HEALTH PLAN HEROES: THE CEOs WHO Restored The American Dream

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Foreword by
MARILYN BARTLETT

HEALTH PLAN HEROES:
THE CEOs WHO ARE RESTORING THE AMERICAN DREAM

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This book's content overlaps, updates and expands on case study content published in the author's last three books, The CEO's Guide to Restoring the American Dream, The Opioid Crisis Wake-Up Call ~ Health Care Is Stealing the American Dream, and Here's How We Take It Back, and Relocalizing Health: The Future of Health is Local, Open, and Independent.

This book's purpose is to shine sunlight on the Health Plan Heroes whose benefits and care models produce world-class health outcomes while offering tools to ensure these increasingly wide-spread successes can be replicated in communities throughout America.

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PREFACE

By the time I was 40, I had lost ten close friends who were my age or younger. It's a gut punch to be reminded how short our time here is, but one loss hit me harder than any other: a friend died of cancer, and the system failed her in every way. She was a talented tech executive and worked her way to the top levels of Silicon Valley. She should have had access to great health care, but got a harmful treatment plan that led to her financial, physical, and emotional ruin as her legacy to her 10-year-old daughter. It was devastating to witness.

Her death struck me particularly deeply because I realized I was part of the system. I was raised to know that if you see a wrong and don't do anything about it, you are complicit. I had started my career consulting with faith-based and children's hospitals as a revenue cycle consultant—a fancy term for generating as big a bill as possible, getting it out as fast as possible, and getting it paid as quickly as possible. At one time, this was simply to ensure that a hospital didn't forget to bill for something, but it became the root of a scheme that is arbitrary, abusive, and has absolutely devastated the working and middle class in America. Like my friend before her death, hundreds of thousands of victims of our corrupt health care system file for bankruptcy every year—even though 70% of them have insurance. I saw the fear in

my friend's eyes thinking about her daughter's future, knowing that even after working hard and being extremely successful, she wasn't going to be able to leave her with much, if anything.

Not long before my friend's passing, I had been leading the most successful technology platform in health care. I was excited about how patients and doctors could finally realize value from easy-to-use software after decades of mainframe computers. But despite breakthrough technologies that could improve patient outcomes, that's not what hospitals wanted to buy. All they wanted were systems tuned to game every reimbursement opportunity the industry had to offer. Despite being at the top of my game in health care, I couldn't be party to that and vowed I wasn't going to work on technology that I knew was going to do more harm than good. I was frustrated that I didn't have the solution, so I left health care for over a decade.

Around the time I was returning to health care, a high school kid asked me to buy a candy bar for her school fundraiser. Great, I said, were they raising money for a band trip? No. It turned out they were raising money for science lab supplies. What?! Taxes paid for that stuff when I was a kid.

Turns out this often isn't the case anymore, primarily because of health care. Bill Gates devoted an entire TED talk to how health care has been devastating education: larger class sizes, laid off teachers, fewer music and arts classes, and increased college tuition for state universities and community colleges. He also outlined how devastated education budgets would impact the future by preventing bold experiments and limiting opportunities for excellence. When Gates gave his talk, California alone owed more than $60 billion in health benefits costs that it couldn't pay. I started my K-12 education in California at a time when the state was generally considered to have the best education system in the country; today it has the lowest high school graduation rates in the entire country—and the highest student-to-teacher ratio.

The scale of the financial and medical devastation that health care has wrought on America is something most people can't imagine. Financially, health care's hyperinflation has driven

more than two decades of wage stagnation and decline. Today, 60% of the workforce makes $20/hour or less, while health insurance premiums for a family of four are over $20,000 per year.

With over half of the workforce having a deductible greater than $1,000, most Americans are a bad stubbed toe away from financial ruin. And these are the people who have insurance!

For example, even as the country focused on the COVID-19 pandemic, we continue to grapple with an older massive public health crisis, the opioid crisis, which is a self-inflicted wound driven almost entirely by a dysfunctional health care system. While in Boston, not far from "Methadone Mile," I saw two things that we now know are profoundly connected—gleaming billion-dollar medical towers and students "on strike" because of school underfunding.

Believe it or not, we can go a long way to stopping the opioid crisis in its tracks, while fixing education underfunding and preventing or better preparing the country for future crises, through access to great, value-based primary care, a critical foundation for a fair, rational, affordable, and effective health care system.

I've found real hope in the solutions I've discovered. Every structural solution to prevent what happened to my friend and countless others has already been invented and proven, and is working someplace in this country. A small hotel company has the best benefits package of any employer I've ever seen—and they spend 55% less than employers of similar size. In addition to providing quality, affordable health care to employees and their families, they've invested a small fraction of what they saved into the local community and school system, which are seeing stunning results: crime has gone down by 80% and high school graduation rates have dramatically increased to nearly 100%. It sounds unbelievable, but it's true, and it's happening in Orlando right now.

The most amazing discovery I've made in studying successful innovations is that the best way to slash costs is to improve health benefits and outcomes. How could I not share this great news?

The excitement from health-care professionals, elected officials, employers, and other civic-minded Americans is contagious. If you've picked up this book, you are part of the solution.

No matter who or where you are, you can join this effort to catalyze change and restore both hope and health to the community where you live and work.

There is no time to lose, especially after seeing how badly undermined primary care and poor public health infrastructure made the U.S. much more vulnerable to COVID-19. Fortunately, there are many things you can do to prevent further dysfunction.

For example, work to ensure that your company, union or community has access to great primary care. Join the Health Rosetta community to share your successes and learn from those of others. If you are a city leader who makes health-care-related decisions, lead by example with city employees and use your bully pulpit to reinvent health care in your community. If you are a union leader, follow the example of dozens of school districts around the Pittsburgh area, where labor and management leaders put aside old differences to work together for benefits that boost the health—and bottom line—of all parties.

Also, write down every organization you have influence over and share with them that the best way to slash health care costs is to improve health benefits. Share this book with them— we've made a free download available of this and my past books, such as The CEO's Guide to Restoring the American Dream, at www.healthrosetta.org/friends. We care more about spreading success than losing a few book sales.

Whatever your role, start with one organization and one tactic. For too long, we've let health care crush the American Dream. We cannot take another 20 years of economic depression for the working and middle class. Whether we know it or not, we all contributed to this mess. Now, it's on us to fix it. When change happens community by community, it is impossible to stop. Yes, health care stole the American Dream. But, it's absolutely possible to take it back. Join us to make it happen in your community.

To learn more, read on or visit healthrosetta.org. What is the Health Rosetta? The blueprint for evidence-based health purchasing. It's a practical approach built on what successful purchasers do.

For ongoing insight, best practices, and updates, subscribe to the Health Rosetta newsletter at healthrosetta.org/employers. If you have success stories to share about how communities are being rebuilt, or have general ideas or feedback, email me at dave.chase@healthrosetta.org.

INTRODUCTION

If you want to get to the root cause of an issue, just ask, "Why?" That's what I do every time I see employees strike, and usually the answer—no matter the industry—is, at least in part, "health care." A few recent examples:

In the auto industry, in the longest strike between GM and the United Auto Workers (UAW union since 1970, the UAW fought to protect hourly workers' 3% health care cost share, while also arguing for better wages, job security, and other benefits.

In education, the Dedham (Massachusetts Education Association struck—the state's first strike in 12 years—to get the Dedham School Committee to reduce teachers' health insurance contributions.

And in the health-care industry itself, the University of California UC) Service and Patient Care Technical Workers (part of the American Federation of State, County and Municipal Employees Local 3299) struck the university, arguing that UC is outsourcing work to people they pay less and refusing to increase wages for existing workers. That last example may not, on the surface, seem to be a direct response to health care cost concerns. However, health-care spending is the underlying issue here too.

Employers have had to dedicate an increasingly significant part of their budget to health-care costs each year. As a result,

many have compensated by cutting into other parts of the budget—like wages, retirement benefits, etc.—or forcing employees to bear more of that cost burden via high-deductible health plans. Still others, like UC allegedly, have outsourced functions to remove the cost burden of health benefits, which increases the number of working poor who are employed by contractors that do not offer insurance and who cannot afford publicly available health insurance.

The truth is, the public sector could do more to make their health plans more affordable for all people. It could also improve outcomes in their communities if local dollars weren't being swallowed up by, in many cases, frivolous projects like the $1 billion expansion of Massachusetts General Hospital. Hospital leaders' edifice complex often takes large sums of public and/or private dollars away from sectors and initiatives that truly matter for the sole purpose of producing a shiny new building for people to admire—a building whose revenue is dependent on the public's unfortunate need to visit it.

In Texas, health-care dollars could be better used in attempting to reduce the state's obesity rate—it's the 10th highest in the country—by addressing food deserts, improving school lunches, and funding primary care that includes health coaching. Or, the state might follow the superior health care model Pittsburgh-area schools used to ensure smaller class sizes and better teacher pay and benefits.

Understanding how we can free up health-care dollars to accomplish these goals, or really any goals that are important to states, is what our books set out to do. Our books walk readers through how much money is wasted on our current catastrophic health care system at the national level, the state level and even the employer level. Our books further explain how that catastrophic system has given birth to subsequent public-health crises—such as the opioid crisis—and how we allowed this to happen. Finally, our model points the way for us to end the current system by designing low-cost, highquality, parent-approved health plans.

We're spending more than enough money to get the best health care system in the world. In places, we actually already have it—and not just for the rich. The only real question is whether we can massively replicate what we already know works beautifully. My dad passed away from Parkinson's a few years ago, and I can honestly say that I don't know of any model in the world that could have exceeded the care he received through his Health Rosetta-type health plan. As a country, we can easily afford to implement this model, as it's much less costly than the disaster that is our status quo health system.

Changing the world starts with changing health care's status quo, and to do that, all of us must first rally together. I am counting on you to rise to the challenge to drive change in whatever sphere you have influence. With this book as your guide, I encourage you to go forth and continue to push forward the health-care revolution that's gaining more and more momentum each and every day.

Health care isn't expensive. What is expensive is profiteering, price-gouging and edifice complexes that prioritize building Taj Mahals over disaster readiness. After all, only $0.27 of every $1 ostensibly spent on health care goes to the primary value-creators—nurses, physicians and other clinicians.

CASE STUDIES

This chapter highlights wise employers and smart benefit strategies that have created replicable microcosms of high-performing health-care systems as good as any in the world. It's in employers' enlightened self-interest to follow suit.

CASE STUDY:

Wada Farms

Headquarters:	**Pingree, ID**
Industry:	**Agriculture (potatoes)**
Sector:	**Private**
Client Size:	**250**
Employees on plan:	**235, with 500 total lives on plan**
Plan funding:	**Self-funded**
Case study:	**2017–2021**

Key takeaways

1. The self-funded direct-contracted plan that Wada Farms implemented in 2017 has been so effective and successful that the company hasn't had to adjust either premiums or the plan's design.
2. Over four consecutive years, Wada Farms has seen its health plan expenditures decrease and employees have been happy with the plan.
3. The partnership that Wada Farms established with the local hospital, Bingham Memorial, has been both beneficial and sustainable for the company, employees/patients and provider stakeholders.
4. Compared to earlier years, when many Wada Farms employees didn't enroll in the company health plan because of its high cost and low quality, today 95% of the workforce has joined the plan.

Stacie Adams, VP of human resources for Idaho-based Wada Farms, recalls when health care "was kind of a naughty word." The family-owned potato grower and shipper had faced

challenges with providing affordable healthcare to their workers for more than two decades, and each year the company's leadership encountered the same dilemma: How could Wada Farms improve the value of medical benefits and still remain solvent?

Wada Farms became an early adopter of self-funding in 2005, when it sought to provide good benefits to its very diverse workforce. Listening to the needs of its employees, Wada Farms first implemented a "mini-med" program with a limited set of essential health benefits. That worked for a while, and based on the 95% participation rate, employees were clearly pleased with the plan.

Health reform posed significant obstacles

When health-care reform arrived in 2013, however, Wada Farms was no longer permitted to offer that plan, so Wada Farms' leadership had to search for new solutions. That's when the employer's struggles really began. As Adams explored how Wada could offer a plan that employees could actually afford to purchase that would also offer value, mounting frustration ensued.

The company considered minimal essential coverage (MEC) plans and minimally viable product (MVP) plans, but the premiums were still too high. To get a significant amount of employee participation, Wada had to charge $200 per pay period for low-income workers. As such, most employees opted to go without care.

On top of that, premiums were soaring. Wada's leaders thought they could absorb a 10% to 12% increase year after year, but they couldn't—the company was approaching their threshold for being able to continue offering benefits each year.

Unfortunately, Adams recalls, the escalating expenses put her in the unenviable position of having to calculate whether it was more affordable and a better option to just pay the penalties under the Affordable Care Act instead of continuing to provide health benefits coverage—which was low value and expensive.

This dilemma prompted Adams and company CEO Brian Wada to seek an alternative solution.

Going direct proves viable, cost-saving option

In 2017, Wada Farms began working with a former benefits advisor, Doug Hetherington, who reported that a local hospital that was offering a direct-to-employer program. Bingham Memorial had witnessed the disturbing trend in its immediate marketplace: increasing numbers of employers were discontinuing or considering discontinuing offering health care benefits. Some companies were instructing their employees to purchase coverage on the state insurance exchange. Others were decreasing the value of their health care benefits to the extent that the coverage employees were purchasing wasn't really insurance: high deductibles and first-dollar premiums were required before the plan began paying for claims.

This situation wasn't good for employers or employees and their families, and it wasn't good for Bingham Memorial because high-deductible plans often meant that medical bills went unpaid. The hospital collaborated with Health2Business to create a direct-contracting solution for employers like Wada Farms. This solution, called Bingham Direct, allows employers to offer comprehensive health benefits to employees in an affordable, sustainable direct-contract model.

Such programs result in a win for employers and employees because they're an affordable option. They're a win for hospitals like Bingham because they gain new patients and reduce bad debt.

Adams still remembers having a hard time believing that the Bingham Direct program would work. "We ran the numbers and looked at our actual employee behavior, and we were told that we would see at least a 30% decrease in expenditures," she said. "And we did—year over year." From 2017 through 2021, the savings continued. Wada Farms in 2021 found that it was spending

significantly less on health care than it did in 2017— approximately $500,000 less. In addition, the employees have a plan with a $0 deductible.

"We now have a plan that our employees love," Adams said. "We have probably 95% of our workforce that have joined the plan because we can offer it at a premium that's affordable to them. The amazing part is that, since 2017, we haven't raised premiums for employees, and we haven't changed plan designs."

Through Bingham Direct, Wada Farms now offers health fairs and operates vaccination clinics, and Spanish-speaking employees have access to a bilingual service agent at the hospital. Adams refers to Bingham Direct as "a complete community resource as far as improving the health and well-being of Wada Farms' employees."

As Bingham Healthcare gains more patients, the organization has been able to add more resources and provide better care, equipping it to compete successfully against larger urban health systems in the region. For Wada Farms, the benefits continue to accrue, as its costs remain stable, and its employees have access to both a health plan they can afford and more comprehensive care and services.

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>
> ***– Stacie Adams, VP Human Resources, Wada Farms***

CASE STUDY:

Matheny Motors

Headquarters:	**Parkersburg, W VA**
Industry:	**Automotive and trucking**
Sector:	**Automotive and transportation**
Employees:	**344 total employees, with 184 enrolled**
Plan funding:	**Self-funded**
Case study:	**2019-2021**

Key takeaways

1. In shifting from a carrier-controlled fully insured plan to a self-funded plan, Matheny Motors reduced costs by $357,000 in 2020 alone and reduced per employee per month (PEPM) costs by 16% and total costs by 21%. The plan forecast a total 37% in savings in just two years of the new model.
2. Before going self-insured, Matheny Motors had incurred consecutive 20% and 30% cost increases and was projected to receive a 40% increase in 2020.
3. In the first two years of the new plan, Matheny has been able to increase employees' paychecks because of the savings on health services, and employees are happier—and assured that the company is looking out for them.
4. Matheny's concierge nurse navigator program has been hugely successful in guiding employees to medically appropriate, high-quality and cost-effective care options, and employees who use the navigator have no deductibles.

Heading into 2020, Matheny Motors, a fourth-generation automotive and truck industry company in West Virginia, was about to get hit with a 40% cost increase from its longtime national carrier. Besides taxing the company's resources and employees' personal finances, those back-to-back cost increases were putting Matheny, which operates in six states, at a competitive disadvantage in attracting new employees. "When we wanted to hire someone new, we were unable to compete with the local dealer—it always came back to the health coverage," said Matheny CEO Tim Matheny.

To add insult to injury, the carrier kept Matheny on edge each year as the company awaited the bad news about the next year's increase—but wouldn't give the company any concrete data about what its costs were or why the increase was wanted. "Each year, we just felt like we were stuck in that status quo—like we had no option other than to just take the increase and figure out how to pass on some of that cost to employees," said Matt Martin, Matheny's HR director. "And our employees were already challenged by those costs."

The prospect of a 40% cost increase from the carrier, when its employees already had a $5,000 deductible, prompted Matheny to seek a benefits advisor, Bryce Heinbaugh, CEO of IEN Risk Management, to help the company develop its own plan. To get the data it needed to project its health plan costs, the company was relegated to asking employees to provide the information on their utilization, claims and pharmacy spending over the previous year. With those details and a commitment to developing a full-scale self-insured plan through direct contracting for all but primary care, Matheny finally found a stop-loss carrier to help them take the plunge.

Comprehensive approach yields cost savings across the board

After just one year, Matheny had already saved $357,000 and was on track for further savings in 2021. It wasn't an easy sell

initially, getting employees who were used to the status quo to understand that the new plan would be both better for their health and easier on their wallets. Because of employees' negative experiences with health coverage over the years, Matheny had to develop a full-on education and communications plan to make their case that change was good for the employees. That approach included having the plan's team travel to each Matheny location to meet with employees face to face, to both explain why the traditional model didn't serve them and convince them that the shift would eventually put money back into their pockets.

That education strategy was hugely successful—so much so that Matheny repeated the road trip in the second year of the plan to check in on employees. Once employees understood what was at stake and how the new plan worked—and were convinced that the company would support them if any issues arose—most supported the major change, Martin recalled. The carrot was the promise of significantly reduced deductibles, which Matheny instituted from day one of the new plan, dropping deductibles from $5,000 to $4,000.

The foundations of the new self-funded plan included implementing reference-based pricing (RBP), developing a high-performance plan design, and identifying and using high-quality services vendors. Matheny also brought in an independent third-party administrator (TPA) and pharmacy benefits manager (PBM) and contracted with Centers of Excellence for complex specialty care.

Nurse navigator key to identifying best care options and reducing costs

One of the keys to tapping the savings was the company's decision to bring in a concierge nurse navigator to help employees make informed, cost-effective choices for their care and help ensure that employees accessed high-quality providers and facilities with a track record of good outcomes. The navigator also helped employees obtain second opinions for major diagnoses,

which in some cases resulted in employees avoiding unnecessary treatment. In one case, that navigator's intervention avoided having an employee undergo expensive, debilitating and unnecessary chemotherapy because of a misdiagnosis of cancer. In other cases, employees who needed major procedures were supported in receiving treatment from Centers of Excellence, not local facilities.

Employees were very grateful for the support, according to Faith Barron, RN, the nurse navigator. "It really develops a relationship, and it's a great opportunity to show employees that we're really working for their benefit to get them the best care that we can," Barron said. To make using the navigator services even more appealing, Matheny eliminated out-of-pocket costs, including deductibles, for employees who followed the navigator's guidance for services, from hospital stays to surgical procedures, as well as lab and imaging. "As the word got out, I had more and more employees coming to see me to explore their options," Barron said.

On the pharmacy front, Matheny developed a drug formulary that ensured employees would be able to get the medications they needed, at the lowest out-of-pocket cost. The company sourced cost-effective options, including international purchasing, for all medications. It also excluded certain high-cost specialty drugs from the formulary and instead steered members, as appropriate, to manufacturer patient assistance programs that offered the drugs at low or no cost based on the employee's income. "That's an incredible feeling for the employee to know that they can get the medication they need for a serious diagnosis," said Barron, who meets weekly with the PBM and addresses quickly any drug-access issues that arise.

One key factor in the success that Matheny has achieved in reducing costs while improving the care its employees receive has been its commitment to truly knowing the health services providers in every market where the company operates. That strategy, combined with contracting only with high-quality providers,

has helped Matheny develop a provider network that's far superior to the one it had through the national carrier.

And the employees are reaping the benefits, according to Tim Matheny, the CEO.

"Health care is no longer our top cost—and it's not even in the top 10 anymore. Employees' paychecks have increased over the last two years because of the savings we've had, and we now have happy employees," Matheny said. "We've also had good outcomes, so now there's just a positive attitude about what we've done with the plan."

Health care is no longer our top cost–and it's not even in the top 10 anymore. Employees' paychecks have increased over the last two years because of the savings we've had, and we now have happy employees."

– Tim Matheny, CEO, Matheny Motors

CASE STUDY:

Great Lakes Auto Network

Joey Huang is a career shifter. Despite graduating from dental school and coming from a family of physicians, he opened up a car dealership, Great Lakes Auto Network (GLAN).

Huang's first location is down the street from his father's practice. And he couldn't completely escape the health care industry. As a small business owner, he was tasked with the problem of how to improve and lower the cost of his employee health insurance plan.

The majority of Huang's employees make under $50,000 a year. Asking households to hand over $1,300 or $1,400 every month for health care that didn't meet their expectations wasn't received as a valuable benefit.

But Huang is a strategic businessman who researches other profitable businesses and learns from their successes. He knew that offering better benefits at a low cost would attract and retain the best talent, plus add an extra bonus of saving his company money.

His love for researching best business practices and his familial connections to physicians and providers in the Ashtabula, Ohio, area led him to transitioning to a self-funded plan. He enlisted the help of Bryce Heinbaugh, IEN Risk Management managing partner, to implement the transition.

Prioritizing transparency

If you're an employer who currently has an advisor who doesn't fight to disclose every fee and cost, including their own compensation, consider finding a new one. IEN advisors help

employers remodel their plans using Health Rosetta principles, which focus on value-based care and complete transparency of costs in every avenue of health care.

Ethical advisors, ones like Heinbaugh, believe they have a fiduciary responsibility to their plan sponsor, working in the employer's best interest by laying out every cost.

Great employers, like Huang, have the same transparent relationship with their employees. Before changing plans, Huang hosted meetings and sent out educational material about the new benefits plan to resolve confusion among employees who were skeptical of the change.

After the first year of transitioning GLAN to a self-funded plan, Heinbaugh reduced its health care spending by 38%. It managed its costs so well that GLAN underspent what it estimated to pay for the year and received a claims reimbursement for $138,000. This allowed GLAN to double the size of its workforce and open new locations, expanding from three to six dealerships.

Like any good businessman, Huang reinvested these savings back into his company and shared the wealth with his employees. Employees' cost for family coverage dropped to $980.

Huang added new employee benefits like hosting "health care holiday months" when employees don't have to pay premiums for the month. He also gives employees two options of medical coverage along with valuable add ons, with choices for dental, vision, short-term and long-term disability, voluntary life insurance, accident and catastrophic coverage.

