enterprise Index was correlated with lower health care costs (as shown in Figure 3), health care cost increases and voluntary turnover. On average, a ten-percentage-point increase in the index equated to \$160 reduction in health care cost per participant.

Therefore, an organization that has an average of 1.5 dependents for each employee could experience a reduction in annual health costs of \$400 per employee by increasing its index by ten percentage points.

Even though, due to the sample size, Sibson cannot state with statistical significance that there was a correlation with other metrics, the data did show that participants in the top quartile for the Healthy Enter-

TABLE III**CONTINUUM OF MATURITY MODEL CHARACTERISTICS TESTED IN THE HEALTHY ENTERPRISE STUDY**

Characteristic	Continuum of Maturity		
	Focus on Treatment	Focus on Prevention/Management	Focus on Optimal Behavior
Health	Provides high-quality and cost-effective treatment	Reduces health risks and manages conditions	Optimizes health and fitness
Time Off	Replaces pay, rehabilitates, returns to work	Advocates safety, accountability and risk management	Promotes lifelong health and personal and professional renewal
Behavioral Health	Treats personal and work-related mental health/substance abuse issues	Addresses factors leading to substance abuse and mental health issues	Stimulates psychological well-being (mental, emotional, social)
Communications	Clarifies benefit coverage	Shapes behavior	Promotes proactive approach to health and well-being
Organizational Behavior	Addresses unacceptable behavior	Shapes desired behavior	Leaders model behavior consistent with organization's values
Workplace Support	Treats minor injuries and/or handles medical emergencies	Detects and prevents problems to avoid more serious health issues	Empowers a culture of health
Measurement and Metrics	Measures and manages costs, utilization and treatment outcomes	Measures and targets interventions for prevention and disease management initiatives	Measures, assesses and targets interventions to improve physical, emotional and social capacity

Source: Sibson Consulting's *Healthy Enterprise Study*.

prise Index achieved better outcomes across the board. Table II shows the relevant data.

THE CONTINUUM OF MATURITY MODEL

The Continuum of Maturity Model is used to compare organizations to one another according to their level of maturity on a three-level continuum. Based on Sibson's research and experience in working with clients, there are three broad stages on a continuum of maturity for a healthy enterprise. Distinguishing characteristics are how proactive the organization is in focusing on treatment, prevention/management or optimal health/behavior:

- **Focus on treatment.** These organizations focus on addressing health care and workplace behavior issues after they occur. They often become aware of issues through large claims increases, workplace accidents or workplace disruption. They concentrate on reducing costs rather than improving outcomes.
- **Focus on prevention/management.** These organizations focus on identifying the risks and conditions that lead to more serious issues and promote better behaviors and health by identifying risks and conditions and then addressing them through supportive resources.
- **Focus on optimal health/behavior.** These organizations have a commitment to optimizing the be-

TABLE IV
REPORTED MATURITY AND IMPACT ON OUTCOME METRICS

	Percentage Reporting Effective	Impact* on Outcome Metrics
Treatment	39%	Moderate
Prevention/Management	27%	Moderate/High
Optimal Behavior/Health	17%	High

*Impact was measured based on the number of strategies in each stage that were correlated with better outcomes.

Source: Sibson Consulting's *Healthy Enterprise Study*.

havior, health, fitness and financial well-being of employees. It is imbued throughout the culture as a means to enable employees to fully engage in their work and their personal lives. Healthy behavior is encouraged, exhibited and rewarded.

Sibson used *Healthy Enterprise Study* data to test whether it matters where employers are in this maturity continuum. The Continuum of Maturity Model takes into account 16 characteristics. Table III shows the seven characteristics that were tested in the *Healthy Enterprise Study*.

Table IV summarizes the level of maturity participants in the *Healthy Enterprise Study* reported and the relative impact. Interestingly, only two in five respondents (39%) reported overall effectiveness of the treatment-focused strategies, which drops to only one in six (17%) for strategies aimed toward optimal health and behaviors. This is unfortunate because strategies focused on optimal health and behavior had the greatest impact on the outcome metrics. While almost every cell on the maturity model was correlated with multiple outcomes, only the health plans characteristic with a focus on treatment were correlated with only one outcome. Unfortunately, this is where most employers spend the bulk of their time in trying to reduce health care costs.

FINDINGS ON OUTCOMES

Respondents to the *Healthy Enterprise Study* were asked to provide their average health benefit expenses per employee, including medical, prescription drug coverage, wellness and disease management programs for both the employer and employee portions (excluding employee out-of-pocket costs).

Respondents were also asked to provide the average percentage increase in actual health care cost increases over the past two years. Sibson used this information to calculate an absolute dollar increase, which

is an effective benchmark for assessing cost outcomes. Turnover is another valuable outcomes measurement. Because a healthy enterprise operates a more effective workplace and is supportive of the needs of its employees, it should exhibit a lower rate of voluntary turnover relative to other employers in its industry.

