Current Trends in Health Care

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Health Care Industry Trends

Agenda:

- Introductions
- Health Care Marketplace
- Federal, State, and Local Government Developments
- Regulatory and Technological Developments Pressuring Industry
Health Care Marketplace

- Affordable Care Act – March 23, 2010
- Consolidation
- Insurance and reimbursement reforms
- Continued heightened enforcement in fraud and abuse, HIPAA/Privacy and antitrust
- Uncertainty arising from political landscape
- Challenges for patients (employees) and employers
Election Outlook

*What does it mean for policy and politics in Washington, DC?*
Presidential Election

- Agency turnover
  - How long does it take?
  - Which positions will be the hardest to fill?
  - Which nominations might take the longest to confirm?

- Impact on federal agencies and regulation and rulemaking
Senate Election

- What does a Republican Senate mean?
- What does a Democratic Senate mean?
- How will both interact with different White House scenarios and the House of Representatives?
- Key retirements and committee leadership changes and what it means
Post-Election Policy Outlook

- 30,000-foot view after November 2016
  - Government spending/entitlement/taxes
  - Affordable Care Act and employee benefits
  - Other top line issues
Provider Consolidation

- **Response of ACA - Continued shift from Fee- For Service to Value Based, Outcome Based, Population Health Management Environment**

- **Antitrust and State Attorney Generals**
  - Penn State Hershey Medical Center and Pinnacle Health System
    - US District Court in Pennsylvania declined to block FTC injunction
    - *We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the hospitals intended here*
  - Advocate Health Care and NorthShore University Health System
    - US District Court in Chicago declined to block FTC injunction
  - Carolinas HealthCare System
    - Sued by DOJ and AG alleging higher medical costs and suppressed competition due to anti-steering restrictions placed on insurers
  - Health insurance companies and life sciences companies also experiencing active consolidation period
Fraud and Abuse Enforcement

- Federal Anti-Kickback Statute
- Federal Stark Anti-Referral Statute
- Federal False Claims Act
- Corporate Practice of Medicine Prohibition
HIPAA, Privacy & Data Security

- **General**
  - Shift from closed EMR Systems to Sharing
  - Example – Epic Everywhere
  - Limitations
    - Substance Abuse Confidentiality 42 CFR Part 2
    - Mental Health (loosening restrictions)

- **PIPA**
  - New Changes to Illinois Personal Information Protection Act (HB1260) Effective January 1, 2017
HIPAA, Privacy & Data Security

- **Security**
  - Update on latest Breaches
    - Hollywood Presbyterian Hospital - $17,000 Bitcoin Ransom
    - Prime Healthcare in Southern California
    - MedStar Health - DC
  - **Tips**
    - Look at the third-party vendors
    - Subcontractors of those vendors
    - Review the EULAs

- **Cyber threat preparedness**
New Healthcare Environment and Transformation

- Video Visits (Telemedicine)
- Mobile Apps (PwC – 2x increase in use of mobile health apps in 2016)
- Continued Partnerships
- SmartChoice, MRI
- Price Transparency
- MACRA
Q&A
Making the Move from Fully Insured to Self-funded Health Plans: Business Opportunities and Legal Considerations

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Ben Wagner
Senior Vice President
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Chief Human Resources Officer
Drinker Biddle & Reath
Case Study

A recent case study of a fast-growing organization with 260 covered employees, found it was spending $1.6 million annually on their fully insured health plan. The company was facing a 22% (~$350,000) increase at their annual renewal. An analysis was performed with limited claims data and the decision was made to transition to a partially self-funded arrangement. As a result of moving to this funding arrangement, the first year savings were $120,000 through lower taxes and carrier profit and an additional savings of $100,000 due to favorable claims experience. The total savings in year one was $220,000 and cash flow advantage of holding the $250,000 Incurred But Not Reported reserve. The projected savings in year two is an additional $280,000 (when comparing to an estimated 10% fully insured increase in year two) for a two year total savings of $500,000.
Medical Plan Funding Options

- Fully Insured Non-Participating
- Fully Insured Participating
- Minimum Premium
- ASO with Stop Loss (Partially Self-Funded)
- ASO (Fully Self-Funded)

Funding Differences:

- Participating = Plan Sponsor participates in actual claims experience
- Minimum Premium = Plan Sponsor participates in actual claims and holds reserves
- ASO = Administrative Services Only

Fixed Monthly

Maximum Cash Flexibility
Why Would A Company Consider Self-Funding?

