WILCO
BUSINESS REVIEW
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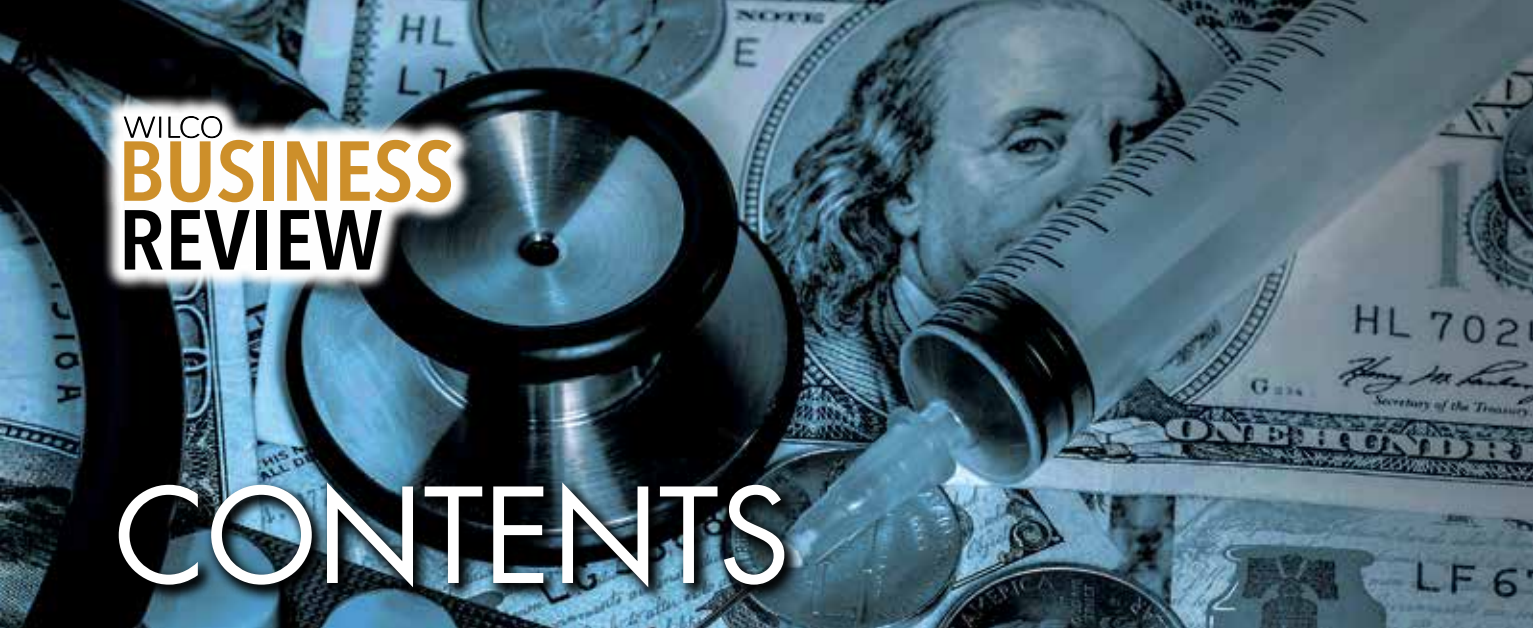
Williamson County, Texas

FIVE TEXANS
ARE CHANGING THE WAY AMERICAN COMPANIES PURCHASE HEALTHCARE FOR THEIR EMPLOYEES

PRACTICAL WAYS TO ACHIEVE BETTER EMPLOYEE OUTCOMES AT LOWER COST

Increase Employee Benefits • Eliminate Deductibles & Co-Pays
Lower Your Healthcare Spend • Increase Quality in Your Plan

Taylor Rogers
Principal - Benefits Advisor
Cairn Advisors



WILCO BUSINESS REVIEW

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Texas Medical Management Founder Sean Kelley

photo by Todd White

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FEATURED

YES, YOU CAN

SELF FUND YOUR COMPANY'S HEALTHCARE

Self funding can be an answer to providing your employees with high quality healthcare. The contributors and subject matter experts in this special section have put a spotlight on the manner and process to improve your employees' outcomes, eliminate their deductibles and co-pays, and drastically reduce your corporate healthcare spend.

