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.

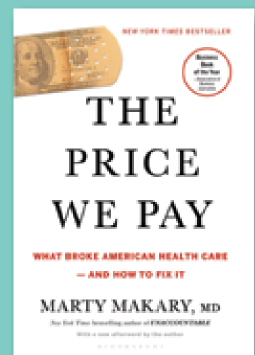
> **"We are not here to criticize physicians or providers. This is not about us versus them; this is about working with doctors to provide the best outcomes for members, physically and financially."**

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.

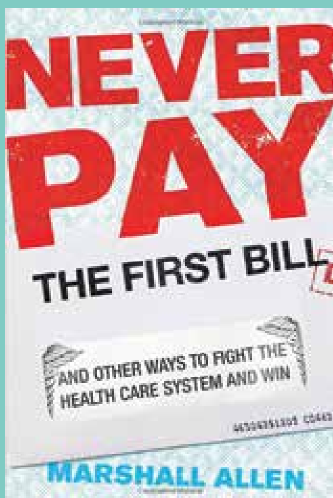
CAIRN CAST

- ★ **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.

Giving Voice to the People Who Matter

Patients and Surgeons are the most important people in the operating room. Employers just happen to be the ones who pay for it.

Ann Marie Kennon
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Sean Kelley is Founding Partner of Texas Medical Management (TMM), which specializes in facilitating surgeries for self-funded employers' health plans. Kelley began doing his part to fix the health care system when he recognized the unreasonably high cost of care wasn't about better quality but, instead, was largely due to unnecessary interlopers who add no value to the process.

Kelley is sounding a wake-up call for CEOs who are not yet self-funded. "As in life, many healthcare insiders believe it's always someone else making all the money. Having run surgical practices in a major hospital system, I became certain it is the hospitals making most of the money. Consider a car maker who knows, to the last bolt, what he is paying for in his manufacturing process. This is not the case for his costs for health care, and no business owner would ever blindly pay other bills in the manner they are obliged to for health care."

MEANINGFUL CHANGE

Kelley says hospital systems, big pharma, and even implant systems have all staked a claim in the industry, but it is those affecting the outcome most who are left outside. He explains; "First, there is a lack of transparency about quality and cost. Second, facilities are taking about 85 percent of the money and, because outsiders cannot assess their quality, surgeons only get 7 percent."

As such, a main motivation of free market advocates is to fix the system through transparency and competition. Kelley, through TMM, is taking on areas where they can determine the quality of the surgeon and cut costs with no impact on patient outcome.

Today, his model provides a win-win in the operating room. "We decided we could improve the quality and change the cost of healthcare. Because of the unreasonably high hospital overhead hospitals, we knew employers were paying a premium for those surgeries. But outpatient surgeries like hernias or joint replacements don't need a full-service hospital. So, we peer-select mid-career surgeons, invite them to work in outpatient surgery centers, save up to 70 percent on the cost, and pay the surgeon within ten days, saving them time and money for billing and collection."

Kelley's clients are self-funded employers who, like many in the free market lane, are saving so much money, they are offering surgery to their health plan members at no cost and in some cases paying for travel. They are even able, sometimes, to include perks, like cash bonuses–to their health plan members.

BETTER, FASTER, CHEAPER

As employers' gain transparency into their healthcare spending, they are able to measure costs and determine provider quality. Thus they use their value sense to find the highest quality and experience at the best cost. A transparent marketplace obtains quality relative to cost. Kelley says TMM is also expanding their scope to include maternity advocacy and oncology, which, like every other healthcare vertical, should be open to competition on quality, cost, and experience.

"Our model is simple and works across many healthcare domains; reward quality physicians and providers by paying them fairly and fast. We reward their quality by sending them patients, which benefits their business. The patient benefits from our curated quality. The employer benefits because we've done the homework to provide the most efficient care."

photo courtesy Sean Kelley

Surgery is complicated, but it doesn't have to be.

Kelley's 'homework' involved eschewing the 10,000 page legislative documents put together by all the health care lobbyists. "We can never outspend lobbyists; but there are existing laws that are opening up the market to transparency. Those same laws benefit employers and employees, allowing them to see cost up front. The difference is Texas Medical Management is transparent on quality and cost, information necessary to help employers make certain they know low-cost doesn't mean low quality. If we're not willing to hold ourselves accountable, how transparent are we?"