Heinbaugh connected Huang with services that help GLAN employees navigate the health care landscape, such as the Concierge Nurse Navigator Program that gives employees access to a nurse who acts as a patient advocate. The nurse helps employees schedule appointments, making sure they choose in-network clinicians and hospitals.

Huang credits his industry-leading benefits plan with his success in attracting the top talent in the area. Lower costs, better benefits, and improved talent acquisition: what's not to love?

That is why it's always astounding when employers are reluctant to or skeptical of changing their health care plan. But the hope is that once they hear enough stories like Heinbaugh's and Huang's, they will change their mind and realize that overpaying for sub-par insurance is *not* the only option.

CASE STUDY:

Servants of the Lord & the Virgin of Matará

Headquarters: **Washington, DC (founded in Argentina)**
Sector: **Religious order and charitable organization**
Members: **120 in United States**
Plan funding: **Self-funded**
Case study: **2020-2022**

Key takeaways

1. After being hit with several double-digit premium increases from a carrier-controlled plan, the Servants of the Lord & the Virgin of Matará religious order switched to a self-funded health plan that promised significant savings and prevented the sisters from having to divert a large amount of donor funds to health care.
2. The level-funded plan features an independent TPA and PBM, and cost-effective contracted rates for all services, from doctor's visits and hospital care, to pharmacy, imaging, and dental and vision care.
3. In the first year of the new plan, the sisters saved more than $224,000, a 32% reduction over to the previous year's total expense outlay of $693,867. Year-two savings were also substantial, at $209,249 compared to the carrier plan.

For almost a decade, Servants of the Lord and the Virgin of Matará, a Catholic missionary order founded in Argentina, had been plagued by serial, double-digit premium increases from

their carrier-controlled health plan. For the 120 sisters living in the United States, who rely on donations to meet all their needs, the ever-rising expenses were both a burden and a conflict: The order had to raise more and more money each year just to pay the premiums, leaving them fewer funds to meet other needs and support their mission of serving the poor.

By 2019, premiums had risen to $478 and deductibles to $4,000 per sister, and total plan expenses were almost $700,000 a year. Because the Servants of the Lord's members are a predominantly young population, most members' individual costs never met the deductible—the sisters were essentially paying full freight for an overpriced plan that most of them barely used.

Recognizing that their situation was untenable, the sisters began working with benefits advisor Katy Talento of AllBetter Health, who helped them design a no-deductible, no-copay plan using independent, transparent vendors. The new plan incorporated an independent third-party administrator (TPA) to process claims predicated on Medicare-based rates negotiated with physicians and hospitals rather than a carrier network. The level-funded financing approach protected the sisters from unpredictable risk and gave them a consistent cost to expect each month.

New plan covers all needs and is consistent with order's mission

The sisters also partnered with an independent, flat-fee pharmaceutical benefit manager (PBM) that helped members apply for pharmaceutical manufacturers' patient-assistance programs when any sisters required high-cost drugs. The advisor negotiated with pharmacy vendors to obtain lowest possible prices— in some cases, no cost at all—for specialty medications and some brand medications, by tapping into manufacturers' charity programs. In addition, the advisor helped the sisters design self-funded dental and vision benefits.

To help the sisters make the transition to the new plan relatively seamlessly, the plan incorporated a navigator service to support sisters in identifying high-quality, cost-effective care and services providers that the plan had contracted. For example, because the sisters are located in convents throughout the country, the plan worked with national imaging centers and laboratory chains to obtain discounted pricing.

"By designing a plan with no deductibles or copays, the superiors in charge of each convent didn't have to worry about cash flow to manage out-of-pocket costs each time they sent a sister to the doctor or pharmacy," Talento said. In addition, the new plan was designed to adhere to the sisters' faith by arranging for members to use Catholic facilities and care providers whenever and wherever feasible.

"This was particularly important for the sisters—having the freedom to use the hospitals and doctors they were most comfortable with, and to craft health plan documents that were consistent with Church teaching," Talento said.

Savings compared to carrier plan accrue quickly

The move to a self-funded, level-funded plan has been an enormous success for the religious order. After just one year, the sisters had saved $224,000—a 32% reduction compared to the previous year's $693,867 expense with the carrier plan. By year two, expenses were still well below the old model, at $484,316. Besides providing both financial relief and considerable peace of mind for the order, the savings enable the sisters to increase the amount of donor-provided resources used for their primary mission.

The sisters also appreciate the relative simplicity of the new plan—with no deductibles and no copays—and the fact that plan members now have expert assistance navigating the complex health system in our country. That help has also yielded health improvements for some members. One sister who had

been experiencing serious digestive issues and had been on a high-priced specialty medication received personalized condition-management services that eventually enabled her to go off the medication.

Later, another plan member was able to access needed gall-bladder surgery through a contracted provider that charged a bundled fee for all associated services, saving thousands over what the order would have paid with the previous carrier. A third sister who developed cancer was able to receive her treatment at a vastly reduced rate—and with no balance billing—by accessing a financial-assistance program with the navigator's intervention. "The savings have been tremendous," Talento said, and the sisters are now receiving far more personalized care than in the past.

> "By designing a plan with no deductibles or copays, the superiors in charge of each convent didn't have to worry about cash flow to manage out-of-pocket costs each time they sent a sister to the doctor or the pharmacy."
>
> *–Katy Talento, AllBetter Health*

CASE STUDY:

Woodard Cleaning & Restoration

Headquarters:	**St. Louis, MO**
Industry:	**Cleaning services and home restoration**
Sector:	**Private**
Employees:	**238, with 160 on plan and 304 total lives**
Plan funding:	**Self-funded**
Case study:	**2020-2021**

Key takeaways

1. When it faced a 37% annual premium increase from a carrier-controlled plan for 2020, following a 20% hike the previous year, Woodard Cleaning & Restoration opted for self-funding its health benefits.
2. Woodard had three goals for its new plan: to reduce company and employee spending on benefits by first targeting the burdensome $5,000 deductible, to improve the quality of the benefits it offered, and to create a more positive experience for employees weary of dealing with a plan that was low quality and didn't feel like a benefit.
3. The new self-funded plan reduced per-employee-per-year (PEPY) costs by $1,572 in the first year—from an expected total of $1,012,786 on the carrier plan to $761,101—through direct contracting and an aggressive approach to pharmacy benefits. The negotiated vendor contracts across the board have enabled Woodard employees to obtain many services and needed medications for $0 out of pocket.

Heading into 2020, Woodard Cleaning & Restoration of St. Louis, MO, faced an enormous premium increase from its carrier-controlled plan: a staggering 37%, which would have increased the company's per-employee-per-year (PEPY) expenses by $1,572. And that predicted increase had come on top of a 20% hike the year before.

For the family-owned business, which started as a carpet cleaning company in 1946 and today offers a range of carpet/rug cleaning and home restoration services, the sticker shock prompted the CEO, Justin Woodard, to say, "Enough is enough." The company knew it was unwilling to ask employees to shoulder any more of the health plan cost burden when the employees already had a $5,000 deductible for everything except preventive care. Woodard also wanted to exit the out-of-control cost increases the commercial carrier market was demanding without adding any value.

The existing carrier plan was not only expensive but also low quality—with a narrow provider network that limited employees' care options while increasing their out-of-pocket costs. Woodard wanted a solution that not only saved money for the company and its employees but also provided a more positive health benefits experience.

Because Woodard had no access to its own data and therefore no way to determine how to improve the plan or its claims experience, in 2020 the company sought the services of an advisor, Adam Berkowitz of Simpara Benefits. The advisor helped Woodard develop and make the transition to a self-funded plan structure that would provide the company maximum control and flexibility—and the ability to actually "make the health plan a benefit again," Berkowitz said.

With Berkowitz's guidance, Woodard identified an independent third-party administrator (TPA) and an independent pharmacy benefit manager (PBM) and developed a specialty pharmacy management solution. The plan design involved direct contracting with providers that adhered to high-quality services standards and delivered those services at a fair price.

Expenses reversal yields near-immediate effect

From the start, Woodard began seeing cost savings from the restructured approach to benefits. Instead of paying the $1,012,786 that the carrier plan would have cost, the self-funded plan came in at $761,101—for a per-employee-per-year (PEPY) expense in year one of $4,756.88. The carrier plan, by comparison, would have cost $6,329 per employee.

The new plan also helped deliver a more favorable claims experience, and the plan's improved performance and better management enabled Woodard to significantly reduce its stop-loss coverage—by an impressive 52% going into year two. Although the savings and cost stabilization were substantial across the board, the success is even more impressive considering that Woodard managed to make the shift and slash employees' deductible costs at the same time. As part of the plan's design, employees who make smart, informed decisions and use the preferred contracted providers and facilities incur $0 in costs outside their premium and their deductible expense is waived.

One employee, for example, was able to obtain a needed MRI from a plan-contracted facility with no out-of-pocket cost. His grateful response was simply, "You guys rock—and you actually care. It's so refreshing."

When asked by a business acquaintance whether the new self-funded plan had met the company's expectations, Justin Woodard, the CEO, replied, "No, it has actually wildly exceeded any and all of our expectations."

In addition to reducing health benefit expenses, the shift to a new plan model and the savings that accrued helped Woodard meet another company-wide objective: to upgrade and invest in the company's facilities and increase employee compensation. The money the company has saved enabled Woodard to build a brand-new 100,000-square-foot facility and raise salaries.

Change management key to a smooth plan rollout

When Woodard decided to embark on its journey to more cost-effective, higher-quality benefits, it departed somewhat from its usual “crawl, walk, run” business strategy and decided instead to plow ahead full steam with the new self-funded plan. That meant that the company had to be well prepared to both clearly communicate the new benefits approach and also help employees adjust to a different way of seeking health services.

Woodard first established clear lines of communication—among leadership, human resources (HR) and employees. It then developed a messaging strategy that assured employees that although the impact of the change would be immediate, so would the gains. For the first time in many years, the CEO said, employees were informed that their premiums would be going down and that their deductibles, previously $5,000, would go away entirely provided they opted for services from plan-contracted providers. To facilitate employees making informed, cost-effective choices, Berkowitz helped Woodard set up an in-house benefits navigator concierge service, which Simpara Benefits considers a critical function for employer-controlled plans.

The foundation of the communications strategy was the newly created “Woodard Direct,” an information dissemination platform that delivered to employees a roadmap of how the plan would be implemented and updated them frequently on progress. It also regularly reported the short-term savings and benefits improvement “wins” as they occurred—in turn creating positive PR for the company and excitement among employees.

In the first two years of the new plan, both the financial and human benefits have been substantial—and palpable. For one pregnant employee who was getting care at an out-of-network facility, the plan advisor was successful in negotiating an agreement for birth, delivery, obstetrics care and pediatrics care that

came in at 100% of Medicare pricing and $0 out-of-pocket cost for the employee.

Through the plan's creatively structured pharmacy benefits, Woodard employees have been obtaining their medications at significantly reduced cost compared to the previous plan. In one case, an employee who before had been taking a full day off work simply to manage health care and coordination for her high-needs child, who is on high-cost medications, the plan has reduced the prescription costs by 80% and avoided having the employee take a day off work each month.

When asked by a business acquaintance whether the new self-funded plan had met the company's expectations, Justin Woodard, the CEO, replied, "No, it actually wildly exceeded any and all of our expectations."

CASE STUDY:

Shine Solar

Industry:	**Energy**
Sector:	**Private**
Client size:	**221**
Plan funding:	**Self-funded**
Case study:	**2020-2022**

Key takeaways

1. Shine Solar utilized multiple strategies to convert from a traditional carrier-controlled high-deductible health plan to a high-value, risk-managed plan that reduced costs for the company and its employees—enabling more employees to actually access the benefits the company offered.
2. In the first year, 2021, Shine Solar saved $1,968 per employee. In year two, premium expenses decreased a further 15%—reducing cost PEPY to $1,345.
3. By structuring open direct contracts with regional hospitals, health systems and providers to save money, Shine Solar has been able to reduce both deductibles and coinsurance to $0 and also offer no-cost primary care and mental health care.
4. Shine Solar has been so successful in its cost-containment strategy that it's been able to reallocate capital expenditures to help fuel company growth and improvement projects, including partial funding of a new warehouse.

Shine Solar, which operates in five states, has focused its business model on disrupting the electrical power market to deliver sustainable energy resources. One business expense—health

plan expenditures—was hindering growth for the progressive company. Despite a total annual outlay of nearly $608,982, employee deductibles with the carrier-controlled plan were an unaffordable $3,000 and co-insurance rates were 20%.

In 2019, when Lance Young joined Shine Solar as its director of administration, he quickly realized that the company's traditional carrier-controlled health plan was more of a burden than a benefit for employees. Its high annual cost increases, which in turn translated into high premiums and high deductibles, made it unaffordable—and therefore inaccessible—for many Shine Solar employees.

Further, Young was put off by the traditional broker's strategy of claiming a "win" when he negotiated what would have been a double-digit cost increase down by 7%. In fact, Young pointed out, what Shine Solar was incurring was still a 4% increase. When the same conversation happened the following year, Young and the leadership team brought in a third-party consultant to help Shine Solar navigate another solution.

The consultant introduced Shine Solar to Adam Berkowitz of Simpara HR, who helped the company leave the carrier-controlled system and develop a self-funded health plan—one that would actually provide Shine Solar visibility into where the company's premiums were going and how its hard-earned funds were being spent. Under the carrier-controlled plan, Shine Solar had little access to the data driving the premium increases. Later on, when Shine Solar finally obtained access to its data, the reason for the rate hikes was clear: It was the carrier's profits, not medical claims, that were driving premium increases.

The company first established direct-contracting rates with regional hospitals, health systems and providers, and developed transparent rate schedules. Berkowitz also helped Shine Solar implement a concierge care navigation service to assist Shine Solar employees in obtaining appropriate, cost-effective care. This kind of expert guidance helps companies better manage the typical 2% to 5% of the employee population that drives higher claims costs.

Savings quickly mount in first two years of new plan

By collaborating with Berkowitz to develop the new plan, which features a $0 deductible, $0 co-insurance and free primary and mental health care after a monthly payroll premium deduction of just $75, expenses dropped. “Shine Solar has saved a lot of money, reduced the bloat, and eliminated the middleman and the bureaucracy,” he said. “We’ve been able to take those savings and apply them to growing our business in a market sector that’s just exploding right now.”

By the end of the first year, the company saved $1,968 per employee, compared to the previous carrier-controlled plan. Just 16 months into the new plan, Shine Solar’s health benefits expenses had dropped to $1,012,719 and its per-employee-per-year (PEPY) cost was down to $1,345.

The new self-funded plan also tackled and reconfigured the company’s pharmacy benefits and associated expenses using independent pharmacy benefit management strategies. In year one, by using supply chain management principles and focusing on unit costs of medications, Shine Solar was able to reduce employees’ out-of-pocket expenses for generic drugs from 20% of cost after meeting the deductible to $1, and brand drugs from 20% of cost to $25. “Aligning and optimizing this supply chain is an important way to manage expenditures and improve plan efficiency,” Berkowitz said.

The company’s success with the new health plan not only lowered expenses over consecutive years but also resulted in higher employee satisfaction with the improved, more comprehensive benefits. As a big plus, Shine Solar has been to use some of its reduced health plan expenditures to improve its operations and infrastructure, including building a new warehouse partially funded by the funds it no longer spends on health care. “The company is happy, and the employees are happy,” said Young.

It's a strange win-win, because you never hear of companies that say, 'I'm able to provide better benefits for my employees–and save money.'"

– Lance Young, CHPC,
Director of Administration, Shine Solar

CASE STUDY:

Gasparilla Inn & Club

Advisor Organization:	**Mitigate Partners**
Headquarters:	**Boca Grande, Florida**
Industry:	**Service and Hospitality**
Sector:	**Private**
Client size:	**450 total, 270 benefit eligible**
Employees on plan:	**130 for 6 months of year / 215 for 6 months = 185 average for the year**
Total lives on plan:	**327**
Plan funding:	**Self-funded**
Plan year:	**7/1 - 6/30**
Case study:	**7/1/2016 - 6/30/2019**

Key takeaways

1. Reduced health care spending by 34%, saving $1.8 million over 3 years
2. No increases for 4 years
3. Eliminated deductibles, from $2,500 individual / $4,500 family to $0

Client testimonial

"We're saving probably between $5,000 and $10,000 a year as a family. That's the difference between a few mortgage payments and college savings for my son."

– Nathan McKelvy,
Assistant Food and Beverage Director, Gasparilla Inn

Client background

Gasparilla Inn & Club is an upscale island resort on the Southwest Gulf Coast of Florida that was suffering from rising health care costs year after year.

From 2013 to 2016, Gasparilla Inn had a 12% average increase per year in health insurance premiums under its fully insured plan with a traditional publicly traded carrier. During this time period, Gasparilla Inn was also overspending on health care. On average, its health claims spending was 35% below the amount of premiums collected a year (65% loss ratio), which benefited their carrier's bottom line. Gasparilla Inn's total health care spend with the old plan was projected to increase to $1.3 million in July 2016, threatening the resort's ability to provide benefits to its employees.

To combat rising costs, Gasparilla Inn had three main goals: 1) cut spending, 2) reduce employee cost and 3) minimize member disruption.

Approach

Gasparilla Inn's advisor, Carl Schuessler of Mitigate Partners, was able to gain the trust of C-level executives by exposing how much its old health plan was draining its finances. He worked directly with the CFO and CEO to create a vision of improved clinical outcomes, coupled with better financial outcomes for the employer and employees.

One of Gasparilla Inn's main goals was to increase health care and health benefits education among its employees. Prior to implementing the new plan on July 1, 2016, Gasparilla Inn conducted six benefits education meetings in June 2016 to help employees understand their new benefits before the big change. Gasparilla has continued to hold these meetings annually, every June, to ensure that employees remain informed about their health benefits.

In addition to rising health spending, Gasparilla Inn had several challenges. The first obstacle had to do with its employees. Due to the nature of its business as a resort, Gasparilla Inn only operates during October to July, so most of its employees are seasonal workers. They have 130 employees on the health-care plan for the first six months of the year and then a total of 215 employees on the plan for the second half of the year. On average, Gasparilla Inn has 185 employees on its healthcare plan year-round.

In January 2016, the Affordable Care Act (ACA) came into effect. This made employee enrollment more challenging, as the ACA mandated that all employees who returned in October 2015 and had accumulated the required hours must be offered coverage.

The second challenge was a product of Gasparilla Inn's location. The Southwest Gulf Coast is one of the nation's most expensive regions for health care, with up to 2,000% markups for common treatments and procedures like knee replacements and CT scans. Price variation is a major issue in standard Preferred Provider Organization (PPO) network contracts. Quality scores are equally as important, as there are high-quality, low-cost providers and low-quality, high-cost providers. Good plans actively manage the affordability and value of health-care options and services.

Cost of CT Scan in Tampa

System (location)	Avg. Billed	Avg. Cost	Medicare Pays	Units of Service
Florida Hospital (Tampa)	$5,193	$80	$168	3,545
St. Joseph's (Tampa)	$4,244	$107	$167	6,508
Brandon Reg. (Tampa)	$8,022	$67	$166	3,318
Morton Plant (Clearwater)	$4,136	$49	$165	5,145
Palms of Pasadena (St. Petersburg)	$7,301	$110	$179	2,166
Sarasota Memorial (Sarasota)	$3,529	$145	$185	15,725

The graph shows average cost, Medicare pricing, and average billed amount for a CT scan across six hospitals in the Tampa, Florida, region. Traditional carrier networks contract a discount off billed charges, resulting in exorbitant health care spending for plan sponsors.

Schuessler was tasked with providing better, more affordable coverage for all employees. In order to find the root cause of the resort's rising health costs, he pulled a report detailing the resort's health-care spending from 2013 to 2016, a time period when Gasparilla Inn was still under a traditional fully insured plan. Schuessler discovered that the resort was overspending on health care, as claims paid were only 65% of the amount of premiums resulting in a huge profit for the carrier.

After exposing this to Gasparilla Inn, Schuessler worked with its executives and leaders to move the resort off its fully insured plan and construct a better, more affordable health plan.

Top-level results

In July 2016, Gasparilla Inn moved off its fully insured plan onto a self-funded plan. By July 2019 it had saved over $1.8 million—a 34% reduction. Under the new plan, Gasparilla Inn is projected to save $5 million over the next five years.

When faced with a decision to go self-funded, Gasparilla Inn considered working with a traditional insurance carrier, but instead chose its current self-funded health plan. In light of what the traditional carrier projections were for 2016 to 2018, the cumulative savings are $3.8 million a 67% reduction from what it would have been had they stayed with the old-line carrier.

With Schuessler's help, Gasparilla Inn achieved its first goal of reducing health-care costs. Its Per Employee Per Year (PEPY) Medical Expense average is now $2,993—75% under the national average—and its Per Member Per Month (PMPM) Prescription Drug Expense average is now $47.53. That's 48% under the national average.

Gasparilla Inn's employees don't have copays for any imaging when performed at one of its directly contracted providers. This translates into significant savings for employees, as the average cost of MRIs/CT scans in the Southwest Gulf Coast of Florida can cost well over $1,200; one employee received a claim worth $38,400.

Schuessler devised a plan that focuses heavily on value-based care, making preventative medicine and procedures like cancer screenings extremely affordable or free. For example, employees can receive a preventative colonoscopy covered at 100%, including polyp removal during the same visit if they are found. Under the ACA, preventive colonoscopies are covered at 100%. However, if polyps are found, the removal is classified as a diagnostic code and billed as a separate charge to the patient. Diagnostic colonoscopies are more expensive than preventative ones, and in the Tampa area, the procedure can range from $1,300 to more than $19,000.

The new plan also had a direct impact on employees. Gasparilla Inn employees formerly paid a $2,500 (single) and $4,500 (family) deductibles, which was a lot compared to the average employee salary. Today, they have a $0 deductible with significantly reduced or nonexistent copays.

Gasparilla Inn's new plan eliminated the risk of expensive out-of-network fees and surprise medical billing, as employees

now have no network restrictions and are free to go to any hospital or clinician in the U.S.

The new plan focuses on value-based care with an emphasis on increased access to direct primary care services and affordable preventative treatments. Employees now have access to free primary care services, including transportation to appointments if necessary.

Employees were also given more accessible options for primary care, such as a clinic that is 400 yards from the resort. Primary care providers are funded through a value-based care model, not fee-for-service, meaning that clinicians are rewarded for improved health outcomes instead of the number of services provided.

Using the significant savings it accrued from changing health plans, Gasparilla Inn hired a benefits champion, Liz Schrock, in July 2016. Liz is responsible for the administration of all aspects of the employee benefits program. Her main role is to educate more than 215 employees year-round about their health benefits and how to make smart health care decisions. Gasparilla Inn employees have the ability to go to Schrock for any health-care benefits questions. She also works with community partners to resolve complex claims. She is considered the "mother hen" to her teammates. Schrock puts the resort and its employees' best interests at the of forefront of her daily priorities. Having a resource like Liz and early education programs helped employees better understand and accept their new benefits plan before it was fully implemented.

