APPENDIX I

BENEFITS OPTIONS FOR SMALL BUSINESSES AND SOLE PROPRIETORS

By David Contorno

I am a small business (or individual)… how can I create a benefits package in the Health Rosetta mindset?

Health Rosetta is more a mindset than a single strategy, a collection of principles and practices rather than a health plan. While there are some regulatory and market conditions that make it easier to follow this model as an employer group gets larger, there are still some things that anyone can do.

Small Businesses

Within the ACA, a small employer was defined as one with fewer than 100 full time equivalent employees (FTEs). However, in October 2015, President Obama signed the PACE act allowing each state to decide to either keep its traditional definition (50 employees in most cases) or go to 100. Most states opted to keep it at 50, although some states, NY for example, moved it or kept it at 100. So, from a regulatory perspective, 50 employees or fewer seems to

be the most common "small group." As an employer moves up in size, some of the financing side strategies definitely become easier.

Although all of our strategies are common sense, they are still innovative to health care, and small businesses do have to get even more "non-traditional" to accomplish similar results. The primary reason is that the ACA put more restrictions on the products insurance carriers can offer in this space; in addition, there is the possibility that larger-sized small employers may be subject to certain ACA mandates that these plans may not comply with.

Mandates, however, do not apply to most employers under 50 FTEs. This means there is no penalty for offering non-ACA compliant plans (or even no coverage). For this size employer, there are a few potential solutions:

1. Contract with a local direct primary care (DPC) doctor for your employees. Studies show that for about 80 percent of people, a proper functioning primary care home can provide 100 percent of the care they need. The national average cost is $50-$150 per employee per month. There are generally no additional fees, no co-pays, and no claims to file.
2. Primary care alone cannot serve the needs of the remaining 20 percent and can leave other people anxious about the "what if's". In this case, a "health sharing plan" can provide that additional protection. While many of these plans came out of a faith-based exemption under the ACA, several have developed in recent years that either remove or significantly downplay the religious affiliation requirements. Ironically, although most sharing organizations want to avoid any traditional insurance terms, for fear of being regulated like insurance, most operate the way insurance was always intended to operate: All members pay enough into the pot to fund judicious and fair disbursements of benefits to cover moderate to large medical encounters. (The small to moderate stuff should either be paid for out of pocket or handled by the DPC

doctor mentioned in #1 above.) A good sharing program will recognize the benefits of DPC and give a discount on the membership fees when included. I priced out a family of four, with DPC and the sharing program (with an initial patient responsibility of $1000 per medical need) in Western North Carolina and the total cost for all was well under $700 per month for the whole family. I have seen many single premiums in traditional programs at this price point lately.

3. If DPC is not an option, either because you have a highly distributed workforce or because there simply aren't any near you, you may still be able to bring in many of its benefits of primary care in a virtual format. Generally, this costs around $100 per month for an employee.
4. Lastly, as the Association Health Plan (AHP) Rule rolls out, it *may* offer an opportunity for employers to more easily band together. Contrary to widespread misconceptions, I believe this will only give such groups access to limited benefits. However, it could lift small businesses out of the small group market, which operates under community rating requirements. If so, this would allow a Health Rosetta advisor to construct a plan that truly addresses incentives designed to reward quantity over quality in ways not otherwise available to smaller groups.

Larger Small Businesses

As an employer moves out of the 50-employee market, regulations become more onerous, but at the same time, it becomes easier to operate in a Health Rosetta environment. Here are a few points to consider for employers of 50 to about 100:

1. Contrary to popular belief, self-insured does not inherently mean more risky; it can actually be less risky than a fully insured plan if you want it to be. Risk can be the result of an inexperienced benefits broker but it can also be

a deliberate choice. Due to the pressure the ACA applied to fully insured plans, there are today many new forms of protection or risk management for smaller employers, e.g., aggregate-only policies, spaggregate, monthly aggregate accommodation, non-laserable contracts, and, as mentioned in #2, level funding (not to be confused with carrier-based level funding).

2. Not all self-inured plans are created equal. If you take a fully insured large carrier plan, and put that same plan, PPO network, pharmacy benefit management, etc., into a self-insured model, you have functionally changed absolutely nothing. You still have relinquished full control of both costs and utilization to an entity that benefits as costs rise. Also, most carriers expressly prohibit Health Rosetta principles because they actively lower costs—which in turn lowers their profit.
3. A "level funded plan" is often viewed as a safe, "dip a toe in the water" path to becoming self-insured. When the carriers saw this happening, they came out with their own versions and designed them to maximize profit. They do this by inflating the fixed costs, reducing the claims funding, and, in the rare case where there is leftover claims funding, keeping one-third to one-half of what you overpaid. With a proper level-funded model, the self-insured employer gets far more control, far more flexibility, reduced fixed costs, and 100 percent of the excess claims funding back.
4. Once an employer determines that it can construct a financially feasible self-insured arrangement with a proper third-party administrator and PBM, all the Health Rosetta principles can easily be applied.
5. These plans can and should be designed to meet all the ACA mandates for both the employer and the individual.

Individuals

What can you do as an employee not in a decision-making capacity at a company, or as someone who is self-employed or

unemployed? You can do a lot! First off, please remember that health insurance does *not* equal health care. Health insurance is just one way to pay for care. Another is the health sharing programs mentioned above, which have been operating for a couple of decades and are used by approximately one million people. And there is still another way: It's called cash.

The tens of millions of people with high deductible plans can save enormous sums by using cash, as demonstrated by my own hernia operation. Even using a facility 800 miles away from my home, which had much higher quality than any in my area, and paying 100 percent of my own costs, including travel, I paid one-third of what my out-of-pocket would have been had I stayed local and used a traditional insurance plan. Most of the time, you do not need to travel anywhere near that far to find a high-quality facility, but if you were going to get way better care and save thousands of dollars, wouldn't you be willing to?

These same principles can be applied to prescriptions. Especially with generics, the cash price is often below your plan's co-pay. And when you unknowingly overpay for the drug by showing your insurance ID card, you are actually hurting yourself down the road in the form of higher premiums—and you are often hurting the pharmacy thanks to "clawbacks." This is when your plan's PBM pulls back the difference between the co-pay and cost of the drug in order to enhance their profits, even though they literally provided no value, especially in that particular transaction.

It may not be easy, because the system doesn't want it to be, but for an individual, the solution is relatively simple: You need to demand total cost and quality information (getting that is the hard part), compare these data with your insurance coverage, and only then decide where to go for care. Instead, most Americans take an "insurance first" approach. In nearly all other economic transactions, we determine best value first, then we figure out how to get the money needed to pay for it. If we all did that in health care, things would change for the positive *very* rapidly.