

NOTICE OF REGULAR MEETING

NOTICE OF SAN LUIS HEALTH BENEFIT TRUST MEETING IN ACCORDANCE WITH SECTION 38-431.01 OF THE ARIZONA REVISED STATUTES OF THE STATE OF ARIZONA, NOTICE IS HEREBY GIVEN TO THE TRUSTEES OF SAN LUIS EMPLOYEE HEALTH BENEFIT TRUST AND TO THE GENERAL PUBLIC THAT THE TRUSTEES OF THE SAN LUIS EMPLOYEE HEALTH BENEFIT TRUST WILL HOLD A BOARD MEETING AT 5:30 P.M., WEDNESDAY, DECEMBER 11, 2019. THE MEETING WILL TAKE PLACE AT THE CITY HALL, COUNCIL CHAMBERS, LOCATED AT 1090 E. UNION STREET, SAN LUIS, ARIZONA, 85349. EVERYONE FROM THE PUBLIC IS INVITED TO ATTEND THE OPEN MEETING.

In accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, the City of San Luis does not discriminate on the basis of disability in the admission of or access to, or treatment of employment in its programs, activities, or services. For information regarding rights and provisions of the ADA or Section 504, or to request reasonable accommodations for participation in City programs, activities or services contact: ADA/Section 504 Coordinator, City of San Luis Human Resources Department, 1090 East Union Street, San Luis, Arizona 85349; (928) 341-8579.

Notice is hereby given that pursuant to A.R.S. §1-602.A.9, subject to certain specified statutory exceptions, parents have a right to consent before the State or any of its political subdivisions make a video or audio recording of a minor child. Meetings of the City Council are audio and/or video recorded, and, as a result, proceedings in which children are present may be subject to such recording. Parents in order to exercise their rights may either file written consent with the City Clerk to such recording, or take personal action to ensure that their child or children are not present when a recording may be made. If a child is present at the time a recording is made, the City will assume that the rights afforded parents pursuant to A.R.S. §1-602.A.9 been waived.

THIS NOTICE IS APPROVED BY:

/s/ Maria Munoz, HR Benefits Coordinator

AVISO DE JUNTA REGULAR

AVISO DE JUNTA DEL FONDO DE BENEFICIOS MEDICOS DE ACUERDO A LA SECCION 38-431.01 DE LOS ESTATUTOS REVISADOS DEL ESTADO DE ARIZONA. SE LE INFORMA A LOS MIEMBROS DE LA MESA DE PERSONAL DE SEGURIDAD PUBLICA Y PUBLICO EN GENERAL QUE EL PRESIDENTE Y MESA DIRECTIVA DE FONDO DE BENEFICIOS MEDICOS, SAN LUIS, ARIZONA TENDRAN UNA JUNTA REGULAR A LAS 5:30 P.M. MIERCOLES, DICIEMBRE 11, 2019. LA JUNTA SE LLEVARA A CABO EN LAS OFICINAS DE LA CIUDAD, EN LA SALA DEL CABILDO, UBICADA EN EL 1090 E. UNION STREET, SAN LUIS, ARIZONA, 85349. EL PUBLICO ESTA CORDIALMENTE INVITADO.

De acuerdo con el Acta de Americanos con discapacidades y la Sección 504 del Acta de Rehabilitación del 1973, la Ciudad de San Luis no discrimina por causa de discapacidad la admisión y acceso a sus programas, actividades, servicios o en el trato en cuanto a empleo. Para mas información referente a derechos y provisiones del Acta de Americanos con discapacidades o Sección 504, o para solicitar adaptaciones que sean razonables para la participación en programas, actividades o servicios de la ciudad, contactar al: Coordinador del Acta de Americanos con discapacidades/Sección 504, Departamento de Recursos Humanos de la Ciudad de San Luis, 1090 Este Calle Unión, San Luis, Arizona, 85349; (928) 341-8579.

Por medio de este aviso y de acuerdo con los Estatutos Revisados del Estado de Arizona, sujeto a ciertas excepciones reglamentarias, los padres de familia tienen el derecho de dar o no dar el consentimiento antes que el Estado o alguna subdivision política grabe a un menor de edad, ya sea en audio o video. Las juntas del Concilio se graban en audio y/o video y como resultado, el hecho de que haya menores presentes puede ser sujeto a que sean grabados. Para que los padres de familia puedan ejercer sus derechos pueden solicitar por escrito con la Secretaria de la Ciudad a tal grabación, o tomar acción personal para asegurarse que su hijo/hija menor no esté presente cuando la grabación se lleve a cabo. Si un menor de edad esta presente en el momento de la grabación, la Ciudad asumirá que los padres de familia están cediendo los derechos sobre una posible grabación de acuerdo con el Estatuto Revisado del Estado de Arizona §1-602.A.9.

ESTE AVISO ES APROBADO POR:

/f/ Maria Munoz, Coordinadora de Beneficios de Recursos Humanos

AGENDA
Regular Meeting
City of San Luis Employee Benefit Trust
Council Chambers – City Hall
1090 E Union Street
San Luis, AZ 85349
Wednesday, December 11, 2019
5:30 P.M.