CASE STUDY:

Rosen Hotels & Resorts

In my experience, speaking with many employers who have slayed the health-care-cost beast, there has been one recurring theme: A leader took the bull by the horns— and did so knowing that success involves weaving employees into the reinvention process rather than trying to pull the wool over their eyes.

Harris Rosen is the founder, COO, and president of Rosen Hotels & Resorts, a small regional chain in Orlando, Florida. Though he's not a health-care expert, he intuitively knew what PwC data famously showed: half of health care spending doesn't add value. In a business of ups and downs in which staff costs are a major factor, Rosen surrounded himself with a special executive team to tackle this challenge.

To date, they've adopted more Health Rosetta components than any other company I know, saving approximately $315 million on health-care costs since 1971 and spending 50% less per capita than the average employer. If all employers followed suit, we could conservatively remove $500 billion of waste from health care and shift it to more productive sectors of the economy.

Their plan has also grown from 500 to 5,700 lives as the company has grown. They have a very culturally, racially, socio-economically and demographically diverse employee base, including many immigrants who often haven't had and pharmacy and, as you'll see below, are better than most of us have ever had.

Rosen also uses focus groups and surveys to match up programs with employee needs, and they continuously refine their programs. Here are a few elements of what makes their program successful:

- They have a comprehensive, onsite 12,000 square-foot medical center that provides access to many routine health care services, far more than typical primary care. They furnished it with used but modern and functional medical equipment for 10 to 15 cents on the dollar. Employees are able to visit the center "on the clock," thus removing a major barrier to receiving care.
- They take great care of individuals, hiring health coaches and nurses to serve as coaches and navigators throughout a medical journey. They use robust, evidence-based approaches to case management, inpatient care management, care transitions and medication compliance management.
- They have eschewed the blunt-instrument approaches most employers use to cut costs (high copays, deductibles) in favor of $5 office visit copays, zero copays for 90% of pharmaceuticals, and no coinsurance. Where necessary, they offer free transportation to appointments to further remove barriers to care.
- Company events serve food approved by nutritionists and the director of health services. They also offer cooking courses.
- They offer the most effective kind of wellness programs for free, including onsite stretching and exercise (e.g., Zumba, kickboxing, walking programs, spinning, boot camp), flu shots and vaccinations, family planning, educational materials, nutritional services, health fairs, and physicals on a schedule informed by the U.S. Preventive Services Task Force, which is far more conservative than the one workplace wellness vendors push.
- They provide free health screenings for colon cancer, diabetes, breast cancer (onsite mammograms), high cholesterol, hypertension, and sexually transmitted diseases, along with visits from registered dietitians. Furthermore, this program follows evidence-based guidelines from

organizations like the U.S. Preventive Services Task Force to minimize misdiagnosis and overtreatment.

- Despite physically demanding jobs, onsite physical therapy has led to opioid prescription rates that are one-sixth of the national average.
- They have a mandatory stretching program for housekeepers and other employees with a higher risk of injury, and the program has reduced injuries by 25%.
- Fifty-six percent of their employees' pregnancies are high risk, as a result of high rates of advanced maternal age, diabetes, hypertension and HIV. The company is very proactive about helping employees manage pregnancies (a premature birth can cost $500,000).
- The company cafeteria provides discounts for healthier foods to reduce consumption of unhealthy foods (e.g., discounts on salads). The dietitian and director of health services analyze employee cafeteria offerings for portion size and nutritional benefit. They also use signage to educate employees about nutrition, use smaller plates to control portion sizes, and limit fried foods.
- They focus on better management of chronic conditions and have even seen a drop in the development of new chronic conditions. This is especially important for workers coming from developing countries, who often have complex diseases.

Rosen is partnering with other businesses in their community to expand this approach, demonstrating that it's worth ruffling a few feathers to gain the dual benefits of lower costs and a healthier, more satisfied workforce. The ripple effects extend well beyond the company, boosting employee well-being and their broader community's economy. For example, in an industry that sees employee turnover approaching 60%, Rosen has turnover in the low teens.

Rosen pays for full-time employees' college tuition after five years of employment. They also pay state college tuition for employees' children after just three years of employment.

They've also used money that would have been overspent on health care to fuel a range of creative philanthropy. Rosen started by paying for preschool in the underserved, once crime-ridden Tangelo Park neighborhood in Orlando. He's also continued to fund various programs to help those kids develop, such as paying for their college education in full (tuition, room/board, and books). The results have been breathtaking:

- Crime has been reduced by 63%.
- High school graduation rates went from 45% to nearly 100%.
- College graduation rates are 77% above the national average.

The cost over 24 years of the Tangelo Park program has been $11 million—roughly the amount Rosen saves in one year on health care. Recently, Rosen has agreed to adopt another underserved community called Parramore, which is five times the size of Tangelo Park.

For Harris Rosen, the approach is simple: Get involved; care for your people.

CASE STUDY:

Copper State Bolt & Nut Company

Advisor organization:	**Wincline**
Headquarters:	**Phoenix, AZ**
Industry:	**Manufacturing**
Sector:	**Private**
Client size:	**500+ Employees**
Employees on plan:	**313**
Total lives on plan:	**586**
Plan funding:	**Self-funded**
Case study:	**1/1/2017 - 12/31/2019**

Key takeaways

1. Reduced health care spending from $500+ (PEPM) in 2017 to under $300 (PEPM) in 2019.
2. Achieved a 40% savings in just two years. Over $1.3 million annually.
3. Employees pay $0 (deductible waived) when seeking second opinion.

Testimonial

"Without Wincline's involvement, I have no doubt that an employee would have unnecessarily had his colon removed if the plan did not require a qualified second opinion. This saved the employee from unnecessary life-changing surgery and improved the quality of his life. Instead, he received another recommended surgery all for 9% of what would have been paid in years past saving the employee and the plan

hundreds of thousands of dollars. Now, Copper State gets a capable, loyal and productive employee who appreciates what was done for him."

–Sam Tiffany, Human Resources Manager,
Copper State Bolt & Nut Co.

"What I like about Wincline is their commitment to end the dirty data and provide complete transparency, and their belief that they can transform health care."

–Sarah Shannon, President,
Copper State Bolt & Nut Co.

Client background

Copper State Nut & Bolt was combating rising health care costs on a carrier-based partially self-funded plan. Previously, they didn't have any strategy to handle the rising health-care costs and were simply reacting and accepting the renewal rate increases year after year. In 2017, Copper State Nut & Bolt was facing a 30% rate increase from their incumbent carrier when Health Rosetta Advisor John Harvey, and his firm Wincline, took over. To combat rising costs, it had three main goals: 1) cut unnecessary health-care costs, 2) reduce employee cost, and 3) reduce unnecessary waste and misaligned incentives in the plan.

Copper State Nut & Bolt is a manufacturer based out of Phoenix, Arizona, with over 30 locations across the U.S. They are a specialty manufacturer that provides an array of products to the industrial, manufacturing and construction industries. Prior to changing plans, Copper State was overspending on health care while the old-line carrier was unnecessarily profiting from Copper State's health plan through misaligned incentives and excessive hidden fees.

Approach

Copper State Bolt & Nut was continuing to face year-over-year rising health-care costs without a strategy to manage their health plan. In 2017, Copper State Bolt & Nut partnered with

Wincline, a fee-only advisory firm that aligned with their interests, to create a proactive healthcare strategy to reduce costs, remove excess waste in the plan and improve overall benefits for the employees.

Through active plan management and aligned interests, Copper State Bolt & Nut was able to identify that their existing partially self-funded plan was being mismanaged and root out waste that was increasing the profits of the carrier. John Harvey of Wincline helped Copper State Bolt & Nut by guiding them through a two-year process moving off a carrier-controlled self-funded bundled plan and onto a transparent open-network approach leveraging reference-based reimbursement and direct contracts.

This transition to Copper State Bolt & Nut reducing year-over-year costs and gaining control of their health-care expenses did not come without its surprises and challenges. First, in 2017, Wincline helped Copper State Bolt & Nut transition from a paid stop-loss contract to an incurred stop-loss contract providing the necessary risk management to protect the plan and its employees. In addition, Wincline identified nearly $100,000 in outstanding stop-loss reimbursements that the old carrier failed to issue back to the plan.

Further investigation found that the incumbent plan was paying a large portion of carrier fees through claims portion of the medical plan, which is often how carriers include hidden and unscrutinized fees. One of these fees was a "Medical Shared Savings Fee" that charged Copper State Bolt & Nut 3% (not to exceed $3,000 per claim) of the provider's billed charges for each individual in-network claim. Putting administrative fees inside the medical plan and claims reimbursement is a practice that carriers leverage to reduce their fixed administrative fees in order to appear competitive with other carriers. Wincline was able to advise Copper State Bolt & Nut by identifying and separating all the fixed fees from the medical plan so that the company had a clearer picture of the excessive administrative fees.

Also, Copper State Bolt & Nut discovered that its old carrier-administrator was applying their use of in-network benefits

to out-of-network providers to increase their "cost containment fees" but were not administering the plan correctly per terms that were outlined in the plan documents. Copper State Bolt & Nut plan documents expressed clearly that there were no out-of-network benefits on the plan. However, the old carrier was using their network adequacy program that gave them authorization to use in-network benefits to out-of-network providers that boosted the carrier's own so-called "cost containment" fees.

In addition, after identifying waste, hidden fees and blatant mismanagement, Wincline helped Copper State Bolt & Nut partner with an independent TPA, execute an independent stop-loss contract, and leverage a transparent open network with reference-based reimbursement to reduce the overall health plan costs. This approach was the main driver Copper State Bolt & Nut leveraged to reduce its health care spending by 40%, or $1.3 million annually, compared to their incumbent carrier plan.

To help plan members and employees take advantage of their new health plan, Wincline created the member champion role to address employee questions, navigate members and drive members through optimal care pathways (second opinions, primary care, physical therapy, musculoskeletal surgeries and more). The new member champion position was key to assisting members through the complex health-care system to getting optimal high value care. In addition to engaging members and creating a member champion position, Copper State Nut & Bolt required second opinions for surgeries to ensure that the member was getting the best care possible. Plus, if a member sought a second opinion and still needed surgery, there would be no cost to the member and the deductible would be waived. This made the smart choice the easy choice.

Top-level results

Two years after partnering with Wincline, Copper State Bolt & Nut reduced health plan costs by 40%, a savings of $1.3 million annually.

The company's per-employee-per-month (PEPM) expense went down significantly from $500+ PEPM to under $300 PEPM, allowing Copper State Bolt & Nut to reinvest these savings into improving overall employee benefits.

Through active plan management, a new member champion position and smart care pathways, Copper State Bolt & Nut was able to provide superior health care and benefits to its members and completely waive deductibles and all costs for members when pursuing the high-value care pathway. In addition to employees saving money, the plan prevented a lot of unnecessary care and improved employees' overall experience in their healthcare journey. The employer is now able to reinvest those savings back into providing better benefits for their employees over the long term.

CASE STUDY:

Enovation Controls

A small Oklahoma manufacturer removes 97% of pricing failure

When you think of innovative organizations that provide a best-of-breed health benefits package and spend far less than peer organizations, you wouldn't necessarily think of small manufacturers in Oklahoma, where as much as 75% of the population doesn't have an established primary care relationship. Yet Enovation Controls, a provider of products and services for engine-driven equipment management and control solutions with about 600 employees, has managed to save approximately $4,000 per covered life each year by working with a transparent open network (TON).

A TON puts together a network of the highest-value providers for different kinds of care and gives self-insured employers a set of fair and fully transparent pricing— typically a bundled price—for medical services/procedures ranging from a specific treatment (e.g., knee replacement or coronary stent) to a specific condition (e.g., diabetes or kidney disease) across multiple providers, and sometimes, multiple settings.

Enovation Controls chose The Zero Card to manage their TON. They achieved a 70% participation rate among eligible plan members, focusing on high-cost services like surgeries and imaging. Justin Bray, Enovation's vice president for organizational effectiveness and human resources, attributes the high rate to two primary factors:

1. **Communications** – During the rollout of the TON, Enovation shared their current health care costs with employees, along with the consequences for the company and each individual. They then compared those costs with the costs of care under specific scenarios with TON. The message: We've found a better way. Most people were shocked by the vast price disparity and the fact that lower-priced providers often delivered the highest quality, in part because these doctors perform a given procedure more frequently, improving with repetition, which lets them operate efficiently with fewer errors and expensive complications.
2. **Ease of use** – Employees have access to a single app or phone number that directs them to network providers where they can get care with zero out-of-pocket costs. Instead of dealing with a mountain of bills and paperwork following the procedure, they receive a thank you survey to ensure that the experience went well. As Bray explained, this is particularly critical, as surgeries and imaging are some of the highest-cost items they have to cover. Because of the focus on higher-cost items, Enovation has achieved well over 90% of projected savings, even with less than 100% participation. The calculation of those potential savings compared the historic "allowable" amount from the company's claims history with a true market amount through the TON network—that is, what a provider would accept if you showed up with a bag of cash for a bundled procedure such as a total knee replacement.

The savings over historical allowable amounts from their traditional PPO network ranged from 21.92% to 81.28%, with an average of 59.23%.

Here's an example of a line item for one procedure for one employee:

"Spinal fusion except cervical without major complications"

Bray shared what this meant to one employee who approached him at a high school football game to say thank you. This person had recently had expensive surgery and didn't have to pay a dime out of pocket—no bills, no explanations of benefits, no anything. On a $30,000 salary, the maximum allowable out-of-pocket cost of $2,500 under the previous health plan would have been a financial disaster, the employee said.

Enovation Controls Employee Monthly Premium Costs

Historic allowed amount	$129,138
TON network	$38,000
Savings	$91,138

Summary information provided by Enovation Controls.

Like every other health care purchaser, Enovation Controls knows that tackling high-cost procedures is central to slaying the health-care-cost beast. Its TON program even extends to items like complex cardiac and neurosurgical procedures, for which employees have access to the same centers of excellence as large employers, such as Mayo Clinic. Whether the Mayo Clinic or a local surgery center, high-quality providers are happy to provide a deep discount in return for more business, less hassle, and avoiding claims processing and collections processes. Once the procedure is complete, the provider gets paid within five days for the full bundled price.

Plus, the bundled prices frequently carry warranties, meaning that postsurgical complications within 60 to 90 days are addressed at no charge—another bonus for employers.

Using data from Mercer, Enovation Controls estimates that they save $2 million on health care every year, compared with peer manufacturing organizations. For a relatively small company, this is a highly meaningful amount of money, which it has been able to reallocate to increased R&D. While companies in their sector typically spend 4% of annual revenues on R&D, Enovation spends 9%, helping it stay ahead of the competition and attract and retain the best engineers.

Enovation Controls Per-Capita Spending

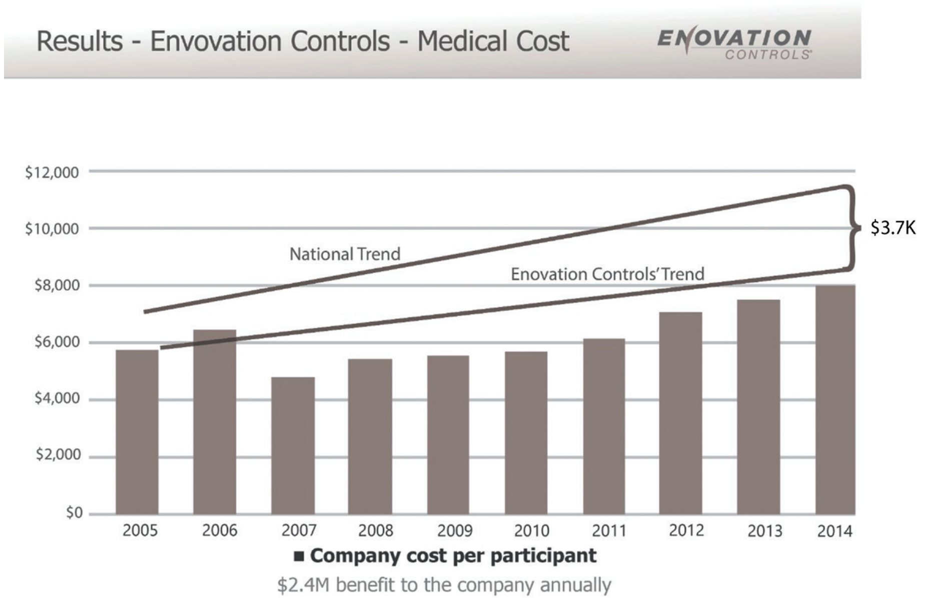


Figure: Summary information provided by Enovation Controls.

When a small manufacturer with few dedicated resources can pull this off, it begs the question why every employer or union isn't doing the same. Smart employers like Enovation Controls demonstrate that it's possible, even in a state with some of the highest obesity rates and overall health-care costs. Since a new primary care model or TON can be implemented at any point in a benefits cycle, there's no need to wait.

CASE STUDY:

Keystone Technologies

Educating employees to reduce health-care expenses

Growing companies that increase the size of their workforce are rewarded with the benefits of increased productivity and more business opportunities. But more employees come with a greater responsibility for employers to provide better employee benefits, without pushing their bottom lines.

It's a challenge that Keystone Technologies, a small but quickly growing company from Eureka, Missouri, was struggling to do, as its health-care costs continued to grow with every new employee they hired.

The irony is that Keystone is a health care IT firm that provides cyber and computing solutions to hospitals, health systems and senior-living communities. And even though they specialize in IT services that increase the efficiency and security of health-care companies, they were struggling with how to properly manage their own health care benefits.

Keystone is a disturbing example of how all companies, even those working in the health-care space, are victims of the inefficiencies and predatory practices of our dysfunctional health-care system.

Under its incumbent plan, it was facing a 55% cost increase from its insurance provider and spending 62% above premiums collected (162% loss ratio). The incumbent plan's lack of transparency made it difficult to see where the money was going or what the costs would be, from year to year.

In my experience, these are the types of plans that disempower employers, make them feel helpless to combat rising

health-care costs, and perpetuate profit-driven incentives in the health-care industry.

But fortunately, Keystone is part of the growing number of employers that put their foot down and reject the status quo of low-quality, high-cost health benefits. It had a vision for a new health care plan: one where costs were lower, employee paychecks were higher, and access to health-care services could be free.

Its determination to find a solution and keep the business alive led it to Health Rosetta advisor Adam Berkowitz, the founder and president of St. Louis, Missouri-based Simpara Benefits, who guided the company to achieving its dream for a better future.

Within one year, Berkowitz helped Keystone reduce spending by 10%, and by the second year with the new plan, spending dropped 25%. Yearly costs per employee were reduced from $12,000 (PEPY) to $9,441 (PEPY).

Berkowitz managed costs by switching Keystone over to a self-funded plan that incorporated a budget-friendly, maximum-funded plan, where Keystone pays for its maximum liability of claims costs on a monthly basis. Under this new plan, if covered claims are less than what the employer paid for, then the employer receives a refund for unused claim liability at the end of every year. And since changing plans, Keystone has a return worth $60,000, an average of $2,000 per employee per year.

If it had stayed with its old plan, Keystone was facing a 62% increase in premiums. It didn't know how to avoid the increase or where it was coming from. Luckily, Keystone had Berkowitz, a true problem solver who discovered that the old plan had Keystone overspending for health coverage. The company was squandering valuable resources with diminishing returns; and this plan was asking it to increase wasteful spending every year.

To combat the increase, Berkowitz unbundled Keystone's health plan, purchasing benefits from a variety of vendors. This increased vendor competition, thereby lowering prices and improving price transparency for Keystone employees.

So instead of the predicted 62% increase, Berkowitz reduced spending by 40%, providing Keystone ample flexibility and leverage to grow their business without the burden of out-of-control health-care costs.

Employees now have access to a plan that covers 100% of their health costs, which has allowed employees to take expensive medication at no cost to the employee. Their deductibles were cut in half, and single employees now pay an annual $2,500 and families pay $5,000, a price well below the national average.

Improving member education

One of the most effective strategies that Berkowitz devised to keep health-care costs down was educating employees and providing the resources so that they could make smart health-care decisions for themselves. Having a good plan is only part of the battle.

Keystone improved workforce health and lowered its health care expenses by teaching employees how to make healthy lifestyle choices, how to find the best prices for medicine and services, and the importance of getting second opinions for treatments.

Employees now have access to tools that promote better health outcomes, like an online health-care platform that guides users to make better health-care choices.

And while digital tools are *not* the *sole answer* to solving our health care problems, they are valuable supplements that complement a good health-care plan by improving how plan members use their health benefits.

For Keystone employees, online health-care tools helped them become more comfortable with shopping and increased their understanding of health-care costs. These tools prompted employees to share their experiences with their peers (i.e. finding savings on prescriptions and getting low-cost or free procedures) and helped to bolster the idea that employees have the power

and responsibility to be wise health-care consumers and advocate for their own health.

Berkowitz's work with Keystone is an example of an advisor who took his duties to the next step, by helping individuals realize that they have control over their healthcare plan. Too many people think the other way around, and are left feeling trapped.

It's not enough to help create efficient health-care plans for organizations. We need to empower employers and employees and give them the knowledge and tools to understand their benefits so that they have the power to seek out the best care and say "no" to plans and providers that don't meet their standards.

CASE STUDY:

Langdale Industries

Company in a one-hospital town saves money while ensuring great care

By Brian Klepper

Large American businesses with tens or hundreds of thousands of employees have recruited high-profile benefits professionals to orchestrate sophisticated campaigns focused on the health of employees and their families—and on the cost-effectiveness of their programs. Even so, few large firms provide comprehensive, quality benefits at a cost that remains consistently below national averages. For midsized businesses—firms with 100 to 5,000 employees—the task is significantly more difficult without the right people and focus. Health benefits managers in these companies have far fewer resources, typically work alone without the benefit of a large staff, and are often overwhelmed by the complexity of their tasks. As a result, they often default to whatever their broker and health plan suggest.

But some excel. For them, managing the many different issues—chronic disease, patient engagement, physician self-referrals, specialist and inpatient overutilization, pharmacy management—is a discipline. Barbara Barrett is one of them.

Barrett is director of benefits at TLC Benefit Solutions, Inc., the benefits management arm of Valdosta, Georgia-based Langdale Industries, Inc., a small conglomerate of 24 firms and 1,000 employees. Langdale is engaged primarily in producing wood products for the building construction industry, but is also in car dealerships, energy and other industries.

Valdosta is rural, which puts health benefits programs at a disadvantage. Often, as in this case, there is only one hospital nearby, which means that there is little if any cost competition. Compared with those living in urban areas, rural Georgians are more likely to be less healthy and suffer from heart disease, obesity, diabetes and cancer. So, the situation is far from ideal.

And yet, from 2000—when Barrett assumed responsibility for the management of Langdale's employee health benefits—to 2009, per employee costs rose from $5,400/year to $6,072/year. That's an average increase of 1.31% per year, compared to an average annual increase of 8.83% for comparably-sized firms nationally. To put this in context, average firms spent $29 million more than Langdale from 2000 to 2009 to provide the same kind of coverage. Langdale's savings were $29,000 per employee—all without reducing the quality of benefits or transferring the cost burden to employees.