- ERISA Plan – ERISA preempts state insurance and other laws related to benefit plans
- Greater Plan Design Flexibility – Not subject to state mandates ($)
- Increase access to claims reporting & care management programs
- Greater ability to customize health awareness/prevention programs
- Cash Flow Advantage of holding reserves
- Reduced Administrative Expenses within the plan
- Comfortable With Retention Level of Risk (Stop Loss) vs. Cost of Offloading Risk
- Believe claim experience, demographics and prospective costs are better than rest of Insurance company’s Book of Business

Historically, partial self-funding was pretty common for employers with 300+ employees
How Do Insurance Companies Price Risk?

Manual vs. Experience-Based Rating

- **Manual Rates**: Based on the carrier’s entire book of business and rated solely on the location and demographics of the insured population
- **Experience Rates**: Based on the actual claims experience of the insured population
- **Blended Rates**: Combination of Manual & Experience rates based on the size of the insured population

**Credibility Chart – Sample:**

\[ \% \text{ Credibility} = \text{what } \% \text{ of the final cost is based on Experience Rates} \]

<table>
<thead>
<tr>
<th>Estimated Employee Count</th>
<th>Estimated Membership Count</th>
<th>% Credibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>105</td>
<td>20%</td>
</tr>
<tr>
<td>150</td>
<td>315</td>
<td>40%</td>
</tr>
<tr>
<td>300</td>
<td>630</td>
<td>60%</td>
</tr>
<tr>
<td>500</td>
<td>1,050</td>
<td>80%</td>
</tr>
<tr>
<td>800</td>
<td>1,680</td>
<td>100%</td>
</tr>
</tbody>
</table>

Important question to ask - how do your Experience Costs compare to Manual?
Fully Insured vs. Partially Self-Funded

- **Fully Insured**
  - Claims
  - Administration (non-claim costs)
  - Fixed Liability for the Employer

- **Partially Self-Funded**
  - Claims
  - Stop-Loss Premium
  - Administration
  - Fixed Costs for the Employer
  - Expected Liability for the Employer
  - Corridor for Maximum Claims
  - Projected Savings

- **Lower Fixed Costs**
Why are more companies now looking to self-fund?

**Fully Insured**
- Administration (non-claim costs)
- Plan administration
- Network access
- Pooling Charge
- Insurer Profit
- Risk Charge
- State Premium Tax

**Partially Self-Funded**
- Administration
- Stop-Loss Premium
- Plan administration
- Network access
- Pooling Charge
- Insurer Profit

**Additional Costs Post-ACA**
- Comparative Effectiveness Research Fee
- Excise Tax on Rx Manufacturers
- Tax on Medical Device Manufacturers
- Transitional Reinsurance Program Tax
- Excise Tax on Insurance Companies

**Additional Costs Post-ACA**
- Comparative Effectiveness Research Fee
- Excise Tax on Rx Manufacturers
- Tax on Medical Device Manufacturers
- Transitional Reinsurance Program Tax

**Difference in Cost:**
- ~ 3 - 5% Lower Cost for Partially Self-Funded Plans
- ~ 5 - 8% Lower Cost for Partially Self-Funded Plans
Measure Potential Cost Volatility (FI vs. SF)

Monte Carlo Simulation - Sample

Potential Volatility of Total Costs Under Self-Funding

- <5% of simulations resulted in costs 10% higher than FI costs
- Projected SF Costs lower than FI in 78% of simulations
What is Stop Loss Insurance?

**Definition:** Excess risk insurance purchased to financially protect the plan

**Individual Stop Loss**

Individual Excess risk coverage covers expenses of an individual who exceeds an established yearly deductible for the policy year (i.e., $50K, $100K+). Claims for individual excess risk are reimbursed on an ongoing basis throughout the plan year and the contract is typically purchased with no cap on reimbursement level.

Protects the plan from one huge claimant catastrophically impacting costs

**Aggregate Stop Loss**

Aggregate excess risk coverage covers expenses for the entire group that exceed an established attachment point for the policy year – generally expressed as a % of expected cost (i.e., 110% - 125%). Claims are typically reimbursed at year end after claims have been paid and audited. Please note, most aggregate stop loss contracts have an annual reimbursement cap of $1M.

Protects the plan for several claimants, under the Individual Stop Loss Level, from catastrophically impacting plan costs.
Average Monthly Specific Premium Rate at Popular Deductible Levels

<table>
<thead>
<tr>
<th>Individual Deductible</th>
<th>Adjusted Composite Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000</td>
<td>$190</td>
</tr>
<tr>
<td>$100,000</td>
<td>$107</td>
</tr>
<tr>
<td>$125,000</td>
<td>$102</td>
</tr>
<tr>
<td>$150,000</td>
<td>$70</td>
</tr>
<tr>
<td>$200,000</td>
<td>$51</td>
</tr>
<tr>
<td>$250,000</td>
<td>$36</td>
</tr>
<tr>
<td>$300,000</td>
<td>$32</td>
</tr>
<tr>
<td>$350,000</td>
<td>$20</td>
</tr>
<tr>
<td>$400,000</td>
<td>$15</td>
</tr>
<tr>
<td>$500,000</td>
<td>$13</td>
</tr>
<tr>
<td>$750,000</td>
<td>$7</td>
</tr>
</tbody>
</table>