Tracking absence-related metrics appears not to be a priority for survey respondents. Less than half of the respondents were able to report unscheduled absence, extended absence and workers' compensation costs. These survey respondents may be missing an opportunity to demonstrate how their investments have an impact on workforce readiness. However, these are important statistics, as noted below:

- **Unscheduled absence.** There are significant costs associated with unscheduled absences beyond what can be quantified through the wages paid for a day not worked. Like turnover, absence can be an indicator of employee withdrawal. A healthy enterprise should exhibit lower levels of unscheduled absence. The median number of lost workdays for the respondents that do track absences was four days, while 10% reported ten days or more. For an employer with 10,000 employees, the extra six days lost per employee amounts to 230 full-time-equivalent employees ($6 \times 10,000 / [52 \times 5]$).
- **Extended absence lasting longer than five days.** Extended absences can result in a significant disruption of operations for those who have to pick up the slack. One-quarter of the respondents that reported indicated that one in 12 employees (8%) had an absence lasting longer than five days.
- **Workers' compensation cost as a percentage of payroll.** Workers' compensation costs are a measure of workplace safety, and the health of the workforce can pose a significant risk in the workplace (e.g., a machine operator has a heart attack while on the job). The 90th percentile was 18 times higher than the tenth percentile. Even after

adjusting for industry differences, the cost at the 90th percentile was still 13 times higher than the cost at the tenth percentile.

In Sibson's experience, a healthy enterprise initiative should have a significant impact on the rates of absence and disability, which appears to be the case for the top quartile of the study.

COMMENTARY AND CONCLUSION

The results of Sibson's *Healthy Enterprise Study* suggest that employers that want to become a healthy enterprise should:

- **Establish a dedicated initiative leader and a wellness committee.** This can ensure good program leadership and oversight.
- **Develop a healthy enterprise strategy that is aligned with the organization's business strategy.** An aligned strategy helps crystallize the vision of the desired state, makes the initiative more real to employees and helps leadership understand how the initiative supports the business strategy.
- **Inventory and assess the "current state."** This may include the services and offerings currently available, but also the outcomes achieved, perceptions and effectiveness of these programs.¹⁰
- **Involve key stakeholders.** They include leadership, employees and other potential internal business partners.
- **Reevaluate the many investments the organization makes to become a healthy enterprise.** It may be possible to invest differently without spending more. For example, many organizations provide financial counseling, which can have a beneficial effect on employees' health to the extent that it relieves stress and anxiety. These efforts often are introduced in a fragmented way: through retirement programs, employee assistance programs and voluntary benefit programs. These resources can be redeployed as part of a financial literacy/wellness program that provides more comprehensive and immediately useful financial counseling.
- **Take steps to get employees to embrace the initiative.** Employees need to embrace the initiative enthusiastically, which requires leadership support, a broad set of effective resources and communications focused on changing behaviors.¹¹
- **Create an effective workplace.** Employees cannot contribute to organizational excellence if the appropriate tools and resources are not available. Employees will not extend discretionary effort at their job if they are working in a toxic work environment, where there are various forms of ag-

gression (e.g., harassment and bullying) in the workplace or a lack of trust and respect.

- **Pay attention to dependents.** Dependents can represent half or more of an organization's medical costs. Moreover, dependents can significantly influence the behaviors of employees. As a result, it is important to think about the strategies employed to engage dependents and to address their unique needs.
- **Measure outcomes.** It is important that there is focus in what is measured. Identify the metrics that will determine if the employer is achieving the stated strategy. Measuring success, shortcomings and failures is as important as measuring costs. Employers should share these key metrics across various constituents within the organization, both to foster support and to show progress.

In addition to the cost savings associated with being a healthy enterprise, there may be productivity gains to the extent that healthy employees are more satisfied with their jobs and more engaged in their work than unhealthy employees. Under Sibson's definition of *engagement*, an engaged employee has both *vision*, defined as knowing what work to do, and *commitment*, defined as wanting to do it. Employees may face barriers to engagement such as health issues (i.e., employees who are dealing with health issues such as cancer or diabetes may not be able to work efficiently even if they have vision and commitment), personal issues (e.g., financial, legal, family) and organizational (i.e., "toxic" work environment, absence of the tools, resources or support necessary to be productive). According to Sibson's research, increased employee engagement typically leads to improved productivity, motivation and retention.

The return on investments made to become a healthy enterprise is potentially considerable. For example, a recent *meta study* (a study of studies) conducted by Harvard University concluded that the return can be 3.27:1 on medical costs and 2.73:1 on absence and related costs. The programs that were the subjects of the reviewed studies were generally carefully crafted with the intent of measuring an outcome.¹² This suggests that employers need to carefully design their healthy enterprise initiatives to ensure they will produce a return on investment.

The authors believe that all organizations are making investments to some extent in organizational health. For many, these investments are imbedded in health care costs, workers' compensation costs, recruitment expense and training costs. Some organizations can be characterized as unhealthy or suboptimal in their performance; others can be characterized as healthy enterprises. HR professionals have a tre-

mendous opportunity to help their organizations advance along the continuum of maturity. ◀

Endnotes

1. J. Michael McGinnis, P. Williams-Russo and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion." *Health Affairs* 21 (2): 78. <http://content.healthaffairs.org/cgi/reprint/21/2/78>. This study found that individuals' health is determined 40% by behavior, 30% by genetics, 15% by social circumstances, 10% by medical care and 5% by environment. This data suggests that through a comprehensive healthy enterprise strategy, employers can have an impact on 70% of the determinants of the health of the workforce (i.e., the total of all factors except genetics).

2. Malcolm Gladwell. *Outliers: The Story of Success*. New York: Little, Brown and Company, 2010: www.gladwell.com/outliers/index.html. In the introduction, Gladwell cites research around how communities affect health and outcomes and the book addresses how some of the same community factors lead to success.