NOTE: Some members of the Board of Trustees of the City of San Luis Employee Benefit Trust may attend the meeting telephonically. If authorized by majority vote of the Board of Trustees, an executive session will be held immediately following the vote in accordance with A.R.S. §38-431.03(A) and the meeting will be temporarily recessed while the Board retires to executive session which will not be open to the public.

1. CALL TO ORDER/ROLL CALL

2. CONSENT AGENDA

All matters are considered to be routine by the Employee Benefit Trust Board and will be enacted by one motion. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.

2. A. MINUTES OF:

- Regular meeting held on June 12, 2019
- Regular meeting held on September 11, 2019

3. DISCUSSION AND POSSIBLE ACTION ITEMS:

3. A. Discussion and possible action on any and all matters regarding changes to the contract renewal date for Healthiest You. **(Susan Posada, Consultant and Broker).**

3. B. Discussion and action on any and all matters regarding the contract approval of ESurgeries Network. **(Susan Posada, Consultant and Broker)**

3. C. Discussion and possible action on any and all matters regarding the increase to budgeted expense for SIARMED's audit. **(Susan Posada, Consultant and Broker).**

3. D. Discussion and possible direction to staff on any and all matters regarding informational update on Employee claims status report. **(Susan Posada, Consultant and Broker)**

4. ADJOURNMENT

Employee Benefit Trust Board Meeting

2. A.

Meeting Date: 12/11/2019

Summary

MINUTES OF:

- Regular meeting held on June 12, 2019
 - Regular meeting held on September 11, 2019
-

Attachments

Minutes 06/12/2019

Glenn's email - Board meeting 06122019

Minutes 09/11/2019

MINUTES
Special Meeting
City of San Luis Employee Benefit Trust
Council Chambers - San Luis City Hall
1090 E. Union Street
San Luis, AZ 85349
June 12, 2019
6:00 p.m.

1. CALL TO ORDER/ROLL CALL: Chairman Gerardo Sanchez called the meeting to order at approximately 6:04 p.m.

PRESENT: Gerardo Sanchez, Chairman
Emma Torres, Vice-Chairwoman
Maria Sabori, Secretary
Gustavo McGrew, Board Member

ABSENT: Maria Gonzalez, Board Member

OTHERS PRESENT: Tadeo A. De La Hoya, City Manager
Melissa Lopez, Deputy City Clerk
Africa Luna-Carrasco, Council Member
Edgar Carbajal, HR Department
Glenn Gimbut, Assistant City Attorney
Maria Muñoz, HR Benefits Consultant
Monica Castro, Director of Finance
Ralph Velez, City Consultant
Susan Posada, Benefits Consultant

2. CONSENT AGENDA:

2. A. MINUTES OF

- Regular meeting held April 10, 2019
- Regular meeting held April 24, 2019
- Special meeting held May 8, 2019

MOTION: Vice-Chairwoman Emma Torres/Secretary Maria Sabori to approve the consent agenda as presented. Motion passed unanimously.

The vote was as follows:

Gerardo Sanchez, Chairman	Aye
Emma Torres, Vice-Chairwoman	Aye
Maria Sabori, Secretary	Aye
Gustavo McGrew, Board Member	Aye

3. DISCUSSION AND POSSIBLE ACTION ITEMS:

3. A. Discussion and possible action on any and all matters regarding Stop Loss Renewal with Symetra Financial. (Susan Posada, Consultant and Broker)

Ms. Susan Posada, Consultant and Broker, informed that there is no increase in the Stop Loss carrier. She added that there is no change in the premium at this time, but foresees increases in the future because of the large claims received every month.

Vice-Chairwoman asked how it can be foreseen that major increase will be done in the future and what can be done in order to avoid the premium go up.

Ms. Posada replied that her prediction is due to the large claims that have been received and also chronic diseases. She explained that there are some claims that cannot be prevented or predicted those are congenital disorder or cancer. Furthermore, she added that by reviewing the biometrics done by Yuma Regional Medical Center during open enrollment it was found that out of the 218 employees, 80 participated in the biometrics, from those 68% needs improvement in their blood pressure and 76% came out with obesity. She stated that all of these factors would anticipate an increase in premiums.

Vice-Chairwoman Torres asked what can be done to prevent premiums from going up in the future.

Ms. Posada replied that the Human Resources Department had done a tremendous job by providing classes and programs to the employees. She added that there is still more to do to bring down the chronic diseases. She stated that one of the options discussed with the Human Resources Department is to provide incentives to the employees that get a wellness check done each year to keep people healthy to reduce the cost. She mentioned that with these types of programs, one needs to be careful because of the wellness programs because of the discrimination laws and the disabilities act.

Chairman Gerardo Sanchez suggested the Human Resources Department to hold a meeting with all employees to give them out the statistics and ask them to work as a group to have a healthy community.

Ms. Posada informed that 20% of the people make 80% of the cost of the health plan.

MOTION: Chairman Gerardo Sanchez/Secretary Maria Sabori to approve the Stop Loss Carrier's proposal and quote for renewal as presented. