Health & Human Services Committee

Thursday, January 16, 2014
8:30 AM - 11:00 AM
Morris Hall

Will Weatherford
Speaker

Richard Corcoran
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Thursday, January 16, 2014 08:30 am
End Date and Time:	Thursday, January 16, 2014 11:00 am
Location:	Morris Hall (17 HOB)
Duration:	2.50 hrs

Discussion of the state employee group plan:

--Jeff Dykes, Division of State Group Insurance, Department of Management Services
--Tony Holmes, Mercer Health and Benefits
--Tom Johnston, EmployerDirect Health Benefits
--Ralph Weber, MediBid

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Department of
Management Services

Overview of the State Group Health Insurance Program

FLORIDA DEPARTMENT of management SERVICES

We serve those who serve Florida

Jeff Dykes, Interim Director

House Health and Human Services Committee

January 16, 2014

Craig J. Nichols, Secretary

Agenda

- **Purpose:** to present an overview of the State of Florida's health insurance program offered to active and retired state employees and their families.
    - Program Administration
    - Legal Aspects
    - Participants and Demographics
    - Financial Perspective
    - Health Plan Options
    - Health Plan Wellness Features
    - Cost-Sharing Provisions
    - Contribution Structure

Program Administration

- The Division of State Group Insurance (DSGI) offers and manages a comprehensive package of health and welfare insurance benefits:
  - PPO and HMO health insurance options
  - Flexible spending and health savings accounts
  - Life insurance
  - Dental, vision, disability and other supplemental insurance products
- Program administration:
  - 22 Positions
  - People First
  - Contracts with insurance carriers and service providers
  - Actuarial, benefit and legal consultant services

Legal Aspects

Participants

Covered Lives: 361,482

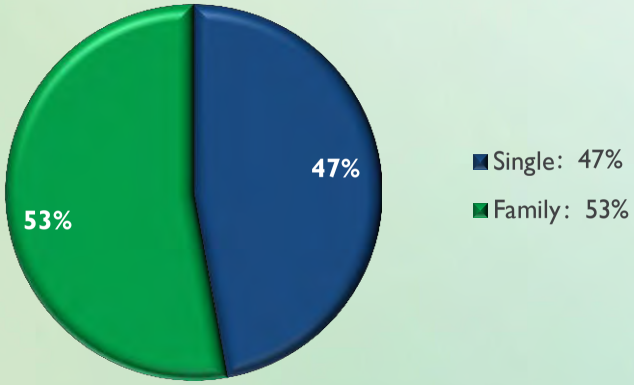
Policyholders: 173,127

Results of 2013 Open Enrollment

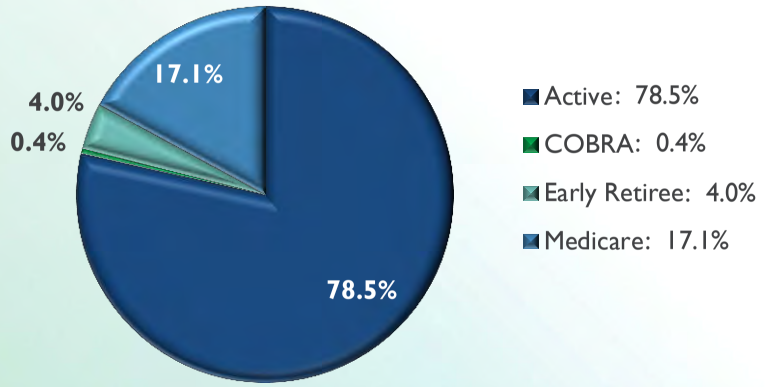
Percentages based on policyholders

Enrollment and Demographics

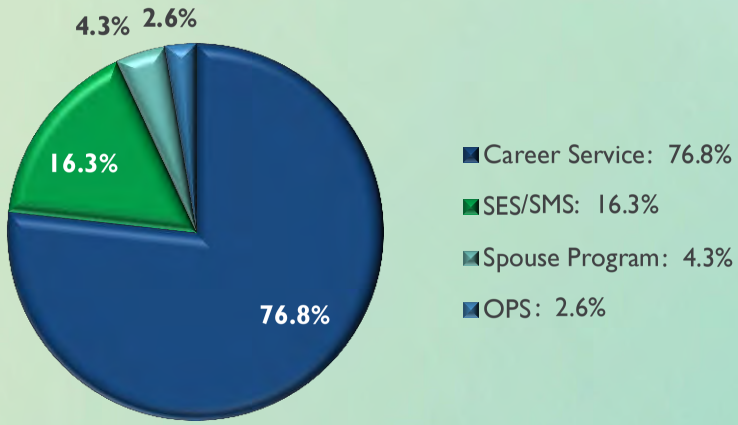
1. Enrollment Tiers



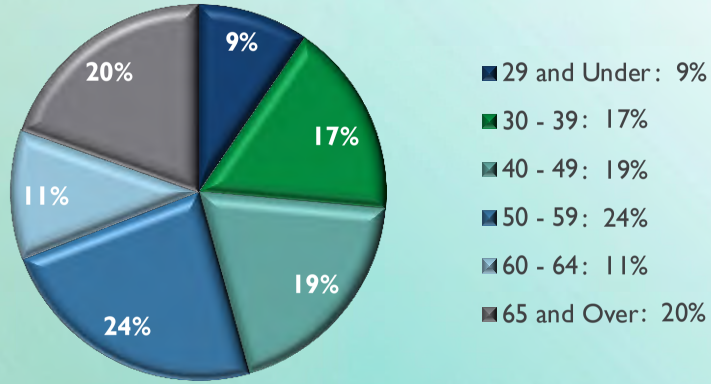
2. Policyholders by Category



3. Employee Enrollment



4. Policyholders by Age Band



Results of 2013 Open Enrollment

Financial Perspective

- Spend is estimated to be $2 billion in FY 2013-14
- Aggregate annual spend growth of 8.7%
- Funded primarily by the state through each state agency's and university's appropriation category:
  - State funding: $1.55 billion, or 90% of total premium
- Employee/non-employee contributions: $393 million
- Other revenue: $89 million

Information as reported by the Self-Insurance Estimating Conference on December 13, 2013.

Health Plan Options

	HMO Standard	PPO Standard	HMO Health Investor	PPO Health Investor
Self-insured[1]	Yes 4 plans	Yes 1 plan	Yes 4 plans	Yes 1plan
Fully-insured[2]	Yes 2 plans	No	Yes 2 plans	No
Enrollment Count[3]	86,832	84,139	587	1,569
Enrollment Percentage[3]	50.2%	48.6%	0.3%	0.9%

HSA[4]	No	Yes	Yes
HSA Enrollment[5]		1,306	

[1]The state bears the financial risk for claims payment
[2]The HMOs bear the financial risk for claims payment
[3]Average enrollment for fiscal year 2013-14 as reported by the Self-Insurance Estimating Conference on December 13, 2013
[4]Health Savings Account – a tax-favored account that allows employees to pay their share of the cost for eligible medical, prescription, dental or vision care services not covered by their insurance plans
[5]Average enrollment for fiscal year 2013-14, Division of State Group Insurance Bureau of Financial & Fiscal Management

Health Plan Wellness Features

Wellness Benefits	HMO Plans[1]	PPO Plans
Online Tools	✓	✓
Health Risk Assessments	✓	✓
Fitness Membership	✓	✓
Smoking Cessation	✓	✓
Weight Management	✓	✓
Nutritional Counseling	✓	✓
Nutritional Supplement Discounts	✓	
Health Counseling	✓	✓
Prenatal Education	✓	✓
Massage and Acupuncture	✓	
Meditation and Guided Imagery	✓	
Exercise Classes	✓	✓
Fitness Equipment, Apparel, Footwear Discounts	✓	✓

[1]Discounts, programs and services vary by HMO

Cost-Sharing Provisions

	HMO Standard	PPO Standard		PPO and HMO Health Investor	
	Network Only	Network	Out-of-Network	Network	Out-of-Network (PPO Only)
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family	$1,250 | $2,500 Single | Family	$2,500 | $5,000 Single | Family
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the allowance	After meeting deductible, 20% of network allowed amount	After meeting deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance
Specialist	$40 copayment	$25 copayment			
Urgent Care	$25 copayment	$25 copayment			
Emergency Room	$100 copayment	$100 copayment			
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between the charge and the allowance		After meeting deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance
Generic | Preferred | Non-Preferred Prescriptions	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail	Pay in full, file claim	After meeting deductible , 30% | 30% | 50% Retail and Mail Order	Pay in full, file claim
	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order			
Out-of-Pocket Maximum	$1,500 | $3,000 Single | Family	$2,500 | $5,000 (coinsurance only) Single | Family		$3,000 | $6,000 (coinsurance only) Single | Family	$7,500 | $15,000 (coinsurance only) Single | Family

Monthly Health Plan Contributions[1]

Subscriber Category	Coverage Type	PPO and HMO Standard			PPO and HMO Health Investor		
		Employer	Enrollee	Total	Employer[2]	Enrollee	Total
Career Service[3] /OPS	Single	591.52	50.00	641.52	591.52	15.00	606.52
	Family	1,264.06	180.00	1,444.06	1,264.06	64.30	1,328.36
	Spouse	1,429.08	30.00	1,459.08	1,298.36	30.00	1,328.36
"Payalls" (SES/SMS)	Single	637.34	8.34	645.68	598.18	8.34	606.52
	Family	1,429.06	30.00	1,459.06	1,298.36	30.00	1,328.36
Early Retirees	Single	0.00	641.52	641.52	0.00	564.86	564.86
	Family	0.00	1,444.06	1,444.06	0.00	1,245.03	1,245.03
Over-age Dependents	Single	0.00	641.52	641.52	0.00	564.86	564.86

Plan Name	Plan Type	Medicare I	Medicare II	Medicare III
		Single – One Eligible	Family – One Eligible	Family – Both Eligible
Self-Insured PPO/HMO[4]	Standard	359.61	1,036.90	719.22
	HIHP	271.07	849.19	542.15

[1]Effective March 1 for April 2014 coverage.
[2]Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month for single and family coverage, respectively.
[3]COBRA participants pay the full single or family premium plus a 2 percent administrative fee.
[4]The two fully-insured HMOs offer Medicare Advantage plans. Those premiums are federally approved and change for each plan year.

Questions?

Jeff Dykes

Interim Director

Division of State Group Insurance

Florida Department of Management Services

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Mercer Health and
Benefits

Tony E. Holmes, FSA, MAAA, FCA

Current Experience

Tony is a Partner in the Atlanta office of Mercer Health and Benefits ("Mercer"). He is Mercer's Consumerism Practice Leader for the South, and a South region and Georgia spokesperson and subject matter expert for healthcare reform, national survey information, and emerging strategies and best-practices with large public and private organizations.

Experience

Tony assists clients with healthcare strategies and innovations, health care reform, emerging market solutions, and financial analysis, as well as alignment with their broader strategic HR and total rewards programs. Tony was recognized nationally in 2012 as the year's "Most Innovative Partner/Consultant" by the Institute for HealthCare Consumerism.

Tony has consulted in Atlanta for over twenty years on healthcare, human resource and employee benefits to private and public organizations in all industries, including several states, healthcare and higher education organizations throughout the South, ranging in size from a few thousand to several hundred thousand employees. He has held senior management positions with a health insurance company. He was formerly a Principal/Partner in Atlanta with two other prominent consulting firms, where he also held office and regional practice leadership roles.

Education

Tony received a Master of Actuarial/Mathematics degree, and a Bachelor in General Studies degree with high distinction from the University of Michigan. He is a Fellow of the Society of Actuaries, Fellow of the Conference of Consulting Actuaries, and a Member of the American Academy of Actuaries. Tony is a regular speaker on strategic, technical, health care reform, industry and innovative trends, consumerism and consumer directed healthcare issues. He routinely presents to public and private associations and events, and is a contributing speaker at numerous financial, HR, consumerism and health management conferences. Tony is routinely quoted in national and regional publications, including The Wall Street Journal and The Atlanta Journal-Constitution.

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State of Florida
Division of State Group Insurance

MARKET-BASED FRAMEWORK FOR HEALTH PLAN PROGRAM CHANGES

January 2014

Mercer Health & Benefits, Atlanta, GA

MARSH & McLENNAN COMPANIES

Agenda

- **Purpose** – To identify opportunities to improve the State of Florida's health plan by comparing today's program to critical success factors, approaches and trends in the employer market today
- Background – basic definitions
- Summary of key findings and observations
- Supporting information to help answer some key questions*
- Discussion & questions
- Appendix (supporting background and detail)

*** Key Questions:**

- How do the State of Florida plans and premiums compare to market surveys?
- How might "best practice" consumerism and "defined contribution" (DC) pricing of plans work for us?
- How do we differ from successful plans that use wellness, incentives, "consumer-driven health plans" (CDHP), and member health and engagement programs and techniques?
- What are three alternative approaches, or phases to consider, to embrace these findings?
- What are some of the key considerations to be evaluated?

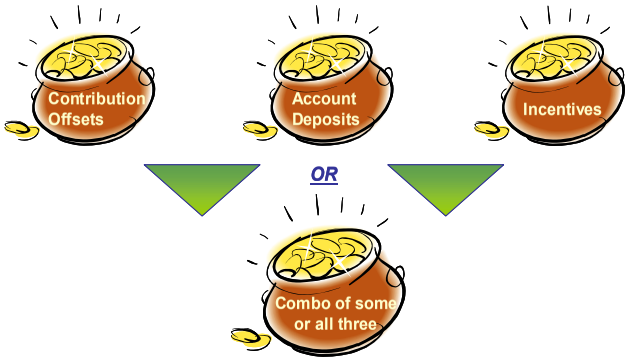
Background — basic definitions
Consumerism, consumer-driven health plans (CDHP) and accounts

- **"Consumerism" –** an activity that encourages or empowers improved health, or informed, or responsible spending for, or use of, healthcare related goods or services
- **CDHP** – typically a Preferred Provider Organization (PPO) medical plan with a "high deductible" and an "account"
- **Accounts** – typically a Health Savings Account ("HSA"), or a Health Reimbursement Arrangement ("HRA")
- State of Florida – offers CDHP options (i.e., Health Investor Health Plans (HIHP)) with an HSA account (both PPO HSAs and HMO HSAs are offered)
- CDHP plans – provide employee incentives (via lower premiums, up-front account deposits that carry over from year to year, visible account balances, etc.) to encourage employees to be active participants in their healthcare consumption and health

Employers create plan savings with some combination of …

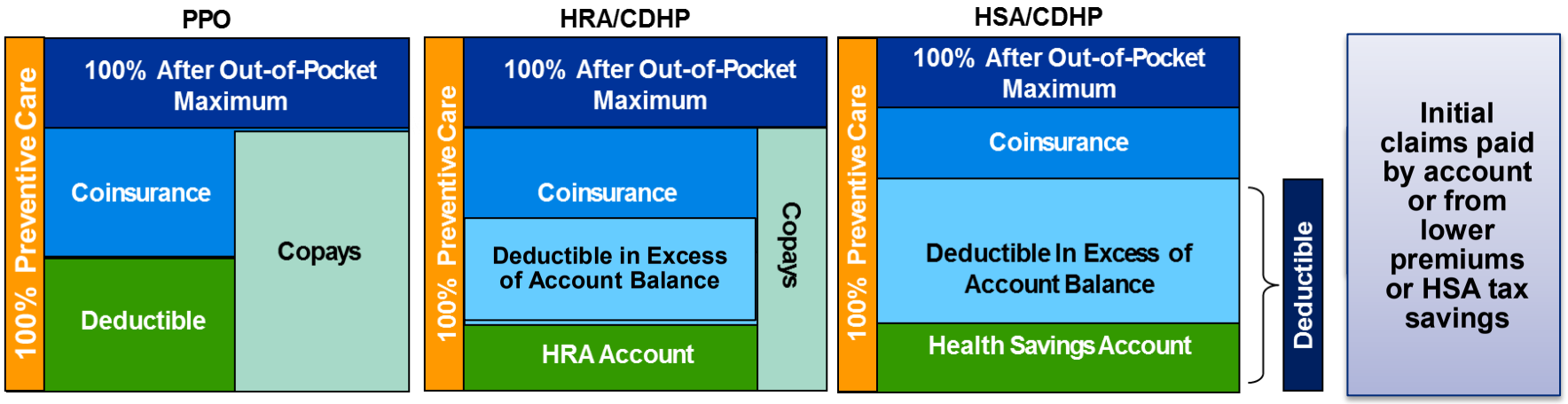
- Increased deductibles
- Increased coinsurance
- Increased or eliminated copays