Langdale Industries - Actual Premium* vs. US Trend and Cumulative Difference					
Year	**US Trend****	**Langdale (US Trend)**	**Langdale Actual*****	**Diff**	**Diff x 1,000 EEs**
2000		$5,400	$5,400		
2001	11.2%	$6,005	$5,471	$534	$534,060
2002	14.0%	$6,845	$5,542	$1,303	$1,303,065
2003	12.6%	$7,708	$5,615	$2,093	$2,092,989
2004	10.1%	$8,487	$5,689	$2,798	$2,797,941
2005	9.7%	$9,310	$5,763	$3,547	$3,546,612
2006	5.0%	$9,775	$5,839	$3,937	$3,936,601
2007	5.7%	$10,332	$5,915	$4,417	$4,417,301
2008	6.0%	$10,952	$5,993	$4,960	$4,959,756
2009	5.6%	$11,566	$6,071	$5,495	$5,494,583
			Cumulative Difference		**$29,082,906**

* For Medical, Dental & Pharmacy

** Source - Kaiser/HRET 2009 Employer Health Benefits Annual Survey

***Trended at an average of 1.31% between 2000 and 2009 *Brian Klepper*

Figure 21:

So how did Barrett approach the problem? Here are a few of her strategies:

- Langdale the company set up TLC Benefit Solutions, a HIPAA-compliant firm that administers and processes the company's medical, dental and drug claims. This allows

Barrett to more directly track, manage, and control claim overpayments, waste and abuse.

- It also gives her immediate access to quality and cost data on doctors, hospitals and other vendors. Supplementing this data with external information, like Medicare cost reports for hospitals in the region, has allowed her to identify physicians and hospital services that provide low or high value. She has created incentives that steer individuals to high-value physicians and services and away from low-value ones. When necessary complex services are not available locally or have low quality or value, she shops the larger region, often sending patients to higher-value centers as far away as Atlanta, three and a half hours by car.
- Barrett analyzes claims data to identify which individuals have chronic disease and which are likely to have a major acute event over the next year. Individuals with chronic diseases are directed into the company's evidence-based, opt-out disease management and prevention program. Individuals with acute care needs are connected with a physician for immediate intervention.
- Langdale provides employees and their families with confidential health advocate services that explain and encourage the use of the company's benefits programs, again using targeted incentives to reward those who enter the programs and meet evidence-based targets.

These are just a few of Barrett's initiatives in group health, but her responsibilities also extend to life insurance, flex plan, supplemental benefits, retirement plan, workers' compensation, liability and risk insurance. The results for Langdale in these areas include lower than average absenteeism, disability costs and turnover costs.

The point isn't that you should just do what Barrett and Langdale have done. The point is that they've been proactive, endlessly innovative, and aggressive about managing the process. This

attitude and rigor have paid off through tremendous savings, yes, but it has also produced a corporate culture that demonstrates the value of Langdale's employees and community. Employees and their families are healthier as a result and are more productive at work. This has borne unexpected fruit: The industries Langdale is in were hit particularly hard by the recession, and the benefits savings from Barrett's efforts helped save jobs.

Barbara Barrett and many others like her on the front line are virtually unknown in health care. Most often, their achievements go unnoticed beyond the executive offices. But they manage the health care and costs of populations in a way that all groups can be managed.

Editor's note: We checked in with Barbara recently and found that, even in the face of new challenges, such as extreme jumps in drug prices, Langdale continues to succeed where others have failed to carefully manage health costs.

Brian Klepper, PhD, is a health care analyst and principal of Worksite Health Advisors, based in Orange Park, Florida.

CASE STUDY:

Pacific Steel & Recycling

How one company reduced their health plan cost by $3.6 million

Recycling plants like Pacific Steel and Recycling from Great Falls, Montana, help eliminate metal waste from our world by turning used materials into a new, functional product. Nearly 700 employees work from 46 branch locations in the Western United States and Alberta, Canada.

Pacific Steel's CEO Jeff Mullhollin and CFO Tim Culliton confronted an all-too-common problem: Health care spending was too high. And unfortunately, the company's expertise in reducing material waste didn't translate to solving the problem of eliminating wasteful spending in health care.

Starting in the early 2000s, Pacific Steel embarked on a journey to fixing its health-care plan.

First, like many other employers, Pacific Steel tried to combat rising health-care expenses by pushing more of the cost onto its employees. But Mullhollin and Culliton soon realized that raising deductibles and contributions didn't address the underlying issues, it just caused another problem: It pushed employees off the plan in favor of cheaper alternatives, like their spouse's plan or marketplace insurance or becoming part of the working uninsured.

The company was fully-insured until the mid-2000s; it later switched to a self-funded health plan with a carrier-based PPO network. But after experiencing a nearly 400% increase in facility costs in the first part of 2013, the manufacturer implemented reference-based pricing (RBP) beginning January 1, 2014. However,

the strategy didn't begin to work until two years later, when the USI health care consulting team came on board, according to Culliton.

Mullhollin and Culliton were led to Scott Haas, Erik Davis and Terry Killilea, PharmD., all senior vice presidents at USI Insurance Services. Haas, Davis and Killilea are principal consultants within USI Insurance Services, providing healthcare consulting solutions to their clients.

This consulting practice ran the numbers provided by the company's TPA and found that some things didn't add up. Many areas were identified where Pacific Steel's 160% of Medicare reimbursement rate was working to its advantage and others where it was wasteful spending. Pacific Steel was often overpaying for certain types of care, spending more than what most other PPO networks pay.

The power of reference-based pricing and direct contracts

That's when USI established benchmarks and metrics to analyze Pacific Steel's health plan data. The USI health care consulting practice repriced the historical claims data to Medicare allowed, which determined the cost basis under the PPO plan as well as the first version of RBP implemented January 1, 2014. Through this process, the USI consulting team developed a second-generation RBP solution. Pacific Steel ended up going through two failed TPAs. But the new finalized RBP model involved a member advocacy component and a new TPA, one known for its adjudication integrity and process management.

The new model reimburses providers at fairer and more equitable rates relative to the previous RBP system. Pricing now varies by type and place of service, provider and facility. It also recognizes that 85%–90% of all health-care encounters are with ancillary providers, and the rest with facility-based organizations for surgeries or procedures.

Realizing that RBP cannot produce stellar results on its own, Haas views this strategy as part of an umbrella of alternative

reimbursement, as the marketplace evolves toward direct contracting arrangements "without the intermediary of a network or carrier in the middle of the relationship."

RBP addresses pricing, but it does not address utilization variance that will occur regardless of payment level of claims. While revised pricing cannot eradicate large claims or control utilization, Haas says the plan will cycle at "a lower cost threshold because of the reduction in claims cost, which primarily is reflective of a reduction in facility cost."

Pacific Steel now has more than 5,000 safe-harbor or direct contract agreements with high-quality physicians and ancillary providers who have agreed not to balance-bill members. This creates an open-access environment, where care essentially can be sought from any provider that Pacific Steel has five direct contracts with and from hospitals and health systems that are based on revised pricing methodology agreements, and others are pending.

USI has also implemented numerous surgical case rates that lead to savings for the plan and the member by paying hospitals, providers and clinicians a single pre-negotiated rate, instead of billing individually. These contracts pay the provider at the point of service and waive all out-of-pocket cost to the member. Haas negotiated rates for common procedures like hip, joint and knee replacements. Under Pacific Steel's contract, a knee replacement at designated providers costs around $20,000 – under most plans, this procedure can cost more than $50,000.

Part of setting those pre-negotiated rates was also doing the research to find the quality providers that practice value-based care. Pacific Steel has an HR representative who works to match employees with the best clinicians. It encourages its employees to seek out the providers that offer the best care for the most value, incentivizing them to use these providers by waiving the copay. This reduces the number of repeat visits and prevents unnecessary treatment and prescriptions.

Conversely, the company deters employees from going to lower-value providers by informing them that they will have to

share the cost for receiving out-of-network care. Being up front about coverage also helps prevent surprise medical bills.

In addition to the cost reduction of the medical plan, the USI health care consulting practice reduced the PBM spend for prescription drugs by over $200,000 in the first year of the revised program. And since 2014, the cost basis of absent specialty-drug utilization has remained flat.

Haas builds plans using Health Rosetta principles. And every plan that incorporates them has what's called the Health Rosetta Dividend, where improving health benefits and lowering costs results in improvement in other areas.

It has made a significant difference at Pacific Steel. The per-employee-per-month composite medical spend, excluding prescription drugs, plummeted 46.1% between the end of 2013 and 2018, falling to $442.32 from $812.13. "That calculates out to an aggregate cost reduction of about $3.6 million," Haas reports.

For Pacific Steel, which has an Employee Stock Ownership Plan (ESOP), meaning that employees are shareholders of the company, when the company does well or saves money, employees see that success too.

While it took a long time for Pacific Steel to find the right plan and cut costs, stories like this should comfort employers, because they show that it's never too late to make a change.

CASE STUDY:

Textum

A small North Carolina textile company learns how to set its own prices

Sometimes the best innovations come from the smallest groups. Textum, an industrial fabric manufacturer located outside of Charlotte, North Carolina, is one of those small businesses continuously creating and testing new ideas; with 31 employees, Textum has produced unique solutions for a wide variety of industries, from thermal protection systems for space vehicles, carbon fiber material for bulletproof vests, to fabrics that are used in carbon-carbon processing.

Textum is used to innovating and excelling at every new challenge it encounters. But, in June 2017, annually rising healthcare bills were one issue that really frustrated and stumped Aaron Feinberg, Textum President and CEO. As a small company, Textum's workforce was like family, and Feinberg knew that rising health-care costs were not sustainable for his employees or the business at large.

Feinberg quickly realized that his company needed a new health benefits plan, and also that he couldn't do it alone. So, he enlisted the help of David Contorno, a Health Rosetta advisor. Contorno is known for helping businesses, large and small, across the U.S., save hundreds of millions in health-care dollars, to create a health plan that functioned as a living document, one that changed as its members' needs and priorities evolved each year.

First, Contorno put the company in a level-funded plan under a BUCAH carrier to ease into the change process in 2018.

Level-funded plans are often referred to as "partially self-funded" plans, as they operate in a similar way to a fully self-funded, employer-optimized plan, but have a lower level of stop-loss coverage, which is what protects employers from large claims. (Level-funded plans work well for small companies that want the cost transparency and the minimal savings that come with self-funded plans, but cannot take on the high claims risk that large companies are able to withstand.)

Textum's level-funded plan had an independent TPA, no PPO network, and all the Health Rosetta principles, which in turn helped Feinburg lower his 2018 health-care costs by $75,762 for the year, or 32%. But, Contorno and Feinburg decided that there were more changes to be made and more savings to be realized the following year.

Negotiating its own rates with direct contracts

In 2019, Contorno introduced several new changes to the health-care plan. After looking through Textum's claims data from previous years, Contorno found that Textum had a history struggling with balance-billing issues from one particular sizable provider, which left many employees to deal with surprise medical bills that not only were a burden to them, but also resulted in less savings than the company could otherwise achieve.

To prevent future surprise bills, Contorno created direct contracts with health-care providers and hospitals in Charlotte that offered the best treatment. He worked with them to negotiate fair rates and payment methodologies for medical services and treatments using reference-based pricing (paying more than Medicare but less than the average PPO network). Then, Contorno bundled surgical and radiological services, implemented international prescription sourcing for low-cost medication, and had the plan waive all out-of-pocket expenses for members when they used these services. Pre-negotiated rates helped Textum employees in a number of ways. It directed them to the best providers,

increased cost transparency, and prevented them from incurring unknown costs. It also improved patient-provider relationships. But Contorno didn't stop there. Taking transparency to another level, Contorno strove to eliminate personal bias by choosing to be paid on a fee and performance basis instead of a commission basis.

In sum, these strategies resulted in reducing Textum's health care spending beyond what Feinburg expected. Textum employees have not seen an increase in deductibles since embarking on this journey to better health care in 2017. The 2018 plan had an expected maximum cost of $176,000. But thanks to the new cost-saving strategies implemented that year, Textum ended up closing the 2018 plan year paying only $155,000 and its health claims spending was 60% below the amount of premiums collected that year (40% loss ratio). If it had stayed on the previous carrier-based plan, Textum would have suffered a sizable $231,000 in health-care spending in 2018.

In 2019, Textum's maximum costs were expected to be $189,000. But, once again, Textum came in under budget, spending just $149,133.

As these numbers so clearly demonstrate, Contorno helped Textum regain control over its healthcare plan. He helped Feinburg realize that employers have the power to negotiate and seek out the quality of care that they know their employees deserve. Unfortunately, not all employers know this, which is why finding the right advisors, those who fight for the best interests of members, is crucial to transforming the status quo and fixing health care.

CASE STUDY:

Pipe Trades Services Minnesota

Headquarters:	**White Bear Lake, MN**
Industry:	**Plumbing and pipe fitting**
Sector:	**Trade unions**
Employees:	**5,000 active, 2,500 retired and total of 18,000 individual lives including dependents**
Plan funding:	**Self-funded**

Key takeaways

1. The Pipe Trades Services Minnesota Wellness Centers were created to provide convenient, comprehensive primary care services and associated care onsite, at low or no cost, for a 99% male population that typically avoids going to the doctor.
2. Despite being used by only 25% of the 5,000 active plan participants, all union members, the centers have proved so successful financially that premiums have not risen in seven years. That's an unparalleled achievement compared to other union-affiliated plans, many of which have had to reduce benefits to cover rising plan costs.
3. Over the years, Pipe Trades Services Minnesota has continued to add services at its centers, such as physical therapy and personal trainers, as well as full-scale behavioral health offerings and a range of fitness and other classes.

By banking on bolstering primary care services as the key to reducing health plan costs and improving members' health, Pipe Trades Services Minnesota (PTSM) has developed an innovative

care model that not only better serves its six participating unions but also helps workers access convenient care when and where they need it. Essentially, by bringing comprehensive primary care “in house” through a network of sponsored wellness centers in which physicians, not actuaries, determine how care will be delivered, PTSM has turned the prevailing depersonalized volume-driven care-delivery model on its head. PTSM has also achieved the unthinkable: containing health-care costs so that the plan’s 5,000 active members haven’t had to incur a higher premium in more than seven years.

“Ten years ago, we were watching the cost of health care go up and up, especially on the primary care side, and not necessarily seeing any value for that,” said Jim Hynes, who administered the plan until his recent retirement and had three decades in the field. “The physicians we’ve hired to work in our wellness centers don’t have daily or hourly patient-volume quotas, and they’re not paid based on the number of patients they see. Our physicians are allowed to do what they were trained to do—spend their time developing a trusted relationship, without being encumbered by billing and coding decisions. And that’s what’s making a difference and changing lives.”

The PTSM Wellness Centers—four are operating in Minnesota today—offer a broad range of services including not only primary care but also behavioral health providers and psychiatrists, cardiologists, and chiropractors and personal trainers, and they provide those services for a nominal $10 copay. There’s no billing and almost no paperwork. However, union members who obtain services at the centers are required to make a Health and Wellness Commitment to incorporating better nutrition and exercise, finding ways to create joy in their lives and, most important, establishing an ongoing relationship with a primary care physician. “It’s a holistic approach,” Hynes said.

Commitment to personal wellness, robust services underlie wellness center model

That's a tall order, given PTSM's population of 99% male plumbers, pipefitters and construction workers. "They're not just regular males, but tough construction worker males who think they don't need doctors. We need them to establish that commitment to support their health and wellness goals and their families," Hynes said.

In return, plan members can expert robust, comprehensive care that's "quarterbacked" by the physician regardless of the services needed. In that preliminary visit, the physician spends a full hour with the patient and takes the medical history in a face-to-face, personalized manner—not by having the member complete a multi-page form with a bunch of checkboxes. That authentic gesture and the unrushed visit, Hynes maintains, helps establish the trusted physician-patient relationship and makes it more likely that members will stick with the program.

The wellness centers' structure is designed comprehensively to support members' needs, with a focus on some of the common health issues workers in the trades experience: physical injuries, low back pain and sub-optimal nutrition that can lead to a whole host of ailments and chronic diseases. The centers have a dedicated low back pain program with four chiropractors on staff, and physical therapists and personal trainers available five days a week. Those providers work together as a team to coordinate needed care and track members' progress.

The centers also have health coaches on staff to help members who want to make life-style changes to improve their health, such as eating better or quitting smoking, for example. The centers have a Healthy Living Club once a week, where a physician provides wellness guidance and answers questions. Vision services are also provided onsite, and PTSM has used a centers of excellence model to contract cost-effectively for other services, such as imaging and gastroenterology.

To support members on their journey to improving health, PTSM also offers a range of classes—from yoga and meditation to exercise and fitness classes—and even a cooking class that's been immensely popular with members' families. In addition, the wellness centers also provide a meal service that members can access to have healthy, fresh-prepared meals delivered at work two days a week or available for pickup on Sundays. "It's all fresh—nothing is frozen and there's no processed food. And it's all healthy, like free range chicken and wild-caught fish," Hynes said.

Initially, there was some pushback by union leadership and board members regarding the rationale for and cost of operating the centers, but that has diminished over time as total costs have stabilized and the centers' popularity and effectiveness have become apparent. "One of the things I've heard, from one of my female physicians, is that some of the younger single males look to the female physicians as their mother hens—helping them figure out some of the health stuff," Hynes said.

Behavioral health services address an underserved need

One of the key differentiators in PTSM's care model is the full range of behavioral health services it offers, onsite at its wellness centers. In addition to mental-health therapists, members also have access to a psychiatrist, as needed, just by walking down the hall. "In my opinion, mental health is the most underserved area in our primary care system, and there are lots of access issues. We wanted to remove that barrier so that members don't have to miss work, find services on their own and pay out of pocket," Hynes said. "We also wanted to reduce the stigma issues associated with mental health, so we call our providers 'coach therapists.'" Those teams are in place at all four wellness centers.

PTSM also eradicated any cost barrier to mental health services, by providing the services as no cost—no deductibles and no copays. That mental health program has worked out far more

successfully than expected. As of July 2018, the centers were seeing approximately 400 patients per month for behavioral health visits. And established patients also have the option of using virtual visits to work through any concerns or crises that arise in between visits.

"Things happen. Life happens. And people might need help coping," Hynes said. "Maybe a teen-aged child is addicted to opioids, or the member has just learned that he has diabetes and had a father who died of the disease at a young age." Those are visits that most typical union members wouldn't be accessing, Hynes observed, because there are too many barriers to obtaining that care elsewhere.

While the wellness centers model has been very successful from the standpoint of helping contain costs, and encouraging disease prevention and driving satisfaction among those who've signed on to the program, PTSM would like to see increased participation, which today stands at approximately 25% of plan members. Hynes acknowledges that increasing participation is expectedly challenging, with a population of predominantly young to middle-aged men who work in the construction trades. "It's something the company is working on, getting more members to establish a relationship with a physician, but it can be difficult with men and particularly with younger men," Hynes said.

> "Ten years ago, we were watching the cost of health care go up and up, especially on the primary care side, and not necessarily seeing any value for that. The physicians we've hired to work in our wellness centers don't have daily or hourly patient-volume quotas, and they're not paid based on the number of patients they see."
>
> *– Jim Hynes, former plan administrator*

CASE STUDY:

Horizon Goodwill Industries

Headquarters:	**Hagerstown, MD**
Industry:	**Retail & job development**
Sector:	**Private**
Employees:	**500, with 150 on plan and 180 total lives**
Plan funding:	**Self-funded**
Case study:	**2019-2022**

Key takeaways

1. In shifting from a carrier-operated health plan to a self-insured one, in incremental steps, Horizon Goodwill saved $250,000 in the first year alone, reducing PEPM costs to $402 from $564. Horizon continues to reap more savings as the plan matures—especially in pharmacy costs.
2. Implementing direct primary care (DPC) has proved a huge win for employees, by increasing care access and services quality, while reducing employees' out-of-pocket costs. Those who use the DPC network incur no out-of-pocket costs for that care, and the company has seen fewer referrals for unnecessary specialty care.
3. In tackling its pharmacy costs with a multi-faceted strategy that includes independent PBM services, international drug sourcing and a pharmacy concierge, Horizon are assured access to all medications they need at affordable costs—and in some cases, no cost.

For Horizon Goodwill of Hagerstown, Maryland, the key objectives in moving away from a carrier-controlled plan were twofold: to reduce spending and provide employees with

higher-quality, more personalized care. Horizon, which offers services ranging from business solutions and job training to human resources assistance and serves 19 counties in four states, had made its foray into the self-funding arena in 2015.

The company decided in 2019 to take a more comprehensive, employer-optimized approach by incrementally implementing reference-based pricing (RBP) with hospital facilities, taking a more aggressive stance in pharmacy benefits management, and establishing direct primary care.

Because health benefits cost represents a large portion of Horizon's overall budget, the company wanted to ensure that it was getting good value for its expenditures by providing affordable, accessible care. Many of Horizon's employees have permanent disability, and as such they have persisting and, in some cases, increasing medical needs. That makes it challenging to obtain significant cost reductions, so the Horizon's goal is to keep costs from spiraling out of control. Working with advisor Ben Bohonowicz of Employee Benefits Services of Maryland, Horizon has been able to achieve all of its goals and stabilize costs in the process.

"I'd never heard of a self-funded plan before we started looking at options to reduce costs. But as we worked with our advisor and his team, I found that we would be able to get the high-quality services that we wanted at a better price—providing more benefit to our members while keeping premiums and deductibles low," said Meykala Plotner, Horizon's HR director.

Taking an incremental approach to improved services

The experiment has been very successful. In the first year, Horizon reduced medical and pharmacy costs by $250,000, a 29% decrease, and per-employee-per-month (PEPM) spending dropped from $564 to $402. In the second year, Horizon tackled its pharmacy spending with a new independent pharmacy benefits manager (PBM) and creative medication sourcing, and

then made the leap into direct primary care (DPC). The latter move both eradicated previous issues with balance billing—a huge concern with employees who earn modest incomes—and ensured more accessible, high-quality care that is 100% funded by Horizon.

The previous arrangement with a hospital-owned primary care network via RBP had been a big source of dissatisfaction for employees. "The hospital network had been very difficult to work with, but when we switched to the direct primary care network, it was a completely different experience," said Plotner, who was among the first to try it out. She appreciated being able to set appointments online and communicate with her physician via text and a virtual meeting platform to address minor issues that didn't require an in-person visit, such as addressing a rash her son developed. "I didn't have to wait in line at a clinic or at the pharmacy—it's removed all those barriers," she said.

One plan member echoes Plotner's observation. "It's a phenomenal service. I was able to connect with the doctor for prescriptions, lab work and medical records transfer. He's very down to earth—and he gets it," she said. Another member reported that the experience made her feel as if she was truly being "treated as a person, not just a patient."

Fortunately, in designing and implementing its DPC plan, Horizon was able to collaborate with and obtain guidance from a large employer in the region that had a decade-long history of using DPC. But putting the program in place, Plotner recalled, still involved numerous phone calls and extensive negotiations to get the provider network in place.

Addressing the challenges

Although the move to a fully self-funded plan has delivered major savings and significantly improved benefits for employees, Horizon Goodwill experienced a few bumps along the path. First, Plotner had to convince the leadership that both the financial and employee impact of making the switch would be

manageable and would ultimately pay off. "This wasn't a decision I could make on my own and just deploy, of course. So we had multiple seats at the table as we developed and implemented the new plan," Plotner said.