3. Kerstin Aumann and Ellen Galinsky. *The State of Health in the American Workforce: Does Having an Effective Workplace Matter?* Families and Work Institute (2009): www.familiesandwork.org/site/support/090928-healthpresentation.pdf. This study found that health outcomes were twice as good for employees working in highly effective organizations relative to those working in low overall effective organizations.

4. T. W. Taris, J. E. Van Horne, W. B. Schaufeli and P. J. G. Schreurs. "Inequity, Burnout and Psychological Withdrawal Among Teachers: A Dynamic Exchange Model." *Anxiety, Stress and Coping*. March 2004 (Vol. 17, No. 1): 103-122: www.fss.uu.nl/sop/Schaufeli/208.pdf. This study found that perceived inequity among workload, effort and commitment and what an employee receives from interpersonal relationships at work and pay/benefits leads to emotional exhaustion, burnout and turnover.

5. Dan Buettner. "The Blue Zones: Lessons for Living Longer From the People Who've Lived the Longest," *National Geographic*, 2010.

6. M. Kivimäki, J. Vahtera, M. Elovainio, J. Pentti and J. Virtanen. "Human Costs of Organizational Downsizing: Comparing Health Trends Between Leavers and Stayers," *American Journal of Community Psychology*, Volume 32, Numbers 1-2 / September, 2003; pp. 57-67: www.springerlink.com/content/1288117u3pm822u4/fulltext.pdf. This study looked at the impact on health among three different groups that went through a significant downsizing. After the downsizing, deterioration of health was most likely in the "stayers" working in groups of major staff reductions and next among the nonemployed "leavers." In the reemployed leavers, the risk of increased health problems was lower than in others including employees working in no or minor downsizing groups.

7. R. Kalimo, T. W. Taris and W. B. Schaufeli. "The effects of past and anticipated future downsizing on survivor well-being: an equity perspective." *Journal of Occupational Health Psychology*, April 8, 2003 (2): 91-109: <http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2003-03018-003>. This study examined worker well-being as a function of past downsizing and expectations concerning future downsizing. Having experienced downsizing in the past or anticipating downsizing in the future was associated with elevated levels of perceived inequity between what workers invest in their jobs and what they receive in return, which in turn were associated with ele-

vated levels of psychological strain, cynicism and absence. Moreover, well-being varied as a function of type of downsizing.

8. All cost comparisons made in this article are adjusted for industry, age and sex demographics, but not geographic factors.

9. Larry S. Chapman. "Meta Evaluation of Worksites Health Promotion Economic Return Studies," *The Art of Health Promotion*. 2005. Larry S. Chapman, M.P.H., an expert on wellness programs, conducts periodic *metastudies* (studies of studies) that show it generally takes three to five years for the full impact of wellness programs to be realized.

10. For more information about this process, refer to "Is Your Wellness Program a Scattershot Effort . . . or on Target to Serve Employees and the Organization?" which was published in the June 2008 issue of Sibson's e-magazine *Perspectives*: www.sibson.com/publications-and-resources/perspectives/volume_16_issue_3/wellness.html.

11. For more information, refer to "Reaching Employees in the Right Place at the Right Time: Four Steps to Successfully Communicating Your Organization's Wellness Program," which was published in the October 2008 issue of Sibson Consulting's *Perspectives*: www.sibson.com/publications/perspectives/Volume_16_Issue_4/wellness.html.

12. Katherine Baicker, David Cutler and Zirui Song, "Workplace Wellness Programs Can Generate Savings," *Health Affairs*, 29, No. 2 (2010).

▶ THE AUTHORS

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International Society of Certified Employee Benefit Specialists

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Improving Wellness Engagement With Behavioral Economics

Behavioral economics is the new engagement tool.

Total rewards professionals involved with employee benefits share a common professional objective: to improve the health, well-being and financial security of thousands of Americans. It is no wonder that frustrations arise when employees make suboptimal choices regarding their health-care benefits. Here are a few examples:

- Too many people go to a hospital emergency room for minor emergencies instead of visiting

By Christopher Goldsmith, Sibson Consulting, and J. Michael Vittoria, MaineHealth

Population health improvement initiatives offer employers a significant value proposition.

or contacting another place of service with lower costs and often faster service (e.g., an urgent-care facility, a primary-care physician, a convenience-care clinic, a telemedicine doctor, a 24-hour nurse line).

- Employees fail to obtain preventive health-care exams, even when the exams are free and the employee may earn an economic incentive.
- Some first-time parents forget to enroll their newborn in their employer's medical plan.

There are many suboptimal decisions, but when it comes to health care, those decisions generally cluster in two areas: poor health habits and ineffective health-care

consumerism. Although many organizations rely on financial incentives to encourage their employees to make better decisions, recent experience has shown that behavioral economics can be much more effective. A blend of micro-economics and psychology, behavioral economics can help reduce employees' suboptimal decisions, improve lives and generate better outcomes for employers.

This article shows how MaineHealth — a health system with more than 15,000 employees — used behavioral economics to improve employee well-being and control costs. But first, a look at the value and potential impact of wellness programs and an overview of behavioral economics and the perils of focusing on financial incentives to increase wellness participation.