… to redeploy dollars saved using some combination of:



Background — basic definitions
Comparison of PPO vs. HSA vs. HRA

Consumer Driven Health Plans — a high-deductible PPO with a health savings account (HSA) or health reimbursement account (HRA)



Primary Differences	HRA	HSA
Account Description	Notional / non-cash; claims paid from general plan assets	Employee-owned cash; deposits in a financial institution
Account is in the employee's name and remains theirs after withdrawing from plan	No	Yes
Employee Contributions Allowed	No	Yes (and tax favored)
Employer Contribution Allowed	Yes	Yes (and tax favored)
Plan must meet qualified high deductible plan design requirements (e.g., eligibility limits, minimum deductibles, maximum out-of-pocket limits, no co-pays, etc.)	No	Yes

Background — basic definitions
Consumerism and the role of defined contribution

Key Concepts

- Properly pricing each plan option to fairly reflect the true difference in the value of benefits from each option is a critical component to consumerism

- Employers are increasingly basing their contributions on the lowest cost plan (e.g., CDHP plan), and using defined contribution (i.e., requiring employees to pay more or "buy-up" for more expensive coverage)

Defined contribution strategies

1. **Core / "buy-up or buy-down" approach**
   - Employer sets the dollar contribution annually that will be contributed:
     - Based on a dollar budget or % of the cost for a "core" plan option
2. **Fixed employer increase approach**
   - This approach allows an employer to manage the longer term increases in their medical costs and incentivizes employees to actively engage in their health care decision making
   - Employer increases their contribution by a set amount each year for the "core" plan:
     - Approach requires employees to pay the projected difference in the cost increase
     - Increase is typically determined in advance based on budgets, not year-to-year medical inflation
3. **Flat dollar subsidy / voucher**
   - Allows employees to use HRAs to purchase individual coverage (vs. getting taxable cash back)
   - Approach is rare; employers who attempt to use this DC strategy will likely be subject to the $2,000 (per employee) employer minimum value penalty regulations under the Affordable Care Act

Summary of key findings and observations

1. **The State of Florida's plans lag some key large employer survey* trends:**
   - State of Florida enrollment is in plans with lower premiums and higher benefits than industry benchmarks
   - Virtually no (~1%) enrollment in State HIHP / HSA plans, versus significant growth of CDHPs nationally
   - Employers increasingly use incentives to grow participation in new wellness / condition-specific programs
     – State of Florida has no incentives and few such programs

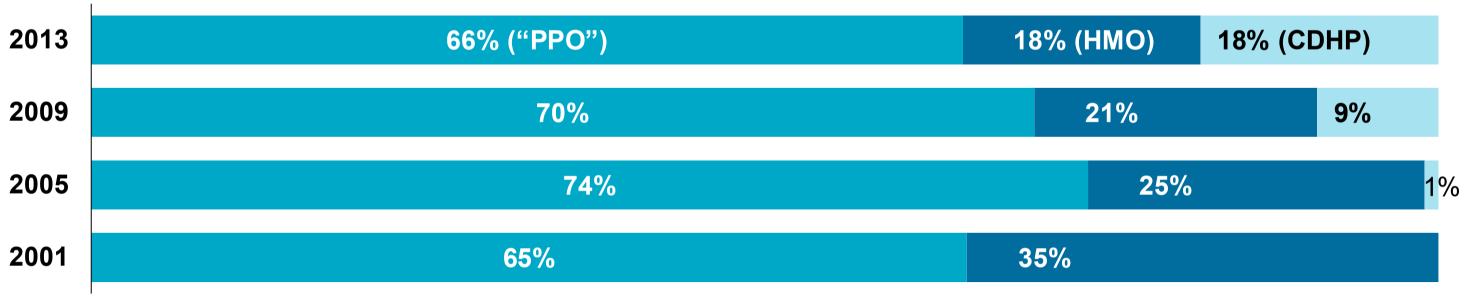
2. **Effective employer health plans use common success strategies to help control costs:**
   - They encourage good purchasing behavior by offering a broad range of benefit choices that use defined contribution and "buy-up / buy-down" consumerism pricing
   - They focus on employee engagement – wellness, incentives, employee education and "account-based" Health Savings "HSA" and Health Reimbursement "HRA" plans

3. **Significant financial opportunity exists for the State of Florida:**
   - Begin building the foundation to improve health and significantly lower health costs over time
   - Change requires "breaking inertia," substantial communication and investment, and strategies to respond to health care reform's 2018 excise tax (or "Cadillac tax")
   - Timing will be impacted by unique State of Florida implementation needs and HR issues

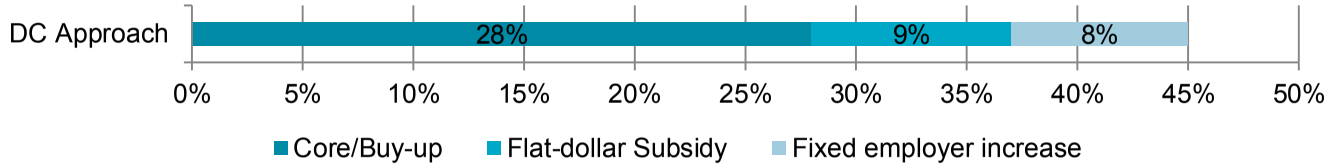
*Mercer Employer-Sponsored Health Plan Annual Survey – "Large Employer (LE)" has 500 or more employees

Survey findings and observations for large employers (LEs)
Versus State of Florida plans and premiums

- State of Florida HMO enrollment (56%) and CDHP (HIHP <1%) is higher and lower than LEs, respectively



- 45% of LE's use a DC approach; the State of Florida charges the same for both HMO and PPO plans



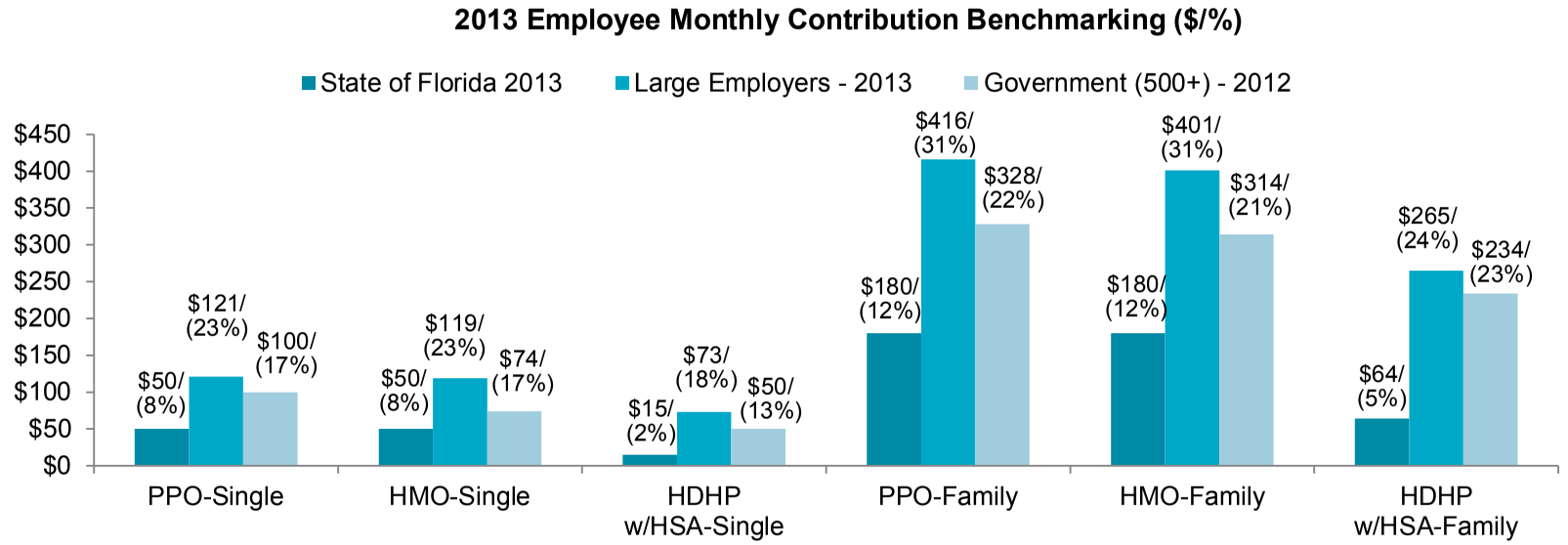
- State of Florida's total plan costs and annual trend increases are higher than Mercer survey National data, partly given the very limited number of historical State of Florida design and premium changes

	National	State of Florida
PPO 2013 Medical Plan Cost	$10,658 (South $9,894)	$13,400 average career service premium
HMO 2013 Medical Plan Cost	$11,134 (South $10,753)	
Annual Cost increases since 2007 **before** plan changes	7.4% - 9.8%	Approximately 6% - 8%
Annual Cost increases since 2007 **after** plan changes	4.1% - 6.9%	Approximately 6% - 8%
Increase in PPO / HMO Single and Family employee contributions since 2007	Single: 36% - 38%, Family 20% - 26%	0% for career service employees
Pre-Medicare Retiree's % share of medical costs	37%, for 49% who share costs*	100% of established non-actuarial value
Medicare Retiree's % share of medical costs	38%, for 46% who share costs*	100% of retiree rate

*Of the 24% Medicare and 17% pre-Medicare eligible total surveyed employers that offer any coverage

Survey findings and observations
Versus State of Florida plans and premiums

- Plan value is determined by the richness of benefits or “actuarial value.” (AV) is defined as the percentage of total average claims dollars paid by an employer’s plan
- Average LE PPO plan has AV of 87% versus the State of Florida's PPO AV of 86% – roughly the same
- More than half of the State of Florida's enrollment is in HMOs with a 93% AV
- State of Florida employee contributions – dollar contributions and cost sharing percentages – are both much lower (refer to chart below) than market levels



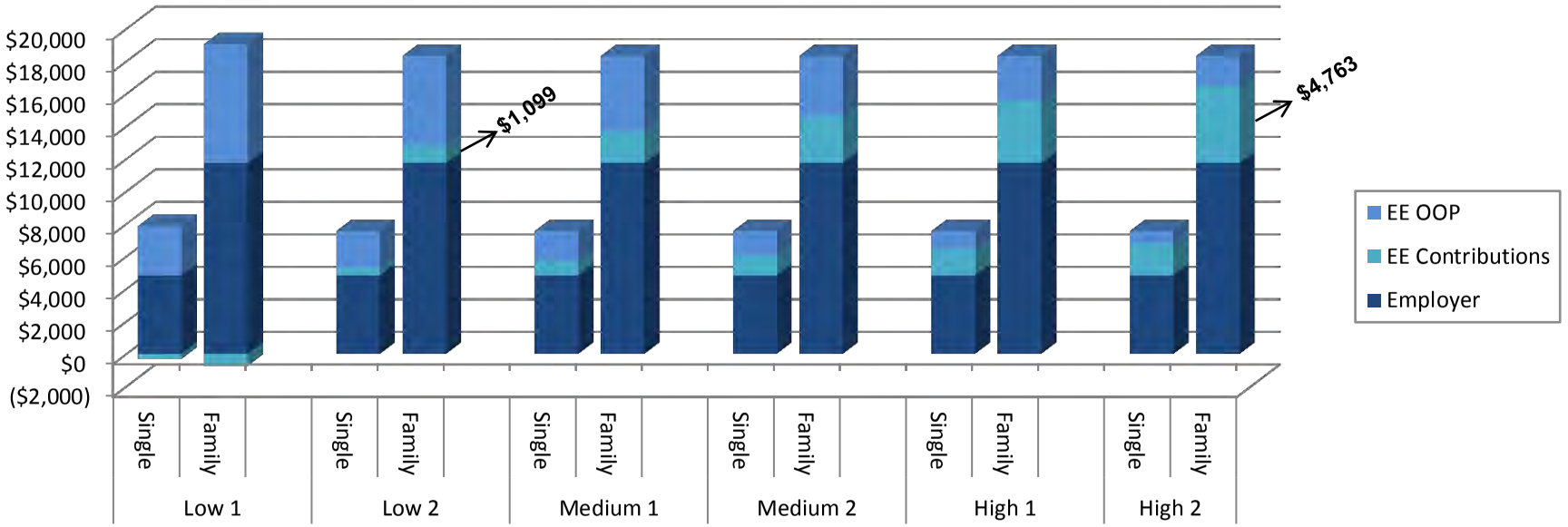
Note: 2013 Employee cost sharing % shown in ()
Source: Mercer’s 2012 and 2013 National Survey of Employer-Sponsored Health Plans

- Supporting data for other elements compared to 2012 benchmark ranges in Appendix (p. 18)

"Best healthcare practice" — illustration 1: based on national survey data
Consumerism and DC approach to pricing plan options

Start with solid foundation success elements – offer broad choice of benefit plans with fairly priced or defined contribution premiums to encourage consumerism

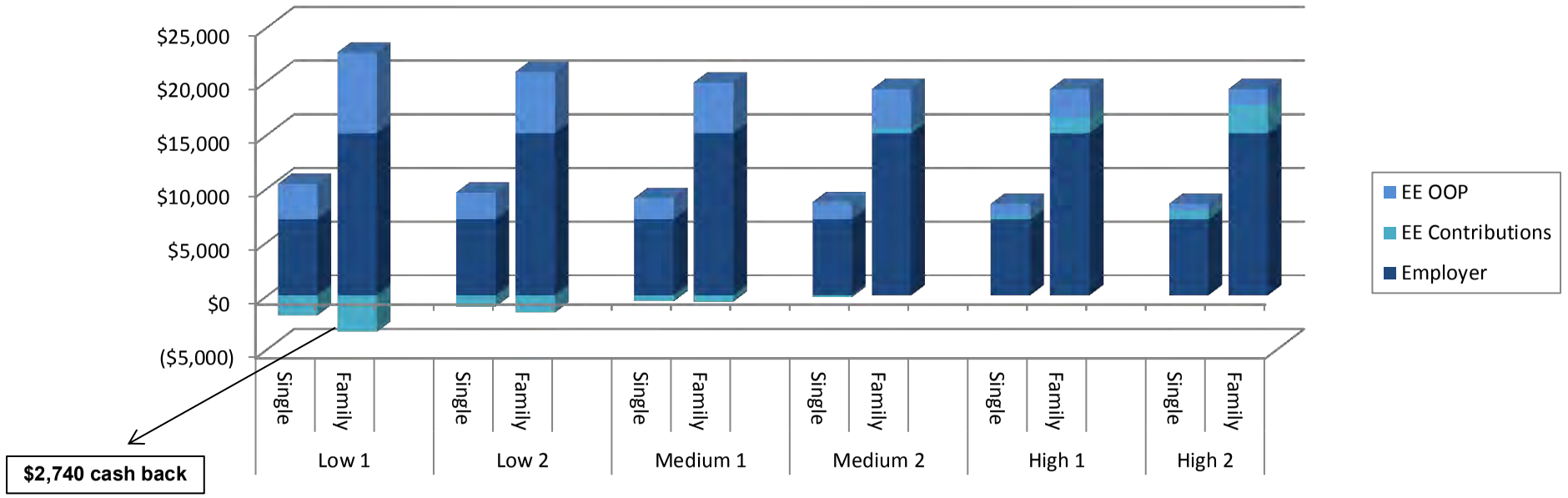
- Offer a complete range of plan options with significantly different actuarial values (see 30% spread below); For the Low 2 plan (70% AV), employee contributions are $1,511 less ($1,964 minus $453) than the High 2 (90% AV) for Single Coverage, and $3,664 less (**$4,763 minus $1,099**) for Family coverage
- Reflect true benefit value differences by providing an equal core "buy-up / buy-down" employer DC amount (i.e., $4,835 in the table), regardless of the plan selected
- Make the sum of employee contributions and out-of-pocket (OOP) equal for every plan option