Educating the employees proved even more challenging initially than expected. Most of Goodwill's staff had a poor understanding of health benefits generally, so helping them understand how the changes would occur, why the new plan was different, and how it would affect their care-seeking activities—and numerous meetings. "A lot of our employees find benefits confusing, so when we started making these changes, we began holding mandatory meetings and spent time breaking down the benefits so that people really understood them," Plotner said. Horizon also sent out regular written communication and incrementally surveyed employees to gauge how the new plan was being received. It was, as Goodwill's advisor put it, a matter of "having those conversations all year."

Taking a multi-pronged approach to reducing Rx costs

Carving out the pharmacy benefits and moving to the new PBM, which Horizon Goodwill compensated solely on administrative charges, also caused some ripples initially because the changes, although positive, were extensive. Horizon introduced mail-order options for employees' maintenance medications and sourced internationally for some high-cost drugs. It also helped eligible employees who needed very expensive brand medications enroll in the manufacturer-sponsored patient-assistance programs to get their medications at low or no cost.

The company also put in place a pharmacy concierge to help employees identify the best and most cost-effective option for their medications, while also implementing a sort of pharmacy safety net: assuring employees that Horizon would ensure access to all needed drugs and that even if layoffs occurred, employees wouldn't lose access to their medications. This commitment,

arranged by uncoupling member access to medications from the employer, was a major comfort to Horizon employees, Plotner said, when the pandemic hit. Overall, the patient-assistance programs Horizon has been able to tap for employees have saved a large sum for the company and for employees.

In the end, the self-funded plan has been a big win for Horizon's employees and continues to produce further savings. In 2022, the company's PEPM decreased by 21.2%. In the past, Plotner said, many employees didn't even get primary care at all, and now enrollment in the direct primary care offering has been steadily increasing. Likewise, the RBP strategy has enable many employees to obtain the specialty care they need closer to home, rather than driving to Baltimore as many had to do with the previous carrier network, Plotner said.

I'd never heard of a self-funded plan before we started looking at options to reduce costs. But as we worked with our advisor and his team, I found that we would be able to get the high-quality services that we wanted at a better price—providing more benefit to our members while keeping premiums and deductibles low."

– Meykala Plotner, Horizon Goodwill HR director

CASE STUDY:

Kenny Pipe & Supply

Employer:	**Kenny Pipe & Supply Inc. (KPS) Nashville, TN**
Health Rosetta Advisor:	**David Johnson, Alera Group**
Industry:	**Plumbing Fixture and Trim Manufacturing**
Sector:	**Private**
Client size:	**130**
Employees on plan:	**128**
Total lives on plan:	**290**
Plan funding:	**Self-funded**
Case study:	**7/1/2017- 7/1/2020**

Client testimonial

"Alera Group is a partner of Kenny Pipe & Supply. You understand us, our benefits, and our goals, and help us reach them. It's valued and appreciated."

– Jerry Drennan, CFO, Kenny Pipe & Supply

KEY RESULTS

Employee	Employees have	Savings of
$766k	**$0**	**$1,964**
Savings over 3 years or $5,892 savings Per employee	Deductible when choosing high quality providers	Per Employee Per Year (PEPY)

Kenny Pipe & Supply Inc. (KPS) is a family-owned wholesale plumbing, pipe, and valve distributor based in Nashville, Tennessee. The company had been on a self-insured plan for a number of years; however, with an aging population and growing company the health plan began to see its healthcare costs

spiraling out of control without any roadmap or options from their previous broker and ASO carrier. In 2016, Kenny Pipe was facing a 50% increase to employees if a change wasn't made.

The company had three main goals:

1) Improve quality of care and appropriateness.
2) Reduce costs for employees.
3) Reduce overall plan cost.

Approach

David Johnson of Alera Group began working with Kenny Pipe & Supply in July 2017 after educating the employer on other options to reduce health-care costs, improve care outcomes and take back control of their health spend. Kenny Pipe & Supply was in a carrier-controlled, self-funded plan prior to Johnson's involvement. In this model the plan was not actively managed and health spending was rising year over year with no end in sight.

Johnson worked with the Kenny Pipe & Supply benefits team to evaluate the uncontrolled prices, population needs and overall risks of the plan. In 2017, David helped Kenny Pipe & Supply transition into a benefits captive to help mitigate the effects of rising stop-loss premiums.

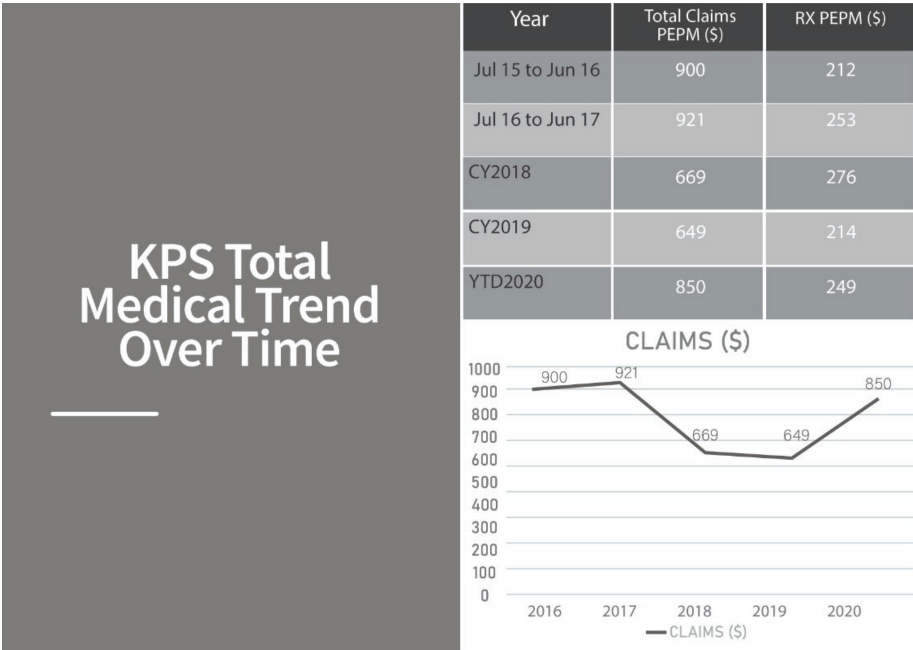
The captive was a good foundational step that KPS took to help stabilize their stop-loss underwriting premiums, but KPS knew they'd have to deliver health care differently to really make a positive and sustainable change for their employees. With a high-priority focus on lowering costs for employees, KPS decided to make the transition, moving away from a traditional network model to a reference-based pricing (RBP) model.

Within the first month, KPS saw health-care prices go down for both the plan and its members. With the transition to reference-based pricing, they pursued a new partnership with a third-party administrator (TPA) that provided a hands-on approach to the plan and for employees.

David and KPS continued to look for cost-saving approaches the following year, identifying a transparent pharmacy benefits manager (PBM), leveraging a specialty drug sourcing solution, and conducting a full pharmacy analysis to identify high-cost claims. These were successfully implemented, saving KPS over $750,000 in health-care costs, allowing the company to reinvest savings back into the employees, and reducing member out-of-pocket spending while improving patient outcomes.

Top-level results

As Johnson continued to educate the organization's decision makers on areas of savings and elements of a high-performance plan, he was able to walk through the current health care spend of their traditional plan and show them a new path forward. He used data to show their current out of control prices at 250%-300% of Medicare rates, while the model he would implement would reduce that cost to 140% of Medicare through a reference-based pricing model. It was an obvious decision to move forward with the RBP model, and it paid off in direct savings, bringing PEPM costs down 27% within the first year.



Year	Total Claims PEPM ($)	RX PEPM ($)
Jul 15 to Jun 16	900	212
Jul 16 to Jun 17	921	253
CY2018	669	276
CY2019	649	214
YTD2020	850	249

Within the first year, Kenny Pipe & Supply saw immediate savings, reducing per-employee-per-month (PEPM) costs from $921 to $669, with an additional decrease in PEPM cost the following year. The following year, Johnson and KPS tackled pharmacy spend, moving to a fully transparent pharmacy benefits manager with a specialty drug sourcing solution, providing a full picture of their pharmacy claims and conducted a pharmacy analysis identifying high-cost claims. This brought PEPM Rx (pharmacy) spend down from $276 to $214.

From 2019 to 2020, KPS hit an unusually high claims year, experiencing five stop-loss claimants, i.e., high-cost procedures or diagnosis (infection complication, cancers and musculoskeletal surgeries). But with a well-managed self-funded health plan, KPS was able to manage the higher than average spend year. Typically, this would be catastrophic to a health plan, however, with the high-performance model in place and a savvy advisor managing the plan, KPS was able to keep costs under what they were paying at their top claims spend in 2016, actively managing their risk.

Health Rosetta dividend

Traditional, status-quo health plans have squandered money at the expense of the employer and employee raises. An actively managed health plan implements cost-saving solutions, reconstructing previously entrapped spending into direct savings for the employer and employees. By transitioning to an employer-optimized plan, Kenny Pipe & Supply has saved over $750,000 in health-care expenditures over three years. In addition, their employees were provided a $0 deductible and $500 maximum copay when seeking care at the highest-quality and highest-value providers. It's been a win for the employer-sponsored health plan and a win for employees.

With KPS's Health Rosetta Dividend they were able to implement a 401k match program, improve the health benefits available to members, reduce employee out-of-pocket costs and contribution costs, and are actively managing their high-performance plan to provide the highest quality care for their members. This puts Kenny Pipe & Supply in the driver's seat to better manage the finances of their business, and retain and recruit employees.

Expect more from your advisor

Johnson worked closely with Kenny Pipe & Supply's leadership to identify a long-term strategy and gain quick wins in the process. With a CFO motivated to manage costs without compromising benefits, Johnson focused on demonstrating the flexibility and opportunities available in an actively managed self-funded plan, versus the existing carrier-controlled (ASO) plan that they were stuck in. He worked alongside KPS' CFO and benefits team providing education, data and support along the way. Together they identified the best approach for KPS, taking into consideration employee education, minimal disruption, a dispersed workforce, reduced cost, and ensuring the highest quality care available. Educating employees on the changes being made with

a hands-on approach was a key component in keeping engagement and plan satisfaction high.

Johnson and KPS are in constant contact around proper and positive means of education and communication to ensure members understand their options and receive the best care. Monthly communications were put in place, along with a direct hands-on approach from the organization's leadership, with employee meetings and opportunities to address employees' questions and concerns.

Johnson and KPS both consider quality of care to be of the utmost importance for its members. They sought out solutions that met the plan's needs to deliver improved benefits at a lower cost with incentives for employees to make smart choices on where they seek care. In addition, employees were provided a $0 deductible and $500 maximum copay when seeking care at the highest-quality and lowest-cost providers; compared to previously incurring a $1,000 deductible each year and a $3,000 maximum out-of-pocket cost to the employee.

In addition, Johnson was able to identify one individual's high drug cost of $10,000 per month. By having the proper solutions in place, the company was able to reduce their spend on this drug to $2,500 per month, saving $90,000 annually, and saving the employee $1,200 per year. Because the plan is actively managed, refinements continue being made as issues arise. This flexibility enables KPS to identify and provide the best quality of care possible as situations change.

CASE STUDY:

State of Montana Health Plan

Headquarters:	**Helena, MT**
Industry:	**Public employees**
Sector:	**Government**
Employees:	**31,000**
Plan funding:	**Self-funded**
Case study:	**2017-2019**

Key takeaways

1. A creative approach and a willingness to both examine all costs and abandon a health plan model that wasn't serving state employees and threatened to break the bank (the plan lost $29 million in 2014 alone) set Montana on a path to developing a bold, innovative approach to cost containment— by using expert advisors and changing its whole contracting model. By 2017, the health plan had bolstered its reserves to $112 million.
2. When Montana discovered that approximately 43% of its health plan costs derived from 11 hospitals, and that those hospitals' prices varied significantly, the state hired an expert TPA and adopted a Medicare-informed pricing model that capped the amount it would pay for any services.
3. Bolstering primary care, by enhancing an existing network of plan-affiliated health centers and eradicating employee copays for services rendered at those facilities, effectively reconfigured the entire services-delivery spectrum.
4. Dismantling its previous pharmacy approach and existing vendor relationships, bringing in an independent

PBM, and steering members toward cost-effective options helped the health plan save 23%.
5. Embracing such wholesale change in a public, government- run entity to achieve cost containment isn't for the faint of heart, but it can be done.

The State of Montana was experiencing a budget crisis in 2015, largely because of runaway health care expense for its 31,000 employees, when Marilyn Bartlett, a longtime health insurance executive with a background in finance, came to the rescue by stepping in as the state's health plan administrator. The trajectory was clear—and alarming. The state's health plan, self-funded through employee contributions, had lost $29 million in 2014 and its reserves were in the red by $9 million, putting it on a path toward insolvency within two years if spending continued increasing at the same rate. The state legislature issued a mandate via legislation: bring the health plan back from the brink by containing costs and restore its reserves to the required balance.

To underscore the urgency, a Senate Bill was enacted that essentially froze employee compensation until the plan could "right the ship," as Bartlett put it. "We had our marching orders from the legislature, the unions and the governor: deal with cost containment and simultaneously secure health benefits and care for the employees."

Identifying costs and cost drivers: challenging but doable

To tackle that very tall order, Bartlett first examined costs—a tough task considering that the state had no data warehouse, and vendors with which the state contracted were reluctant to divulge the requested information. Based on her experience as former controller and chief financial officer of two health plans, Bartlett instead used an actuarial database as a starting point in conjunction with Excel to figure out where the cost drivers existed.

What she discovered was no surprise but was illuminating all the same. About 43% of the plan's costs were in hospital facilities, primarily centered in 11 larger facilities and only 13% in smaller critical access hospitals. Pharmacy costs tallied at 8% and, interestingly, the state's affiliated health centers, where the bulk of primary care and chronic-condition management services were provided, accounted for only 3% of total costs. Bartlett knew then that one of the keys to cost reduction would be shifting as much care as feasible and medically appropriate to those lower-cost centers. "I really wanted to focus on that," she said, "but I also knew that there would be savings in the pharmacy section."

In Montana's case, one key to unlocking potential savings was in understanding all the "pricing" games that go on in the background in health care. What Bartlett knew was that the so-called discounts that hospitals purport to offer health plans don't really save money but instead serve as mechanisms for obtaining the business and the plan's patient population. She also understood that the whole structure of prescription drug rebates is designed to keep the money in the middlemen's—pharmacy benefit managers (PBMs)—pockets, and that those rebates never make their way to the consumers.

"One thing that's always bothered me is that price, not costs, is the issue," she said. Even if the health plan negotiated deeper "discounts" with particular provider networks or hospitals, for instance, that wouldn't do much for the state's bottom line if prices continued to rise. The key was in pinning down costs and going from there.

That's what Bartlett decided to do, and she faced a veritable wall of resistance because the hospital cost data, hidden somewhere in the hospital's charge master, is not public information. And the details on what happens between the charges and the negotiated discount is similarly hidden from public view—they're confidential and proprietary documents. "So, why would we agree to pay something based on a price," she said, "that we have no control over and is not public? We were in financial trouble. We wanted control over future reimbursement increases."

The key, she discovered, was in finding out what Medicare pays hospitals for its beneficiaries' care and using that data as both a reference point and a starting point for developing a new relationship with the entities that deliver care to state employees. That relationship would be predicated on total reimbursement transparency.

"Our goal was to [structure] Montana hospital reimbursement as a markup of Medicare for all facility services," she said. Even if Medicare, the world's largest payer, obviously doesn't cover all services—pediatrics and maternity, for example—it's a common reference point and its data's availability reveals and potentially overcomes all the differences in billing prices from one facility to the next.

With this knowledge base, Bartlett was equipped to begin negotiating and contracting with Montana hospitals individually and to establish requirements, via legislation, to protect both the plan and state employees—the patients. One requirement was to prohibit any balance billing to patients post care episodes.

Addressing the challenges—one by one

One of the hitches to getting the new plan model off the ground was that Bartlett—or anyone else, for that matter— was not permitted, by virtue of the state's procurement regulations, to build facility networks without going through an RFP process. So, Bartlett created an RFP for a third-party administrator (TPA) to provide network-building services.

The opposition to the state's planned network, which after all would cover a large number of Montanans, was, in a word, fierce. Carriers were opposed because the model would disrupt highly profitable provider networks, and the hospitals pushed back because the reconfigured and newly empowered health plan would disrupt their payment model and force them to lose control of their charge structure. Even legislators, some of whom sat on hospital boards, contested the shift.

"We were very public about what we were doing, and we tried to keep all stakeholders involved. But there comes a point when, if you can't do something through consensus you have to keep your goal in mind and do what's best for the plan," Bartlett recalled.

The state did just that, terminating its existing carrier contract and putting out an RFP for TPA-managed reference-based pricing services. Only one TPA, a local company with national reach called Allegiance Benefit Management, expressed interest and came on board to help the state procure and use the Medicare data to assess the plan's position and to assist with contracting.

After digging into the data, Bartlett found discrepancies between what the hospitals were being reimbursed and what was actually going into their pockets from the supplemental payments they received from the Centers for Medicare & Medicaid Services (CMS) for Medicaid services. She also discovered issues with the plan reimbursing hospital pharmacies for outpatient medications that should have been covered at the plan's contracted rate.

To deal with hospitals' concerns about incurring financial risk and potential losses with the new Montana health plan, Bartlett assured hospitals that they could receive up to 250% of Medicare if warranted, but in most cases no more than that—250% would be the cap. In essence, the plan wouldn't set prices *per se*, but with the cap in place, based on the cost data the state had available, the Montana plan would still save money over the previous arrangement. The state also built in some adjustment time to adapt to the new model.

Ironically, the two hospitals that agreed to come online first under the new arrangement also happened to be lowest-cost, highest-quality facilities in the mix. "Those hospitals really helped us figure out how we would model maternity services and process claims, and our TPA really helped us through this whole process," Bartlett said.

On to the next targets: pharmacy costs and improved primary care

Montana then turned to reducing pharmacy costs, by using a purchasing cooperative and removing its existing pharmacy benefits manager (PBM) from the network after Bartlett discovered that the health plan was getting a bad deal out of the arrangement. That single move saved 23% because the PBM had been benefiting from what's called "spread pricing" (the difference between what the manufacturer charges and what the retail pharmacy charges). Montana also reconfigured the pharmacy structure to be more transparent and to ensure that the state received 100% of any rebates the pharmaceutical company provided. In many cases in the United States, PBMs, which are essentially loosely regulated entities, can pocket high percentages of those rebates.

Further, Montana launched a collaborative effort with Montana independent pharmacists, the University of Montana pharmacy school and the state's new PBM to increase medication adherence among members and help steer patients toward cost-effective options for obtaining their medications.

Those two major initiatives yielded dramatic savings for Montana, even in the first year of the new plan. It saved $7.4 million in the first year alone, significantly whittling the $9 million drain on reserves. At the same time, the plan had also improved its health centers, with help from a third-party vendor, to bolster primary care and entice members to use those services by instituting a $0 copay for preventive services and chronic disease management. Today, the centers have a robust roster of services that include not only clinicians but also health coaches, behavioral health services and exercise physiologists, and chronic disease support services. "We removed any barriers to care access so that members could more easily use the centers, which now serve 73% of our members," Bartlett said. That shift resulted in fewer referrals for specialty services and possibly unnecessary

testing that typically occurred when members obtained services at hospital-owned clinics.

"I think we're seeing this nationwide—that primary care really does need to be the focus. And that one of the best ways to manage costs is to improve patient health by enhancing primary care," Bartlett said.

Racking up the successes

By 2017, just two years into the new health plan initiative, Montana had not only eradicated the reserves deficit but actually bolstered its reserves—to an impressive $112 million. Further, employees didn't have any rate increases and none were projected for the ensuing three years—all without any reduction in the benefits the members had in the health plan. Members also saw no increases in their out-of-pocket expenses under the new plan. In an ironic twist, the plan's savings were at one point used to help bolster the state's General Fund.

"It's a lower-cost plan," Bartlett said, and it's no longer a drain on the state's finances. Quite the opposite, in fact. The initiative has been so successful that Montana has been able to reallocate some of the savings for use in other areas.

> "We were very public about what we were doing, and we tried to keep all stakeholders involved. But there comes a point when, if you can't do something through consensus you have to keep your goal in mind and do what's best for the plan."
>
> *–Marilyn Bartlett,*
> *former Montana state health plan administrator*

CASE STUDY:

Bennett School District

Headquarters:	**Bennett, CO**
Industry:	**Public schools**
Sector:	**Government**
Employees:	**150**
Plan funding:	**Self-funded**
Case study:	**2013-2019**

Key takeaways

1. By switching to a self-funded health plan, Bennett School District was able to slash employee annual deductibles—from $4,000 per family to $500—without skimping on benefits.
2. Since switching to a self-funded plan, Bennett School District has saved more than $1.6 million and cut its spending by more than one third. Two years into the plan, Bennett was the only district in the region that was able to give its employees a raise. It also used savings to improve student resources and give out holiday bonuses.
3. The site-based direct primary care benefit that Bennett implemented with Nextera delivered high employee satisfaction, convenient care and considerable savings to employees— reducing employees' individual out-of-pocket doctor's visit costs by approximately $900 a year.
4. The health plan's claims experience has been so positive—with annual claims dropping significantly—that Bennett has been able to reduce its stop-loss expenditures by 20%.

Several years of successive health benefits cost increases were hitting Bennett School District hard. In 2013, the district's employees were already saddled with a punishing $4,000 annual deductible and, to add insult to injury, the plan was facing a 21% cost increase from its carrier. The escalating costs were cutting into student resources and staff compensation, impairing education quality and causing employees' considerable stress. And there was no relief in sight.

Bennett's approach

Deciding that enough was enough, the district, located about 30 miles outside Denver, embarked on a courageous journey. It abandoned the status quo coverage from a traditional national carrier and pursued self-funding and a multi-faceted cost-saving strategy that encompassed every component of its benefits. With the guidance of advisor Bryan Perry of Peak Benefits, Bennett decided to create a new health plan by first unbundling its benefits and putting them out to bid.

The district also hired an independent third-party administrator (TPA) and independent pharmacy benefits manager (PBM), put in place a stop-loss policy to cover unexpected big-ticket catastrophic claims, and implemented a reference-based pricing strategy that assured the district would be able to cap its expenditures for hospital services. Later, it implemented a direct primary care solution on its school sites that not only saved its employees money but also provided convenient high-quality care for employees and families.

Keith Yaich, the district's chief financial officer, didn't need any convincing that it was time to take a risk and try a new approach. "We had a situation one year when we paid about $1 mil-lion in premiums but only had $180,000 in claims, so we knew self-funding was a solution worth trying," Yaich said. That solution has been so successful, he reports, that Bennett has since been able to "put more than $1 million back into the district's books instead of paying to profit 'Big Med.'"

Although unbundling at first seemed a daunting task— "It was terrifying, actually, because we'd never done anything like this before," Yaich recalled—the district soon found that market forces worked in their favor. Potential services vendors were more than willing to quote on the district's business.