Ann Marie Kennon
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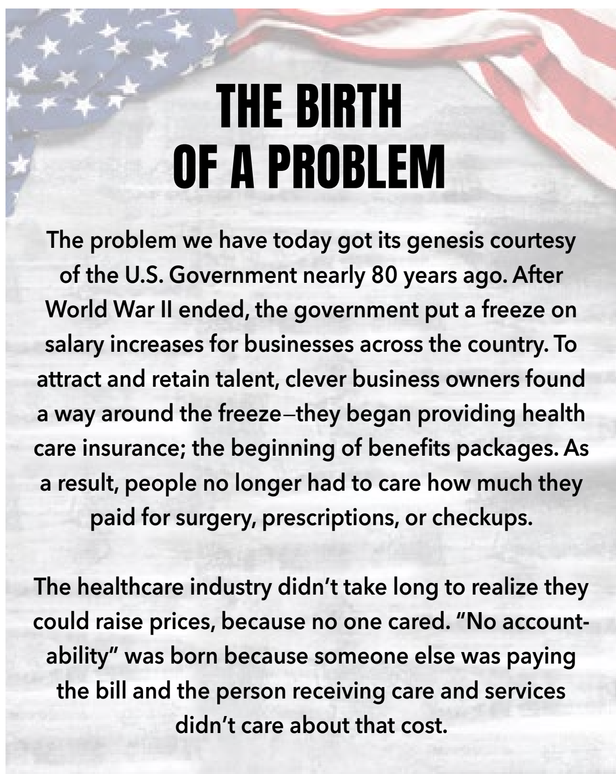
JOE LAMANTIA WANTS YOU TO

CONTROL YOUR OWN HEALTHCARE DESTINY

Self-funded healthcare is a cost-effective solution to avoid continually rising premiums in a fully-insured plan. With self-funding, employers can easily spread the risk of costly claims over a large number of employees and dependents.

When Joe LaMantia's healthcare broker admitted he wasn't allowed to disclose how much he made off of Joe's beer distributorship business, Joe knew it was time to ditch major medical and fashion a better plan for his companies. "The goal is to demystify self-funded plans for C-suite employees, and the major problem is ignorance," he says. "We were controlling our losses, our premiums were going up every year, and we were not allowed to see the data. Sadly, the benefit system that was put in place to take care of us has evolved into a commercial industry that keeps companies from understanding and therefore advocating for themselves, or even having the ability to shop around for the best value."



THE BIRTH OF A PROBLEM

The problem we have today got its genesis courtesy of the U.S. Government nearly 80 years ago. After World War II ended, the government put a freeze on salary increases for businesses across the country. To attract and retain talent, clever business owners found a way around the freeze–they began providing health care insurance; the beginning of benefits packages. As a result, people no longer had to care how much they paid for surgery, prescriptions, or checkups.

The healthcare industry didn't take long to realize they could raise prices, because no one cared. "No accountability" was born because someone else was paying the bill and the person receiving care and services didn't care about that cost.

BEVCAP: BIRTH OF A COMPANY

As CEO of L&F Distributors, when this quintessential Texan got tired of seeing rates go through the roof, he joined a heterogeneous property and casualty captive[1]; which provided him 100 percent access to his own data. A year later, when he realized it was not fully meeting the company's needs, he started his own homogeneous P&C captive; providing coverage for 40 independent beer distributors with 8,000 employees, and each member is an owner and director. All members have control over it.

The success of his captive led to a second company that covered beer wholesalers and, again, a third expansion that put him back in the heterogeneous market outside the beer industry. Today, all three programs are operated by BevCap Management, which covers nearly 30,000 lives across the nation.

In the P&C universe, our auto liability is priced in terms of Power Units, regardless of how many employees each has. LaMantia says, "We have had great results, and my rate per power unit has been the same for the past three years. You can't say that about the typical insurance industry; they have had enormous increases in the past year, but we are able to maintain that because we use a different universe for our premiums."

BevCap maintains rates because their carrier uses loss data from companies trained to put things in place to mitigate claims and help them perform better than the general population.

[1] CAPTIVES ARE COMPANIES FORMED UNDER A PARENT COMPANY. HOMOGENEOUS MEMBER COMPANIES ARE FROM THE SAME INDUSTRY. HETEROGENEOUS INCLUDES MEMBERS FROM ANY INDUSTRY.