"Best healthcare practice" — illustration 2: based on State of Florida plans
Consumerism and DC approach to pricing plan options (continued)

Consumerism unlikely until a buy-up / buy-down approach is adopted that engages employees with accurately priced, broader options, and higher contributions

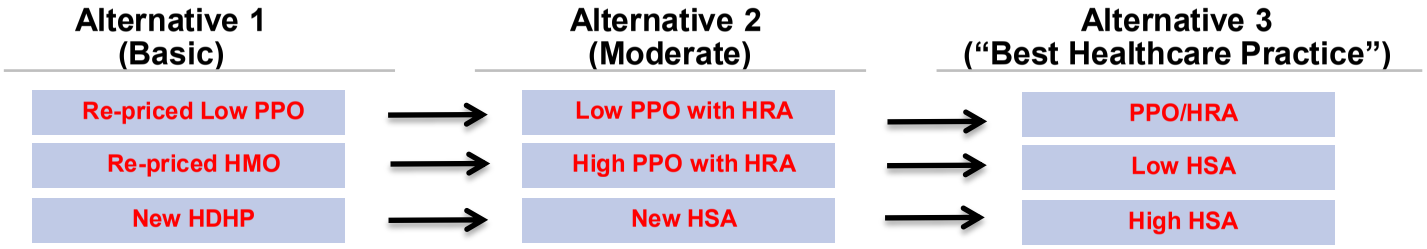
- 99% of enrollees are in plans with the same employee contributions and only a 7% difference in richness of benefits ("actuarial value"), creating little consumerism, or real choice, between benefits and premiums
- It would be a challenge to offer new, less rich benefit options alongside current plans and contributions – large taxable "cash back" (with HR, communication and administrative issues) may be required
- "Adverse selection" can also be a big issue – including employees or dependents who today do not participate – may choose to "opt back in" to the plan to obtain both benefits and significant "cash back"



Engagement via wellness, incentives, consumerism and health activities
Current plans lag some key employer trends

- **The State has little HIHP / HSA enrollment (~1%)** – likely little chance of CDHP growth until actions are taken to "break the inertia" (e.g., investment in effective communication campaigns, varying prices by plan, active and mandatory open enrollment, visible leadership endorsement, account-based incentives, etc.)
- **Successful, large organizations partner CDHPs with accounts, wellness and incentives:**
  - 62% of employers with >5,000 employees used incentives in 2012 – up from 39% in 2010
  - Incentives drive program effectiveness – completion rates for health risk assessments and biometric screenings are twice as high when incentives are used
- **Employers are rapidly adopting CDHPs** to simultaneously achieve multiple objectives:
  - Avoiding or delaying the 40% health care reform "Cadillac tax," effective 2018
  - Maximize employee engagement with consumer purchasing choices and health activities
  - Achieving financial savings by avoiding (versus cutting) costs – significant cumulative 5-year savings
- **We illustrate 3 alternative pathways (next slide)** to add over time new consumer choices, integrate health management and CDHP; and leading to a "best health care practice" state (alternative 3)
- **Pace of change is dependent** on the degree of activity with the following actions:
  - Revising the number and type of plans offered, with prices accurately reflecting benefit costs by plan
  - Embracing CDHP options relative to more traditional plan types
  - Introducing incentives and disincentives to encourage CDHP, wellness and healthier behavior

Health management — illustrative pathways for the State of Florida
"Relative" pros / cons of 3 alternatives



Dimension	Alternative 1 (Basic)	Alternative 2 (Moderate)	Alternative 3 ("Best Healthcare Practice")
Financial	Savings primarily available via plan design cuts or increased contributions	→	Significant trend reduction over time and "win-win" savings via avoided costs
Employee impact & health consumption	Limited or modest health improvement; minimal behavior change, and limited negative impact on employees	→	Greatest opportunity for reduction of health risks, with significant change to how employees engage in their health
Organizational	Minimal administrative impact	→	Significant administrative impact; requires cultural shift over time
	No direct or short-term impact on employee attraction and retention	→	High potential HR impact (+/-); consider competitiveness of wages, as benefits move toward CDHP / "best practice"
	Impact to employee relations limited to higher cost-shifting and cuts over time	→	Potentially large employee relations impact (+/-) during the transition, with financial "win-win" over time avoids cuts
	Basic communication and benefit delivery needs	→	Extensive internal / external communication; infrastructure investments needed (e.g., web tools, incentives, portals)

Key considerations

- This document highlights the more unique differences and critical success factors for the State of Florida
- Adopting major fundamental and comprehensive program change likely requires multiple years to decide and implement, perhaps transitioning to an ultimate state over multiple years and three or more phases
- **Some foundation / strategy decisions are particularly key given the current state of the program:**
  - Short- and long-term financial goals, and potential impact on broader HR / total rewards objectives
  - Desired competitive position and resulting savings from traditional plan design and contribution changes
  - Comfort with trade-offs from moving to CDHP plans – “how far, how fast?” – for your participants
  - Interest in offering a broad choice of plan options with proper pricing and defined contribution
  - Desire and flexibility to pursue incentives and disincentives to support health initiatives
- **Key practical items to consider even after core decisions are made:**
  - Impact of general changes on special groups (e.g., early retirees, Medicare-eligible retirees, “payalls”)
  - Activities to support change (data analyses, compliance, procurements, communication, administrative)
  - Timing will be impacted by unique State of Florida implementation needs and HR issues

Appendix

Background
Project Objectives

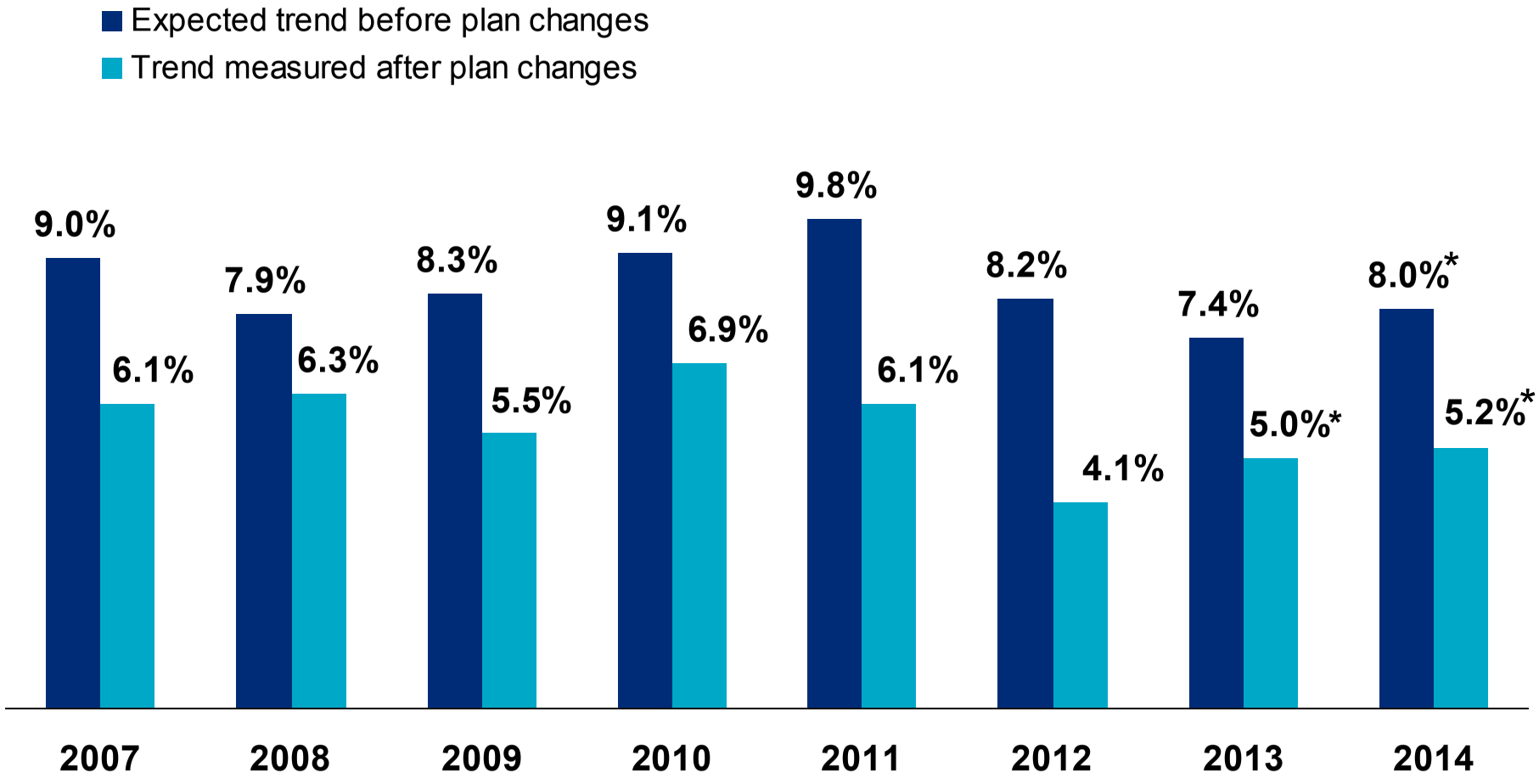
- The Department of Management Services, Division of State Group Insurance, (DSGI) requested that Mercer assist in developing a market-based, strategic framework for changes to the State of Florida's medical and prescription drug plans

Objectives:

- Mercer agreed to provide a PowerPoint presentation that meets the following objectives:
  - Provides an overview of trends in employer responses to health insurance market changes including an identification of critical program elements necessary to build the framework of a successful multi-year strategic plan
  - Reviews and analyzes the State's current program against market survey data and best practices
  - Discusses and illustrates three alternative approaches that could be used as part of a multi-year strategy. The alternative approaches will take into consideration the speed and intensity of change to the State's program over three to five years
  - Discusses the potential implications of the "Cadillac tax" regulation scheduled to take effect in 2018
  - Discusses any specific concerns that are unique to the State's program, or employee groups, such as early retirees, Medicare-eligible retirees, "payalls," etc.

Background
Market trends

Employers see underlying cost trend falling below 8%. They plan to hold their actual cost increase to around 5.2% in 2014



* Projected

State of Florida annual trend preliminary data indicates that increases after plan changes has ranged from 6% - 8% (except for FY 2011-2012 when self-funding / Rx changes were made)

Foundation — plan offerings

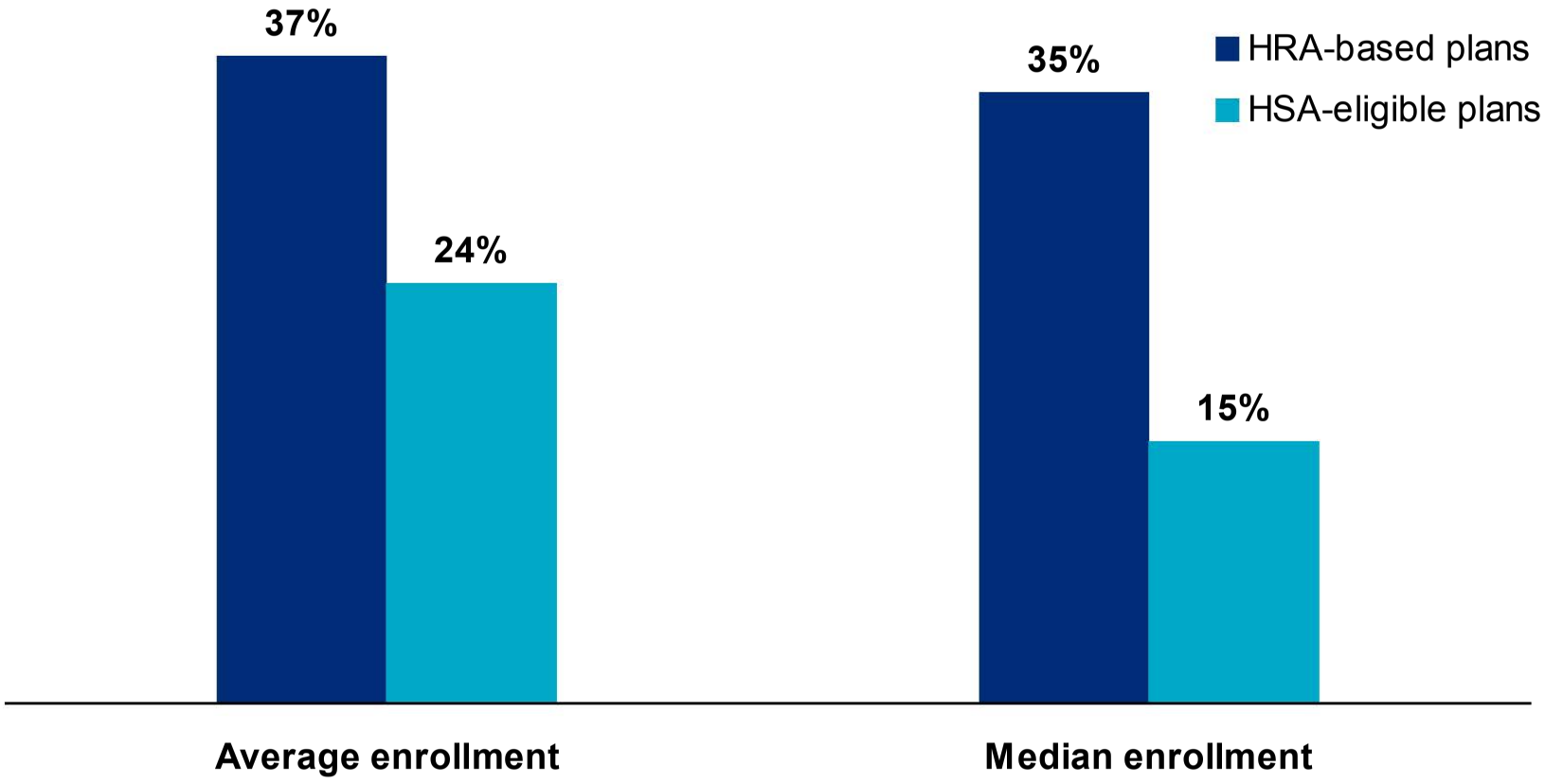
Consumer-Driven Health Plans (CDHP)

- Over the past three years (Table below), both the percentage of large employers offering CDHPs, and the percentage of covered employees enrolled in CDHPs, has nearly doubled:
  - In 2012, over a third of all large employers offered a CDHP, and 15% of their employees were enrolled. The larger the employer, the more likely they are to offer a CDHP
  - Of employers with 20,000 or more employees, 65% offered a CDHP in 2012
  - The State of Florida, like other large employers, offers a CDHP option (i.e., Health Investor Health Plans (HIHP)) with a health savings account (both PPO and HMO are offered)

Number of employees	2008	2009	2010	2011	2012	Very likely to offer CDHP in 2013
10 - 499	9%	15%	16%	20%	22%	21%
500 - 999	14%	16%	18%	26%	35%	36%
1,000 - 4,999	22%	20%	24%	34%	33%	39%
5,000 - 9,999	28%	42%	39%	42%	46%	49%
10,000 - 19,999	40%	39%	41%	46%	53%	59%
20,000 or more	45%	43%	51%	48%	59%	65%