Figure 1 | Healthy Enterprise Index: Health Costs and Other Outcomes

Key Outcomes	Top Quartile	All Others	Percentage Difference
Annual health cost (per member per year)	\$3,431	\$3,769	-9%
Annual health cost Increase	\$235	\$302	-22%
Turnover	8.1%	12.1%	-33%
Extended absence	3.9%	6.1%	-37%
Workers' compensation cost	0.74%	0.89%	-17%

Source: Sibson Consulting

Value and Potential Impact

Population health improvement initiatives offer employers a significant value proposition. As shown in Figure 1, the key outcomes for employers with scores in the top quartile of Sibson's Healthy Enterprise Index — which quantifies the efforts of employers that have effective wellness programs — are much better than for organizations in the other three quartiles.

Behavioral Biases and Heuristics

Increasing employee engagement in wellness programs is an important issue for many plan sponsors. One common problem is that employees tend to fall back on behavioral biases and heuristics and mental shortcuts that impede participation and obstruct behavior change. (See Figure 2 on page 52.)

It is important to realize that heuristics can serve as either barriers or bridges to behavior change. Behavioral economics can help employers minimize the effects of negative heuristics while they use positive heuristics to encourage employees to make the right choices.

- **Negative heuristics that behave as barriers include:**
 - **Endowment effect:** People place a greater psychological value on what they own than on what they would pay to acquire the same item.

The main problem with incentives is that they are not effective in overcoming the behavioral biases and heuristics ...

- ! **Complexity aversion:** People give up when choices are too numerous or complex.
- ! **Status quo bias:** People are reluctant to explore change.
- ! **Probability neglect:** People overvalue low-probability contingencies and undervalue high-probability contingencies.
- ! **Hyperbolic discounting:** People discount the value of future payouts far more than a present value analysis would indicate.
- ! **Sentinel event sensitivity:** People are overly swayed by emotionally charged events that may not be at all relevant. Positive heuristics that can function as bridges to behavior change include:
 - ! **Optimism bias:** People are generally optimistic about their ability to perform a reasonable task.
 - ! **Clue-seeking bias:** People look for clues to what the right choice might be.
 - ! **Bandwagon effect:** People are inherently social and will follow an admired leader.
 - ! **Availability heuristic:** People are swayed by the information in front of them and will often not conduct further research if they believe they are well informed.

The Problem with Financial Incentives

In trying to increase employee engagement, many plan sponsors leap to the incentive conclusion: "We will pay people to engage in wellness." The main problem with incentives is that they are not effective in overcoming the behavioral biases and heuristics that keep many employees from actively participating in the organization's wellness program.

Moreover, incentives can be challenging to design and implement well. While incentives can help raise attention, they sometimes backfire. And, although incentives can influence participation, the correlation is often low.

Financial incentives can miss the mark. If they are:

- ! **Too low:** they may fail to motivate behavior change
- ! **Too high:** they may be more expensive than necessary to obtain the desired behavior

- ! **Too distant:** they may appear to be uncertain or too far off to overcome the personal costs of behavior change today.

Another way financial incentives can fail is if they appear to be crowding out intrinsic motivation. Employees may see them as cheapening a task that they already perceive as interesting, fun or noble.

Financial incentives can also run into problems if the qualification requirements are flawed. For instance, there may be:

- ! **Too many ways to earn an incentive,** which can be overwhelming.

Figure 2 | Common Mental Shortcuts

Shortcut	Health and Benefits Examples
People are anchored to old value systems	"My parents smoked tobacco and lived to 100 years old. Why should I quit?"
People are inconsistent regarding their present behavior and their future promises	"I know I need to lose weight. I will change my diet when my diabetes gets worse."
People are overly confident and ignore change	"I don't need to wear a seatbelt. My driving must be in the top 10 percent."

Source: Sibson Consulting

■ **Too long of a qualification period**, which can cause procrastination and noncompliance.

Organizations that are considering using financial incentives need to ask the following questions:

- Is the change toward a positive habit sustainable?
- Do the incentives encourage unhealthy behavior, such as purging or short-term unhealthy dieting, to meet certain weight or body mass index (BMI) requirements?
- Are the incentives too easy to “game” by those who want to earn the incentive without working toward wellness?

When designing wellness incentive arrangements, some total rewards professionals may ask colleagues in the compensation function for help. This is not necessarily a good idea, because short-term cash incentive plans are often based on a rational model of expectancy theory, in which people who participate in a wellness program or attain a goal expect to earn an incentive.

With behavioral and lifestyle change as a goal, expectancy theory is not as useful as applied behavioral economics techniques incorporating a pre-commitment strategy, which may work better. Under a precommitment strategy, people commit to making a behavior change and receive an incentive payout promptly. If they follow through with the behavior change, they retain the

reward. But if they fail to follow through with their commitment, they forfeit the incentive.

A precommitment strategy leverages two principles:

- 1 | Behavioral compliance with a large request (e.g., stop smoking, lose weight, etc.) is enhanced if there is compliance with an initial, smaller request (e.g., a pledge to stop smoking or lose weight).
- 2 | It is far more psychologically challenging to give up a reward already being received than it is to change a behavior in exchange for a future reward promise.

A precommitment wellness strategy can be combined with medical plan choice architecture to create high levels of engagement. Choice architecture refers to how options are configured. Ordering, relative positioning, names used, decision factors identified, defaults used, even colors and fonts influence decisions and choice making.

The MaineHealth Case Study

MaineHealth, one of the nation’s top 100 integrated health-care delivery networks, has focused on employee wellness for many years. Recently, however, participation in health



Watch a video about this topic at www.worldatwork.org/workspan.

risk assessments and biometrics had leveled off to about 53 percent, despite an annual investment of \$1.6 million in employee wellness incentives. Improving participation was important because engagement in wellness is associated with significant cost differences at MaineHealth. When comparing plan participants who participate in the wellness program with those who do not participate, MaineHealth found:

- Health risks are just as prevalent in both populations
 - Per capita health claims on an age- and gender-adjusted basis are \$1,200 per year lower among wellness program participants
 - Short-term disability claims are \$954 lower per claimant among wellness program participants and the duration of disability was reduced from an average of 80 days for nonparticipants to 62 days for wellness participants
 - Preventive care compliance among employees with chronic conditions (particularly diabetes) is much higher among wellness program participants.
- MaineHealth deployed seven behavioral economic principles to dramatically improve wellness engagement:
- 1 | To overcome employee inertia, it required all employees to actively re-enroll in a health plan for 2013.
 - 2 | It re-ordered its presentation of plans by putting its new Healthy Saver plan first in the lineup. This is a consumer-driven health plan (CDHP) type program with an employer-funded health savings account (HSA) contribution.
 - 3 | The most popular plan, the health maintenance organization (HMO) plan, was renamed the Healthy HMO plan and presented second in the lineup.
 - 4 | To participate in the Healthy Saver or Healthy HMO plan, employees were required to make a commitment to wellness during open enrollment. To enroll in one of these options, employees had to complete a health risk assessment, have their biometrics (BMI, blood pressure, cholesterol and blood glucose levels) professionally measured (not self-reported) and designate a primary-care physician.
 - 5 | MaineHealth established a basic plan that served as a default option. This plan had lower coverage, no employer-funded HSA contribution and higher payroll deductions than the other plans. This would be the only plan option available to employees who did not complete the eligibility requirements described previously. Because it was an obviously less-desirable option than either the Healthy Saver or the Healthy HMO plans, it was intended to motivate employees to complete their wellness requirements to be able to gain access to the better plans.
 - 6 | A \$1,200 annual surcharge was levied on tobacco users who enrolled in any of the health plans. Tobacco use was verified by a urine test. Employees who tested

positive were subject to the surcharge until they could show they had successfully stopped using tobacco.

- 7 | The maximum incentive value for meeting various wellness participation and achievement standards was decreased from \$338 to \$250.

The results showed:

- Wellness participation by employees enrolled in health benefits increased from 53 percent to 98 percent, while MaineHealth's cost of providing employee health benefits were projected to decrease by 3.1 percent in 2013.
- Tobacco use declined by more than 1 percent in the first three months of the program as more employees took advantage of tobacco-cessation plans.
- Expenditures on wellness incentives increased in the aggregate, but were spread over many more employees in the workforce. The average wellness incentive expenditure per employee decreased from \$288 in 2012 to a projected \$233 for 2013.
- More than 20 percent of employees who enrolled in a health plan chose the new Healthy Saver CDHP option, which was slightly better than behavioral models projected.
- The percentage of employees who chose not to enroll in a health plan was virtually unchanged from the prior year, meaning that the plan design changes and new wellness requirements did not cause employees to seek coverage elsewhere.

Conclusion

Companies that leverage the principles of behavioral economics can realize attractive gains for their workforce and the organization. A rational approach begins with understanding the suboptimal choices being made by the workforce and the potential value gains associated with improved decision making and behavior change. With a blended understanding of rational microeconomics and irrational consumer behaviors, plan sponsors will be positioned for dramatic gains. **WE**

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J. Michael Vittoria is vice president of corporate benefit services at Maine Medical Center/MaineHealth in Portland, Maine. He can be reached at vittoj1@mmc.org.

resources plus

For more information, books and education related to this topic, log on to www.worldatwork.org and use any or all of these keywords:

- Wellness programs
- Health care + behavior
- Behavioral + economics.

Exceptions – Contract and BA Agreement

We have suggested changes to better clarify the obligations of both parties under the Agreement for Services and the Business Associates Agreement. We do not wish our suggested modifications to impede our opportunity to contract with NDPERS and are willing to negotiate the final language for the contract.

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instructions on how to respond to the request.

- 9) **OWNERSHIP OF ¹WORK PRODUCT:** ~~All work product, equipment or materials created or purchased under this contract belong to STATE and must be delivered to STATE at STATE'S request upon termination of this contract. CONTRACTOR agrees that all materials prepared under this contract are "works for hire" within the meaning of the copyright laws of the United States and assigns to STATE all rights and interests CONTRACTOR may have in the materials it prepares under this contract, including any right to derivative use of the material. CONTRACTOR shall execute all necessary documents to enable STATE to protect its rights under this section. ²~~
- 10) **APPLICABLE LAW AND VENUE:** This agreement shall be governed by and construed in accordance with the laws of the State of North Dakota. Any action to enforce this contract must be brought in the District Court of Burleigh County, North Dakota.
- 11) **MERGER AND MODIFICATION:** This contract, the RFP and the proposal shall constitute the entire agreement between the parties. In the event of any inconsistency or conflict among the documents making up this agreement, the documents must control in this order of precedence: First – the terms of this Contract, as may be amended and Second - the state's Request for Proposal and Third – Contractor's Proposal. No waiver, consent, modification or change of terms of this agreement shall bind either party unless in writing and signed by both parties. Such waiver, consent, modification or change, if made, shall be effective only in the specific instances and for the specific purpose given. There are no understandings, agreements, or representations, oral or written, not specified herein regarding this agreement.
- 12) **INDEMNITY:** Contractor agrees to defend, indemnify, and hold harmless the state of North Dakota, its agencies, officers and employees (State), from and against claims ³~~based on the vicarious liability of the State or its agents, ⁴~~ but not against claims based on the State's contributory negligence, comparative and/or contributory negligence or fault, sole negligence, or intentional misconduct. ⁵~~This obligation to defend, indemnify, and hold harmless does not extend to professional liability claims arising from professional errors and omissions.~~ The legal defense provided by Contractor to the State under this provision must be free of any conflicts of interest, even if retention of separate legal counsel for the State is necessary. Any attorney appointed to represent the State must first qualify as and be appointed by the North Dakota Attorney General as a Special Assistant Attorney General as required under N.D.C.C. § 54-12-08. Contractor also agrees to defend, indemnify, and hold the State harmless for all costs, expenses and attorneys' fees incurred if the State prevails in an action against Contractor in establishing and litigating the indemnification coverage provided herein. This obligation shall continue after the termination of this agreement.
- 13) **INSURANCE:** Contractor shall secure and keep in force during the term of this agreement, and Contractor shall require all subcontractors, prior to commencement of an agreement between Contractor and the subcontractor, to secure and keep in force during the term of this agreement, from insurance companies, government self-

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DELIVERABLES: Except to the extent that they incorporate CONTRACTOR'S proprietary software, tools, know-how, techniques, methodologies and report formats (collectively, "Contractor's Proprietary Information"), all documents, data, and other tangible materials authored or prepared and delivered by CONTRACTOR to STATE under this contract (collectively, the "Deliverables"), are the sole and exclusive property of STATE once paid for by STATE. To the extent Contractor's Proprietary Information is incorporated into such Deliverables, STATE shall have a perpetual, nonexclusive, worldwide, royalty-free license to use, copy, and modify Contractor's Proprietary Information as part of the Deliverables internally and for their intended purpose.

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that result from CONTRACTOR'S willful misconduct or negligent performance of its obligations under the contract,

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insurance pools or government self-retention funds, authorized to do business in North Dakota, the following insurance coverages:

- 1) Commercial general liability, including premises or operations, contractual, and products or completed operations coverages (if applicable), with minimum liability limits of ~~\$250,000 per person and \$1,000,000 per occurrence.~~
- 2) Professional errors and omissions with minimum limits of \$1,000,000 per occurrence and in the aggregate, Contractor shall continuously maintain such coverage during the contract period and for three years thereafter. In the event of a change or cancellation of coverage, Contractor shall purchase an extended reporting period to meet the time periods required in this section.
- 3) Automobile liability, including Owned (if any), Hired, and Non-Owned automobiles, with minimum liability limits of \$250,000 per person and \$1,000,000 per occurrence.
- 4) Workers compensation coverage meeting all statutory requirements. The policy shall provide coverage for all states of operation that apply to the performance of this contract.
- 5) Employer's liability or "stop gap" insurance of not less than \$1,000,000 as an endorsement on the workers compensation or commercial general liability insurance.

The insurance coverages listed above must meet the following additional requirements:

- 1) Any deductible or self-insured retention amount or other similar obligation under the policies shall be the sole responsibility of the Contractor.
- 2) This insurance may be in policy or policies of insurance, primary and excess, including the so-called umbrella or catastrophe form and must be placed with insurers rated "A-" or better by A.M. Best Company, Inc., provided any excess policy follows form for coverage. Less than an "A-" rating must be approved by the State. The policies shall be in form and terms approved by the State.
- 3) The duty to defend, indemnify, and hold harmless the State under this agreement shall not be limited by the insurance required in this agreement.
- 4) The state of North Dakota and its agencies, officers, and employees (State) shall be endorsed on the commercial general liability policy, including any excess policies (to the extent applicable), as additional insured. The State shall have all the benefits, rights and coverages of an additional insured under these policies that shall not be limited to the minimum limits of insurance required by this agreement or by the contractual indemnity obligations of the Contractor.
- 5) The insurance required in this agreement, through a policy or endorsement, shall include:
 - a) "Waiver of Subrogation" waiving any right to recovery the insurance company may have against the State;
 - b) a provision that Contractor's insurance coverage shall be primary (i.e. pay first) as respects any insurance, self-insurance or self-retention maintained by the State and that any insurance, self-insurance or self-retention maintained by the State shall be in excess of the Contractor's insurance and shall not contribute with it;
 - c) cross liability/severability of interest for all policies and endorsements;

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except for professional liability

SECTION 9 - BUSINESS ASSOCIATE AGREEMENT

(Revised 10-2013)

This Business Associate Agreement, which is an addendum to the underlying contract, is entered into by and between, the North Dakota Public Employees Retirement System ("NDPERS") and the **ENTER BUSINESS ASSOCIATE NAME, ADDRESS OF ASSOCIATE.**

1. Definitions

- a. Terms used, but not otherwise defined, in this Agreement have the same meaning as those terms in the HIPAA Privacy Rule, 45 C.F.R. Part 160 and Part 164, Subparts A and E, and the HIPAA Security rule, 45 C.F.R., pt. 164, subpart C.
- b. Business Associate. "Business Associate" means the **ENTER BUSINESS ASSOCIATE NAME.**
- c. Covered Entity. "Covered Entity" means the **North Dakota Public Employees Retirement System Health Plans.**
- d. PHI and ePHI. "PHI" means Protected Health Information; "ePHI" means Electronic Protected Health Information.