If you have between 60 and 500 employees, odds are–even if you put this magazine down right now–you will be considering self funding options in the next two to three years. Perhaps you haven't been able to give your employees the pay raises you feel they deserve; look no further than the skyrocketing increase in health insurance premiums year over year. Every year at renewal you tell yourself that these increases are not sustainable.

It's not just unsustainable for your company–the deductibles your employees pay inflate every year as well. To avoid these costs, many people do not seek care when they're sick, or to manage chronic conditions. Further, they seldom, if ever seek preventive care. Obviously, this has a significant and nocent effect on productivity.

It will most definitely pay you to survey and scrutinize other businesses already engaged in this new paradigm. Pay close attention to the methods they employ to improve healthcare outcomes, eliminate deductibles and co-pays for their employees. Familiarize yourself with the means available to save substantially while maintaining your role as fiduciary with the savings incurred on your healthcare spend.

Don't assume you are not a great candidate for a self funded plan.

You don't have to have $5 million in the bank. These plans are not only viable, but have been thriving in thousands of companies across the United States for years.

When your employees are spending less or nothing at all for their wellness, it will increase their satisfaction and retention. The savings you will incur will allow you the freedom to offer raises from year to year, further strengthening your retention position.

~Mike Payne

WHAT CAN WE DO
DIFFERENT?
~Self-funded Employers

CEOs: THE GATEKEEPERS FOR EMPLOYEE SELF-ADVOCACY

by Ann Marie Kennon

"BUSINESS OWNERS ARE LARGE HEALTHCARE CONSUMERS. THE EXPENSE ASSOCIATED WITH THEIR EMPLOYEES' HEALTH CARE IS OUT OF CONTROL, AND THE CURRENT PATH IS NOT SUSTAINABLE."
~ TAYLOR ROGERS

What can we do different? Ask Roy and Michael Jones, principals in one of the most successful mortgage companies in America, headquartered in Georgetown, Texas. The Joneses began to seek alternative ways of administering healthcare for their employees due to precipitous increases in premiums from year to year combined with higher out-of-pocket costs for employees. Add to that Roy Jones' personal encounter and a very large medical bill that left him wanting to leave a legacy of having done something about the incessant and spiraling cost of healthcare.

THE TIPPING POINT

Roy Jones' granddaughter was a dependent; he took her to a freestanding E.R. for some inflammation. They observed her overnight, gave her morphine and antibiotics, and released her the next morning.

Her bill was $132,000 and Roy, feeling helpless, vigorously scrutinized the charges.

After reading "The Price We Pay" by Marty Makary, he eventually settled the bill for substantially less.

That was when Roy decided enough was enough.

WHAT CAN WE DO ABOUT A HEALTHCARE SYSTEM THAT IS FAILING US?

Enter Taylor Rogers, a benefits consultant. Rogers encouraged Thrive CEO Roy Jones to read Dr. Marty Makary's bestseller "The Price We Pay" to understand how employers could shape healthcare from the bottom up. He was quickly sold on reinventing the way healthcare was administered and delivered to his employees. Jones teamed up with Rogers and they founded a new company—one that would operate on Free Market Principles and provide employers throughout the United States an opportunity to improve their healthcare plan dramatically. This new approach would deliver a higher quality of experience to employees and simultaneously lower costs.

Rogers and Jones agreed on one aspect of the industry, and the environment—that it was completely untenable. As Rogers said, "You can't manage what you can't measure."

Their innovative new advisory firm was named CAIRN—a stone marker used to show the way. Rogers says, "CAIRN's goal is to put companies on a path to success using an innovative process."

Thrive owners explained to their employees that changes would be made, not for the company's bottom line, but to enhance the employee healthcare program. Even so, when they embarked on the new way of doing business, dropped their major medical plan, self funded their healthcare, and created partnerships with free market providers, it was it was clear that members needed robust support and education.

HOW DOES IT WORK?

CAIRN is an innovative new company that is fully vested in the idea that healthcare costs are not only manageable but can be lowered. Plus, as costs come down, the company has more money to lower premiums and out-of-pocket costs paid by employees.

Michael explains, "We went from fully insured to open network, reference based pricing[1], and direct fee-for-service contracts with providers and pharmacies." When some employees initially expressed anxiety about not having a traditional carrier, CAIRN, HR, and the executive team took the reins and reached out to people personally. Roy and Michael walked them through

[1]See p. 10 glossary

individual needs or experiences, held "town halls," and monthly all-hands calls to bolster employee confidence in the transition.

For instance, although the employees had a prescription card, the company also negotiated agreements with local pharmacies. The pharmacies provided transparent pricing in exchange for a reasonable administration fee. The company's prescription spend dropped from $418 per employee per month to $68. This same type of negotiation took place with primary care doctors, labs, and imaging providers with similar results and tremendous savings.

As the old saying goes, "The proof is in the pudding." At the end of CAIRN's second year, Thrive had saved nearly $2 million on healthcare.

PRINCIPLES AND VALUES

Applying free market values in the self-funded market is a fast-growing concept. Fiduciaries of health benefits are obligated, under law, to steward payroll deducted contributions responsibly. Unfortunately, in today's traditional environment, that is increasingly difficult.

In its simplest form, CAIRN brings together *willing buyers and willing sellers*. It puts healthcare in the same lane as every other consumer purchase; no one brings a third person with them to purchase a car, then pays that person to tell them which car to buy and the options to install. Interlopers like that are common in traditional plans—middlemen who take a piece of the pie without delivering any benefit to the company paying for the plan, or the employee who uses it.

Dr. Keith Smith, an innovator in the free market medical movement says, "The free market is an exchange between buyers and sellers that is mutually beneficial, where both parties emerge feeling like it was a good exchange."

KEY TAKEAWAY

Rogers says, in closing, "The result of our efforts is that this concept is a tremendous benefit to employer groups. They are seeing meaningful savings and a greater level of transparency."

Rogers says CAIRN stands ready to evaluate employer issues with healthcare and will offer a no obligation review and comparison between what employers now use and what they could expect out of a plan created by CAIRN. When employees see the data and incentives and are given access to make their own decisions, four out of five will choose free market options. "At Thrive," he says, "engagement has steadily grown organically due to the water cooler effect. Employees come back from services, tell everyone how great it was, and that it didn't cost them anything out of pocket."

When employees are empowered, through resources and education, they tend to make better healthcare decisions for themselves and their families.

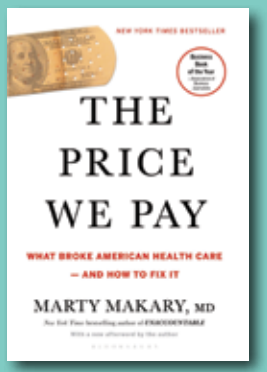
> **"We are not here to criticize physicians or providers. This is not about us versus them; this is about working with doctors to provide the best outcomes for members, physically and financially."**

Marty Makary M.D.: "The Price We Pay"

Dr. Makary is a Johns Hopkins surgeon and Professor of Health Policy & Management. He is a leading voice for physicians writing for the *Wall Street Journal* and *USA Today* and is a member of the National Academy of Medicine. He has been named one of America's 20 most influential people in healthcare by *Health Leaders* magazine.

He is the founder of Restoring Medicine, an advocacy effort to help people who can't afford their medical bills. Dr. Makary also serves as executive director of Improving Wisely, a national physician collaboration to reduce unnecessary medical care and lower healthcare costs.

His current research focuses on healthcare transparency and the re-design of healthcare. His book "Unaccountable" turned into the TV series "The Resident" and his newest bestselling book, "The Price We Pay", was described by Don Berwick as "a deep dive into the real issues driving up the price of healthcare" and by Steve Forbes as "a must-read for every American".



~martymd.com

WHAT CAN WE DO
DIFFERENT?
~Self-funded Employers

INTERSECTIONS IN VALUE

Q&A with Taylor Rogers and Rich Hejny

Doctors and insurers use a lot of big words. Here are some of CAIRN's common sense and empowerment solutions.

★ We are working to **mitigate high cost pregnancies** and deliveries. We connect members with independent **maternal-fetal medicine (MFM) experts** at no cost. One of our doctors reviewed a high risk patient's sonograms and asked her if anyone had ever spoken to her about kidney stones. She was not aware of any but mentioned she had frequent UTIs and her urologist regularly prescribed antibiotics. The MFM doctor explained that her existing treatment bordered on malpractice; i.e., her kidney stones were a serious hazard that could lead to other complications. He insisted she treat the kidney stones as soon as her baby was delivered. The member was referred, and it all happened because we were able to give her case a second set of eyes. It's all about outcome.