* Composite rate adjusted to a "Paid" contract basis for comparison purposes.
* Benchmarking based on Infolock Data
Challenges In Stop Loss Marketplace

Health Reform
- Unlimited lifetime dollar max for plan participants
- Shorter waiting periods increase claim exposure
- Medical loss ratio (MLR) requirements will accelerate carriers’ need to promote other profit centers

High-Cost Claims
- Often receive lesser discount than routine claims
- Claims incidence over $1M has increased 1000% in last 36 months
- 0.6% of population driving ~30% of costs – highly impactful
- Specialty Pharmaceuticals driving up Rx spend

Insurance Market
- Annual pricing does not provide predictability/stability
- Lasers represent additional price/risk increase
- Provider contract requirements do not allow for managed claims/alternative programs
- Carriers/TPAs auto pay 70%+ of all claims

Purchasing the right stop loss coverage level and contract is VERY Important
Who Should Consider A Self-Funded Medical Plan?

*Companies Looking To:*
- Take a long-term cost perspective
- Benefit financially from good claims experience
- Gain greater control and flexibility over plan design
- Better reporting and transparency of healthcare costs
- Use data for Wellness, Chronic Condition & Rx Program Management
- Beat Trends
- Lower Premium Taxes and ACA fees

*Companies Who Are:*
- Comfortable with some level of Risk Retention & Stop Loss Contracts
- Comfortable with additional Administrative & Compliance Requirements
Employer Point of View

Chief Human Resources Officer’s Experiences and Lessons Learned
Self-Funding – Key Legal Issues

- Required Documentation
- New Rules (and Opportunities) Related to Self-Funding
- Stop Loss Coverage
- Wellness Programs
- Third Party Administration
- Administrative Services Agreements
- HIPAA Privacy Compliance
Required Documentation – Much Stays the Same…

- **ERISA-Required Documentation**
  - Plan Document
  - Summary Plan Description (SPD)
  - Summary of Material Modifications (SMM) to SPD
    - Within 210 days after the end of the plan year in which a modification or change is adopted
      - includes a change in funding from insured to self-funded
  - Summary of Benefits and Coverage (SBC)
    - *Self-insured plan* - plan administrator (usually the plan sponsor) has obligation to provide (with insured, shared the obligation with insurer)
    - Updated SBC template (along with updated instructions) was issued in April 2016 and must be used to prepare SBCs for a plan’s first open enrollment period beginning on or after April 1, 2017

The Changing Health Care Landscape and How It Affects Your Company
Required Documentation – Much Stays the Same… and Some Key Differences

- **Cafeteria Plan**
  - Pre-Tax Premium Payments
  - Health and Dependent Care Flexible Spending Account
  - Health Savings Account
  - Employee contributions mean the plan has plan assets
    - Self-funded plans with plan assets has trust requirement unless benefits are paid solely from employer’s general assets
    - For a self-funded medical plan, identifying funding from employer’s general assets is imperative to avoid trust requirement

- **Review Plan Governance –**
  - Are delegations in place?
  - In all of the above documents, need to be able to describe who is responsible for:
    - Plan administration (fiduciary), and
    - Plan design (non-fiduciary)
New Rules (and Opportunities) Related to Self-Funding

- **Health Plan Nondiscrimination Rules**
  - Code Section 105(h) applies to medical plans
  - Benefits and eligibility tests apply
  - Nondiscrimination rules for insured plans under ACA are delayed

- **ACA Employer Reporting Requirements**
  - Employer takes on additional responsibility of reporting about covered individuals/dependents and months covered
  - Employer takes on responsibility of soliciting SSNs

- **PCORI and TRP Fees** – Employer reports and pays
  - Consider contracting for TPA to carry out
New Rules (and Opportunities) Related to Self-Funding

- **Venue-forum selection**
  - Where the plan is administered
  - Where the breach took place, or
  - Where a defendant resides or may be found

- **Language in plan and SPD:**
  - **Restriction on Venue** - Any action in connection with the plan can only be filed in the federal district court in [insert city and state, either where plan sponsor is headquartered or where plan is administered].
New Rules (and Opportunities) Related to Self-Funding

- **Time limit on filing lawsuits**
  - No ERISA statute of limitations on filing lawsuit; use most analogous state statute of limitations
  - Pick your own … what is reasonable? (90 days, 180 days, one year, 2 years, 3 years)