2. Obligations of Business Associate.

2.1. The Business Associate agrees:

- a. To use or disclose PHI and ePHI only as permitted or required by this Agreement or as Required by Law.
- b. To use appropriate safeguards and security measures to prevent use or disclosure of the PHI and ePHI other than as provided for by this Agreement, and to comply with all security requirements of the HIPAA Security rule.
- c. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains or transmits on behalf of the Covered Entity as required by the HIPAA Security rule.
- d. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI or ePHI by Business Associate in violation of the requirements of this Agreement.
- e. To report Covered Entity (1) any use or disclosure of the PHI not provided for by this Agreement, and (2) any "security incident" as defined in 45 C.F.R. § 164.304 involving ePHI, of which it becomes aware without unreasonable delay and in any case within thirty (30) days from the date after discovery and provide the Covered Entity with a written notification that complies with 45 C.F.R. § 164.410 which shall include the following information:
 - i. to the extent possible, the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during the breach;
 - ii. a brief description of what happened;
 - iii. the date of discovery of the breach and date of the breach;
 - iv. the nature of the Protected Health Information that was involved;
 - v. identify of any person who received the non-permitted Protected Health Information;

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. For purposes of reporting under this Section, the term "security incident" shall be limited to the successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. Business Associate shall also report any "Breach" of "Unsecured PHI", as such terms are defined at 45 CFR 164.402

- vi. any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - vii. a brief description of what the Business Associate is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
 - viii. any other available information that the Covered Entity is required to include in notification to an individual under 45 C.F.R. § 164.404(c) at the time of the notification to the State required by this subsection or promptly thereafter as information becomes available.
- f. With respect to any use or disclosure of Unsecured Protected Health Information not permitted by the Privacy Rule that is caused by the Business Associate's failure to comply with one or more of its obligations under this Agreement, the Business Associate agrees to pay its reasonable share of cost-based fees associated with activities the Covered Entity must undertake to meet its notification obligations under the HIPAA Rules and any other security breach notification laws;
 - g. Ensure that any agent or subcontractor that creates, receives, maintains, or transmits electronic PHI on behalf of the Business Associate agree to comply with the same restrictions and conditions that apply through this Agreement to the Business Associate.
 - h. To make available to the Secretary of Health and Human Services the Business Associate's internal practices, books, and records, including policies and procedures relating to the use and disclosure of PHI and ePHI received from, or created or received by Business Associate on behalf of Covered Entity, for the purpose of determining the Covered Entity's compliance with the HIPAA Privacy Rule, subject to any applicable legal privileges.
 - i. To document the disclosure of PHI related to any disclosure of PHI as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
 - j. To provide to Covered Entity within 15 days of a written notice from Covered Entity, information necessary to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
 - k. To provide, within 10 days of receiving a written request, information necessary for the Covered Entity to respond to an Individual's request for access to PHI about himself or herself, in the event that PHI in the Business Associate's possession constitutes a Designated Record Set.
 - l. Make amendments(s) to PHI in a designated record set as directed or agreed by by the Covered Entity pursuant to 45 C.F.R. § 164.526 or take other measures as necessary to satisfy the covered entity's obligations under that section of law.

3. Permitted Uses and Disclosures by Business Associate

3.1. General Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may Use or Disclose PHI and ePHI to perform functions, activities, or services for, or on behalf of, Covered Entity, specifically **consultant services to develop, issue and evaluate proposals for the group health plan** – provided that such use or disclosure would not violate the Privacy Rule or the Security Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.□

3.2. Specific Use and Disclosure Provisions

Except as otherwise limited in this Agreement, Business Associate may use □PHI and ePHI:

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Number: 2 , except for the specific uses and disclosures permitted by Section 3.2 of this Agreement	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:17:30 AM
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- a. For the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- b. To provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B), but Business Associate may not disclose the PHI or ePHI of the Covered Entity to any other client of the Business Associate without the written authorization of the covered entity Covered Entity.
- c. To report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §§ 164.304 and 164.502(j)(1).

4. Obligations of Covered Entity

4.1. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

Covered Entity shall notify Business Associate of:

- a. Any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that any such limitation may affect Business Associate's use or disclosure of PHI.
- b. Any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that any such changes may affect Business Associate's use or disclosure of PHI.
- c. Any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that any such restriction may affect Business Associate's use or disclosure of PHI.

4.2. Additional Obligations of Covered Entity. Covered Entity agrees that it:

- a. Has included, and will include, in the Covered Entity's Notice of Privacy Practices required by the Privacy Rule that the Covered Entity may disclose PHI for Health Care Operations purposes.
- b. Has obtained, and will obtain, from Individuals any consents, authorizations and other permissions necessary or required by laws applicable to the Covered Entity for Business Associate and the Covered Entity to fulfill their obligations under the Underlying Agreement and this Agreement.
- c. Will promptly notify Business Associate in writing of any restrictions on the Use and Disclosure of PHI about Individuals that the Covered Entity has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.
- d. Will promptly notify Business Associate in writing of any change in, or revocation of, permission by an Individual to Use or Disclose PHI, if the change or revocation may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Agreement.

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3.3 Business Associate may de-identify PHI in accordance with the requirements of 45 CFR §164.514(a)-(c), and may use or disclose the information that has been de-identified.