★ We had a member at Cancer Center A. The prescribing physician wrote in the case management documentation that the patient would receive a 12-week course of the *generic* formula of **Taxol chemotherapy.** The center then billed our plan $30,000 for the *brand name* drug. We did our due diligence and were able to procure the generic formula from a reputable commercial provider for $9 per dose, for a total of $108. The problem we then ran into was Center A would not allow the member to use the pharmacy program to provide the medication but pay them a considerable amount of money—still significantly less than $30,000—to administer them. We want Center A to get paid for their services but we don't want them to mark up the drug 26,000 percent. Cancer Center B was willing to treat the patient with the generic medicine, but was farther away. We explained we could hire a limousine to take her to and from Center B for 12 weeks and still save thousands. The lesson is not to allow an insurer or provider to use procedural intimidation, fears about delays in treatment, or obscure terminology to ensure they can bill maximum amounts.

★ Often, **free-standing E.R.s** are treated as risky sites of care by commercial health insurance plans due to their out-of-network status. We work with many of these independent facilities to establish reasonable reimbursement rates to provide additional access points for employees. These facilities provide access to quick and convenient care in the event of an emergency.

★ A member was about to undergo cranio-facial surgery for a sinus complication. It was a $40,000 operation so we sent the case file to a **free market surgery center.** Upon review, they determined the member did not need the surgery. As it happened, the member was panic-stricken about the surgery and what the results might look like. The doctors told her that she still may need the surgery at some point in the future, but she did not need it now. They canceled the surgery, gave her some interventions—much to her relief—and she is doing well as of the latest update. The client saved $40,000, the member did not have to have her face cut open, and we assimilated some alternative interventions to give her the outcome she needed.

★ **We never count out the major medical plans,** especially when they put their money where their mouth is. One client was in a self-funded plan with a $1.6 million maximum liability. The client was concerned about a member's potential need for Gamifant, which is typically priced just under $7,000 per 2ml unit. Stop-loss excluded the medication as a covered benefit to the policy, leaving the employer exposed to more than $1 million in additional liability. With a maximum liability of more than $2.6 million, a major medical carrier bet on themselves to manage the risk, and offered the employer a $635,000 fully-insured medical plan. We explained they should be prepared for significant renewal increases, and limited access to claims data, but the math would work in their favor. Assuming they received a 100

percent increase at the first renewal, their net exposure was still half of what it would have been on the self-funded plan.

★ Providers occasionally say, "We don't take that insurance," when they don't immediately recognize a logo. They often don't understand that **the plans we build are essentially cash** and we ask, "You don't take cash? We can pay for care however you wish us to pay for it." Our only criteria is that the price we are being asked to pay is disclosed up front. When a provider says, "No", they are essentially telling our member they only accept blind payment for services; i.e., most commercial plans automatically process and pay claims. That should be a red flag to consumers.

★ In his book, *Never Pay the First Bill*, Marshall Allen quotes a statistic that **80 percent of medical bills are incorrect**. Why is that okay? Consumers are intimidated and assume that the provider always has it right. The most powerful tool for us to help the members is to assert that we know we have it right; we have the right provider and appropriate price, so we just make it free. Scan the code for more by Allen in CAIRN's podcast.

CAIRN CAST

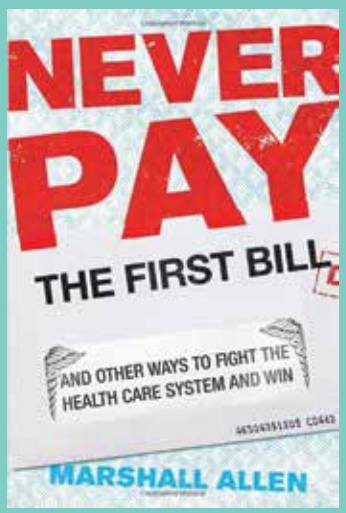
★ **Consider how hard it is for your company to generate a net profit.** A mortgage lender may need to produce $200 million in loan volume to generate $1 million in net profit. The plan we designed for our client saved them $1.8 million dollars over an 18 month period. If we save them $1.8 million over a 24-month period (as we have done with Thrive), we estimate reproducing the effort of generating $360 million in new loan origination—for the same net gain to the company's bottom line. In leaner industries; e.g., manufacturing or restaurants, where services do not result in large profit margins, companies are forced to replace an entire shift due to annual premium cost increases that are irrespective of correlating increases in net profits.