Employees increasingly enrolled in HRA and HSA account-based plans

Percent of covered employees enrolled*, among large CDHP sponsors



*When CDHP is offered as an option alongside other medical plan choice

Foundation — competitive position
Plan design comparison to benchmark ranges

- The table shows the **medians** for surveyed plan provisions. Note that while the HRAs have similar survey data for the cost-sharing provisions shown (similar to qualified high deductible plans like with HSAs), employers often retain the use of HRAs with physician and/or pharmacy co-pays (i.e., more likely to report such HRAs as PPOs)
- Benchmark ranges based on National Jumbo, Large, Government, and State employers

2012 Mercer Survey Data	Benchmark Ranges				2013 State of Florida			
	PPO	HMO	HSA	HRA	PPO - Standard	HMO - Standard	PPO - Health Investor	HMO - Health Investor
Employee Contribution $ - Single	$100-$117	$74-$132	$35-$66	$73-$82	**$50**	**$50**	**$15**	**$15**
Employee Contribution % - Single	14%-25%	15%-23%	4%-19%	3%-23%	**8%**	**8%**	**2%**	**2%**
Employee Contribution $ - Family	$270-$391	$300-$373	$164-$259	$274-$308	**$180**	**$180**	**$64**	**$64**
Employee Contribution % - Family	21%-29%	17%-28%	14%-23%	5%-27%	**12%**	**12%**	**5%**	**5%**
Deductible - Single*	$300-$500	$0	$1,500	$1,500	$250	$0	$1,250	$1,250
Deductible - Family*	$750-$1,000	$0	$3,000	$3,150-$3,300	$500	$0	$2,500	$2,500
Coinsurance	20%	0%	20%	15%-20%	20%	0%	20%	20%
Out-of-Pocket Maximum - Single	$1,500-$2,500	None	$3,300-$3,800	$3,000-$3,525	$2,750	$1,500	$4,250	$4,250
Out-of-Pocket Maximum - Family	$3,250-$5,000	None	$5,700-$6,000	$5,025-$6,000	$5,500	$3,000	$8,500	$8,500
% active employees enrolled	57%-66%	18%-33%	4%-16%	4%-16%	42.5%	56.2%	0.9%	0.4%
Employer Contribution to HSA - Single	N/A	N/A	$500-$750	N/A	N/A	N/A	$500	$500
Employer Contribution to HSA - Family	N/A	N/A	$1,000-$1,520	N/A	N/A	N/A	$1,000	$1,000
Employer Contribution to HRA - Single	N/A	N/A	N/A	$500-$782	N/A	N/A	N/A	N/A
Employer Contribution to HRA - Family	N/A	N/A	N/A	$1,000-$2,296	N/A	N/A	N/A	N/A

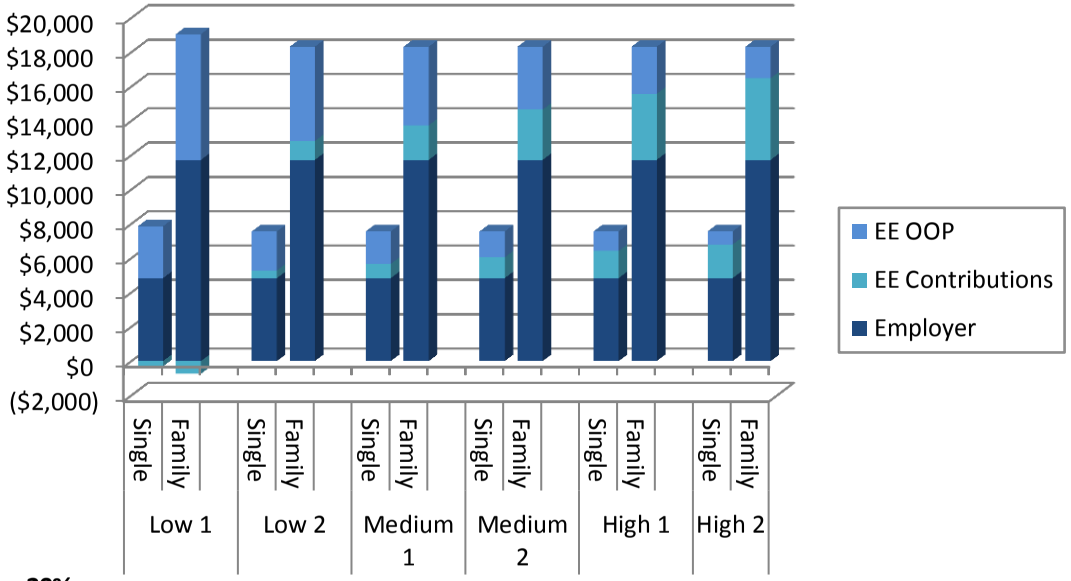
Red = notable variations

Note: Out-of-pocket maximums include deductible.

*__Average__ Deductible for National Large Employers for PPO is $666 Single and $1,545 Family, and HSA is $1,808 Single and $3,655 Family.
Source: Mercer's 2012 National Survey of Employer-Sponsored Health Plans

"Best healthcare practice" / trends — national survey illustration
A consumerism and defined contribution approach to pricing plan options

Illustration 1: Offer a Mix of Account-Based and Traditional Plans and Use a Defined Contribution (Core / Buy-Up / Buy-Down) Approach



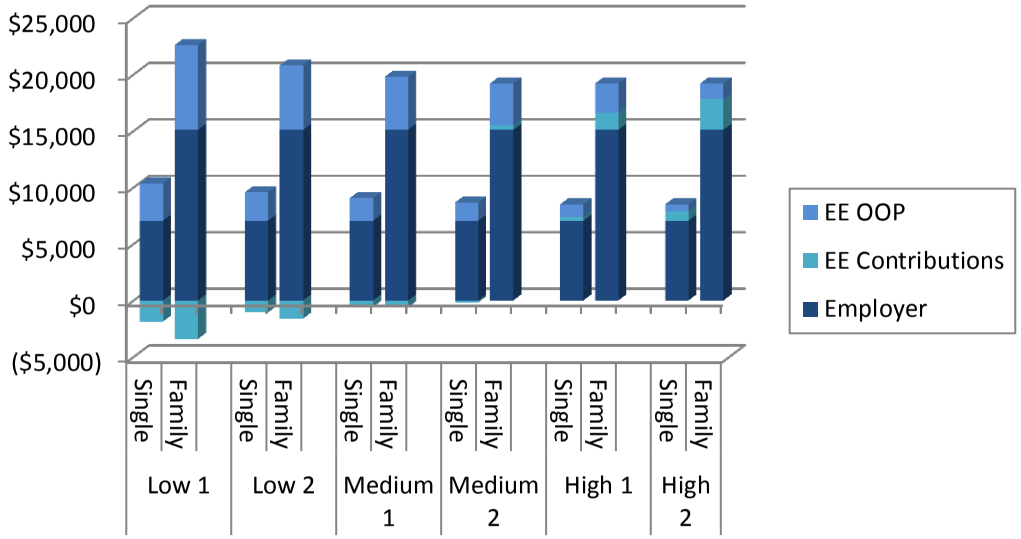
Single/Family - 20%

	PEPY	Plans Vary by Actuarial Values					
	Actuarial Value	0.60	0.70	0.75	0.80	0.85	0.90
Single	Total Plan Cost	$4,533	$5,288	$5,666	$6,044	$6,422	$6,799
	Employer Paid	$4,835	$4,835	$4,835	$4,835	$4,835	$4,835
	EE Contributions	($302)	$453	$831	$1,209	$1,586	$1,964
	EE OOP	$3,022	$2,266	$1,889	$1,511	$1,133	$755
Family	Total Plan Cost	$10,992	$12,824	$13,740	$14,656	$15,572	$16,488
	Employer Paid	$11,725	$11,725	$11,725	$11,725	$11,725	$11,725
	EE Contributions	-$733	$1,099	$2,015	$2,931	$3,847	$4,763
	EE OOP	$7,328	$5,496	$4,580	$3,664	$2,748	$1,832

"Best healthcare practice" / trends — State of Florida illustration
A consumerism and defined contribution approach to pricing plan options

Illustration 2: How the State of Florida's Plans Might Look if Part of a Consumerism Portfolio Offering (using the current 12% employee approximate cost share of aggregate premium levels)

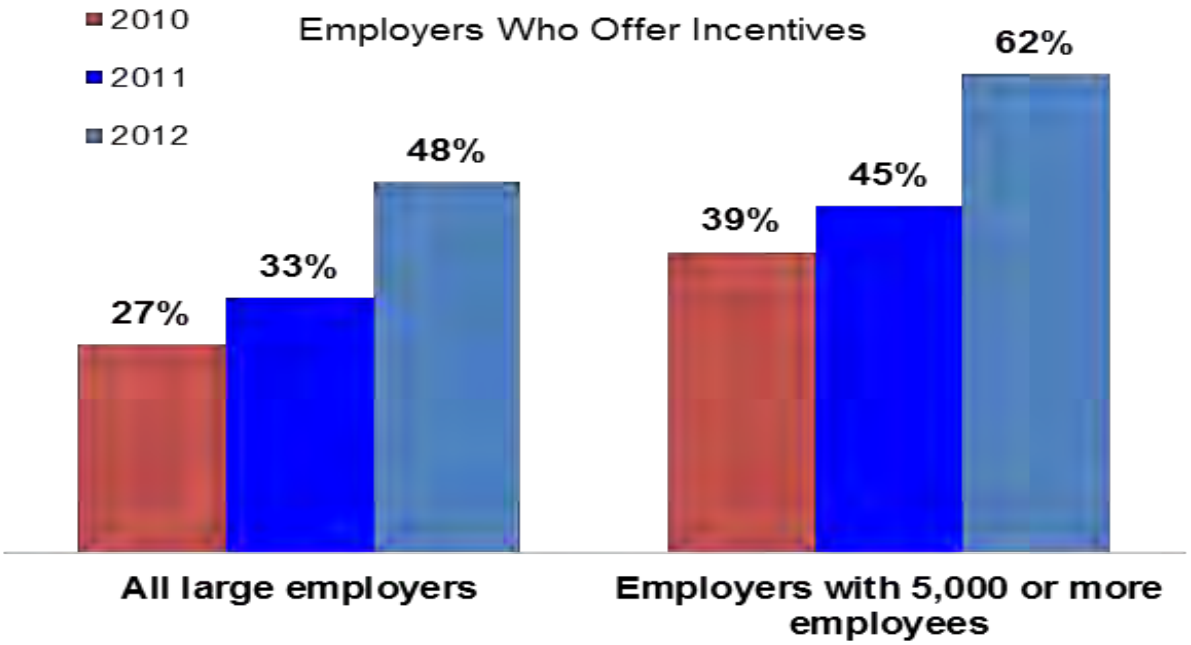
- The red circled numbers show pricing to buy-up / buy-down from the Standard PPO



	PEPY	Plans Vary by Actuarial Values					
					CDHP w/ HRA or HSAs	Standard PPO	Standard HMO
	Actuarial Value	0.60	0.70	0.75	0.80	0.86	0.93
Single	Total Plan Cost	$5,200	$6,000	$6,500	$6,900	$7,400	$7,900
	Employer Paid	$7,063	$7,063	$7,063	$7,063	$7,063	$7,063
	EE Contributions	($1,863)	($1,063)	($563)	-$163	$337	$837
	EE OOP	$3,300	$2,500	$2,000	$1,600	$1,100	$600
Family	Total Plan Cost	$11,700	$13,500	$14,500	$15,500	$16,600	$17,800
	Employer Paid	$14,440	$14,440	$14,440	$14,440	$14,440	$14,440
	EE Contributions	($2,740)	($940)	$60	$1,060	$2,160	$3,360
	EE OOP	$7,500	$5,700	$4,700	$3,700	$2,600	$1,400

Health management — incentives
Prevalence among large employers

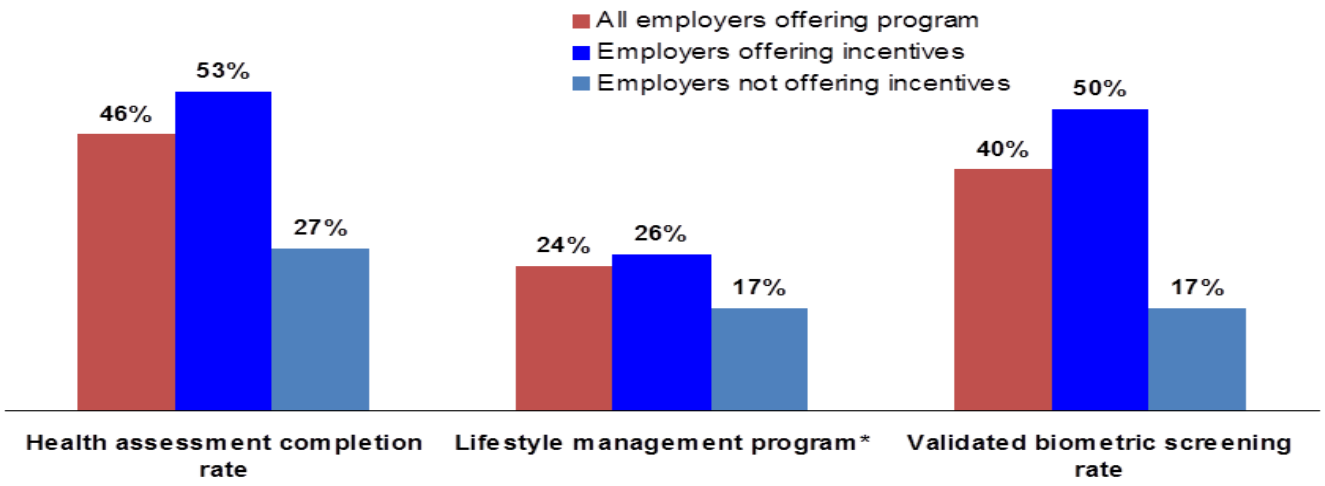
- The use of wellness and incentives is growing and large employers are tying incentives to wellness programs that include behavior modification, health assessment completion, and biometric screenings. Disincentives and outcome-based incentives are on the rise



- Almost half of all large employers (48%) in 2012 used incentives
- 62% of employers with 5,000 or more employees used incentives in 2012

Health management — incentives
Impact on participation in wellness programs

- When incentives are used:
  - Health assessment completion participation rates nearly doubled (from 27% to 53%)
  - Biometric screening participation rates more than doubled (from 17% to 50%)
  - Participation rates in lifestyle coaching increased from 17% to 26%



*Lifestyle management participation is defined as employees who had an assessment completed

Health management — engagement
Keys to CDHP enrollment (10%-50%) — key implementation decisions

	Initial Projected Enrollment	Moderate Enrollment	Higher* Enrollment
• Meaningfully lower EE CDHP / further increased PPO contributions	✓	✓	✓*
• Active enrollment (versus passive) / "Break Inertia" drop current plans	✓		
• Effective communication / education strategy and employer endorsement:			
– Visible leadership endorsement as key initiative	✓		
– Intensive / aggressive communication campaign and investment			✓*
– Communication of future strategy 2014+ (full-replacement)			✓*
– One or more mandatory meetings	✓		
• Plan design considerations and employee incentives:			
– Meaningful funding by company of CDHP ($500 single / $1,000 Family)	✓		
– Transition from copays to coinsurance for office visits			✓*
– Remove Rx copays (coinsurance with cap or make Rx subject to medical deductible)		✓	✓*
– Offer 1st year only additional incentive for CDHP enrollment (e.g., $500)			✓*
– Up-front, income-based, matching, voluntary benefit offered CDHP deposits		✓	
• Offer automatic enrollment CDHP or only CDHP plans to new hires			✓*
• Projected enrollment	0%-20%	20%-30%	30%-50%

***A combination of all the checked items likely needed to get 30-50% 1st year CDHP enrollment**

Innovation — health care reform
"Cadillac tax"