The plan also decided to engage in reference-based pricing (RBP), in which the self-funded entity strikes arrangements in hospital contracting to pay a multiple of (or markup on) the prices that Medicare reimburses for hospital services. RBP is a complicated but effective cost-containment tool, but it's not easy to pull off because of hospitals' concerns about incurring losses, the district found. To alleviate that, the district promised that they would never pay less than what the services cost, and that they would ensure the facilities ended up in a profitable position.

Even though Bennett's contracting efforts were ultimately successful, that's not to say that there weren't challenges. From the start, Yaich had to convince a wary board and superintendent that the self-funding risk was worth taking and that Bennett would be able to provide the benefits its employees needed. Savings with the new plan accrued so quickly, however, that the early naysayers became staunch supporters.

Likewise, employees were initially reticent, fearing access issues and worrying about the unknown. Overcoming that obstacle took time—and a lot of education. The new plan's advisor had to help employees first understand how the status quo works and why it doesn't serve their interests, and to also convince them that their benefits would be stable—that no one would deny a claim, for example. "That was the hardest part—getting them to realize that we were doing this to help them, and that we're all on the same team," Yaich recalled.

Along the way, there were a few hiccups getting the plan into its most optimal form. Bennett had to change TPAs a few times, to get the high-caliber services they needed. And the plan switched its PBM a few years into the new plan. The advisor also had to do a little handholding with local clinics in the beginning to explain how the plan worked and how they would get paid,

to convince them to come onboard. Those "join us" negotiations proved a bit more difficult with the hospitals, but Bennett eventually prevailed there, too, and has since developed a strategy to help ensure that employees seek services from the district's preferred facilities unless those services weren't available or the employee's health condition necessitated going to another out-of-network facility.

One of the huge successes Bennett experienced after it went self-funded was realizing that most prices—even for specialty care—can be negotiated, on the front end or even the back end. In one example, an employee had a claim for cancer treatment that exceeded $200,000. After the plan personnel and Yaich intervened, the bill eventually settled for approximately $30,000. "That actually brought it all to light for me—what goes on behind the scenes in health care [pricing]," Yaich said.

The health plan also had to deal with some balance billing that employees incurred for testing and imaging and adjusted the benefits so that employees only had to meet a $100 deductible for such services. And overall, by educating and guiding employees on how to access cost-effective care options, Bennett was eventually able to structure coverage so that employees who took advantage of plan-preferred services and the district's medical management guidance incurred no deductibles and no copays. Those who opted not to use the medical management services paid a $2,000 deductible—still far less than in the old plan.

"It's really nice to have the flexibility to adjust these things," Yaich said. "We really have control over our plan now. And as the word has gotten around about what we're doing here, we've seen an increase in people who want to join our district."

The district also took an intervention approach on its path toward pharmacy benefits solutions, first empowering the PBM to secure the drug rebates that typically go into a middleman's pocket and sourcing internationally for lower-price alternatives when costly drugs were prescribed. The district also pursued mail order avenues for maintenance medications and had to

directly contract with a few local pharmacies to ensure that employees had convenient access to medications when needed.

The biggest win Bennett has experienced since going self-funded is in its direct primary care services. The district had a number of high utilizers who had been incurring significant out-of-pocket costs for doctor's visits, but those who moved their primary care to the district's onsite direct-case facilities saw substantial savings in addition to highly convenient onsite services for themselves and their families. "We've been able to put $530 back into employees' pockets annually in copays and deductibles," Yaich said.

> "We had a situation one year when we paid about $1 million in premiums but only had $180,000 in claims, so self-funding was a solution worth trying. The [new plan] put more than $1 million back into the district's books instead of paying to profit 'Big Med.'"
>
> ***– Keith Yaich, Bennett School District CFO***

CASE STUDY:

Ashtabula Area City Schools

Ashtabula Area City Schools (AACS) is located in the inner city of Ashtabula, OH, and is the 8th poorest school district in Ohio. The year 2019 was the most costly year in AACS's history and they were struggling to keep up with the increasing cost of providing health insurance.

Employer:	**Ashtabula Area City Schools** **Ashtabula, OH**
Health Rosetta Advisor:	**Bryce Heinbaugh,** **IEN Risk Management**
Industry:	**Public School System**
Sector:	**Public, Union**
Client Size:	**450**
Employees on plan:	**385**
Total lives on plan:	**1,100**
Plan Funding:	**Self-funded**
Case Study Dates:	**8/1/2020- 7/31/2021**

Client testimonial

"During my first contact with Faith (dedicated nurse), I was in Ashtabula County Medical Center, admitted with a staph infection on my foot. The doctors wanted to send me home with I.V. antibiotics. I contacted Faith about doing my 8 weeks of I. V. antibiotics at home or at the hospital daily. She told me that the carrier was not set up to allow at-home therapy at that time. Within two days, Faith was back in contact with me, stating that she had received approval for at-home therapy with a visiting nurse one time per week. Faith has been a valuable asset to my personal health care and also for others."

– Plan Member, Ashtabula Area City Schools

KEY RESULTS

$204 M	20%	$0
In Healthcare savings	YoY Savings	Employees pay nothing for Making smart healthcare decisions

When the city voted against raising taxes to fund rising health-care and educational costs, AACS knew they needed to do something different. Change was needed especially because their population was aging, with a large portion of the employees and families suffering from comorbidities and chronic disease. AACS engaged Bryce Heinbaugh and the IEN Risk Management team (IEN) to design a health plan to address their top priorities:

- Save money for the school district.
- Improve member satisfaction.
- Improve health outcomes.

Approach

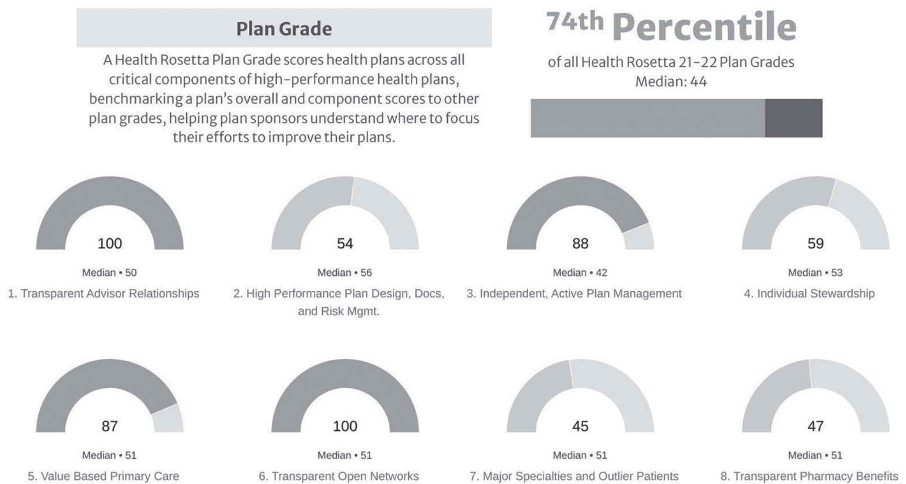
The IEN team introduced AACS and the multiple unions to the proven Health Rosetta strategies used to lower healthcare costs and improve benefits including Health Rosetta principles and case studies from across the U.S. Bryce showed how AACS could follow these models in their community.

AACS implemented a few strategies in early 2020. The health plan was limited in the strategies they could utilize because they were with an Administrative Services Only (ASO) carrier-controlled plan. The carrier was inflexible and did not share meaningful data.

In August 2020, with IEN's guidance and support, AACS transitioned to an entirely open-ended, self-funded health plan allowing them to implement more Health Rosetta components. AACS's new health plan offers:

- Independent partners, including pharmacy benefit manager, a local pharmacy, and third-party administrator to manage their plan
- Direct primary care
- Diabetes management solution
- Centers of Excellence (COE)

These programs pair with the support of concierge nurse navigators who quarterback the care journey of the employees and families for better management of comorbidities and chronic diseases.



Top-level results

As a result of implementing these proven Health Rosetta strategies, AACS's plan saved over $2.4 million in just under one plan year. That's a 20% year-over-year savings. And the disease state of the population has already improved.

AACS received a renewal from their carrier-controlled plan May 2020. AACS was ready to move to a Health Rosetta plan in August 2020 that immediately reduced their costs from $13.2 million to $12.5 million just on changing the plan infrastructure and putting AACS in the driver's seat to offer better benefits at

a lower cost. AACS continues to reduce their total spend, save employees money, and connect with the right independent providers to create a win-win-win scenario for the greater Ashtabula community.

AACS took the time to educate employees and their families about the improvements incorporated into the new plan, reminding them that not only were their benefits better at a lower cost, they had upgraded support from dedicated nurses to help them with their health journey. While change was a challenge for members and the employer, the plan believes all members received the care they needed through the transition because there haven't been any claim-denial grievances.

For the 2021-2022 year, the AACS was short $2 million in the operating budget. Again, voters declined to approve increased funding. It was only because of the new health plan that AACS avoided making any cuts.

Expect more from your advisor

The AACS's back was against the wall and needed to lower healthcare costs sustainably to avoid detrimental long-term cuts to AACS's operating budget.

Heinbaugh and the IEN Risk Team continued to educate the AACS leadership team on proven Health Rosetta principles. Bryce shared many case studies (like this one) that were happening across the United States and demonstrated to AACS it was far riskier to stay in their current plan.

They continued to get buy-in and thoroughly educated the superintendent and the union health-care committee, which helped lead the change effort and communicate to union members the value of the new plan. They recorded video messages and kept proactively communicating with teachers and staff to ensure that they understood the changes and opportunities in the new Health Rosetta-style health plan. An effective and inspiring video showed Heinbaugh and the IEN Risk Management team in front of a historic house in Ashtabula demonstrating that IEN

is a local business and a committed supporter of the Ashtabula community.

After making the full plan change in August 2020, the initial transition was rocky, but the IEN Risk Management and school leadership teams continued to rise above to serve employees and their families.

There are many stories to show the success, and one about a plan member who needed a $200,000 kidney transplant stands out. Through the new plan the patient was offered the assistance of a dedicated nurse to help them through this emotional time. The nurse was able to identify that the plan member could receive this benefit through Medicare and scheduled an appointment at a top Center of Excellence where all the care could take place and be covered for the member. The plan was able to save, the member was able to save, and, above all, the member had a better healthcare outcome and journey as a result of the new benefits.

AACS is now in the driver's seat as they continue to provide better benefits at a lower cost, helping to sustain their operating budget and improve employee satisfaction and morale. Employees know that the AACS has their best interests at heart. They continue to have free access to a dedicated nurse team, local direct primary care, local independent pharmacy and more. This is not only a case of how an employer can save money and improve benefits, but a story of how a local community came together around a shared goal and changed its destiny forever.

CASE STUDY:

City of Milwaukee

City slashes health-care costs by improving benefits

By John Torinus

Because the economic pain of out-of-control medical costs is so high and federal government reforms are so slow, school districts, counties, and municipalities are moving on their own to find savings across the four major platforms for containing health care spending: self-insurance, consumer-driven incentives and disincentives, onsite proactive primary care and value-based purchasing.

The city of Milwaukee, WI, with 6,500 employees, is one spectacular example. The city has held its health care costs *flat* for the last five years, stopping its previous hyper-inflationary trend of 8%-9% annual increases. Milwaukee spent $139 million on health care in 2011 before switching over to a self-insured plan in 2012. Costs dropped to $102 million in 2012 and have stayed at about that level ever since—even in the face of 6% annual inflation for employer plans nationally over the same period.

If the old trend had continued, health costs for 2016 would have been about $200 million, double what they actually were.

Instead, the cost savings have had many additional positive ramifications: raises for county employees, no layoffs, flat employee premium contributions, better health outcomes for employees and their families, improved productivity, lower absenteeism, and less pressure to raise taxes.

Michael Brady, benefits manager, led this intelligent management approach in close collaboration with the mayor, city

council and unions. As with other enlightened group plans, there are many moving parts. Here's a sampling:

- An onsite wellness center and workplace clinic, headed by nurse practitioners, has sharply reduced hospital admissions. Onsite physical therapy was added last year. These services are free for employees and spouses.
- Relatively low deductibles (now $750 per single employee and $1,500 per family) were implemented to create a consumer-friendly environment.
- Coinsurance was set at 10% for members who use United Healthcare's Premium Provider program, which uses only doctors designated as top doctors by UnitedHealthcare. Coinsurance is 30% for providers outside that group. This tiered approach, aimed at improving health outcomes, is a form of value-based purchasing.
- Participants in the city's wellness program can earn $250 in a health account. Good progress has been made on hypertension and smoking (now 12% vs. the U.S. average of 14%), but, as seen with other employers, there has not been as much traction on obesity. There have been some improvements on chronic disease management of diabetes.
- While workplace wellness programs typically have no or negative ROI, approaches that use solid clinical evidence to address costly chronic illness and
- procedures without encouraging overtreatment are sometimes lumped into the same category as typical workplace wellness programs. However, they are highly different in goals, execution and results.
- A $200 ER copay has cut non-urgent ER visits by 300 per year.
- An intense program to reduce injuries, started in 2008, has resulted in 70% drop-in work hours lost to injury. The program has saved $10 million per year compared to the previous trend line.

- Milwaukee now spends about $15,000 per employee per year, well below the national average and not too far off the $13,000 at the best private companies.

Government entities are not known for bold innovation, so this track record is an eye-opener, especially in a unionized environment. "The results," said Brady, "are nothing short of amazing considering changes in the city's workforce demographics and the challenging environmental hazards that city employees regularly face."

These changes have taken place at the same time that the nation as a whole has experienced much more disappointing progress from federal reforms (e.g., much higher deductibles for plans sold on ACA exchanges, double-digit premium rises for employers in many states, and a cost to the federal government of about $5,000 per subsidized plan member per year).

Clearly, most of the meaningful reform of the economic chaos from health care in this country is coming from self-insured employers, like the city of Milwaukee.

John Torinus is chairman of Serigraph Inc., a Wisconsin-based graphics parts manufacturer, and author of The Company That Solved Health Care.

CASE STUDY:

Pittsburgh (Allegheny County) Schools

Investing in kids while ensuring teachers receive better care

Bucking old habits that are devastating education funding elsewhere, forward-looking teacher union and school board leaders in Allegheny County, Pennsylvania, are proving that it's not really so difficult to slay the health-care-cost beast and save their kids' future—even in an expensive and contentious health-care market. Understandably, unions want their members to be compensated fairly and to keep schools from being decimated. Recognizing that they share the same goals, the school board decided to take a new approach.

Assuming the current trend continues, kindergartners entering Pittsburgh-area schools will collectively have $2 billion more available to invest in education and services over the course of their school years than their counterparts across the state in Philadelphia. In Philadelphia, schools pay $8,815 per member for teacher health benefits. The Allegheny County Schools Health Insurance Consortium (ACSHIC), with 48,000 covered lives, pays $4,661 per member, $199 million less per year. Class sizes in Pittsburgh are 30% smaller, teachers are paid better with better benefits, and there are four times as many librarians.

Rewarding wise decisions

Jan Klein, ACSHIC's business manager, describes a model that is very consistent with the Health Rosetta blueprint. In a nutshell, they make smart decisions free or nearly free (e.g., primary care is free, and going to high-quality care providers

involves very low or no copays or deductibles) and poor decisions expensive e.g., paying more to see higher-cost, lower-quality care providers). It's a much more subtle, yet more effective, strategy than blunt-instrument, high-deductible plans that often lead to deferred care, bankruptcies, reduced teacher compensation, fewer arts programs ... the list goes on.

The consortium is managed by 24 trustees, equal parts labor and management. When consultants attend consortium meetings, they often can't tell who is who. Many times, union leaders are more aggressive in pushing forward new initiatives. While other employers have blithely accepted 5% to 20% annual health-care cost increases, the consortium spent $233 million in annual claims in 2016—down from $241 million in 2014. The consortium is able to manage their costs without any stop-loss insurance because they have control over what they call their benefit grid, a program that was defined and embraced by both union leaders and teachers.

They've accomplished this, even though care-provider-organization consolidation in Western Pennsylvania has reduced competition and raised health-care costs with little to no improvement in quality of care—and despite an ongoing war between the largest hospital, the University of Pittsburgh Medical Center (UPMC) and the largest local insurance carrier, Highmark.

Understanding that the best way to spend less is to improve health care quality, ACSHIC found that the path began with the following steps:

- Educating consortium trustees on quality rankings of hospitals, including sending them to a Pittsburgh Business Group on health forum.
- Retrieving hospital quality data through third-party data and tools (e.g., Imagine Health, CareChex and Innovu).
- Validating vendor information by confirming that it was not influenced by bias.
- Selecting the most effective resources by identifying credible partners/vendors.

Once educated, the trustees provided the following direction to the team developing the new school district health plan:

- Use quality measures from respected third-party sources.
- Create tiered products so people are free to go wherever they want for care—but they pay more if they choose sites that have lower quality and value.
- Focus on ease of access to regional clinics and hospitals.
- Focus on the relationship between cost and quality (the former turned out not to be indicative of the latter).
- Educate members, especially about why the local academic medical center was placed in a high-cost tier (it wasn't the highest-quality facility for many kinds of care).
- Address member concerns (e.g., will this really save money?) through continuous communication.

Results

Health care purchasing before (October 2013 - September 2014)

# 1 Hospital in the region (highest quality rating)	#23 Hospital in the region (low quality rating)
33,352 Services*	31,047 Services
293 Admits	362 Admits
$4,941,146 in total costs	$15,089,972 in total costs

**Services include imaging, lab tests, outpatient procedures, etc.*

Intervention to improve value: tiered benefit offerings

- The enhanced tier has no deductible and pays 100% of hospital charges.
- The standard tier has a deductible and pays 80% of hospital charges.

- Out-of-network care has a larger deductible and pays 50% of hospital charges.
- Lower cost and higher quality is determined by third-party, independent benchmarks.

Health care purchasing after (October 2015 - September 2016)

#1 Hospital in the region (highest quality rating)	#23 Hospital in the region (low quality rating)
40,046 Services (up 20%)	6,620 Services (down 79%)
328 Admits (up 12%)	113 Admits (down 69%)
$7,170,357 in total costs (up 45%)	$5,548,832 in total costs (down 63%)

**Services include imaging, lab tests, outpatient procedures, etc.*

In sum, the consortium reduced hospital spending by $7.36 million, a 36.8% reduction.

Going forward

The consortium expects to continue enhancing benefits with only a very modest premium increase of 1.9% for members. Here are a few plan attributes going forward:

- The enhanced tier has no deductibles.
- Primary care visits have no copay.
- Specialist visits have a $10 copay.
- There’s an employee assistance program provider.
- There’s a second opinion service.

Their determination to serve kids led education leaders in Pittsburgh to move past tired assumptions about labor and management being forever at odds over health benefits. With any luck, their steely resolve in the face of local challenges will

inspire teachers' unions and school boards throughout the country to say "no" to health care stealing our kids' future. Imagine how much better schools would be if every school district replicated Pittsburgh's approach.

If you are a parent or community member, share www.healthrosetta.org/schools with leaders in your local schools for this and other examples of success. You can find calculators on how avoiding wasted health care bureaucracy can allow for health and well-being for our future and kids.

CASE STUDY:

DeSoto Memorial Hospital

Advisory organization:	**Mitigate Partners**
Headquarters:	**Arcadia, Florida**
Industry:	**Hospital**
Sector:	**State Hospital District - Governmental, County**
Client Size:	**220 employees**
Employees on plan:	**160 employees**
Total lives on plan:	**318 covered members**
Plan funding:	**Self-funded**
Case study:	**10/1/2018 through current**

Key takeaways

1. Reduced health-care spending by 54% or $1.2M by implementing solutions that have been recognized and endorsed by the Health Rosetta. PEPY costs started at $14,000 and are currently running at $6,000 PEPY.
2. Stop-loss provided proactive discounts for the proposed model, equating to a 58% discount in year one, translating into a $150,000 reduction in stop-loss premium.
3. DeSoto was able to reinvest the dividends saved through the health plan into lowering employee contributions and improving plan benefits and member experience, a fundamental component of Health Rosetta-centric plans.

Testimonial

On experience with Health Rosetta Advisors and Mitigate Partners

"We were introduced to Carl Schuessler and Barry Murphy by Dr. Lee Gross from Epiphany Direct Primary Care and immediately realized that Mitigate Partners had the answers to questions that others were afraid to ask. Today's health insurance Environment is designed with one goal in mind: maximize profits for the insurance companies.
No one in the traditional health-care industry wants to truly reduce the cost of health care for the patients. However, Mitigate Partners has built a 'better mouse trap'—The FairCo$t Health Plan utilizing some logical principles that everyone can agree upon: cut out the middleman, minimize administrative costs, pay cash at the time of service, and look for the best quality. The mainstream health-care providers are not concerned about the cost to the patient; they are only concerned about keeping as much of the patient's premium as they can by creating endless trails of administrative hurdles before authorizing a necessary service."

– Vincent Sica, CEO, DeSoto Memorial

On direct negotiation

"It's amazing how much hospitals will discount the price of something if they know they will be paid at the point of service."

–Vincent Sica, CEO, DeSoto Memorial

On member advocacy

"It was blowing my mind when they turned around and said the medical advocate program would do everything for you."

– Jason Newton, Stroke Coordinator, DeSoto Memorial

On the improved benefits

"The benefits we have at the ho11s1pital are more so focused on the employees…I have gone through the process of an estimated cost of

$42,000. What did I pay? Absolutely nothing. So, before I was paying all that money on my premiums, I never used the plan because I was reluctant. I have this copay, this deductible. We don't have those issues. Every concern I have had since day one of this plan, I have addressed, and I have taken care of this year, and I have paid absolutely nothing out of pocket. We deserve that. I know I do."

–Hannah Barbera Johnson, Register, DeSoto Memorial

On dividends

"The less we have to spend on the plan, the more we are able to put back into salaries, back into maybe additional benefits or increasing benefits."

–Lois Hilton, HR Director, DeSoto Memorial

After hearing about how Mitigate Partners was significantly reducing health insurance costs for our current employers, Patient Rights Advocate (PRA asked if they could capture our clients' success stories. PRA has been creating videos to showcase how real price transparency and direct contracting are lowering costs for innovative employers nationwide. The group has shared videos with the U. S. Department of Health and Human Services (HHS leadership and the White House Administration to highlight successful price transparency models in action and to support the need for real transparency.

Please take a minute to view the DeSoto Memorial videos below by clicking the links to see how Mitigate Partners are significantly reducing employers' health care costs while improving employees' clinical outcomes:

- Learn how they saved 54% or $1.2 Million in their Health Plan
- DeSoto Memorial Hospital Employee, Hannah Johnson, shares her Healthcare Advocate Story

Client Background

As a small 49- bed hospital, even though DeSoto Memorial had a self-funded health plan for their employees, costs continued to increase year after year, eventually reaching $2.2 million, and they knew they had to do something different to change their trajectory. DeSoto Memorial Hospital has 220 employees in rural Arcadia, Florida. Prior to changing plans, they were overspending on their health-care benefits jeopardizing employee retention, allowing waste in the system, and not capitalizing on their own core business for their employees, providing quality health care. They also had to eliminate obstetrics because of budget constraints, requiring local residents to drive over an hour for routine deliveries.