WHAT CAN WE DO DIFFERENT?

~Self-funded Employers

This is how much waste there is in the system...

~Joe LaMantia

I CAN SEND AN EMPLOYEE AND SPOUSE FROM EL PASO TO A FREE MARKET SURGERY CENTER IN AUSTIN...

PICK THEM UP IN A LIMO, PUT THEM IN 5-STAR HOTEL...

PAY THEIR EXPENSES AND GIVE THEM A $1,000 CASH INCENTIVE...

WAIVE THEIR DEDUCTIBLE AND CO PAY...

AND THE TOTAL COST IS STILL 20 TO 30% LESS THAN AT A LOCAL HOSPITAL.

THE BEVCAP UNIVERSE

ILLNESS

In 2017, LaMantia created a partnership to found Retro Health, a disease management program for the chronically ill. "The problem," LaMantia says, "was employees who were out of compliance; not taking their meds, not seeing their doctors. In any universe of employees, there are likely 40 percent who are chronically ill, but those individuals make up 80 percent of the cost because they are not being accountable for their own health."

By funding doctor visits at worksites, on company time, LaMantia brought many chronically ill employees into compliance, saved the company more than $1.5 million, and saw a 60 percent drop in hospitalizations. "If patients didn't show up, we called them at home. We actually saved several lives, and developed greater trust relationships between employees, physicians, and the company."

Being in greater control of chronic conditions helped reduce the company's overall health costs. In 2014, BevCap's total claims cost was $475 per employee. In 2020, as a growing number of employees participated in the health clinics and began to meet their clinical goals, the cost fell to $415—a reduction of 14 percent.

"The bottom line," LaMantia says, "I don't mind spending $100,000 on doctor visits to save $1 million on hospitalizations. It's better for the employee and saves me money."

SURGERY

BevCap, in most cases, has no copays and very low deductibles for procedures, and covers expenses for imaging and urgent care with contracted providers.

The average deductible for companies in the captive is $750, and BevCap is still saving money. LaMantia says, "In 2020 our company paid about $7,400 per employee; roughly the same amount we paid for them in 2014. Compare that to other mid-sized and small companies who have been saddled with an 8 percent or more per year increase since then. LaMantia Beer Companies, over the past seven years have saved more than $10 million, and have happier, healthier employees."

PHARMACY

In spite of all the research and success, LaMantia says pharmaceuticals is one of biggest unresolved problems, but BevCap is struggling to get a handle on it.

LaMantia explains, "America pays more for drugs than any other country in the world. When you look at the financial statements of larger specialty drug manufacturers, you see a 40 percent margin net profit to sales. That is not 40 percent on the product, that is margins on sales."

In the BevCap universe, for those who need the most expensive chemical therapies, the members implement medical tourism. Patient and spouse are flown, at company expense, to the Cayman Islands for treatment, and it still costs BevCap 70 percent less than if they purchased the drug domestically. "That's a band-aid and it doesn't include too many types of treatments," LaMantia says. "Plus, we are still talking about a $100,000 bill but, in-country, it could be $800,000 to $1 million. What that does is create a situation where larger companies have the motivation to form a group captive."

In the past, if companies had at least 20,000 employees they did not need a captive. However, if one or more employees happen to have a sickness that will cost in excess of $1 million to treat, those companies can no longer afford that. A captive is a reasonable alternative, and makes good business sense. A lot of the work is done behind the scenes so the companies do not have higher overall costs.

KEY TAKEAWAYS

The group captive gets things done where those in typical insurance cannot, and allows members to have influence over every part of the process. As owners of the plan, when a problem arises, captive members don't call a broker; they call the COO of the insurance company, the head of the hospital, or the CEO of the provider group to work it out.

LaMantia says, "C-suite employees need to get involved in their health care. First, they have fiduciary responsibility to the employees because they are putting in their hard-earned money. Second, they need to recognize the system is so complex, and intentionally hard to understand. Ideally, what I want, is for the CEO to look at the company bills and say, 'This is crazy.' You don't need to be a healthcare expert to make a difference." Put simply, remaining in the existing healthcare plan is like this bank allegory:

NO ONE IN THEIR RIGHT MIND WOULD OPEN A BANK ACCOUNT, DEPOSIT $10 MILLION, GIVE THE CHECKBOOK TO A TOTAL STRANGER, GIVE HIM SOLE SIGNING ABILITY ON THOSE CHECKS, THEN TELL HIM, "YOU DON'T HAVE TO LOOK AT 98% OF THE BILLS THAT COME IN, OR GIVE ME THE DATA. JUST WRITE THE CHECK." THAT IS WHAT THESE BUSINESS PEOPLE ARE DOING WITH MAJOR MEDICAL PLANS. IF YOU'RE IN THE SYSTEM, THIS IS HOW IT WORKS.