4.2. Permissible Requests by Covered Entity

Covered Entity may not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Covered Entity, except that the Business Associate may use or disclose PHI and ePHI for management and administrative activities of Business Associate. [1]

5. Term and Termination

- a. Term. The Term of this Agreement shall be effective as of the date of contract award for the retiree health valuation, and shall terminate when all of the PHI and ePHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI and ePHI, protections are extended to any such information, in accordance with the termination provisions in this Section.
- b. Automatic Termination. This Agreement will automatically terminate upon the termination or expiration of the Underlying Agreement.
- c. Termination for Cause. Upon Covered Entity's [2] knowledge of a material breach by Business Associate, Covered Entity [3] shall either:
 1. Provide an opportunity for Business Associate [4] to cure the breach or end the violation and terminate this Agreement and the Underlying Agreement if Business Associate [5] does not cure the breach or end the violation within the time specified by Covered Entity;
 2. Immediately terminate this Agreement and the Underlying Agreement if Business Associate [7] has breached a material term of this Agreement and cure is not possible; or
 3. If neither termination nor cure is feasible, Covered Entity [8] shall report the violation to the Secretary.
- d. Effect of Termination.
 1. Except as provided in paragraph (2) of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI and ePHI that is in the possession of subcontractors or agents of Business Associate. [9] Business Associate shall retain no copies of the PHI or ePHI.
 2. In the event that Business Associate determines that returning or destroying the PHI or ePHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. ~~Upon explicit written agreement of Covered Entity that return or destruction of PHI or ePHI is not feasible, Business Associate [10] shall extend the protections of this Agreement to that PHI and ePHI and limit further uses and disclosures of any such PHI and ePHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains that PHI or ePHI. [11]~~

6. Miscellaneous

- a. Regulatory References. A reference in this Agreement to a section in the HIPAA Privacy or Security Rule means the section as in effect or as amended.
- b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity [12] to comply with the requirements of the Privacy Rule, the Security Rule, and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

Number: 1	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:19:08 AM
or to provide Data Aggregation services to the Covered Entity			
Number: 2	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:19:20 AM
either party's			
Number: 3	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:19:32 AM
the other, the non-breaching party			
Number: 4	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:19:41 AM
the breaching party			
Number: 5	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:19:49 AM
the breaching party			
Number: 6	Author: akoski	Subject: Cross-Out	Date: 04/09/2014 10:19:56 AM
Number: 7	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:20:07 AM
the breaching party			
Number: 8	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:20:16 AM
the non-breaching party			
Number: 9	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:20:29 AM
Except as permitted herein,			
Number: 10	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:20:41 AM
and			
Number: 11	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:21:03 AM
Covered Entity understands that Business Associate's need to maintain portions of the PHI in records of actuarial determinations and for other archival purposes related to memorializing advice provided will render return or destruction infeasible.			
Number: 12	Author: akoski	Subject: Inserted Text	Date: 04/09/2014 10:21:13 AM
the parties			

- c. Survival. The respective rights and obligations of Business Associate under Section 5.c, related to "Effect of Termination," of this Agreement shall survive the termination of this Agreement.
- d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit ~~Covered Entity~~ ^[1] ~~comply with the Privacy and Security Rules.~~ ^[2]
- e. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything this Agreement confer, upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever. ^[3]
- f. Applicable Law and Venue. This Business Associate Agreement is governed by and construed in accordance with the laws of the State of North Dakota. Any action commenced to enforce this Contract must be brought in the District Court of Burleigh County, North Dakota.
- g. Business Associate agrees to comply with all the requirements imposed on a business associate under Title XIII of the American Recovery and Reinvestment Act of 2009, the Health Information Technology for Economic and Clinical Health (HI-TECH) Act, ^[4] ~~and, at the request of NDPERS, to agree to any reasonable modification of this agreement required to conform the agreement to any Model Business Associate Agreement published by the Department of Health and Human Services.~~

7. Entire Agreement

This Agreement contains all of the agreements and understandings between the parties with respect to the subject matter of this Agreement. ^[5] No agreement or other understanding in any way modifying the terms of this Agreement will be binding unless made in writing as a modification or amendment to this Agreement and executed by both parties.

IN WITNESS OF THIS, **NDPERS** [CE] and **ENTER BUSINESS ASSOCIATE NAME** [BA] agree to and intend to be legally bound by all terms and conditions set forth above and hereby execute this Agreement as of the effective date set forth above.

For Covered Entity:

For Business Associate:

 Sparb Collins, Executive Director
 ND Public Employees Retirement System

 Signature

 Printed Name

 Title

 Date

 Date

-
- ☒ Number: 1 Author: akoski Subject: Cross-Out Date: 04/09/2014 10:21:38 AM
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- ☒ Number: 2 Author: akoski Subject: Inserted Text Date: 04/09/2014 10:21:44 AM
the parties
-
- ☒ Number: 3 Author: akoski Subject: Inserted Text Date: 04/09/2014 10:23:46 AM
, including, for the avoidance of doubt, any participant or beneficiary of Covered Entity
-
- ☒ Number: 4 Author: akoski Subject: Cross-Out Date: 04/09/2014 10:24:40 AM
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- ☒ Number: 5 Author: akoski Subject: Inserted Text Date: 04/09/2014 10:23:11 AM
In the event of any inconsistency or conflict between this Agreement, and the Underlying Agreement or any other written agreement between the parties, the terms, provisions and conditions of this Agreement shall control and govern.