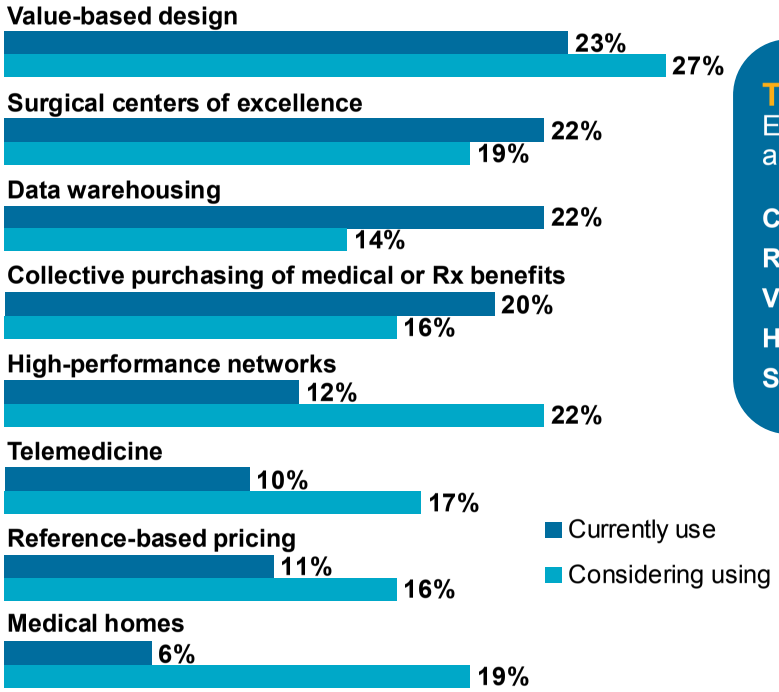
- A 40% "Cadillac tax" will be levied on the aggregate cost of employer-sponsored coverage in 2018
- The tax will apply on behalf of employees, former employees and surviving spouses who receive employer-sponsored coverage with a value equal or greater than $10,200 for "self-only," and $27,500 for "coverage other than self-only"
- Higher thresholds ($11,850 / $30,950) will apply to retirees and workers in high-risk professions and for single multi-employer plan coverage ($27,500)
- Cost indexing will apply after 2018, and will be based on the consumer price index (CPI) +1% for 2018 and 2019. After 2020, cost indexing will be based on CPI with no additional margin
- As 2018 approaches, employers like the State of Florida will need to consider whether to adjust their plan designs and plan offerings to avoid the "Cadillac tax"
- Of all PPACA provisions employers are currently facing, 48% of employers surveyed in Mercer's 2012 National Survey of Employer-Sponsored Health Plans said that their biggest worry is the "Cadillac tax"

Innovation — population specific

- What considerations are there for particular groups at the State of Florida?
  - Early Retiree Approach – Lower cost options would be available to early retirees, likely benefiting those who want lower contributions by selecting from additional new options. While early retirees do not pay the full actuarial value, they can continue to pay the “established” active premiums as they do today. Public exchange options exist as well
  - Payall Approach – “Payall” employees currently pay very low contributions so implementing a DC approach that is calibrated to current contribution levels would likely result in large taxable “cash back” (with HR, communication and administrative issues) for this group. Potential higher contribution strategies or limiting plan options may need to be discussed if the goal is to introduce consumerism or avoid risk selection for this group
  - Medicare-eligible retirees Approach – Medicare-eligible retirees may have alternative options available such as Medicare Advantage and Supplement plans. The State could procure its own Medicare Advantage plan or use private exchanges to offer all market options. Since Medicare-eligible retirees pay the full premium, they are unaffected by a defined contribution approach

Innovation — other trends

- Within the spectrum of innovations are those that can improve the quality of care employees receive and make care delivery more efficient
- While many of these and other new solutions are still emerging and may have limited cost savings potential unless used in conjunction with consumerism, early results are promising:
  - For example, more than half of the employers that have implemented reference-based pricing, value-based design, and high-performance networks have already been able to document a positive impact on cost



Top 5 cost savers
Employers using strategy that achieved lower cost as a result:

Collective purchasing	70%
Reference-based pricing	57%
Value-based design	56%
High-performance networks	51%
Surgical center of excellence	43%

Innovation — observations and considerations

- While innovation is rapidly expanding throughout the market, it is increasingly difficult to identify sustainable strategies with likely strong “ROI” for the organization, particularly relative to the risk of unknown health care reform, regulatory, provider, insurer, technology and consumer factors
- The suitability of these innovations for a particular large employer is largely dependent on the employer’s ability to identify and commit to longer term objectives, priorities and resources
- How many resources (staff, IT, budgets, communications, various group’s and constituent support) will be available for health management, innovative and provider initiatives?
- Responding to known and unknown Health Care Reform considerations is a significant compliance, financial and strategic consideration (e.g., the Cadillac tax needs to be closely monitored)

Disclaimer

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use


MERCER

EmployerDirect
Health Benefits

SurgeryPlus+

Transforming Healthcare for Self-Funded Employers.

Brought to you by:

EmployerDirect

Let's build healthier companies.

SurgeryPlus+

Surgeons of Excellence

Direct access to Surgeons of Excellence nationwide.

Savings

Bundled case rates save up to 30%-50% more than traditional insurance and 6%-10% in total health costs.

Service

Personal assistance and no medical bills for members.

Introducing….

SurgeryPlus

SurgeryPlus – bundled case rates

SurgeryPlus negotiates all costs into a bundle BEFORE surgery:

- ✓ Surgeon fees
- ✓ Assistant surgeon fees
- ✓ Anesthesia fees
- ✓ Facility costs
- ✓ Inpatient diagnostics
- ✓ Inpatient therapy
- ✓ Inpatient pharmacy

***No more medical bills for surgery!

Employer WAIVES deductible & coinsurance to drive savings with SurgeryPlus

	PPO	SurgeryPlus
Ex. Knee Surgery Total Cost	$45,000	$22,000
Employee Cost		
Deductible	$500	WAIVED
Coinsurance	$2,500	*WAIVED*
Subtotal employee cost	$3,000	$0
Plan Net Cost	$42,000	$22,000

Total Savings = $23,000 with SurgeryPlus!

Employee SAVES $3,000 AND

Plan SAVES $22,000

SurgeryPlus Plan Design

SurgeryPlus is an easy overlay to any existing self-funded medical plan.

Incentives in plan design drive engagement.

Members considering surgery, now have a choice of providers within their medical plan either: in-network , out-of-network, or with SurgeryPlus.

	In-Network	Out-of-Network	SurgeryPlus+
Deductible (individual)	$500	$1,000	WAIVED
Coinsurance	85%	60%	WAIVED
Office Visit (specialist)	$50	60%	WAIVED
Out of Pocket Maximum	$3,000	$3,000	WAIVED

- **Employee SAVES $3,000 for surgery when using SurgeryPlus (example).** Savings are usually shared 25% to employees and 75% to the health plan.
- **HSA Plans:** Clients with HSA plans must collect deductible and typically provide additional HSA contributions for members who choose SurgeryPlus for surgical procedures.
- **Travel Benefit:** we provide personal assistance to manage flights and hotel reservations. Members also receive up to $100 for local travel or up to $1,000 for non-local travel.
- **Get Well Benefit:** members receive up to $50 on a pre-paid debit card after completion of survey.
- **No Bills:** Members no longer receive unexpected medical bills; bundled case rates are negotiated in advance.

SurgeryPlus Covered Procedures

SurgeryPlus bundled case rates are available for the following medical procedures:

Procedure Type	Examples:
Orthopedic	Hip Replacements, Knee Replacements , Rotator Cuff Repair, ACL Repair
Spine	Lumbar & Cervical, Laminectomy/Discectomy, Spinal Fusion, Artificial Disk
Cardiovascular	Coronary Bypass (CABG), Heart Valve Surgery, Implantable Defibrillators, Pacemakers
General Surgeries	Gallbladder Repair, Hysterectomy
Minor Outpatient	Arthroscopy, Carpel Tunnel
Bariatric	Gastric Bypass, Gastric Sleeve, Lap Band

SurgeryPlus model

Surgeons of Excellence:

Surgeons of Excellence

We don't look to price tags to determine a provider's quality, we rely on data.

EmployerDirect Medical Advisory & Quality Assurance Board established national selection parameters to define excellence by specialty.

Facilities Nationally Accredited:	Surgeon Selection Measures:
+ Leapfrog + Delta Group CareChex® + Thompson Reuters + Beckers Hospital Review + HealthGrades Hospital Quality Ratings + JCAH/Quality Measures + Accreditation of ASC + Healthcare Facilities Accreditation	✓ Board certification ✓ Malpractice History ✓ Patient Satisfaction (i.e. vitals.com; ucompare.com) ✓ Complication & infection rates review ✓ Mortality/Morbidity Rates ✓ High volume # of cases ✓ Outcomes data (3yrs)

** Key differentiator:

We have the unique ability to contract and refer patients directly to specific surgeons. SurgeryPlus creates ability to refer members directly to Surgeons of Excellence for better outcomes.

Surgeons of Excellence Nationwide

Direct Access to Surgeons of Excellence nationwide

SurgeryPlus offers *Direct Access* to Sites of Excellence for Cardiac, Orthopedic and Spine procedures and also additional options with Surgeons of Excellence in our top 40 major metropolitan areas for Orthopedic, Spine, Minor Outpatient and General Surgeries.

<u>No Additional Cost</u> to expand provider network during implementation.

Spine Medical Management

EmployerDirect partners with Dartmouth-Hitchcock Spine Center (ivyMD) to offer medical management for all spine cases

- Health coach support by telephone during Spine Surgery Consultation
- Web-based tools to assist in shared decision-making process and to report outcome data
- Review of spine related medical records by Dartmouth-Hitchcock Spine Center
- Real-time Web Appointment directly with Dartmouth-Hitchcock Spine Center to facilitate the second opinion recommendation prior to surgery and for follow-up questions as needed.
- Written summary of second opinion recommendations

No additional cost to include SurgeryPlus Spine Medical Management !

SurgeryPlus Proves Quality: Better Outcomes

"Employer Direct is developing the highest quality program in the country" – Dr Phil Sanger, CMO

Review of SurgeryPlus completed cases

Type of Procedure	Complications
Overall Complication Rate	0.87%

Complications Summary

+ No readmissions
+ No mortality

If a complication occurs all complications are pre-negotiated at a low percent of Medicare, resulting in even greater savings to the plan for high risk patients.

Savings:

Bundled Case Rates

SurgeryPlus Savings Potential

SurgeryPlus bundled case rates negotiated BEFORE surgery prove 30-50 percent more savings than traditional insurance.

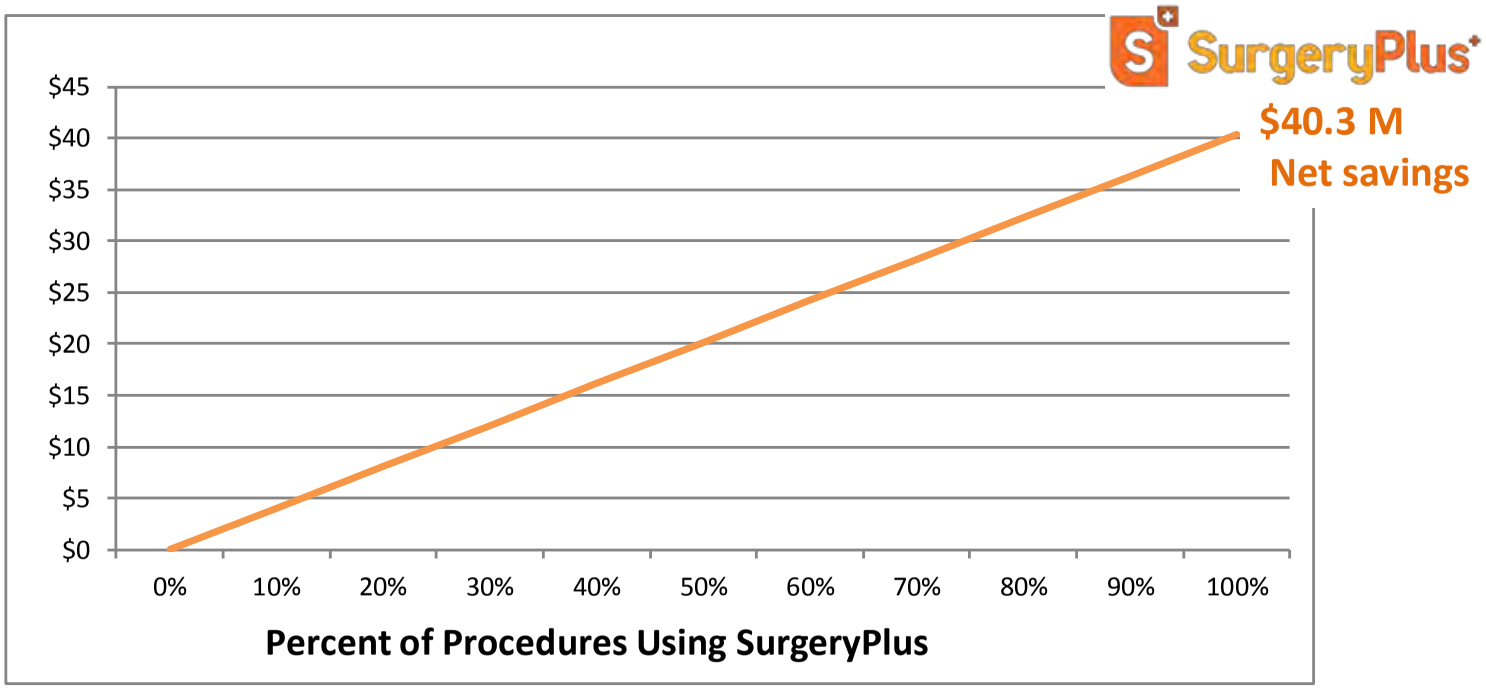
Sample Procedure	Client Historical Cost	SurgeryPlus Bundle Rate	SurgeryPlus $ Savings per case	% Savings
CABG	$ 59,032	$ 35,150	$ 23,882	40%
Knee Replacement	$ 42,878	$ 22,000	$ 20,878	49%
Shoulder Arthroscopy	$ 17,761	$ 6,000	$ 11,761	66%

SurgeryPlus bundled case rates are available to manage 25-30% of total health care costs and with full adoption results in 6-10% potential savings for the health plan overall.

Ex. Potential savings = $40.3 million per year

Member Engagement Drives Savings

Average Savings Based on SurgeryPlus Adoption Rate



- Initial expected adoption rate of 20-40%, based on member communication and plan design.
- Adoption will grow over time with increasing member awareness and provider coverage.

Case Study: Client X Proves Savings with Bundles

Client X: 9,700 employees; national member locations.

- **226 Open Cases**
- **90 completed surgeries**
- **$500,000 / 51% savings for completed procedures!**
- **Another $600,000 savings from members avoiding unnecessary surgery!**
- **Positive Member Feedback (97% surveys completed)**

  **Keys to success are communication and plan design

Example proven savings per procedure with SurgeryPlus

	Category	Type	CPT Code	Client Paid Before SurgeryPlus	SurgeryPlus Bundle	$ Savings per Case with SurgeryPlus	% Savings
1	Spine	Spine - Cervical Fusion	DRG 473	$59,779.00	$26,57800	$33,201.00	56%
2	Ortho	Knee Replacement	27446	$43,682.00	$23,015.00	$20,667.00	47%
3	Ortho	Right Knee Replacement	27447	$43,557.00	$24,206.00	$19,351.00	44%
4	Gall Bladder	Cholecystectomy	47563	$25,045.00	$6,356.00	$18,689.00	75%
5	Ortho	Total Left Knee Replacement	27447	$40,330.00	$24,919.00	$15,411.00	38%
6	Gall Bladder	Cholecystectomy	47562	$22,239.00	$5,546.00	$16,693.00	75%
7	Gall Bladder	Cholecystectomy (Laproscope)	49585	$28,920.00	$13,106.00	$15,814.00	55%
8	Out Patient	Hernia Repair	49650	$23,225.00	$7,347.00	$15,878.00	68%
9	Out Patient	Hysterectomy	58552	$18,935.00	$8,044.00	$10,891.00	58%
10	Gall Bladder	Cholecystitis/Cholangiogram	47563	$16,561.00	$6,581.00	$9,980.00	60%
11	Gi Scope	Hysterectomy/Tubal	58262	$18,814.00	$11,419.00	$7,395.00	39%

SurgeryPlus - client saves over $1.1 million in first 6 months with SurgeryPlus

Service:

Personal Assistance for Members

SurgeryPlus offers Personal Assistants

With SurgeryPlus, Care Coordinators are available as a personal assistant for each member.