- **Out-of-network providers**
  - Are the payments made by the plan to the service provider or to the participant?
  - If to the provider, what is the basis for payments – typically coinsurance
  - If a flat percentage coinsurance, then a percentage of what – usual, reasonable and customary charges; Medicare reimbursement rates; maximum eligible fees established by the TPA; something else?
Wellness Programs and Incentives

- Employee wellness impact on plan costs is more direct and immediate in self-funded plan

- Wellness programs that provide medical care are subject to ERISA
  - Medical care can be diagnosis, cure, mitigation, treatment or prevention of disease
  - Include wellness initiatives in your medical plan documents
Wellness Programs – Legal Compliance

- Nondiscrimination rules may apply under:
  - HIPAA – Prohibits discrimination based on a health factor
  - ADA – Prohibits discrimination based on disability
    - Medical examinations or disability-related inquiries generally prohibited unless voluntary
  - GINA – Prohibits discrimination based on genetic information
Wellness Programs – Legal Compliance

- Wellness program exceptions have developed
- Exceptions under HIPAA, ADA, GINA generally require:
  - Reasonable design to promote health or prevent disease
  - $ limit on incentive based on total cost of health plan coverage
  - Certain notices required
  - Confidentiality rules
  - Reasonable alternative must be offered for outcome-based program (HIPAA)
  - Spouse’s authorization to participate required (GINA)
New ADA and GINA Regulations

- Under ADA, in order for wellness program to require a medical examination (e.g., *biometric screening*), must provide notice and limit incentive.

- Under GINA, in order to collect information about spouse’s health conditions (e.g., *health risk assessment or biometric screening*), must get authorization.
### Summary of Wellness Program Requirements under HIPAA, ADA and GINA Rules

<table>
<thead>
<tr>
<th>FAQ</th>
<th>HIPAA</th>
<th>ADA</th>
<th>GINA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must the wellness program be reasonably designed to promote health or prevent disease?</td>
<td>Yes.</td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td>Is there a specific notice requirement?</td>
<td>Yes. Materials describing the terms of the wellness program must describe the availability of a reasonable alternative standard. Regulations include model notice language.</td>
<td>Yes. Notice explaining the types of medical information collected and how the information can be used and disclosed must be provided. ERIC requires to issue model notice language.</td>
<td>Yes. Notice explaining the types of genetic information collected and how the information can be used and disclosed must be included if authorization is required.</td>
</tr>
<tr>
<td>Must an individual provide prior, written and knowing authorization?</td>
<td>No.</td>
<td>No.</td>
<td>Yes. Spouse’s authorization is required if spouse is providing information about manifestation of disease or disorder.</td>
</tr>
<tr>
<td>Does the rule include specific confidentiality requirements?</td>
<td>No. However, HIPAA privacy and security requirements generally apply.</td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td>Is there a limit on the amount of the incentive that can be offered for employee participation?</td>
<td>Yes. Generally 30 percent of the total cost of employee-only coverage. 50 percent of the total cost of employee-only coverage for tobacco prevention wellness programs.</td>
<td>Yes. 30 percent of the total cost of self-only coverage. For a tobacco cessation wellness program that does not involve medical examinations (e.g., merely asking an employee whether they smoke), the 50 percent HIPAA limit applies.</td>
<td>N/A. The Final GINA Rule relates to incentives for employers to provide information about manifestation of disease or disorder. GINA prohibits wellness programs from offering incentives for employees to provide him or her own genetic information.</td>
</tr>
<tr>
<td>Is there a limit on the amount of the incentive that can be offered for spouse and/or dependent participation?</td>
<td>Yes. Limit for the family participants combined is 30 percent of the total cost of the coverage in which the employee and dependents are enrolled. 50 percent of the total cost of the coverage in which the employee and dependents are enrolled for tobacco prevention wellness program.</td>
<td>N/A. The Final ADA Rule relates only to wellness program incentives offered to employees.</td>
<td>N/A. The maximum incentive that can be offered for a response to provide information about the manifestation of disease or disorder is 30 percent of the total cost of self-only coverage. However, GINA prohibits wellness programs from offering incentives for information about manifestation of disease or disorder.</td>
</tr>
<tr>
<td>How often must an eligible individual be given a chance to qualify for the incentive?</td>
<td>At least once per year.</td>
<td>Not addressed.</td>
<td>Not addressed.</td>
</tr>
<tr>
<td>Must the wellness program offer a reasonable alternative standard to qualify for the incentive?</td>
<td>Yes.</td>
<td>Yes. Reasonable accommodations must be offered to enable employees with disabilities to participate.</td>
<td>No.</td>
</tr>
</tbody>
</table>
Stop Loss Coverage

- ACA removal of annual and lifetime dollar limits makes review of stop loss coverage recommended for all self-funded plans