★ **We never create strategy in a vacuum.** Take, for example, a software company with 400 employees, spending just over $2 million on a fully-insured plan. A self-funding analysis showed an opportunity to save $2 million over the next five years. The effort required to build and manage this plan could be better spent elsewhere on revenue generating activities. In addition, they may be concerned with short and long-term M&A activity. Thus, it made more sense to stay agile on a fully-insured benefit plan.

"THE HEALTHCARE INDUSTRY WANTS YOU TO THINK YOU'RE HELPLESS."

image credit: Twitter/@marshall_allen

Marshall Allen Is a journalist who investigates why Americans pay so much for health care and get so little in return. His best-seller "Never Pay the First Bill" puts a spotlight on Americans spending more on health care and getting less for their money—while the industry makes record profits. Layers of complexity make it confusing and discouraging to do anything about it. It may seem impossible but Marshall believes consumers can push back and succeed.



"Never Pay the First Bill" equips families and employers with the knowledge, strategy and how-to tactics they need to fight back and win. Consumers **can** take back control of their health care.

Allen is also the founder of Allen Health Academy, which produces a curriculum of short on-demand videos to equip and empower employees to navigate the healthcare system. Marshall has investigated the healthcare industry for 15 years, including a decade at ProPublica. His work has been honored with some of the top business reporting honors, the Harvard Kennedy School's 2011 Goldsmith Prize for Investigative Reporting and twice as a finalist for the Pulitzer Prize. *~marshallallen.com*

WILCO BUSINESS REVIEW | SELF-FUNDED HEALTHCARE

ANNOTATED GLOSSARY

ASO- Administrative Services Only (Carrier Third Party Administrator)
A carrier acting as a Third Party Administrator of a self-funded Plan. Many health insurance carriers offer both fully-insured and third party administrative services, which are often called administrative services only (ASO) often performed under an administrative services contract (ASC). Health insurance carriers and their subsidiaries provide most of the administrative services for enrollment covered under TPA agreements for health benefits.

Balance Billing
Refers to a provider billing a patient for the difference between the provider's charge and the payment received from the plan.

Deductible
The amount of expenses that must be paid out-of-pocket by the individual before an insurer or plan will pay any expenses. Typically, the deductible only applies to claims that happen outside of the physicians office unless it is a "Qualified High Deductible Health Plan." For example, a patient with a deductible of $1,500 having an outpatient surgery will be responsible for the first $1,500 of charges for that surgery before the benefit plan makes any payment to the provider.

EPO - Exclusive Provider Organization
Unlike a PPO, participants with an EPO network plan receive a lesser benefit (sometimes no benefit) if they visit medical care providers outside of their designated network of doctors and hospitals.

ERISA - Employee Retirement Income Security Act of 1974
ERISA is a federal law that requires employer health plans to provide plan participants with plan information, requires an establishment of an appeals process for participants, and gives participants the right to sue for benefits and breaches of fiduciary duty. ERISA also describes and provides guidelines for fiduciary responsibilities for those who manage and control plan assets. HIPAA and COBRA are amendments to ERISA.

Facilitator
Vendor Services (Third Party Administrators, Brokers, Consultants, IT vendors, all Non-Medical Providers of Services)
Third Party Administrators, Brokers, Consultants, IT vendors, all Non-Medical Providers of Services.

Fee for Service
In fee for service, doctors and other health care providers receive a fee for each service such as an office visit, test, procedure, or other healthcare service.

Formulary (RX)
A list of prescription drugs available to participants. Formularies vary drastically among drug plans and differ in the number of drugs covered and costs of co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory. Many have step therapy protocol requirements.

Fully Insured plan
A group health plan purchased and insured by a licensed insurance company. The employer pays a fixed monthly premium to the insurance company, regardless of the plan's claim costs. It is the insurance company that assumes the financial and legal risk of loss if claims exceed projections. If the employer has a good claims year, it is also the insurance company who 'wins' and keeps the excess premiums.

HDHP - High Deductible Health Plan
A health plan with lower premiums and higher deductibles than a traditional health plan. Being covered by an "Qualified" HDHP is also a requirement for having a Health Savings Account. If an HDHP is a "Qualified" HDHP, Federal guidelines apply.

HIPAA - Health Insurance Portability and Accountability Act
The HIPAA Privacy Rule regulates the use and disclosure of Protected Health Information (PHI) held by ``covered entities'' (generally, healthcare clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.)

