CASE STUDIES

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

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. Employee's 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 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, provide complete transparency, and the belief 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, AZ with over 30 locations across the US. 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.

Advisor Background

John founded Wincline in June 2016 with over a decade of experience in sales and the employee benefits industry. He did so with a simple mission: To change the way employers experience health care by eliminating the greed and inefficiency in the benefits industry.

As a fee-only, independent employee benefits advisor, John specializes in working with his clients to navigate cost-saving, higher quality benefit solutions. He strives to first understand the company's business, and only then designs innovative benefits plans to align with their corporate objectives.

John leads his team with a broad base of specialties including employee communications, benefits technology, plan design analysis, and consumer-driven health plans. He's been in this industry long enough to know what works and what doesn't. As such, he's highly effective at cutting through the nonsense and uncovering waste, fraud, and mismanagement in the health care industry.

Approach

Copper State Bolt & Nut was continuing to face year over year of 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 helped Copper State Bolt & Nut by guiding them through a two-year process moving off a Cigna self-funded bundled plan an

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 it's employees. In addition, Wincline identified nearly $100k 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 Copper State Bolt & Nut had a clearer picture of the excessive administrative fees.

Also, Copper State Bolt & Nut discovered that it's 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 as they 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 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 deductible would be waived. This made the smart choice the easy choice.

Top-Level Results

Two years after partnering with an independent, fee-only advisor firm, Wincline, helped Copper State Bolt & Nut reduce health plan costs by 40%, a savings of $1.3 million annually.

It's per employee per month (PEPM) 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 it saved a lot of unnecessary care and improved employees overall experience in their health care journey. The employer is now able to reinvest those savings back into providing better benefits for their employees over the long term.

CASE STUDY:

Gasparilla Inn & Club

Advisor Organization:	**Mitigate Partners**
Headquarters:	**Boca Grande, Florida**
Industry:	**Service and Hospitality (seasonal)**
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 five and ten thousand dollars 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 at 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 bottomline. 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.

Advisor Background

Carl Schuessler is the managing principal at Mitigate Partners in Atlanta, Georgia. Mitigate Partners is a Risk Management, Cost Containment and Employee Benefits Consulting firm, which is a partnership of fourteen employee benefit consulting and brokerage firms that allows local management within a collaborative environment with more than 330 years of combined experience.

Carl has been working as an insurance, risk management, and employee benefits consultant for over thirty years. His focus is treating the employer's money like his own. Mitigate Partners goal is to provide best-in-class benefits at substantially lower costs, while improving clinical and financial outcomes for employers and health plan members.

He is an advocate of active health care management and saying no to passive, status quo health care plans that reward insurers more than plan sponsors and its members. Carl has helped large and small companies across various industries regain control over their health care benefits by creating innovative health care plans that meet the specific needs of their employees to achieve their financial goals.

Approach

Carl 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 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 its health care plan for the first six months of the year and then a total of 215 employees on its plan for the second half of the year. On average, Gasparilla Inn has 185 employees on its health care 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 Prefered 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 Tampa, Florida. Traditional carrier networks contract a discount off billed charges resulting in exorbitant health care spending for plan sponsors.

Carl 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. Carl 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, Carl worked with its executives and leaders to move the resort off its fully insured plan and construct a better, more affordable health insurance 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 Carl'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 – 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.

Carl 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 and in the Tampa area the procedure can range from $1,300 to upwards of $19,000.

The new plan also had a direct impact on employees. Gasparilla Inn employees used to pay a $2,500 (single) and $4,500 (family) deductible, 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 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 Liz 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. Liz puts the resort and its employees' best interests at the 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:

Great Lakes Auto Network

The Best Benefits Attract the Best Talent

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, researching other profitable businesses and learning 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 that doesn't fight to disclose every fee and cost, including their own compensation, I recommend 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 for why he attracts 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 to me when I meet employers who are reluctant or skeptical of changing their health care plan. But my hope is that once they hear enough stories like Heinbaugh's and Huang's they will change their mind and realize that overpaying for subpar insurance is *not* the only option.

CASE STUDY:

Keystone Technologies

Educating Employees to Reduce Your Healthcare Expenses

Growing companies who increase the size of their workforce are rewarded with the benefits of increased productivity and more business opportunities. But more employees comes 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 an upsetting 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 who 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 their 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 insurance. 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 exceptional 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 I firmly believe that digital tools are *not* the *sole answer* to solving our health care problems, they are incredible 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 health care 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:

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 refer-

ence-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 health care consulting solutions to their clients.

This unique health care 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 a number of 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 upwards of $50,000.