- Key terms
  - What’s covered? Underlying medical plan has to properly document terms – eligibility, enrollment, benefits
  - Limits
    - Individual – Covers catastrophic claims
    - Aggregate – Covers utilization over a certain level
  - Material Changes – Have to notify insurer
    - Insurer can accept or reject
    - Keep plan documents updated and insurer informed!
Third Party Administration

- Plan will likely hire a TPA with expertise in operating plans
- TPA can provide access to other services and products like prescription drug program, provider network
- Selecting TPA is fiduciary action if TPA will carry out fiduciary responsibilities (e.g., deciding claims and appeals, determining medical necessity)
  - Fully evaluate services, capabilities, fees
  - Fully document the selection process
  - Avoid conflicts of interest/prohibited transactions
  - Plan administrator continues to have duty to monitor its selection, services, fees, etc.
Administrative Services Agreements

- Governs the relationship - Identify each party’s responsibilities (including any fiduciary responsibility of the TPA), term of the relationship, dispute resolution procedures, and what happens when the contract ends

- Finalize the ASA early when negotiations and relationship is fresh

- Key terms for medical plans
  - Claims and appeals responsibility, including run-out
  - Flow of funds to make claims payments,
  - Claim overpayments
  - Indemnification
  - Fees and performance guarantees,
  - ACA reporting
  - Recordkeeping
  - Audit rights
  - HIPAA business associate agreement
  - Termination
HIPAA Privacy Compliance

- Impact of privacy rule tends to be more minimal on insured plans than for self-funded plans
- Office of Civil Rights (OCR) is actively conducting HIPAA privacy and security audits of covered entities (“CE”) and business associates (“BA”)
  - Phase 2 audits announced on March 21, 2016 – so relatively new
- Review required documentation (Does it exist? Has it been updated for HITECH Act?)
HIPAA Steps/Required Documents

- Appoint privacy and security officials
- Privacy notice (notice of privacy practices)
  - Provide to all plan participants
  - On enrollment and within 60 days of material changes to plan
  - Notice must be available on request and every 3 years – plan sponsor must notify participants about notice
- Plan provisions regarding privacy and security
- Business associate agreements
  - Do you have one for each BA?
  - Has the agreement been updated?
HIPAA Steps/Required Documents

- Policies and procedures
  - To whom plan employees may disclose PHI
  - How PHI records will be maintained
  - PHI safeguards
  - Sanctions for employees who violate privacy procedures

- Training
  - Identify your “workforce”
  - When was last training

- Security analysis checklist (confirm physical, technical and administrative safeguards are in place)
Questions?
Seizing Opportunity and Mitigating Risk with Employee Population Health Management Partners

Allison Hofmann
Vice President of Client Services
QualCare, Inc.

Matthew Amodeo
Health Care Partner
Drinker Biddle & Reath LLP
Introducing QualCare Alliance Networks, Inc. (QANI)

Cigna acquired QualCare Alliance Networks in 2015.

**Heritage**
- Prior to Cigna acquisition:
  - Majority-owned by 16 non-profit hospitals and provider-hospital organizations. Built with provider-centricity as core strategy
  - Largest, state-wide provider-sponsored Managed Care organization in New Jersey

**Membership and clientele**
- Clientele includes health systems, unions, local governments, associations, school boards, insurance carriers and other commercial employers

**Provider network**
- Tri-state network (NJ-PA-NY) that includes over 33,000 health care professionals at over 62,000 locations
- Robust workers’ compensation network
- Out-of-state and national wrap network solution

**Operations**
- Operated in New Jersey with **no offshore operations**
- SOC-1 compliant and **disaster recovery ready**
- In 2015
  - 5 M claims processed
  - ~$1.8 B claims paid
  - ~900 K calls handled
  - 38% customer self-service adoption
  - over 1.5 M health care professional self-service transactions
QualCare Alliance Networks, Inc.

- QualCare
  - ASO/TPA/Network access
  - Health plan operations
  - Population health management
  - HMO/POS/PPO network
- Health-Lynx LLC
  - ACO solutions
  - Shared savings (Medicare)
  - Shared savings (health plan)
  - Health care consulting
- Qual-Lynx
  - P&C administration
  - Fully-integrated WC TPA
  - WC/Liability/Property
- QualCare Management Resources LLC
  - Association health plans
  - Captive manager
  - CO-OP management services
  - Regulated entity management
- QualCare Captive Insurance Company
  - NJ licensed captive reinsurer
  - Cell captives
  - Employer stop loss
QANI at-a-glance

**MISSION**
Provide best-in-class solutions and services that comprehensively balance the needs of members, providers and health plans.