DeSoto had many challenges confronting them:

1. 4th poorest county in Florida.
2. 2nd lowest median family income in Florida
3. Lost Obstetrics in February 2018.
4. Foreign medical expenditures averaged 79% the last 4 years prior to 2019, and employees were choosing to get their care at competing facilities rather than at DeSoto Memorial.
5. $2,178,562 total medical/Rx spend ($482,159 Rx)

In 2018, DeSoto was introduced to Carl Schuessler, Jr., DHP, DIA, GBDS, and Barry Murphy, CLU, ChFC, with Mitigate Partners, a fee-only consulting firm with a mission to custom design a health-care strategy to reduce costs for the employer and employee, and improve benefits for employees, all while realizing better clinical outcomes for plan members.

By using the Mitigate Partners' FairCo$t Health Plan design, DeSoto was able to capitalize on direct contracting, add direct primary care (DPC), institute member advocacy for an improved patient experience, and include a suite of cost-containment

partners to reduce all levels of health-care spend. Upon execution of the plan, DeSoto realized over $1.2 million in health plan savings (54% in the first year). DeSoto was able to reinvest those savings into their employees.

Approach

The crux of the DeSoto Memorial Hospital success story and the heart of the Mitigate Partners formula is going directly with provider and employer contracting. Schuessler simply addresses this as "cutting out the middlemen. Hospitals are very familiar with these types of negotiations, but often neglect to utilize this. strategy for their own employee plan. Once the hospital brings these benefits together for their own staff, there is a tremendous opportunity to replicate these solutions to the employer groups in the community that the hospital serves, enabling employers to replicate the hospital's success.

Vince Sica articulates that the "two prongs of payment utilized to actually reduce the cost of health care" include direct primary care and bundled cash pay.

- Direct primary care (DPC) charges a monthly membership fee paid by the hospital and members, and their covered dependents are welcome to visit and/or call their physician as many times as they like with no out-of-pocket charges. Basic lab work, telemedicine and prescriptions are managed by the DPC in addition to referrals to specialists as needed—without copays. Dr. Lee Gross of Epiphany Health Direct Primary Care, who leads DeSoto's DPC strategy, explains it this way: "DPC has eliminated the need to use insurance to access primary care. We are forever changing health care delivery. We are eliminating barriers to access, improving efficiency and communication, adding price transparency, managing the referral process and restoring sanity to health care."

- Bundled arrangements exist when a provider agrees to access a certain amount for all the services associated with a medical procedure in return for prompt payment. Bundled payment arrangements are also designed to pay multiple providers for coordinating the total amount of services required for a single, pre-defined episode of care. Schuessler shared an example of a cash knee replacement surgery that was priced at $70,000 by a local facility but was negotiated down to $25,000 with cash payment and upfront reimbursements.

DeSoto also added a medical advocacy program which identifies the right appropriate doctor and/or provider and directs members to those providers with top quality outcomes at the appropriate price and at the right time of the member's medical journey. This advocacy program not only eliminates waste in-herent in the system, but also improves the experience of the member while reducing overall costs.

The FairCo$t Partners also communicate on each members' care utilizing The Integrated Coordinated Care Board (IC2) in a HIPAA-compliant setting. This platform allows for seamless, integrated care versus the current siloed approach prevalent in today's health-care delivery system.

In addition to several other cost-containment initiatives that are integrated into the FairCo$t model, Schuessler spends time developing a stop-loss protection plan customized to address the new projected risk of the plan. Stop-loss is often a last thought in health-plan design, but by properly integrating the stop-loss solution with the custom plan design, the stoploss partnership becomes a key element in pricing innovation for self-funded plans.

Recognizing the likely impact of the FairCo$t approach combined with DPC, DeSoto was able to have their premium reduced by 58%, or a $150,000 discount on their stop-loss premiums.

Some of the key contract terms in DeSoto's medical stop-loss policy that should be considered for all self-funded clients

include: A+ Superior rated paper to ensure financial solvency and claims reimbursement.

a. Experience in the cost-containment programs that DeSoto incorporated to optimize proactive discounts for the proposed model and solutions.
b. Stop-loss policy that follows the underlying Summary Plan Description (SPD).
c. No New Laser and Specific Advance included as a package.
d. Incurred contract terms for extended run-out protection.

The plan architecture and stop-loss savings were critical to DeSoto's success, but the collaboration of the FairCo$t solution partners is also credited with the impressive outcomes. Schuessler organized a solution partner planning meeting to foster collaboration on all facets of the custom design to construct the vision of DeSoto's health plan.

Lois Hilton, DeSoto HR director, describes the strategic planning meeting that went on for five hours: "We built this plan as a team, with the TPA, Dr. Gross, our reinsurance carrier, etc. I do not think I ever met a reinsurance carrier representative until that day. For all our partners to sit at the table to listen how we were building the plans, and how we were implementing the safety measures for employees and cost control—for everyone to come in with the reduction in costs was amazing. Although it was time consuming, it was very worthwhile and very rewarding."

Top-level results

Three years into the execution of DeSoto's new plan design:

- Relocalized Care = Neighborhood Healthcare
- Removed all barriers to care.

- Since inception in 2019, DeSoto has never raised their premiums or employee contributions.
- DeSoto employees continue to enjoy no out-of-pocket copays and no deductible when they follow the directed care plans.
- $150,000 savings (58%) in stop-loss premiums with Rx in the aggregate. (Rx wasn't included at the outset.)
- Improved benefits for much less cost—a "weaponized" plan design.
- Reduced foreign medical spend to 62% from 79% in the first year—and currently at approximately 45%.
- Hired first full-time surgeon in county history.
- First year renewal rate decreases of -3.2% stop-loss and -14% on aggregate funding factors.

Medical expense per employee per year (PEPY) when hired was $13,852:

- 2019 medical expense PEPY = $4,549
- 2020 medical expense PEPY = $5,595
- 2021 medical expense PEPY = $7,294

The DPC 3-year averages:

	DPC	Non-DPC	% Difference
Paid by plan PMPM	$350.83	$569.28	38.6%
Total Out Of Pocket PMPM (Copay, Coinsurance, deductible)	$44.55	$64.73	31.2%
ER visits per 1,000 members	250	411	39.2%
Specialist spend PMPM	$8.84	$12.48	29.2%
PCP spend per visit	$58.70	$72.42	18.9%

Moving forward: Next steps

Because the local hospital fully understands and has taken the steps to actively manage their own benefit program, they can assume a leadership position in redefining healthcare in their community. What a novel idea! Those providing services talking directly to those in need of services without interference from those who profit by keeping the system dysfunctional.

By openly and directly talking with community leaders about common needs and solutions, it is possible to create a new dynamic where the needs of all can be more effectively addressed. Hospital leadership is in the process of gathering the leaders in County and City government, the School Board, and the Sheriff's department to work together for the greater good for all. Once this community platform is established, private employers can be invited to join.

Mitigate Partners is in a unique position to facilitate such a conversation.

CASE STUDY:

ETEX Telephone Co-Operative

A Texas fiber and telecommunications provider joins the local health care movement

Charlie Cano, CEO and general manager of ETEX, a large largest telecom co-op in Gilmer, Texas, that provides internet, phone and TV for more than 13,000 customers and numerous school districts in northeast Texas, is an engineer by trade. He is accustomed to understanding how things work, but when it came to health insurance, he was totally confused by hidden fees, high-cost pharmaceuticals and constant rate increases.

Paige Mendez, an Employee Benefits Consulting, LLC (EBC) team member who previously worked at the third-party administrator that manages ETEX's benefit plan, recommended that Cano consider another approach to benefits. Mendez introduced Cano to Rachel Means, EBC's CEO, who founded the Tyler, Texas, firm in 2016. EBC's objective was to break away from predatory insurance practices and start an advisory group that would provide health plan members with the highest-quality, most affordable care.

In an hour-long meeting, Means took answered each and every one of Cano's questions, demonstrating a transparency he hadn't experienced from any other advisor. Means told Cano about hidden commissions, fees and other wasteful spending in his company's plan. By the end of the meeting, Cano was convinced that Means could help him achieve his goal of creating a better health plan—one that his 150 employees deserved.

Localizing care

The first thing that Means did to reduce ETEX's health expenditures was to replace its pharmacy benefits manager (PBM) with one that was more transparent. Means pointed out the pain points in ETEX's health plan, much of which came from several high-cost medications plan members were taking. Cano, like many employers, believed that the billed prices of medical services and drugs were final, non-negotiable and due in full. Means helped Cano realize that there is always room for negotiation and that employers have the power to create strategies to find lower prices while still providing employees with the care and medication they need.

Specifically, Means helped Cano find alternative drug suppliers that cut out inflated drug costs and administrative fees. Switching to a fiduciary PBM and sourcing prescriptions from manufacturers and low-cost, local pharmacies slashed ETEX's pharmacy costs by 50% and had the added benefit of supporting Means' and Cano's local community. These changes have reduced per employee per year (PEPY) medical and prescription costs by $5,743 annually since 2017.

Means continued to seek out local, affordable health care options for ETEX's primary care services. She set up contracts with direct primary care (DPC) physicians and imaging centers in the northeast Texas regions of Longview and Tyler. ETEX health plan members now have $0 out-of-pocket costs for X-rays, CT scans, MRIs, minor emergency room/urgent care visits and primary care appointments. Members even have access to $0-cost diabetic supplies, like insulin, pumps and meters, plus no-cost hormone replacement therapy.

DPC a win for employees and their families

When ETEX employees and their families visit their DPC physician, they don't have to sit in a waiting room for half an hour or more for their appointments. Because the DPC model is

based on a membership fee, physicians have more time to listen to patients without time constraints or the pressure of hospital referral quotas to meet. ETEX health plan members enjoy a better patient experience with better outcomes and no out-of-pocket cost.

These changes have not only resulted in better benefits, but also a total savings of $2.5 million in three years. ETEX has seen $863,000 in year-over-year savings since 2017.

Employees now have access to $0-cost high-quality health care, and Cano has used a portion of the savings to give employee bonuses. ETEX's turnover rate has decreased and Cano has noticed that employee morale has increased since implementing these additional programs. Better health care benefits have made ETEX more competitive and attractive to potential hires—so much so that Cano now has a waiting list of candidates who want to work for ETEX.

The ETEX success story shows why providing employees with better, more affordable care using local providers is a win-win for you and your community. Big carriers and profit-focused PBMs harm local pharmacies and physicians, and by extracting them from employers' health plans the way Means did for Cano, businesses not only save money but potentially save their local community.

CASE STUDY:

R. E. West Transportation

Headquarters:	**Ashland City, TN**
Industry:	**Transportation**
Sector:	**Logistics**
Employees:	**140, 95 on health plan**
Plan funding:	**Self-funded**
Case study:	**2019-present**

Key takeaways

1. When R. E. West faced a punishing 25% health premium renewal increase for 2019, with no improvement in benefits and a staggering projected total cost of more than $850,000, the company moved to a self-funded plan and unbundled its components, employing direct contracting for all services.
2. Just one year into the new plan, the company had already saved 15%—$102,000—and was on track for an additional 10% cost reduction in year two. At the same time, employees had richer benefits and lower out-of-pocket costs, including $0 copays for some services, procedures and medications.
3. Employee education and communication, predicated on a comprehensive information strategy and frequent information sessions—were hugely important in both securing buy-in for the new plan and in keeping employees up to date on developments that affected them and their families.
4. By implementing hands-on benefits navigation services using a concierge team, R. E. West employees receive

expert guidance on making informed, cost-effective health care choices.

Even before the COVID-19 pandemic hit, R.E. West Transportation was having difficulties keeping its staff and attracting new talent in part because of its uncompetitive benefits. The five-decade-old, family-owned company, based in Ashland City, Tennessee, operates in 16 states. R. E. West has a long history of taking a progressive approach in its business. That mindset wasn't working when it came to its health plan because of external factors outside its control—namely, an inability to contain its skyrocketing health benefits premiums despite being relegated to mediocre coverage through a national carrier.

The company's health plan woes reached a crisis point a few years ago, when the R. E. West learned that it would be facing a 25% premium-cost increase in 2019 coupled with a further reduction in benefits quality, for an employee population that knew well that the plan was sub-par and too expensive. That increase, especially given that R. E. West was coming off a stable claims year and impressive no-injuries track record, was a bitter pill to swallow for Jenny West, the company's CFO.

"Company-subsidized health care no longer felt like a 'benefit'—it felt more like a liability. We were looking at an annual cost of more than $850,000 without any plan changes. Our ownership and our employees were frustrated," West said. "Everybody was just worn out from all the bad news." So, when an independent advisor, Alex Dampf of Oakmont Benefits, who happened to be in the area, approached West and asked if the company wanted to consider a new way of self-funding its health plan to save money, she and her brother jumped at the opportunity.

That's not to say that R. E. West was going in blindly. The company, which was battle scarred from previous experiences with a self-insured stint—including a member's organ transplant that almost put the company out of business and forced it onto a low-quality fully-insured health plan—insisted on a double dose of due diligence as it proceeded. "We were incredibly

nervous about going self-insured, and our past experience really informed this new one," West said. "It was definitely a leap of faith." Making the bold switch also required sometimes fraught discussions with company executives and employees who were anxious about abandoning the status quo, however poorly it had served them.

Starting over with a fresh slate

R. E. West, with Dampf's help, developed a self-funded initially captive health plan that first unbundled coverage components and then utilized reference-based pricing (RBP) in hospital contracting and bundled fixed fees for surgeries. Dampf also built transparent open provider networks, created a customized pharmacy benefits plan and added stop-loss coverage for peace of mind.

As a value add, the company incorporated a benefits-navigation concierge to guide employees and help them make informed, cost-effective care decisions. The company also began providing telemedicine-based care and launched a comprehensive technology-enabled communications strategy. That communications program helped keep R. E. West employees, including truckers on the road, up to date on all plan developments and allowed for their feedback.

The savings—and the improvements—over the previous fully insured health plan started stacking up quickly. Within a year, R. E. West had saved $102,000 and was on track to save an additional 10% in the plan's second year. And R. E. West also finally had access to its own utilization and cost data, which hadn't happened with the previous carrier—until after the company first cajoled and then threatened to take legal action to obtain its own claims information.

Savings kicked in—quickly

The benefits of the new plan over the previous one, for the employees, were substantial. For example, an employee who needed a dual knee replacement had put off the procedures because he couldn't afford the high out-of-pocket expenses was able to get both surgeries done through the new "bundled surgery" coverage—which includes all associated pre- and post-operative care for a contracted price—at $0 out of pocket.

In addition, by having an expert pharmacy benefits manager working in a transparent pass-through arrangement that served R. E. West, not a carrier and pharmaceutical companies, the company gained flexibility and more purchasing options. For example, using the new sourcing approach, an employee's medically complex son was able to obtain medications that would have cost $40,000 annually before, for less than $20 a month. The self-funded plan included options for buying specialty medications internationally at lower cost and also included a range of commonly prescribed medications that were made available at no cost. Outpatient surgery and imaging services were also fully covered at no cost to employees who utilized network providers, thanks to negotiated contracts with a dozen vendors.

"Almost everyone got a better plan at a lower cost than what they'd had the year before," West said, adding that employees were clearly pleased with the changes.

The comprehensive communications plan that R. E. West developed to keep employees informed about the plan's progress and developments was a huge satisfaction driver with employees and their spouses. In addition to using monthly Zoom meetings, email updates and post mailings, the company also sent updates to truckers using the on-board communications system in the trucks and staged call-in sessions and Q&As on benefits that traveling drivers and their spouses could engage in.

"I think our employees got a lot of comfort from seeing and knowing that their health plan—something that had been bad

for so long—was now a new and positive thing that they knew had been well thought out and put together thoroughly," West said, noting that employees were especially pleased with the richer prescription medication benefit.

R. E. West's health plan still has a $3,000 deductible, but the goal, West said, is to treat the plan like a living document that can continue to be adjusted and improved to deliver more cost savings and meet employees' changing needs. The near-term goal is to keep chipping away at that deductible, West said, and to simultaneously identify more opportunities for $0-cost care for the company's employees. "We're going to continue to buy down that deductible and try to give more value to our people, who we feel have been used and abused," West said, by the broken health care system.

> "Company-subsidized health care no longer felt like a 'benefit'–it felt more like a liability. We were looking at an annual cost of more than $850,000 without any plan changes. Our ownership and our employees were frustrated. Everybody was just worn out from all the bad news."
>
> ***– Jenny West, R. E. West Transportation CFO***

CASE STUDY:

Dann Marine Towing

Headquarters: **Chesapeake City, MD**
Industry: **Marine**
Sector: **Shipping navigational services**
Employees: **200, with 400 lives on plan**
Plan funding: **Self-funded**
Case study: **2017-2019**

Key takeaways

1. Dann Marine Towing faced several years of double-digit cost increases—as high as 35% one year—and was having to raise employees' contributions via deductibles, before it decided to move to self-funding.
2. In the first two years after creating its self-funded health plan, the company reduced spending 25% each year. The savings enabled it to go from a $2,500 individual deductible to $0, and to provide employees low-cost or no-cost access to prescription medications, both generic and certain brand-name maintenance drugs.
3. The health plan navigation concierge service that Dann Marine Towing put in place to help employees explore and select care options has been a huge satisfaction driver—saving them time, money and hassle factor.

Dann Marine Towing, a sixth-generation company, is used to dealing with high-stakes, complex logistics and daunting challenges. Despite managing to remain successful in the highly competitive tugboat industry, the company realized in 2017 that it had met its most significant adversary in its history:

skyrocketing health coverage costs. Several back-to-back big-ticket, double-digit coverage renewals from major carriers—topped off by a whopping 35% increase for 2017—prompted the company to go to a new drawing board: self-funding.

"We had worked with the Blue Cross Blue Shields and Aetnas of the world and for decades, that was how we handled our health insurance. And we were just at their mercy, so to speak, going year after year with the increases they put on us," said Christopher Dann, the company's CFO. "Did they ever come back to us and say, 'you're doing a wonderful job; let's give you a decrease'? No. So, we didn't have much to lose by stepping out on this limb and giving self-funding a shot."

Working with its advisor, Ben Bohonowicz of Employee Benefit Services of Maryland, Inc., Dann Marine Towing (DMT) decided to take the risk and begin self-funding in January 2018. It wanted to get off the merry-go-round of huge increases in carrier market that were threatening the company's bottom line and its ability to keep and attract talent in a competitive industry with a limited supply of marine professionals—and forcing it to offload onto employees an increasingly larger share of the premium costs each year.

Taking an incremental approach

The company started with a reference-based pricing (RBP) strategy initially, and then took "baby steps" toward employing direct contracting and other strategies in remaining plan components. It developed a concierge navigation model to help employees access improved primary care and make better-informed decisions for other needed health services. DMT also added a stop-loss policy that offered more competitive rates based on the company's commitment to aggressive cost-containment efforts.

After only one year of the new model, DMT had saved 25%—reducing its per-employee-per-month (PEPM) cost and reinvesting some of its savings in the plan with the goal of eliminating employee deductibles. That deductible figure, had DMT remained

with the fully insured carrier model, would have been $2,500 for a single employee and $5,000 for a family. DMT achieved the enviable goal of being able to offer employees a $0 deductible and lower cost-sharing.

After this initial success, DMT developed a new multi-part pharmacy benefit, working with an independent pharmacy benefits manager (PBM, that gave employees no-cost access to generic medications and excluded from the plan formulary certain high-cost prescription drugs. That strategy enabled some employees who required those medications to pursue manufacturer-sponsored patient assistance programs, in two instances saving the employer a cumulative total of $95,250 in 2018 and 2019. In addition, DMT began sourcing some medications internationally. Combined, the pharmacy cost-containment initiatives saved the company a significant sum.

The self-funding strategy has been so successful, according to DMT's HR Director Donna Nichols, that the company's total health coverage costs have been flat and employees have not had to bear any cost increases for three years running. "It's been a very good three years," Nichols said.

Challenges mostly logistical

Dann Marine Towing faced some difficulties getting its new plan into place, but those mostly had to do with the business it's in—many of its employees spend their time aboard vessels and are geographically distributed because DMT, although based in Maryland, has a national footprint. Like other companies new to the self-funding space, DMT also had to work closely with its independent third-party administrator (TPA) and adjust its contracting strategies along the way to get the support it needed and the cost containment it sought. "We haven't tried to make massive changes. It's been incremental as we moved along," Dann said.

Communications regarding plan and benefits developments and changes proved another challenge, DMT found. Many of

the company's employees may be away from their homes for up to 30 days at a time, working on the vessels. "We don't have the luxury of being able to bring together groups of employees to present new opportunities—whether it's health benefits or something else," said Dann, "when our employees are working throughout the country."

That geographical reality has also made it difficult for DMT to establish provider networks, a strategy that can be highly effective in cost containment and in ensuring high-quality care. "Finding providers who will accept our plan has been the scariest part for us—but as it's turned out, there have been only a handful of problems," Dann said. "I guess what it really comes down to, in the moment, is the dollars and cents" the company is offering. "That was our 'aha!' moment," he said.

Even though DMT has had to deal with—and in some cases absorb—balance billing when employees don't obtain care at a DMT-contracted facility or provider, the availability of the navigation concierge, who is literally just a phone call away, has helped tremendously. Employees are guided in where to obtain services at the lowest cost to them personally and the company as well, without sacrificing on quality, and they're provided a detailed picture of the total cost of various options.

"Our employees have really appreciated the concierge because it's like one-stop shopping for them, with someone else doing the legwork," Nichols said. "The employee or spouse knows upfront what they'll have to pay, if there is a copay for a particular service, and whether a provider or facility has availability. People have been really happy to have someone do that work for them."

We had worked with the Blue Cross Blue Shields and Aetnas of the world, and for decades, that was how we handled our health insurance. And we were just at their mercy, so to speak, going year after year with the increases. Did they ever come back to us and say, 'you're doing a wonderful job; let's give you a decrease?' No. So, we didn't have much to lose by stepping out on this limb and giving self-funding a shot."

– Christopher Dann, Dann Marine Towing CFO

Executive Summaries Foreword

Marilyn Bartlett

I've been in the business of health benefits for a long, long time now—working first for Blue Cross Blue Shield, then as a CFO for a third-party administrator, and eventually serving in roles that have allowed me to make meaningful improvements in the state of Montana. If I could advise benefits professionals, employers and unions, I would say this: "You cannot settle for the status quo."

So much of this industry is shrouded in secrecy, with opaque payment systems. The money goes into the system from employers, employees, taxpayers and consumers, who don't know what they are paying for. The system now consumes 20% of GDP, with no end to the increase in sight. We need to change this course!

The then Director of Montana's Department of Administration, Sheila Hogan, and Montana's Budget Director, Dan Villa, shared this vision and hired me as Health Care and Benefits Division Administrator to improve the state employee health plan. In that role, I used my experience and the confidence that came with it to decide the price we would pay hospitals as a multiple

of Medicare, rather than simply accept the high costs the hospitals were "willing" to dish out.