Meaningful Use
Meaningful Use is a CMS Medicare and Medicaid program that awards incentives for using certified electronic health records (EHRs) to improve patient care. To achieve Meaningful Use and avoid penalties, providers must follow a set of criteria that serve as a roadmap for effectively using an EHR.

Network (In-Network) Preferred Provider Organization (PPO)
A group of medical doctors, hospitals, and other health care providers who have agreed with an insurer or third party to provide health care at reduced rates or a percentage off billed charges to the insurer's or administrator's clients. Preferred Provider Organizations themselves earn money by charging an access fee to the clients for the use of their network. They also commonly make money off of the percentage of savings amount (the amount in between the billed charges and the paid amounts).

Non-Formulary Drug
Drugs that are non-formulary are typically covered at a lower benefit or not covered by a health plan.

Non-Preferred Name Brand Drug
Part of a Tiered Formulary, Non-Preferred Name Brand drugs will have a higher co-pay than Preferred Name Brand drugs. All Name Brand drugs have higher co-pays than Generic drugs. Formularies vary drastically among drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory. High dollar Name Brand drugs often require prior authorization and clinical review to determine medical necessity.

Out-of-Pocket Maximum
The most a participant will pay during the year for covered benefits. On a written benefit summary provided by the carrier or benefits administrator, this listed out-of-pocket maximum amount may or may not include the deductible depending on how it is written. There can be a lower plan out-of-pocket maximum, in addition to the new ACA Federal out-of-pocket maximum. If the plan out-of-pocket maximum is lower than the mandated federal amount, the participant will continue to pay co-pays until the Federal amount is reached. A participant can have both an in-network and out-of-network out-of-pocket maximum for their plan that accrue separately.

Pharmacy Benefit Manager - PBM
A pharmacy benefit manager (PBM) is a third-party administrator of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and state government employee plans.

Preferred Name Brand Drug
Part of a Tiered Formulary, Preferred Name Brand drugs will have a lower co-pay than a Non-Preferred Name Brand drugs, but a higher co-pay than Generic drugs. Formularies vary drastically among drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory.

Reasonable & Customary (R&C) Usual & Customary (U&C)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The "reasonable" amount sometimes is used to determine the "allowed" amount.

Reference Based Pricing - RBP
A type of cost saving strategy that is utilized by some benefit plans which sets a maximum amount payable for specific procedures. Typically, the reimbursement assigned to a procedure is based on a percentage of Medicare allowables (e.g.,120% of Medicare).

Reinsurance / Stop Loss Coverage
A product designed to protect employers and self-funded health plans from catastrophic losses. There are two types of coverage: Specific - employer protection against a large expenditure by an individual Aggregate - employer protection against excessive claim expenditures for the entire group.

Self-Funded plan / Self-Insured plan
A plan in which the employer assumes the financial risk for providing healthcare benefits to its employees. In practical terms, self-insured employers pay for claims from general assets as they are presented instead of paying a pre-determined premium to an insurance carrier for a fully-insured plan. Unless exempted, such plans create rights and obligations under ERISA. Typically, self-funded employers purchase stop loss insurance to guard against catastrophic claims.

Seller
Providers of medical services, including facilities, hospitals, physicians, ancillary providers, imaging providers, etc.

Stop Loss Coverage Reinsurance
A product designed to protect employers and self-funded health plans from catastrophic losses. There are two types of coverage: Specific - employer protection against a large expenditure by an individual. Aggregate - employer protection against excessive claim expenditures for the entire group

Tiered Formulary Drug Plan
A type of drug plan with financial incentives for patients to select lower-cost drugs. Formularies vary drastically among drug plans and differ in the number of drugs covered and co-pays. Most formularies cover at least one drug in each drug class. Generic substitution is always encouraged and many times is mandatory.

TPA - Third Party Administrator
A company that processes claims and helps manage an employer's self-funded plan. Responsibilities include maintaining eligibility, adjudicating and paying claims, client and provider customer service, utilization management, etc. It also provides services such as arranging for stop loss coverage, provider network access, a pharmacy benefit management company, case management and assisting with employee education. There are three types of TPAs, independent, ASO (carrier owned), and a hybrid of two (an independent who utilizes carrier networks). The type of TPA an employer hires drastically impacts their interactions with a provider.

Usual & Customary (U&C) / Reasonable & Customary (R&C)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The "reasonable" amount sometimes is used to determine the "allowed" amount.