**PRODUCTS**
- Association health plan administration
- Administrative services only (ASO)
- Third party administration
- Network access (PPO, HMO and workers’ compensation)
- COOP/HIX provides:
  - Network management
  - Repricing
  - Utilization management
  - Disease management
  - Provider operations
  - Credentialing

**SERVICES**
- Claims administration
- Care management
- Population health management
- Wellness
- FSA administration
- HIX support services
- Risk administration
- COBRA administration
- Dependent audit administration
- OON fee negotiation
- PBM and other benefit integration

**PLANS**
- PPO network-based
- HMO network-based
- POS network-based
- High deductible

**ADDITIONAL HIGHLIGHTS**
- Certified as an Organized Delivery System (ODS) in NJ across PPO and HMO networks
- Licensed third party administrator in NJ, PA, GA, TX, NC and TN
- All products and services can be completely private-labeled
Population Health Management & Wellness Incentive Programs

➢ Where we are today

➢ Engagement

➢ Considerations

➢ What does the future look like?
Population Health: The connection point

**Wellness**
- Maintain healthy status and prevent illness
  - Health coaching
  - PCP selection
  - HRA completion
  - Online education tools
  - Health screening reminders
  - 24/7 nurse line

**Health risk management**
- Reduce risk through behavior modification
  - Behavioral modification
  - Biometric screenings
  - Targeted outreach
  - Telephonic/written communication
  - Health coaching
  - Support tools

**Care management**
- Right care
  - Right time
  - Right place
  - Coordination of care
  - Network steerage
  - Care transition management
  - ER/readmission avoidance

**Chronic care management**
- Optimize care of chronic condition
  - Health assessment
  - Individual care plans
  - Education
  - Self management
  - Compliance with care guidelines
  - Care gap interventions
  - Provider collaboration

**Improve Outcomes**

**Reduce Costs**

**Enhance Member Experience**
Provider-Centric: Enhancing customer experience through a health service team approach

Our Health Service Team approach supports an enhanced customer experience.

Each contact with a customer is an opportunity to:

- Help them understand their benefits and answer any claim questions
- Optimize their use of available resources and services
- Assist them in navigating through the health delivery system
- Promote their health and wellness
- Promote Client Specific Initiatives
“Plug & Play” technology platform and toolkit

QualCare’s infrastructure is primarily housed on our state-of-the-art “Private Cloud”. The “Private Cloud” provides a highly scalable & flexible infrastructure platform, while ensuring extremely high information security & privacy standards are met.
Population Health Management: Data and Technology

Data Integration
- Customer Demographics
  - Medical/Rx/Lab
  - Health Assessments
  - Biometric Results
  - Behavioral Health
  - Workers' Compensation

Med Insight
- Critical Indicators
- Plan Performance
- Ad Hoc/Drilldown Reporting

Provider Portal
- Patient Panels
- Gaps in Care
- Patient Utilization

Reporting/Data mining

Data analytics

Population Health Management

Predictive modeling/Population segmentation

Provider connectivity

Health management system

TruCare/Health Management System
- Customer Centric
- Individual Care Plans
- Demographics
- Customer Dashboard

DST Care Analyzer
- Care Opportunities
- Risk Profiles
- Provider Efficiency
- Compliance with Quality Measures
The American De-Evolution
Health Improvement Impacts Everybody

75% of the claims your plan incurs are related to preventable diseases and lifestyle choices

**OBESITY**
Annually an obese individual costs almost $4,000 more

**BLOOD PRESSURE**
An individual with hypertension costs almost $1,400 more

**CHOLESTEROL**
An individual with cardiovascular disease costs almost $3,700 more

**TOBACCO/NICOTINE**
An individual that uses tobacco products costs almost $5,900 more

**GLUCOSE**
An individual with high glucose levels/diabetes costs almost $1,700 more


1. [www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm) - 83 million US adults with cardiovascular disease contribute to the $300 billion annual healthcare costs.

2. [http://tobaccocontrol.bmj.com/content/early/2013/05/25/tobaccocontrol-2012-050888.abstract](http://tobaccocontrol.bmj.com/content/early/2013/05/25/tobaccocontrol-2012-050888.abstract) - Statistic is the sum of excess absenteeism, presenteeism, smoke breaks, and health care costs
Best-in-Class Wellness Toolkit

Wellness Services
- Comprehensive suite of wellness solutions
- Customized, results-based wellness solutions (including customized wellness portals)
- Individual & group biometric screenings
- Consult on incentive plan design

Incentive Management
- Administration of incentive program
- Seamless partnership with HR & Payroll
- Employee participation reporting & progress tracking
- Handle program-related employee calls

Wellness Analytics
- Analytics driven via integration of Medical, Rx, Biometric & Health Assessment data
- Comprehensive view of organizational health & identification of problem areas
- Candidate wellness program identification

Self-Service Tools
- Health Assessments & PHR
- Member-specific health reminders
- Unlimited inbound telephonic & online coaching with certified health coach
- Lifestyle-based improvement programs