Care Coordinators are non-clinical personal assistants to help members:

- Select a SurgeryPlus Provider
- Schedule their appointments
- Facilitate transfer for medical records
- Manage travel logistics (if applicable)
- Member Satisfaction Survey

SurgeryPlus integrates with existing programs.

During implementation, SurgeryPlus will coordinate with existing vendors and programs (e.g. case managers, internal member communications, onsite clinics, etc.) to identify key member touch points and drive member utilization.

Members LOVE SurgeryPlus

Overwhelming Positive Feedback from our Members:

"My experience with Employer Direct was absolutely the best. My care coordinator was absolutely great, she kept in touch with me all the way through my procedure and calling when I have my follow up appointment, she was great. I have already recommended this service to my co-worker which has already called for her procedure.." **—Rose**

"No stress - everything was handled for me. Great follow-up from Employer Direct as well as the hospital and the Doctor" **—Nena**

"I am very pleased. I think the best way to put it is, I felt like Joanne really listened to my preferences, requests, concerns etc. and made every effort she could to accommodate me. That, paired with the excellent medical care I received made using Employer Direct services a worthwhile venture." **—Sarah**

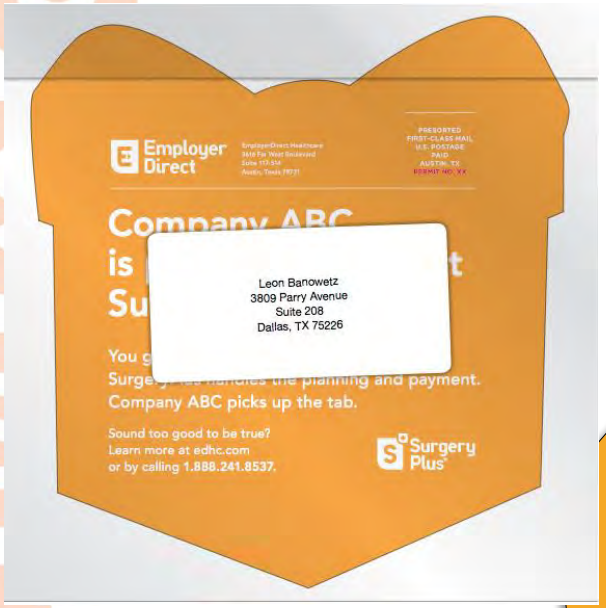
"Working with Employer Direct was a pleasure! Sherri made sure she answered all of our questions and was very patient to make sure everything went smoothly with scheduling and completion of my hip replacement." **—Ronald**

Questions?

Appendix:

Communication Strategy - Keys to Success

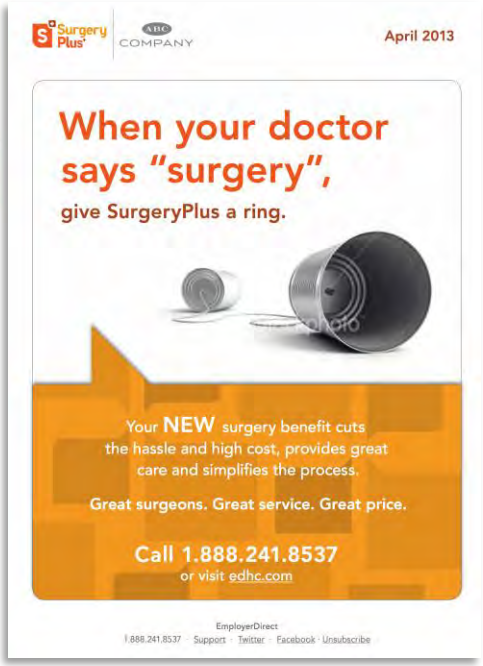
Communication Materials



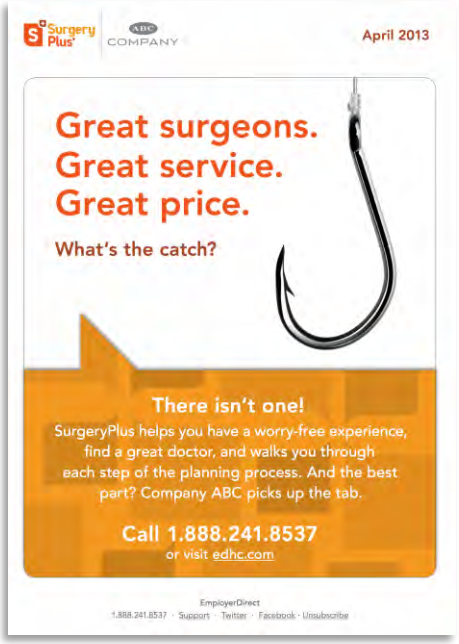
Unique Home Mailers

- Integrated cobranding
- Die-cut design
- Clear sleeve to cut through the clutter

Communications Materials



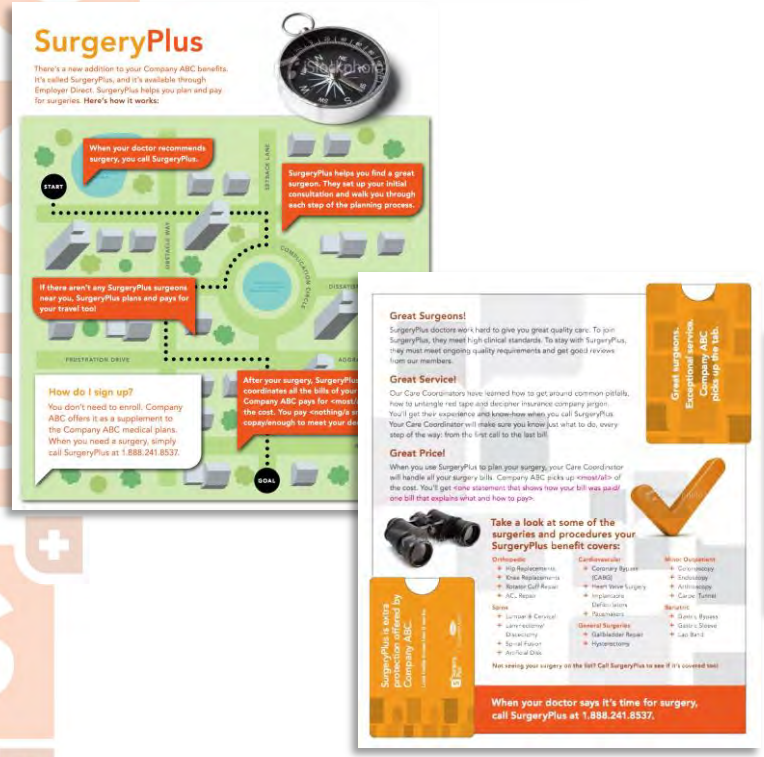
Growing eCard Library

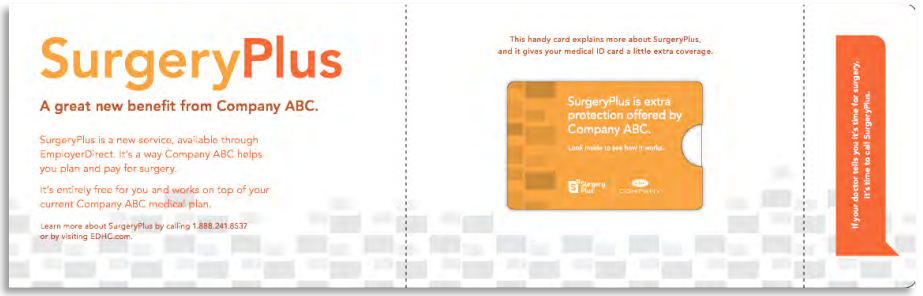


Communication Materials

Wallet Z-card

- Integrated cobranded Z-card and carrier
- Wallet card with marketing panels
- Pocket for medical ID card
- Custom panel with your covered services





SurgeryPlus

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MediBid for Employers

Defined Reimbursement Health Plan™

- If you sent an employee on a business trip, and they stayed in a Ritz Carleton on a Holiday Inn Budget, would you pay for it?
- Network pricing can vary by 1,000 percent
- We show you the "Fair Price". If an employee uses a higher cost provider, they pay the extra out of pocket. When an employee uses a MediBid provider and saves money, the employer and employee alike share the savings.

What is MediBid?

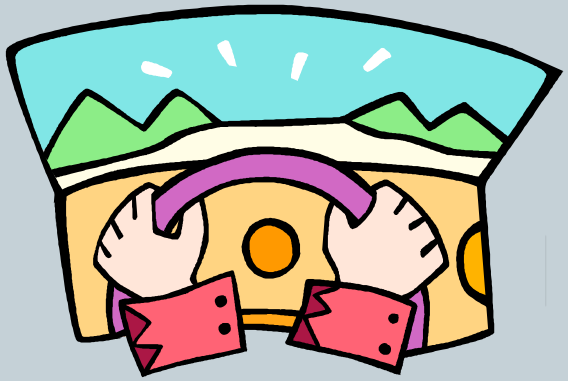
- MediBid is an online Marketplace for Medicine, which has been referred to as "*the Travelocity of Healthcare*"
- The secure online portal allows employees to see the rates charged by various providers
- Employees create a request for medical services online. This request is sent to doctors and hospitals across the US and overseas
- Doctors respond with a custom price for the procedure including their training, experience, board certifications and details on what is included

What Drives Healthcare Costs?

- "Healthcare costs" include monthly premiums paid to finance medical care, plus employees' out of pocket expenses. The pricing of the actual medical procedures are completely opaque. How can we control what we cannot see?
- MediBid changes the paradigm:
  - We design intelligent benefit plans
  - Every medical procedure is tendered out to a competitive bidder
  - We show you the actual prices that network providers charge
  - We allow providers to compete for your business, both in and out of network, reducing your cost of care

Cost Drivers

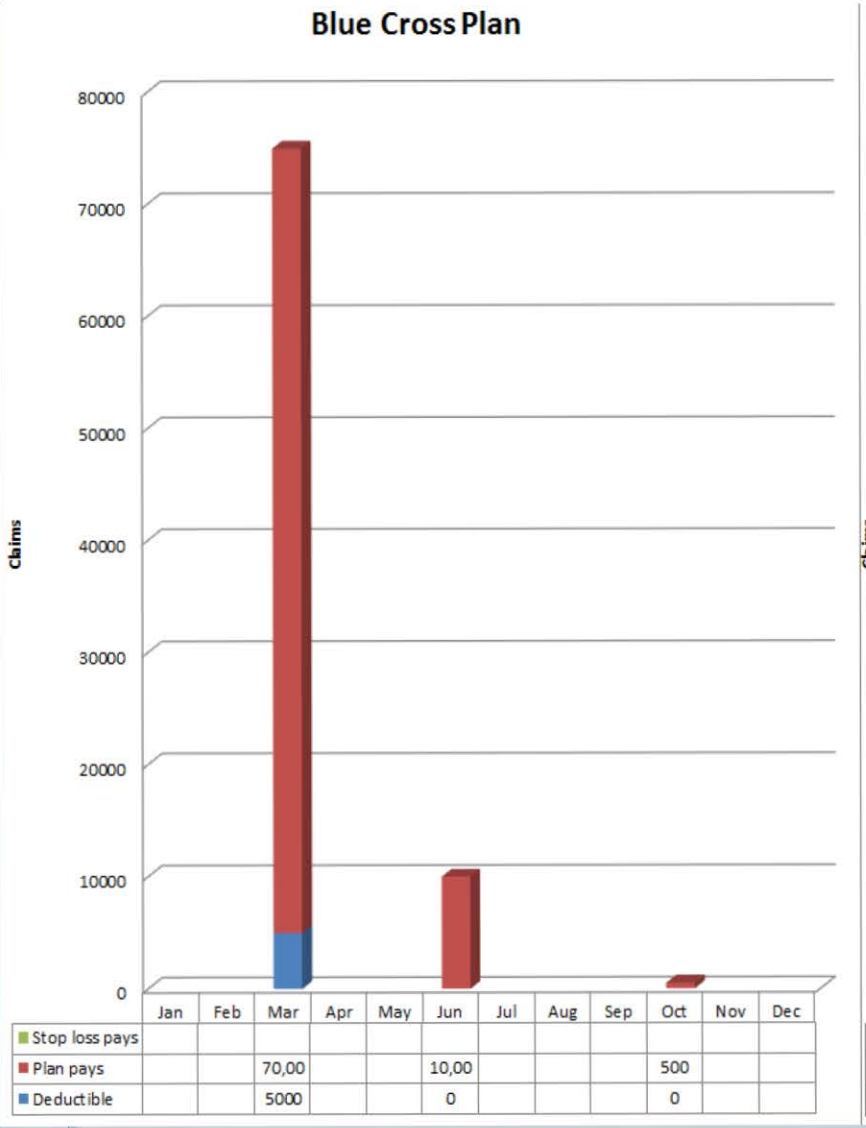
1. Poor plan design
2. Lack of incentive
3. Lack of Transparency
4. Lack of true competition
5. Provider network inefficiency
6. Health of employees
7. Administration
8. Complexity

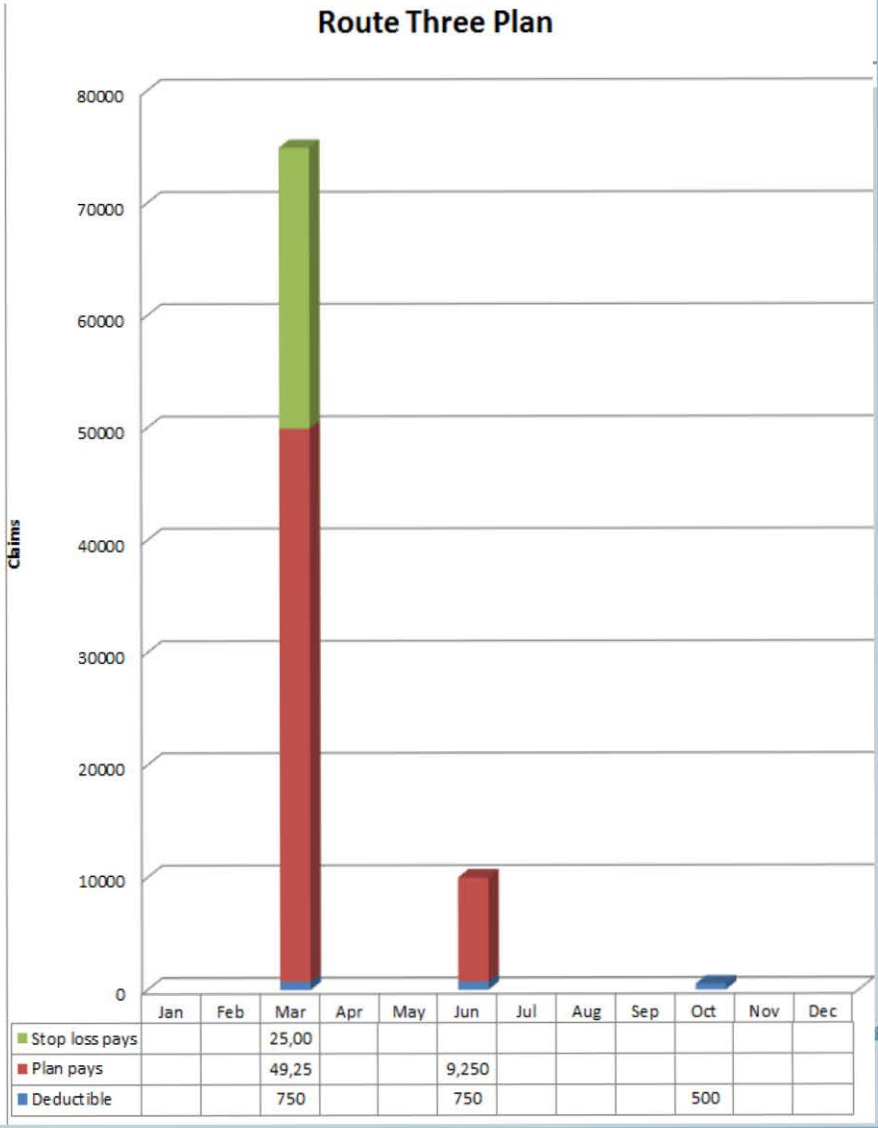


Driver # 1-Plan Design

- MediBid has proprietary plan design elements which drive behavior, create steerage, and reduce medical costs.
- To be effective, a plan needs to eliminate the stress of the “Cliff Deductible”