Companies and captive owners understand that there are good brokers out there, but when an insurance company pays a commission, the employer is necessarily paying much more than he needs to. It's an incentive structure that does not work.

LaMantia explains, "If you look at investment brokers, the broker that handles your finances is under a fiduciary responsibility by law to you and your money. He must disclose what he gets paid. A real estate broker has to disclose who he is working for and what he's getting paid. If you look at the broker who is responsible for providing health care to you, your employees, and their families, there are no restrictions. He doesn't have to tell you anything. How does that add up as the correct way to handle things?

"This is part of the overall system that helps create confusion and thought processes that people are helpless to do anything about health care cost. Just get out of the regular system."

"TYPICALLY, THE BROKER IS NOT YOUR FRIEND. IF HE IS REALLY HELPING YOU, HE IS NOT HELPING HIS EMPLOYER.

ANY RELATIONSHIP IN WHICH SOMEONE ELSE IS PAYING YOUR CONSULTANT TO GIVE YOU ADVICE, IS ONE THAT HAS A HUGE DISCREPANCY OF INCENTIVES."

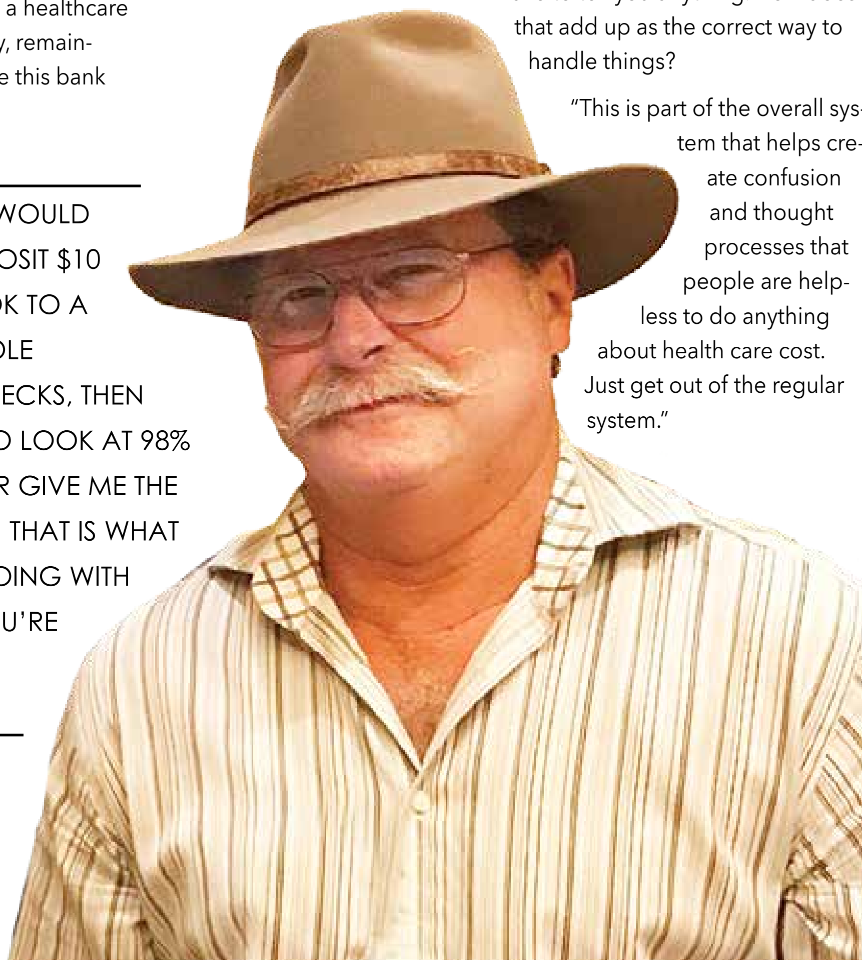


photo courtesy Joe LaMantia