QualCare handles the coordination across these best-in-class vendors & the employer to ensure a seamless program delivery & administration experience
Types of Wellness Programs

- **Participation-Based**
  - (regardless of health factors)
  - 1. Screening Incentive
  - 2. Attend Lunch + Learn
  - 3. Complete an HRA
  - 4. Fitness Center Reimbursement

- **Health-Contingent**
  - Activity-Only
    - (based upon a health factor)
    - 1. Walking Programs
    - 2. Diet Programs
    - 3. Exercise Programs
    - 4. Tobacco Cessation Programs
  - Outcomes-Based
    - 1. Cholesterol
    - 2. BMI
    - 3. Blood Pressure
    - 4. Glucose
    - 5. Tobacco Free
Three Approaches

**Aware**
Improve team morale, incentivize participation in a baseline health screening and drive engagement through dynamic tools, resources and team challenges.

Build Morale and Team Camaraderie

**Active**
Drive engagement by increasing financial incentives, tying incentives to health outcomes and adding meaningful support like tobacco cessation and coaching.

Drive Engagement and Shared Responsibility

**Strong**
Inspire personal achievement by maximizing incentives, shifting alternative goals to require measurable progress and adding personalized improvement goals to support those with the highest risks.

Achieve Meaningful Health Improvement and Cost Reduction
<table>
<thead>
<tr>
<th>Most Important Goal</th>
<th>AWARE: Participation-Based</th>
<th>ACTIVE: Results-Based with Participation Alternatives</th>
<th>STRONG: Results-Based with Improvement Goals</th>
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</thead>
<tbody>
<tr>
<td>Incentive Design &amp; Management</td>
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<td>Participant Portal</td>
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<tr>
<td>Online Coaching, Exercise and Nutrition Content, Device Sync (Fitbit, Pebble, etc.)</td>
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<td>Team &amp; Individual Challenges</td>
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<td>Participant Communication Campaigns</td>
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<td>Bilingual Call Center</td>
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<td>Biometric Screenings</td>
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<td>Biometric &amp; Lab-Based Health Risk Assessment</td>
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<td>Annual Aggregate Report</td>
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<td>Compliance Review of Plan Design</td>
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<td>Appeals Tracking &amp; Administration</td>
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<td>Medical Alternatives &amp; Physician Waivers</td>
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<td>Tobacco Cessation</td>
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<td>High Risk Coaching and Chronic Care Team Support</td>
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<tr>
<td>Personalized Improvement Goals</td>
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</tbody>
</table>

bravo™
Not All Wellness is Created Equal

Best Practice: Improvement vs. Participation

Plan Design Goal: BMI <30
Incentive: $50/month

Alternative Goal Offered:
- Telephonic Coaching
- Log Pedometer Steps
- Attend 3 Seminars

Resources Provided:
- Telephonic Coaching
- Lunch & Learn
- Health Plan
- Weight Watchers
- EAP (Employee Assistance Programs)

Meet Bill
2013 BMI: 36
Height: 5’10”
Weight: 250
No medical issues

Meet Bob
2013 BMI: 36
Height: 6’0”
Weight: 265
No medical issues
Best Practice: Improvement vs. Participation

IS THIS FAIR?

Bill
2014 BMI: 37
Height: 5'10"
Weight: 255
No medical issue

Accomplishments:
- Completed program requirements
- But... saw no health improvement – gained 5 pounds!

Earned $50/month Discount (retroactive/prorated)

Bob
2014 BMI: 32.5
Height: 6'0"
Weight: 238
No medical issue

Accomplishments:
- Stopped drinking soda
- Started jogging every day
- Saw personal health improve – lost 27 pounds!

Did Not Receive Reward...
Best Practice: Improvement vs. Participation

**Do:** Provide tools to help people succeed

**Don’t:** Tie your reward to the use of the tools

**Do:** Reward health improvement regardless of how they got there

💎 Bravo Wellness recommends an approach that inspires real behavior change and drives personal accountability through progress and/or improvement goals.
Legal concerns Employers should be aware of as they develop wellness programs:  

- The ACA supports rewards for participation in wellness programs and also sanctions surcharges for failure to participate. Incentive programs must be available to similarly situated individuals and reasonable alternatives for obtaining the reward/avoiding the surcharge have to be available.

Advice for Employers as they develop incentive-based wellness programs:  

- Take a conservative approach
- Follow developments provided by the EEOC
- Include the wellness program as part of the health plan in order to qualify for the ADA safe harbor for health plans
- Monitor data regarding results of your wellness plan to determine whether it is achieving cost savings and health benefits

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1 A Law Review Q&A: How Providers Can Develop Legal and Ethical Wellness Programs. December 2014 article: [www.advisory.com](http://www.advisory.com)
Case Studies
All four clients have been Bravo clients since 2008, with 8 years of data

Source: Bravo Data & Analytics Department
Five Years of Results

**Situation:** Had wellness initiatives for years, but low participation. Needed a wellness provider who could drive value for their existing initiatives and design an incentive structure to increase.