Part of setting those pre-negotiated rates was also doing the research to find the quality providers that practice valued-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 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:

City of Milwaukee

City Slashes Health Care Costs by Improving Benefits

By John Torinus

Because the economic pain of out-of-control medical costs are 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, Wisconsin, 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 installed 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. U.S. average of 14%), but, as with other employers, there's 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 (see chapter 8's section on this), 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 a 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:

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 employ-

ees, 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 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 came up to 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

Figure 19: 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 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 com-

pany, 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

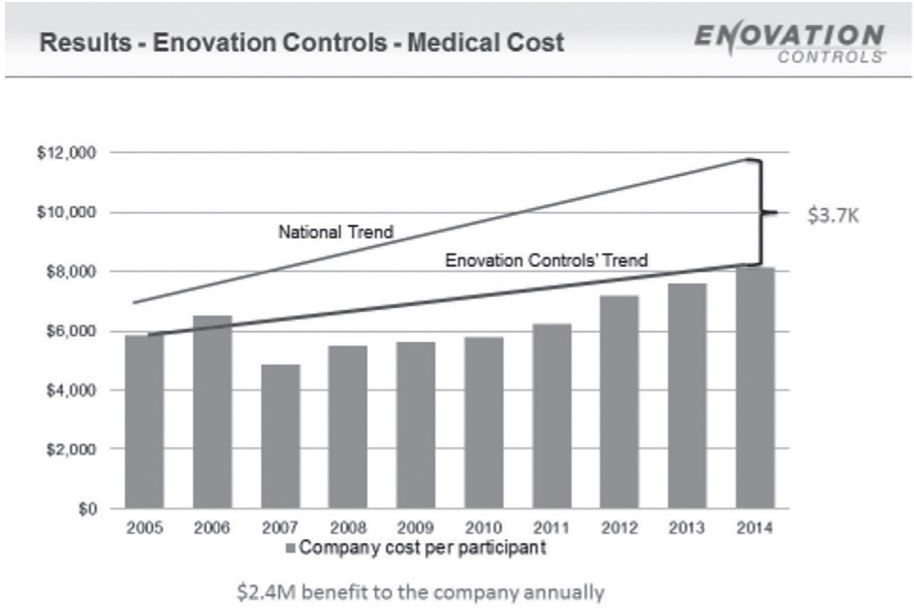

Figure 20: Summary information provided by Enovation Controls.

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:

Langdale Industries

A Rural Wood Products Company in a One-Hospital Town Saves Hugely 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 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
* For Medical, Dental & Pharmacy			Cumulative Difference		$ 29,082,906

** 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 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 pro-

cess. This attitude and rigor has 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:

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 deci-

sions 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 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:

Rosen Hotels & Resorts

Smart Benefits Lead to Huge Gains in Education Outcomes and Crime Reduction

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, socioeconomically, and demographically diverse employee base, including many immigrants who often haven't had regular access to care before. Yet single coverage for the average employee is only $18.75 per week for benefits that include medical, dental,

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, reducing 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:

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 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 healthcare 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 who is well known for helping businesses, large and small, across the US, save hundreds of millions in healthcare 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 healthcare 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 YOUR OWN RATES WITH DIRECT CONTRACTS

In 2019, Contorno introduced several new changes to the healthcare 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 was a burden to them, but resulted in less savings than it could otherwise achieve.

To prevent future surprise bills, Contorno created direct contracts with healthcare 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, and 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 healthcare spending beyond what Feinburg expected. Textum employees have not seen an increase in deductibles since embarking on this journey to better healthcare in 2017. The 2018 plan had an expected max 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 healthcare spending in 2018.

In 2019 Textum's max 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, like Contorno, who fights for the best interests of members are crucial to transforming the status quo and fixing healthcare.

CASE STUDY:

ETEX Telephone Co-Operative

A Texas fiber and telecommunications provider joins the local healthcare movement

Charlie Cano, CEO and general manager of ETEX – one of the largest telecom co-ops in Gilmer, Texas that provides internet, phone, and TV for over 13,000 customers and numerous school districts in the northeast Texas region – is an engineer by trade. He is accustomed to understanding how things work, but when it came to health insurance, he was wrought with confusion about hidden fees, high cost pharmaceuticals, and constant rate increases.

Paige Mendez is now an Employee Benefits Consulting, LLC (EBC) team member who previously worked at the third-party administrator that manages ETEX's benefit plan. Paige recommended that Charlie talk to Rachel Means, CEO of EBC, who founded the Tyler, Texas firm in 2016 to break away from predatory insurance practices and start an advisory group that strove to provide plan members with the highest-quality, most affordable care.

In an hour-long meeting over lunch, Means took the time to answer each and every one of Cano's questions, demonstrating transparency he had yet to experience from any other advisor. Means told Cano about hidden commissions, fees, and other wasteful spending in his company's plan. After talking, Cano was convinced that Means could help him achieve his goal of creating a better health plan – one his 150 employees deserved.

LOCALIZING CARE

The first thing that Means did to push down ETEX's health spend was change its pharmacy benefits manager (PBM) to one that was more transparent. Means pointed out the pain points in ETEX's health plan, much of which came from several high-cost member medications. Cano, like many employers, believed that the billed prices of medical services and drugs were final, non-negotiable, and due in full. But, Means helped him 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 drugs 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 medical and prescription costs by $5,743 a year, since 2017.

Means continued to seek out local, affordable healthcare 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 diabetic supplies, like insulin, pumps, and meters, plus no-cost hormone replacement therapy.

When 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 $2.5M in three years. ETEX has seen $863,000 in year-over-year savings since 2017.

Employees now have access to $0 high-quality healthcare 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 healthcare benefits have made ETEX more competitive and appealing to potential hires, Cano even mentioned they have a waiting list of candidates wanting to work for ETEX.

This case study shows why providing your 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 can not only save money; they can potentially save their local community.