Along with other measures to add efficiency, lower costs, and implement price transparency, we took a projected minus $9 million reserve balance to a positive $112 million in just over two years. Now, I'm trying to help other states do the same, much as Dave Chase is trying to do in putting together Health Rosetta. Information on some of the very same things I did while working for the state of Montana can be found in Dave's books, specifically reference-based pricing, direct contracting, pharmacy benefits transparency, data-driven decisions, and especially value-based primary care. Dave also provides helpful insights and tips for advisors and employers to consider, from the nitty-gritty details that are needed for strong health plan design and in-depth analysis of where the money goes, to broader organizational and community efforts. Hint: It isn't over after you put the plan together. What comes next–driving organizational, community, state and national change–is a longer-term challenge. Thankfully, it's a challenge Dave makes easier by breaking the strategies down into concrete steps.

Dave also walks local leaders, benefits advisors and employers through the serious local, state and national consequences they'll see if things don't change soon. Dave shows that other parts of the budget have to bend and flex, and there's often not much room for that. I saw first-hand what can happen when the health-care system consumes far too many tax dollars. By taking control of health-care expenditures, plan design and contracting, you can change this dynamic. We free up money for public health and primary care, and for pandemics and other unplanned disasters.

When Montana realized significant savings in the state employee health plan, the legislature retained $25 million to help balance the overall state budget, and employees got a premium holiday. Furthermore, state employees received pay raises at the next budgeting cycle, as the health plan did not require additional funding.

More people need to see this big-picture perspective and understand why we must never settle. We must never just accept something because "everyone else is doing it," and we must make the changes needed to secure a better healthcare system. Dave tells us how to do this and provides the support needed to move forward.

Marilyn Bartlett was selected #13 of Fortune Magazine's World's 50 Greatest Leaders of 2019 and was recently inducted into the Montana Business Hall of Fame by Montana State University. Marilyn currently serves as a Senior Policy Fellow for the National Academy of State Policy (NASHP), addressing hospital pricing.

The CEO's Guide to Restoring the American Dream: Executive Summary

The system of employer-provided health insurance resides at the heart of U.S. health-care problems today.

World War II brought tight wage restrictions to employers. To compete for workers, they increased benefits and many began offering health insurance. This uniquely U.S. model blinds workers to the real costs of health care and creates a perverse incentive that discourages preventative and chronic care while rewarding far more expensive acute and reactive care.

"Every employer who has slayed the health-care cost beast has recognized the importance of proper primary care."

Almost one-third of Medicare spending occurs in a patient's last six months of life and covers mostly unnecessary and/or harmful treatments that line the pockets of the health-care industry. Another third of the $3 trillion spent on US health care amounts to fraud and waste—enough to make college free for every high school graduate or to insure every uninsured American six times over.

Though health coverage for employees constitutes enormous expense, most firms don't scrutinize their spending.

Health care is often a company's second-largest expense after payroll. As much as 10% goes to fraud and up to 30% to other waste. Few CEOs would tolerate that in any other line of business. CEOs and CFOs must look at their health-care spending as a source of competitive advantage and not a benefit that HR handles.

> *"Good health not only improves morale and productivity; it enables you to spend less on health care and more on growing your business."*

The average employer pays 260% of the approved Medicare rates for procedures; many pay three, five or even ten times more. Hospitals and insurers win with higher prices. The health care industry pushes the most expensive treatments, even if they don't benefit patients. CEOs should demand fair and transparent pricing, so they and their employees can make better-informed choices. When proper primary care is in place, surgeries drop by one-third to one-half for musculoskeletal ailments like lower back pain. Meanwhile, the lower-cost, more beneficial options, like physical therapy, surge.

Insurers pay hospitals' primary care physicians incentive bonuses to get them to refer patients to specialists, which drives up costs. Instead, company health plans should focus on independent, ethical primary care. Trusted primary care physicians save money because, except where necessary, they avoid specialist referrals and drugs by treating root causes and consulting with patients about more effective treatments.

Preferred provider organization (PPO) networks within insurance plans raise prices and do not focus on quality. Allowing price-gouging providers into networks means high costs for employers and often generates the worst outcomes. The best hospitals in the United States, including the Mayo Clinic and others, generally avoid inappropriate treatment, as seen when you compare them to typical hospitals. High-quality physicians and

hospitals practice evidence-based medicine to reach high standards, avoid surgery where possible and lower costs.

Perhaps the most surprising finding about health care is that prices are flat in the real market made up of patients who pay cash (due to high deductibles) and direct contracts between employers and health care providers. Flat prices are less surprising once you understand that clinicians are paid pretty much the same way as they were during the past decade.

Carriers love out-of-network claims and approve them rapidly because they make more money—30% or more of so-called savings—when they help drive up the mythical "medical trend." This shift to out-of-network pricing also gives them an opportunity to "reprice" a claim, even if they never should have paid it in the first place. Companies should make it easy for employees to use high-quality providers. For instance, they can offer care navigators to guide employees to high-value providers, thus eliminating out-of-pocket costs and saving money for the employee and the employer alike.

Carrier executives promise Wall Street that they will drive profit growth of between 10% and 15% annually; this pressure leads to unsavory tactics, including the bonuses paid out to insurance brokers—clearly putting the interests of carriers above their clients. A brokerage can earn an annual bonus of half a million dollars if it retains 90% or more of an insurer's customers. This incentivizes brokers to maintain the status quo, even if they could find a better deal with another insurer. Ask brokers about bonuses and compensation from insurance firms and whether their largest clients provide health-care services like hospitals and clinics do. Don't assume that your broker works for you.

> *"It's unconscionable to blindly send an employee to a hospital with little or no information on its safety record."*

Between 6% and 10% of a typical firm's employees will account for about 80% of claims and pricey blockbuster procedures like organ transplants or cancer treatments. Ask for a second opinion from a first-rate center like the Mayo Clinic or Seattle's Virginia

Mason. One-quarter of cancer treatments and 40% of transplants prove to be unnecessary. Beware insurers' claims about wellness program ROI. Virtually no firm in the history of these programs has achieved a positive ROI from a wellness program.

Despite the money poured into medicine and hospitals, 200,000 Americans die every year due to preventable medical mistakes.

The US medical-industrial complex encourages doctors to feed patients into its system. Technologies and advanced procedures like cardiac catheterization, for example, save lives, but their vast overuse in some cases harms or kills patients.

> *"Health care is a $3 trillion dollar industry, and 30 cents of every one of those dollars spent on health care is wasted...In 2009, that was $750 billion."*

All this spending delivers a health-care system that ranks as mediocre among the world's wealthiest nations and generates the lowest customer satisfaction among all industries, including cable TV. Only about 10% of physicians recommend health care as a career.

The FBI estimates that health-care fraud costs the nation about $300 billion each year.

Insurers play the "pay and chase" game. Because they get paid a recovery fee, they pay obviously fraudulent claims and investigate afterward to retrieve the money. Insurers never recover most of the money paid out in fraudulent claims.

> *"Estimates of fraud, waste and abuse in health care range from a low of 30%—to over 50%—but are little known among employers."*

Insurance firms and their unwitting customers facilitate fraud, in part, by pushing the "auto-adjudication of claims." Under this system, claims administrators pay virtually every claim automatically, no matter how flimsy the invoice sent by the provider. Credit card companies leave no stone unturned in rooting out fraud, and health-care fraud is 14.3% higher than credit card fraud. Better investigative techniques and more use of AI and

sophisticated algorithms for pattern recognition—such as those used by credit card firms—would eliminate much health-care fraud.

Spiraling health care costs mean that the U.S. middle class is worse off than the generation before it.

At the heart of the American Dream is the expectation that each generation will surpass the one before it in prosperity and quality of life. That Americans can no longer fulfil this dream is due not to lower wages or higher unemployment, but to profiteering and price-gouging.

> *"Hyperinflating health costs have been 95% responsible for 20 years of income stagnation and decline for [the American] middle class and our most vulnerable citizens."*

If health care costs had increased with the pace of inflation since 2007, the average U.S. family would have $5,000 more to spend after taxes each year. Health care, as a percentage of GDP and household spending, keeps increasing. If costs increase at their current trajectory—an average of 8% each year—families will have nothing left to spend on anything else by 2033. This causes so much hardship that experts identify it as a leading cause of social ills, including the opioid epidemic. In many jurisdictions across the United States, health insurance and related costs for one municipal employee exceed the remaining budget for entire departments or volunteer fire stations. As a result, road repair ceases and parks fall to ruin just so that municipalities can pay worker health-care costs.

No generation stands to lose more than millennials, who are challenging the health-care system's absurdities.

Absent dramatic change, millennials stand to pay half their earnings to health care if current trajectories hold. They face a bleak future. Having fueled disruption in the retail, travel and financial services industries, millennials appear ready to demand and lead health-care reform. They are questioning the system and demanding change so their future isn't jeopardized. Millennials are more insistent than previous generations about

convenience, access to their personal medical records and mobile access to physicians.

Many employers have given up trying to contain health-care costs, but a growing number are fighting back.

The Health Rosetta is a non-profit firm that encourages organizations to adopt an approach to health-care costs and quality that reduces costs, aligns incentives and improves outcomes. The Health Rosetta argues that organizations should focus on primary care and prevention. And it affirms the need for employers to apply financial standards to health-care plans equivalent to those applied to employee retirement plans.

> *"Saving money in health care requires employees to be educated, engaged participants in their health."*

By following the Health Rosetta's principles, some firms realized health care spending reductions of 20-40% or more while improving the standard of care for employees. The Allegheny County Schools Health Insurance Consortium (ACSHIC) in Pittsburgh, for example, negotiated per-teacher coverage of $4,661 per year compared with $8,815 in nearby Philadelphia, saving $199 million per year. Class sizes in Pittsburgh are a third smaller than in Philadelphia, and teachers earn more money with better benefits. ACSHIC accomplished better health outcomes at lower costs by educating employees about the importance of primary care and by teaching them to prefer high-quality, evidence-based providers.

Rosen Hotels & Resorts in Florida has been applying these approaches for over 20 years and has cumulatively saved over $400 million compared to their benchmarked competitors—a full 55% less per capita despite having a high disease burden (for example, 56% of their plan members' pregnancies are considered high risk. Rosen offers onsite health services staffed with health coaches, nutritionists and nurses. They also pay for the college education of employees and their children. Unsurprisingly, Rosen's staff turnover is about one-fifth the industry average.

Organizations that successfully manage health care costs often opt for self-insurance.

Employers who self-insure—that is, pay their employees' health claims directly—reduce their exposure to insurance carrier-enabled predatory PPO pricing by 90%. These firms take out stop-loss insurance to protect against shock claims and tend to come out ahead overall, especially when they partner with independent third-party administrators (TPAs as opposed to insurance company-run administrative services (ASOs, to build and administer health plans. Self-insured firms often work with preferred provider organizations (PPOs)—preferably national PPOs—that offer discounted rates.

> *"As with most dysfunction in health care, simple incentives and behaviours often have enormous, counterintuitive and costly consequences."*

The costs of medical procedures change only slightly each year, and some costs decrease. Firms that negotiate directly with health care provider organizations—like individuals who do the same—get better deals than insurance companies, whose prices escalate through layers of intermediaries and whose incentives favour higher prices.

Self-insurance is a sound strategy for firms seeking greater control over spending and the quality of the care they provide to employees, thus ensuring they fulfil their fiduciary duty. This spell out a legal duty to shepherd health funds with the same diligence with which it manages employee retirement funds. Not understanding this fiduciary duty can put a firm at enormous risk. Working with competent benefits and legal advisers ensures that this risk is well managed.

Organizations that successfully manage health-care costs also demand quality and safety data from providers—hospitals, doctors, and the like. Switch providers if they refuse to give it to you.

Insist that providers release personal medical records to employees, so they can make better-informed choices. Insist on

transparent package or “bundled” pricing for health procedures and pharmaceuticals.

Hire a health administrator with financial and statistical skills similar to those of your retirement plan administrator. Give your health administrator the authority and support to negotiate and manage your health-care costs. If you self-insure, hire a properly aligned benefits consultant to help you build your plan with the safeguards you need to manage risk. Consider paying your consultants, at least in part, based on their performance and results.

For a free download of this book in its entirety, along with full versions of other books authored by Dave Chase, please visit www.healthrosetta.org/friends.

Relocalizing Health Care Executive Summary

As of 2020, the health-care system in the United States consumes a full fifth of the American economy. It has become a machine that does not improve health, but proves perfectly attuned to extracting money. Every year, more than any other factor, health care bankrupts Americans, even though 70% of them have insurance. It sucks so much money out of cities, towns and communities that public education, policing and social services have atrophied in many places across America.

Almost by accident, a system of employer-provided health insurance resides at the heart of U.S. health care problems today. This uniquely U.S. model blinds workers to the real costs of health care, and creates a perverse incentive that discourages preventive and chronic care while rewarding far more expensive acute and reactive care.

> *"Our federal government spends 48% of its money on health care and still health care devastates state budgets all across this country, with serious consequences we're already seeing in public health and education."*

For workers, health-care costs have caused wages to decline or remain stagnant in real terms for decades. Spiraling health

spending consume funds employers might use to improve worker benefits and salaries, and to help fund community initiatives—as many once did. Nothing compromises the American Dream more today than the U.S. health-care system.

The solution proves readily available and as obvious as the problem.

Some employers and communities realize that, more than ever, better health-care options attract and keep top talent, and that investment and startups follow talent. IBM chose a new location for 4,000 employees on the basis of where it found the best health care: Dubuque, Iowa. Dubuque and other awakened communities don't seek construction of new hospitals, which encourage more hospital admissions. They strive to build a network of primary health care—local doctors, nurses and health coaches—that focuses on preventive care and patient-doctor co-accountability for wellness.

> *"All of the structural models necessary to fix health care have already been invented, deployed, proven and modestly replicated."*

Increasingly, communities, businesses and organizations nationwide are taking back health care. They walk away from big, conglomerate-run systems that take (and lose to rampant fraud) between half and three-quarters of every health-care dollar out of the communities they purport to serve. They fire their mega carriers and put health care in the hands of the people who care about it most—patients.

Remain healthy by taking care of yourself in partnership with your primary care team, not through hospitals, operations and drugs.

Hospital care, surgeries and pharmaceuticals account for only 20% of health outcomes, but consume the great majority of spending. To stay healthy, take care of yourself and avoid pharmaceuticals or hospitals when possible.

> *"We often limit shop local thinking to retail and food, but it is just as applicable in health care."*

After self-care, the next step should involve your primary care physician, not a specialist, drugs or a hospital. Should hospitals and surgeries prove unavoidable, return to self-care as soon as possible afterward.

As millennials spearhead disruption of media, music, taxis and hotels, they will demand change in health care.

Today, younger employees tend to question the health care they find, at work and elsewhere. Millennials understand that they will spend half their lifetime income on a system that advocates unnecessary treatments and surgeries, and that harms or kills patients at a shocking rate. Fatalities from preventable medical mistakes constitute one of the leading U.S. leading US causes of death.

"If we can't slay the health care beast, millennials will see their future stolen from them."

Millennials use online tools and apps to choose better health-care services. They tend to seek second opinions, eschewing the system's default to clinical care, operations and drugs. Millennials may drive change that benefits everyone.

The scale of the broken U.S. health care system reveals itself in tragic ways.

The decades-long opioid crisis has claimed at least half a million lives and half a trillion dollars. It has eroded the bluecollar workforce to the breaking point. The workforce involved in physical labor suffers from expensive and inadequate health coverage. When physical work results in injury, the system doles out opioids for the pain. Because many people don't receive paychecks unless they work, they neither rest nor recover. This exacerbates injuries, making workers more dependent on painkillers resulting in rampant addiction. More U.S. workers under age 50 die today from opioid overdoses than from anything else.

"I have seen enough to conclude that no incident of failure in American medicine should be dismissed as an aberration. Failure is the system." (Dr. Otis Brawley)

The incidence of opioid-related death and disability has created a smaller workforce. Candidates often can't qualify to work because of their drug use, and workers perform poorly due to drugs and to injury. Whenever the system prescribes an employee opioids, it costs, on average, more than $100,000 per year in treatment and lost wages. The U.S. health-care system's design encourages crises like the opioid epidemic.

Fraud accounts for about $300 billion of annual U.S. health-care spending.

Fraud drives up the cost of insurance, but insurance companies don't pursue it as banks do credit card fraud. When, for example, claims show the same person receiving multiple hysterectomies or circumcisions, the system usually fails to catch the perpetrators and recover the money. The system floods the streets with drugs from fraudulent prescriptions. Incentives allow carriers to keep 30%–40% of the money they get back from fraud. The true losers are businesses, communities and Americans.

> *"The cost of health care fraud is 14,285% higher than credit card fraud."*

Few employers realize that health care costs them more than almost anything else in their business. For some, however, annual double-digit increases have driven change because employers can't afford them.

Many employers no longer try to contain health care spending, but many more are fighting back.

The Health Rosetta is a non-profit firm that encourages organizations to adopt an approach to health-care costs and quality that reduces expenses, aligns incentives and improves outcomes. It argues that organizations must apply financial standards to health-care plans equivalent to the standards they apply to managing employee retirement plans.

> *"There is no well-functioning health-care system in the world not built on proper primary care. The same can be said about health plans."*

The Health Rosetta aims to focus employers and communities on primary care and prevention. Local primary care does a better job of managing problems that most affect employees, including substance abuse. The Health Rosetta affirms the need for employers to push for a local primary care system, one in which physicians have sufficient time to develop relationships with patients. Employers should enlist mayors and local government in the effort to rally firms and citizens around developing a local, primary-care-based health ecosystem.

Organizations that successfully manage health-care spending often opt for self-insurance, and combine it with stop-loss insurance to cover catastrophic claims. Employers who self-insure (pay their employees' health claims directly reduce their exposure to insurance-carrier-enabled predatory pricing, and reduce their spending by half or more. By providing incentives for employees to visit only approved, value-based doctors and specialists—physicians they choose for their excellent results and fair price—firms control spending.

By following the Health Rosetta's principles, firms create captive self-insurance consortiums so that even small employers can obtain local coverage. Employers should consider how Rosen Hotels & Resorts and the Pittsburgh Schools system address this problem. The Pittsburgh consortium negotiated per-teacher coverage of $4,661 per year in comparison with $8,815 in nearby Philadelphia, saving $199 million per year. Teachers thus earn more money, with better benefits. The school system accomplished better health outcomes at lower costs by educating employees about the importance of primary care, and by teaching them to prefer high quality, evidence-based providers.

"The best way to slash health-care costs is to improve health benefits."

Rosen Hotels in Florida has applied these approaches for 20 years and has cumulatively saved over $300 million. [Editor's note: this figure went up to $425 million by early 2021]. In comparison with benchmarked competitors, it spends a full 50% less

per employee while offering much better health care. Rosen provides onsite health services with health coaches, nutritionists and nurses. These in-house services helped Rosen and companies like it manage the COVID-19 crisis and reopen sooner. Rosen employees have no co-pays for almost all drugs, and pay only $5 for a doctor visit. Rosen uses its savings to pay employees more, to cover college education for full-time employees and their children, and—as a shining model for the rest of the country—to donate to community causes. Rosen's community sponsorship has helped reduce crime in its community, Tangelo Park, by two-thirds and increased high school graduation from unacceptably low rates to 100% in many of the ensuing years.

As a result of Rosen's efforts, more than three-quarters of Tangelo Park's high school graduates earn college degrees, in comparison with just 9% of children in similarly disadvantaged communities nationwide. Scholars have estimated the ROI on Rosen's $13 million in donations to the community over the past quarter-century at more than $90 million. At the same time, Rosen's business has grown rapidly and succeeded enormously.

Strive to establish a Health 3.0 system in your organization and community.

Health Rosetta offers a framework for Health 3.0. Before the current system of evidence-based, centrally managed, big-business health care (2.0), Americans benefited from small, locally centered, intuition-based health care revolving around a personal relationship with a primary care physician (1.0).

The 3.0 version of health care combines the personal and local care of 1.0 with the data and technology-driven health care of 2.0, to capture the best of both. By keeping money local, employing modern best practices, and leveraging supportive local, state and federal government, health care can prove twice as effective at half the price.

> *"Since taking over their health-care system, Alaska Native people are becoming the healthiest people on the planet.*

In Alaska, for example, the Nuka system of community health-care services for the Native population has dramatically improved life and health in villages across the state. Nuka has reduced hospital admissions by half and specialist visits by almost two-thirds, while significantly improving health-care quality. By blending the best of modern health care with local, traditional values and a community-controlled, patient-centered and primary-care-oriented approach, the Nuka system has created one of the world's most effective health care systems in just 10 years.

Adopt a resistance mindset. Refuse to remain part of one of America's most corrupt and ineffective systems.

Employees worry about risks to their benefits. Address their concerns with care. Educate them on the state of the U.S. health-care system, its perverse incentives, and how it puts them at risk even if they have insurance.

> *"Employers should remind workers that the US is the undisputed world leader in medical-bill-driven bankruptcy–the No. 1 cause of bankruptcy for Americans. What is worse, 70% of those people had health insurance."*

Illustrate the consequences of the system's shortcomings using the opioid and COVID-19 crises. Help them envision what true patient-centered health care can look like. Build support from the grass roots, communicate often, address naysayer concerns respectfully and openly, and highlight quick wins. Listen to employees, and change methodically—don't try to implement everything overnight. Do it in stages, building on and solidifying your successes.

Seek out local providers of primary care who bundle physicians, health coaches, nutrition experts and wellness advice into per-patient subscriptions, covering visits and preventive care. They should offer same-day appointments, modern technology and transparent, portable electronic health records.

Discourage employee use of providers—including pharmacies—other than those you screen and approve for excellence and low costs. Build your relationships directly, and work with

your benefits adviser, not through a preferred provider organization (PPO).

Hire or contract with professionals who align with your new direction and who demonstrate the right mindset. Ensure that they possess financial and statistical skills similar to those of your retirement plan administrator. Give them the authority and support to negotiate and manage your health care costs. If you self-insure, hire a properly aligned benefits consultant to help you build your plan with the safeguards you need to manage risk.

WHEN EMPLOYER-SPONSORED HEALTH PLANS IMPROVE PATIENT HEALTH, EVERYBODY WINS.

Making Health Care LOCAL

5 STEPS TO BUSINESS SURVIVAL AFTER COVID-19

This is a moment of truth for business leaders.
There are 5 things they can do right now to avoid the worst-case scenario — and they're easy to remember:

- **L** — **LEARN HOW TO BE LIBERATED FROM THE STATUS QUO**
  Stop accepting 5% to 20% annual cost increases
- **O** — **OPTIMIZE HEALTH PLAN INFRASTRUCTURE**
  Work with a Health Rosetta Benefits Advisor
- **C** — **CARVE OUT PHARMACY BENEFIT MANAGER (PBM)**
  Save by accessing and utilizing pharmacy claims data
- **A** — **ADD ADVANCED PRIMARY CARE**
  Reduce downstream costs and offer a better care experience
- **L** — **LEAVE BEHIND VALUE-EXTRACTING PRO NETWORKS**
  The average PPO network pricing is 260% of Medicare rates

GET RECOGNIZED AS A HEALTH PLAN HERO

Patients Rising accepts applications for its health plan hero certification on a rolling basis throughout the year.

Find out more: HealthPlanHero.net