**Solution:** Bravo developed an initial three-year roll out of the new wellness program.

- Year One: Incented employees ($200+/month) for completing risk assessment and for taking part in baseline screening.
- Year Two: Increase incentives begin tying them to biometric goals.
- Year Three: Tighten goals to be closer to NIH standards and introduce progress goals for alternatives.

**Results:** After only one year of applying the new wellness strategy, Southwest General saw a dramatic slowing in the increase in claims. Over the last 5 years annual growth of medical costs has decreased 3.12%.

0% increase in the past four years.
Introducing Wellness

**Situation:** 20% premium increase in their healthcare costs and needed to reduce the trend.

**Solution:** Customized, compliant outcomes-based incentive program along with coaching, nutrition programs, wellness champions in every location, and smoking cessation programs.

**Results:**
- In year three: 7.6% participants stopped smoking and of those who failed BMI year two, 16.4% had a BMI reduction of 2 or more points in year 3
- Net savings of $124 per employee, per year enabling them to continue to invest in wellness programs

99+% Participation each year
Leadership & Culture Impact

**Situation:** Needed to slow down rising medical expenses in order to maintain leadership position in competitive market. Internal wellness program yielded only 60% participation.

**Solution:** Reach more people and see more measurable health improvement, while reducing health costs to 2% below industry standard and reducing absenteeism and safety incident rates.

**Results:**
- High program impact –
  - Obese participants lowered from 37.2% to 31.2%
  - High LDL cholesterol decreased more than 50%
  - High blood pressure decreased 80% amongst participants
  - Nearly 50% of participants with more than 1 risk factor decreased their risks.

$300K Reduction in workers' compensation expenses
Wellness Incentive Programs Are Here To Stay…

*Over The Next 3 To 5 Years, We See The Future Of Wellness Incentive Programs:*

- Focusing on Patient Engagement – Need to understand how people want to be engaged
- Deploying Multiple Technologies – Apps, Web, Phone, Pager, Kiosks, etc.
- Integrating into overall Population Health Management Strategy – The ROI on wellness as a stand-alone program is questionable. However, as part of the larger PHM continuum, it can add more value
Legal Issues in Self-Insured Benefit Plan Direct Provider Contracting

- Employers with some form of Direct Contracting*
  - 2014: 11%
  - 2015-2020: 28% (expected)
  - E.g.: Boeing, GE, Intel, Lowes, Michelin, Teacher’s Retirement System of Texas ($1.5 billion in claims annually), Walmart

- Drivers:
  - Affordable Care Act (ACA) \(\rightarrow\) Provider Consolidation \(\rightarrow\) Higher Health Costs
  - ACA (Cadillac Tax)
  - Lack of transparency and useful employee data from TPAs
  - Narrow Networks can leverage patient volume for lower cost

* Aon Hewitt 2014 Healthcare Survey
Conventional Self-Funded Plan TPA Model

Employer (Plan)

Provider Network Administration
- Credentialing
- Rate Negotiation
- Claims Processing
- Utilization Management
- Wellness Programs

Plan Administration Agreement

Third Party Administrator/Payor (TPA)

Network Provider Agreements
- Hospitals
- Physicians
- Post Acute Providers
- Others

- PMPM Administrative Fee
- Network Access Fee
- Fund Provider Claims
Self-Funded Plan Direct Contracting Model

**Employer (Plan)**

- **Administrative Services Agreement**
- **Hospital/Physician Services**
  - Bundled Episodes: Maternity, Joint Replacement, Heart Surgery
  - Wellness Programs, Care Management, Population Health
- **Healthcare Services Agreement**
- **Bundled Payment**
  - Fee-For-Service, Capitation, Shared Risk/savings

**TPA**

- **“Narrow Network” Providers**

**Provider Health System (“Center of Excellence”)**

The Changing Health Care Landscape and How It Affects Your Company
Legal Issues Involved in ASO Plan Direct Provider Contracting

- **Business of Insurance**
  - If provider is taking payment risk for Employee health care, it is the un-licensed business of insurance? Varies by state
  - State Risk Bearing Entity Rules

- **Utilization Review**
  - Entities, including providers, contracting UM, generally need to be state-certified one agents
  - Restrictions apply to payment methods (cannot encourage denials)

- **State IPA Entity Rules**
  - Entities “arranging for” services may need to be approved by state health/insurance departments

- **Credentialing Liability**
  - Where the Employer selects and contracts directly with providers (vs. the TPA/Payor) Employer has greater exposure for Employee malpractice claims for negligent provider network selection