Compare Plans





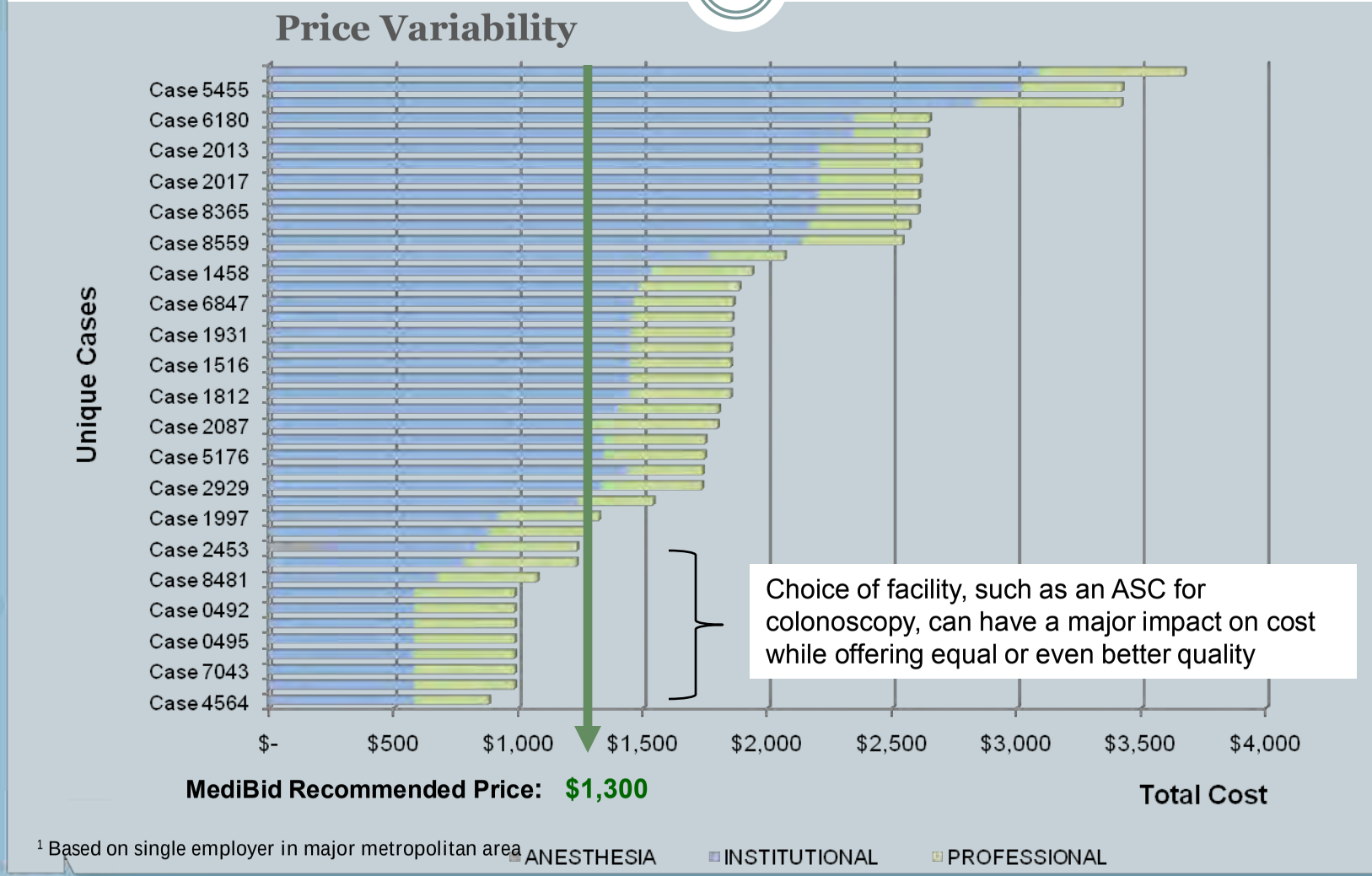
Driver #2- Incentives

- Employers who want their employees to opt for a hospital that is more affordable offer incentives.
- Want employees to shop for cost effective care? Incentivize them with a *reverse co-pay.*
- With larger savings, employers often fund the travel and accommodations for the employee plus a family member.

Driver #3-Lack of Transparency

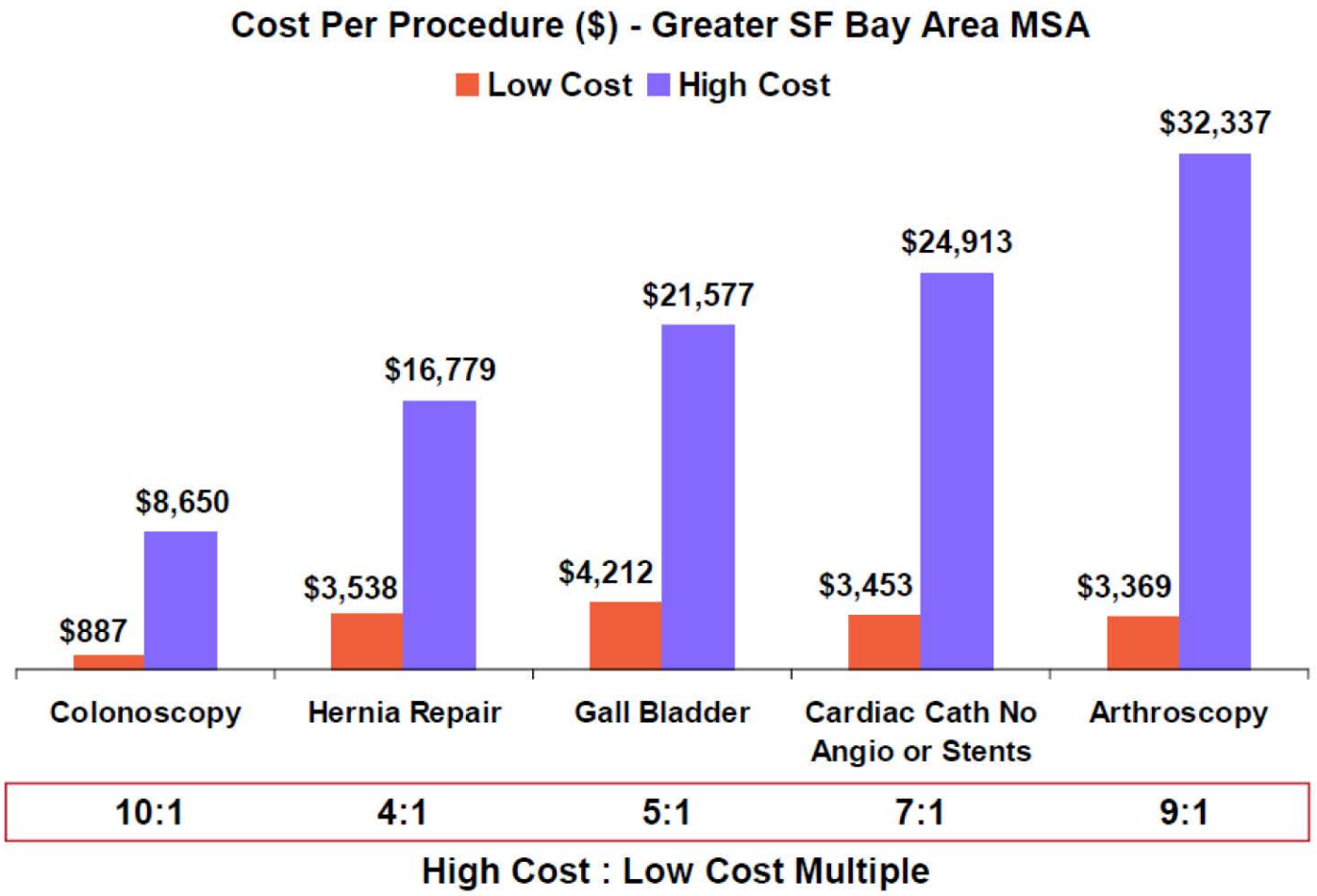
- Within any given network, prices can vary by 1,000% and the patient has no idea how much his provider will charge him
- In the city of Nashville, the price of a colonoscopy can range from $900 to $3,600 in a major insurance network. In San Francisco the variability is 10:1

General Diagnostic Example: Colonoscopy



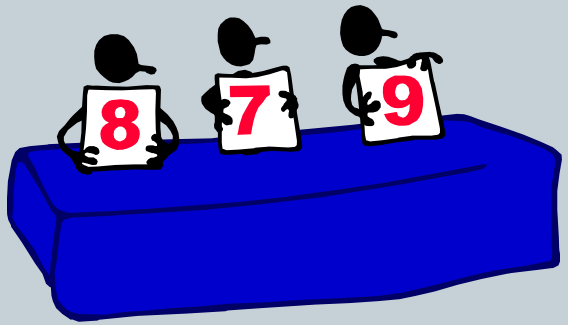
[1] Based on single employer in major metropolitan area

Transparency Matters



Driver # 4-Competition

- The current system is based on a system of price fixing using 14,000 CPT/ICD codes by Medicare
- In any given network not all doctors are paid the same rate for the same procedure, yet the patient can not see these rates in advance
- In a true competitive market, specialization and market share create savings
- When providers set their own rates, they compete on price and quality
- Tendering out every procedure ensures you are always recieving competitive bids



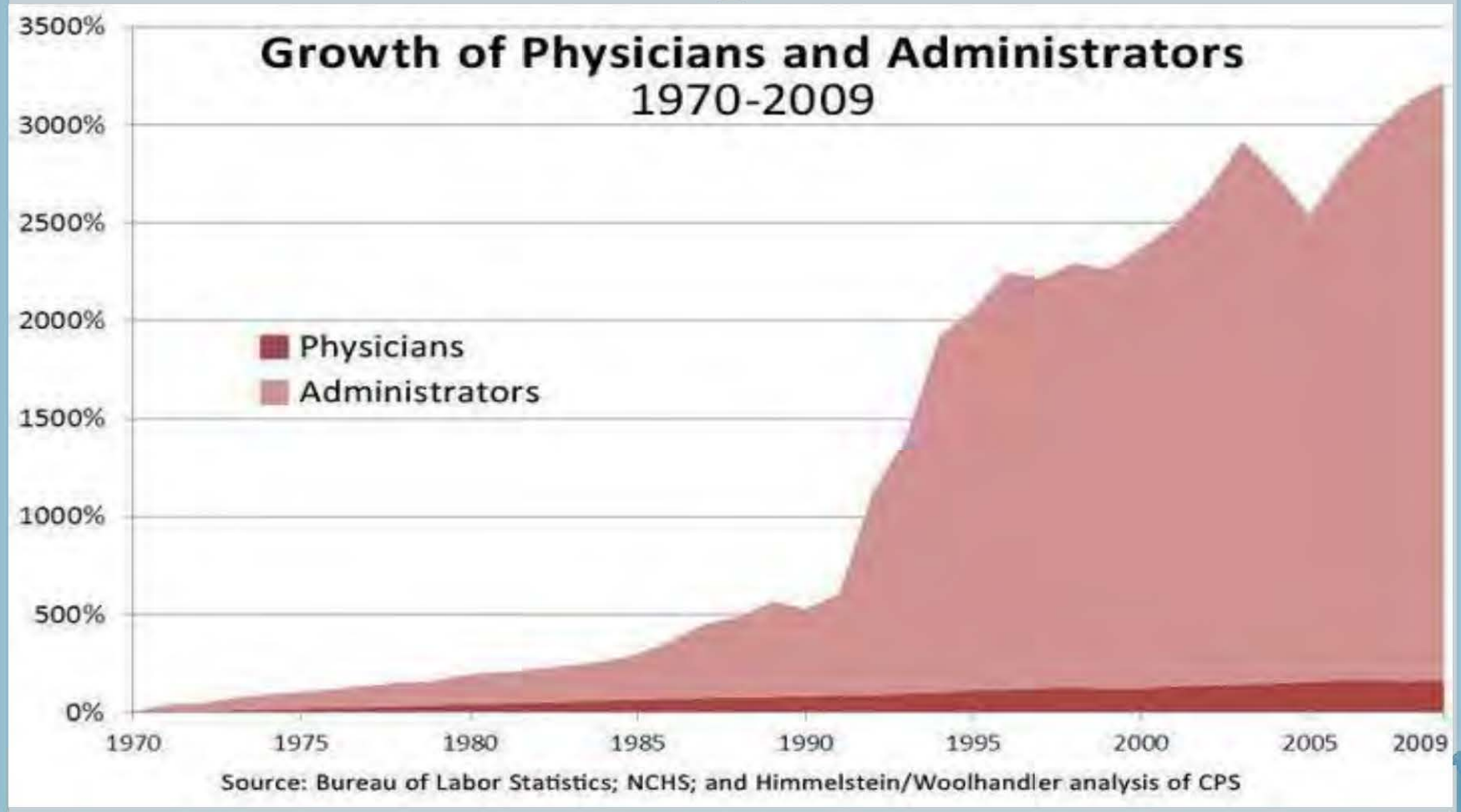
Driver # 5-Network Inefficiencies

- Many carriers want you to believe that increasing deductibles decreases costs, but increasing deductibles can put your plan into a death spiral
- Health insurance carriers want you to believe that they have negotiated discounts of 40% to 60%, but this is misleading. Due to the administrative burden on providers to bill a high price then offer a "discount", the discounted fees are usually higher than cash prices (even the lowest ones)
- The fact is that networks add many middle- into your plan increasing costs

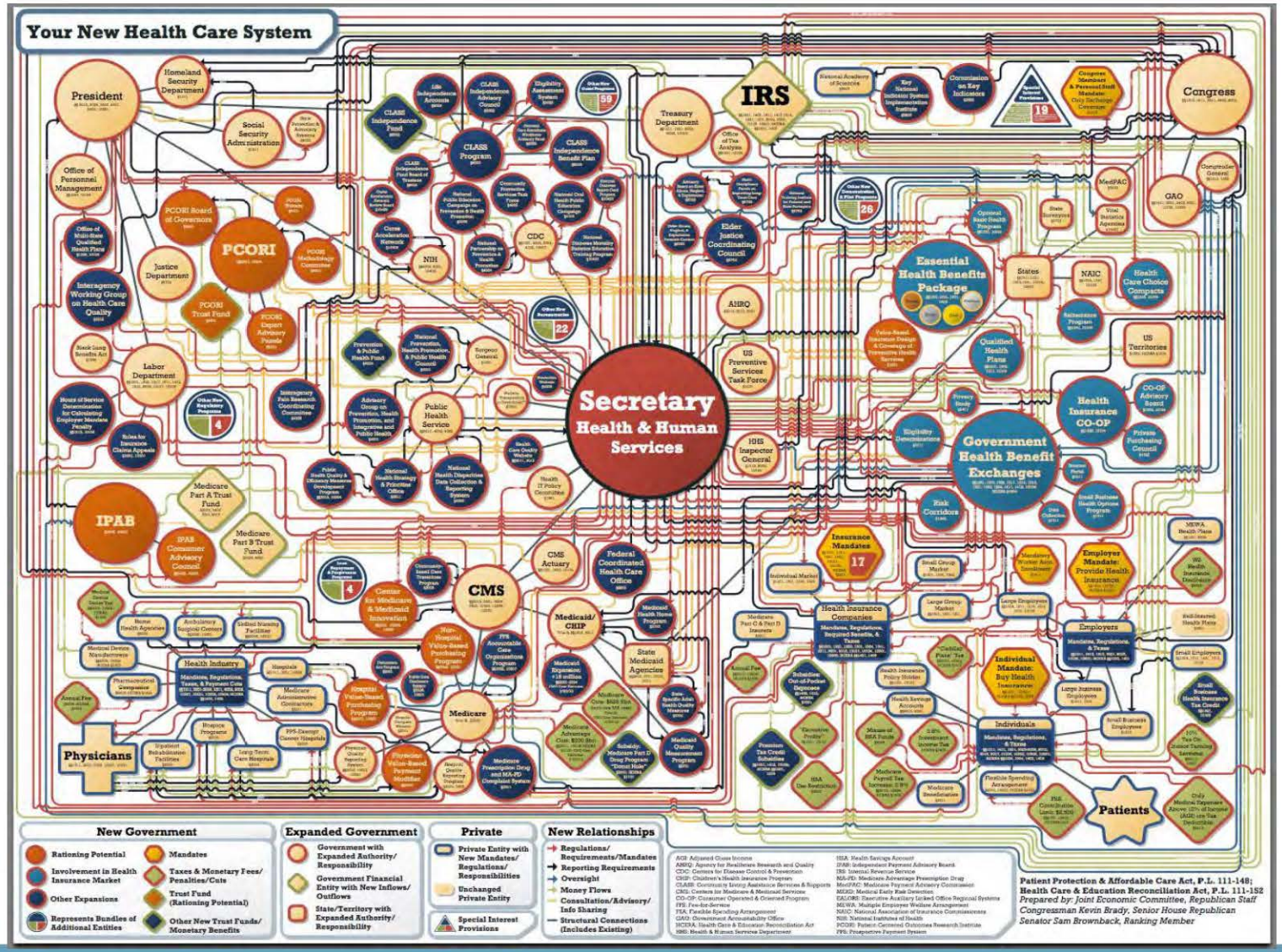
Driver #6-Health of Employees

- Often an employer sponsored health plan will pay for unhealthy spouses when they could be on their own employer sponsored plan.
- Changing the employer split of premiums can help this
- Our Health & Benefits Consultants design plans to ease the financial stress that traditional plans cause. Cliff Deductibles often result in an employee's late stage diagnosis.

Driver #7-Administration



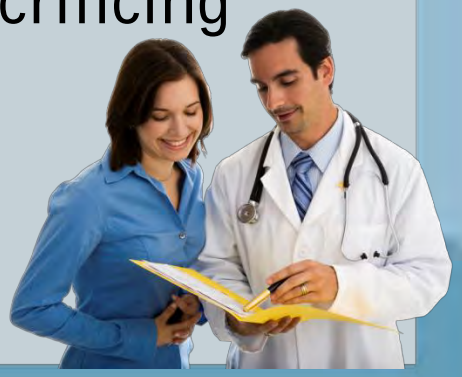
Driver #8-Complexity



In Conclusion

Many years ago the product we purchased was “Medical Care”. Today, the product is “healthcare”, which is simply medical care financing. Too much time and emphasis has been placed on attempting to reduce the financing costs while there has been no focus on the cost of care.

By eliminating third party payers MediBid doctors and facilities reduce their administrative costs and are able to pass that savings onto customers without sacrificing quality. This, along with properly designed and managed health plans and employee incentives, can reduce employer healthcare costs by 40% or more.



UNSUSTAINABLE

The rising cost of healthcare

SPECIAL POINTS OF INTEREST:

- When doctors are allowed to compete on quality and price, the patient wins.
- Lack of transparency accounts for up to 16% of your healthcare spend according to Safeway.
- With 1000% variance in network pricing you won't know how much it cost until you get the bill.

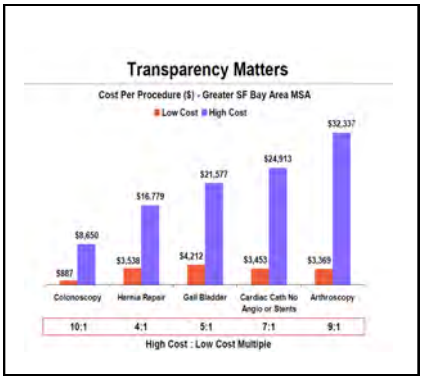
INSIDE:

The Market Place for Medicine® Helps Reduce Health Care Costs.

Healthcare costs have been rising for many years at a rate that outpaces wage inflation. Starting January 2014, this trend will get even worse as some of the more costly mandates of the Affordable Care Act (ACA) take effect. Under the ACA deductibles must decrease, cost reductions for healthy groups will vanish, and there will be reduced competition among healthcare providers as well as healthcare financing companies. Businesses that offer health benefits to their employees have already been forced to make some tough choices, and things are about to get worse.

For decades we have focused on the cost of insurance rather than the cost of care. Since 1996, reimbursement rates under Medicare have been scheduled to decrease almost every year, but these rate decreases have never been implemented. Given that reimbursement rates under PPO contracts are often a multiple of Medicare rates, almost all private payers are affected by the maintenance of the status quo. We continue to work in a system based on price fixing and lack of transparency.

Since the cost of health insurance is based on the cost of medical care multiplied by the number of times we use it, focusing on reducing the cost of insurance is a strategy that will never be effective no matter how many times we try.



Successful CFOs usually tender out large purchases in a "Request for Quote" (RFQ), or competitive bidding process. Each bidder is given the same specs and submits a silent bid based on known variables. Businesses know that competitive bidding with transparency is the best way to keep costs down. But that's NOT how people currently buy health care. We pay premiums to insurance companies, who in turn pay for the care provided and use Preferred Provider Networks (PPO) for "discounted" pricing. PPO prices often vary by 1,000% within their network for any given procedure, but consumers of healthcare are oblivious of these prices when the care is received. Instead of transparency and a market-based approach, pricing is completely opaque. Without pricing transparency, competition between providers is reduced, and there is little incentive to reduce costs.

PPOs often reimburse providers at a lower rate than what is shown to the plan sponsor and employees. Sometimes they charge a "hidden access fee" based on a percentage of savings of charged vs. pre-negotiated rates.

At MediBid.com you can do just what diligent CFOs do with each and every medical procedure: "*…tender out medical service purchases via RFQ and bidders submit a silent bid based on known variables*".

Seekers of medical services create their health profiles and submit a request for specific services.

The MediBid needs-matching search engine then pings all of the matching medical practitioners. The Bidders then create their customized bids, and the Seeker receives an alert each time a bid is submitted.

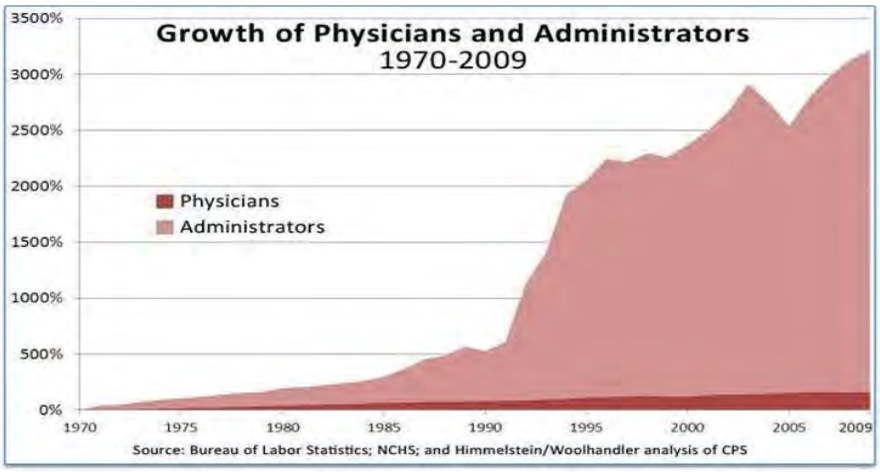
Upon acceptance, Bidders and Seekers are introduced to each other.

Seekers can review the quality parameters of the Bidders such as training, education, and experience, then make a decision based on quality, cost, and value.

Employers give incentives to employees (such as reverse co-pays) for electing to use lower cost providers. This solution is the only one in the market which focuses on the cost of care, not the cost of insurance, and provides the following:

1. Transparency of quality and cost = Value
2. Competition among providers via RFQ
3. Middle-men are cut out of the equation, allowing a further cost reduction
4. Employees are given the tools and the financial incentives to make value decisions which reduce costs

"Knowing what increases healthcare costs is the first step in reining them in."



Knowing what increases healthcare costs is the first step in reining them in. Cost drivers include:

Mandates & Coverage	Waste & Abuse	Cost of Medical Care
Amount of care used	Fraud	Administration
Taxes	Sales charges	Access or PPO Fees

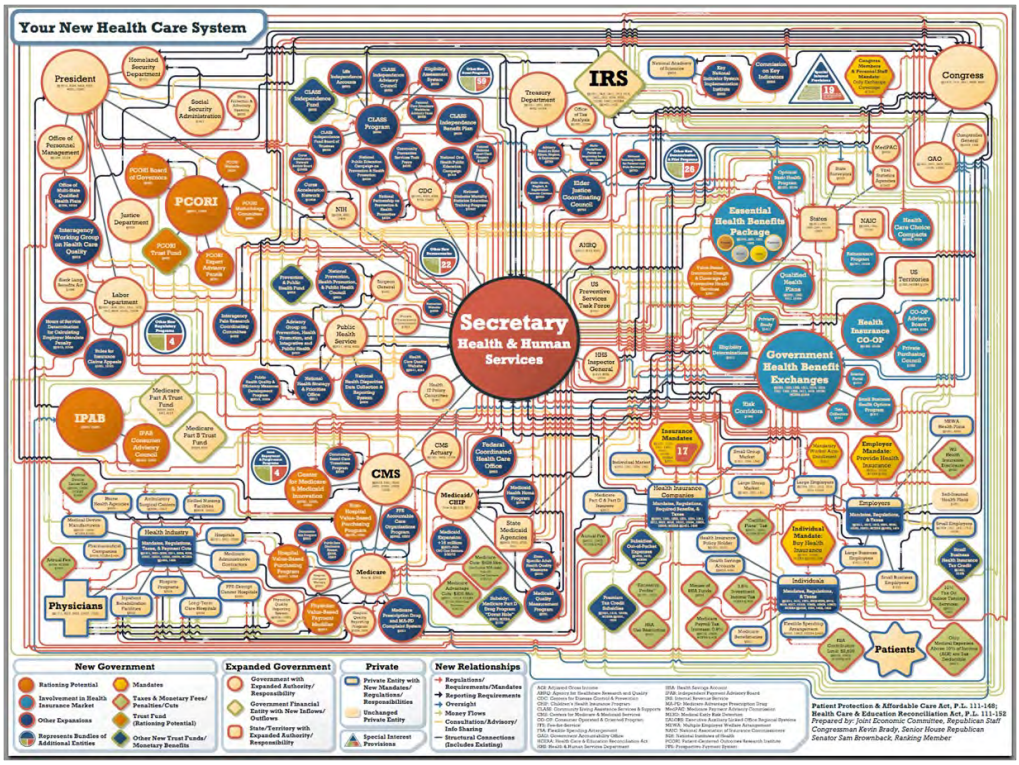
By far the largest drivers are: Mandates & Coverage, Waste & Abuse, and the Cost of Medical Care.

Healthcare Cost drivers

Mandates are set by legislation, and little can be done by employers to change mandates.

Coverage refers to what the plan covers. For example, a plan which covers MRIs will cost more than a plan which covers x-rays.

Waste and Abuse refers to (1) the ordering of unnecessary tests and procedures and (2) overpayment for the treatment received. This is largely due to plan inefficiencies, and poor incentives and controls.



Cost of Medical Care is driven up by Preferred Provider Organizations or PPOs. This is the part of most health insurance plans which gives "negotiated discounts" with certain medical providers. The question that few CEOs ask is: "Discount versus what?" Medical care is usually billed by doctors and facilities at rates between 300% and 1,000% of Medicare rates. Insurance companies "re-price" these claims and give an artificial discount. Carriers don't always pay the providers the discounted rates, as sometimes they "down-code" to a procedure which carries a lower reimbursement or charge a hidden "access fee". Other times they deny or decline the claim, which can even happen after the employer and employee have been billed. Since payers have one contract with providers and another with employers, they can pay the provider a lower amount than they bill the employer. This could represent a loss of millions of dollars to large employers.

Amount of Care Used is usually incentivized by low deductibles, poorly designed plans, lack of "skin in the game", or annual plan deductibles, which once met eliminate consumerism. This item is a multiplier of the cost of care. In other words, the greater the cost, the more this driver increases costs. Ask us about alternatives.

Fraud refers to the billing of services not received, and is frequently undetected. CFOs must demand plan audits, especially in self-funded plans governed under the Employee Retirement Income Security Act (ERISA). The plan administrator should act as fiduciary to protect plan assets.

"Many years ago the product we purchased was "Medical Care". Today the product is "healthcare", which is simply medical care financing."

Healthcare Cost drivers continued

HINT: It may not serve you to have the administrator audit the plan.

Administration, Taxes and Sales Charges combined, generally amount to only 15% to 20% of the plan costs. Premium taxes vary slightly from state to state and have been increased by the Affordable Care Act (ACA). Self-funded plans do a good job reducing all of these charges, yet very little can be done to reduce them in fully insured plans.

Access or PPO Fees…
Commercial health insurance companies and Third Party Administrators (TPAs) usually charge a "rental fee" for the PPO Network. This fee grants access to a selected list of doctors and facilities who have agreed to provide services at certain rates. Contrary to the way it is positioned, these fees actually INCREASE the cost of care. They provide artificial discounts on artificial prices, much like stores that mark up prices in the fall just to put them on sale for Christmas. This gives an illusion of offering a good deal, but in reality is misleading the consumer. With medical care, these "discounts" often have variations of up to 1,000% in one network, in one city, for one procedure. PPO discounts usually increase costs since the employee rarely knows the reimbursement level of their provider. It is usually better to save the PPO access fee and choose a schedule which reimburses on a fixed scale.

Although there are many new companies attempting to offer transparency, on its own transparency can't be monetized. MediBid is the only company that combines transparency with competition and gets rid of a "price-fixing" model with middle men fighting for a piece of the pie.

When doctors are allowed to compete on quality and price, the patient wins.

MediBid doctors and facilities often perform services for 80% less than billed rates and 50% less than Healthcare Blue Book prices. This, along with properly designed and managed health plans and employee incentives, can reduce employer healthcare costs by 40% or more. Why do they do this? Third party payers often pay a lower amount to the health care provider than what they charge the plan sponsor and/or employee. If providers are paid promptly and allowed to set their own rates, they typically receive a similar amount but with a far lower administrative burden in billing and collection. This reduced overhead is usually passed on to customers.

Many years ago the product we purchased was "Medical Care". Today the product is "healthcare", which is simply medical care financing. Too much time and emphasis has been placed on attempting to reduce the financing costs while there has been no focus on the cost of care. This is like trying to reduce the cost of a car by spending 80% less on the tires and still expecting the care to drive safely and efficiently.

MediBid can help you reduce your healthcare costs, while improving quality and access. Employers can often realize reductions in their healthcare spending between 25% and 40%.

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MediBid
Where Needs Meet Solutions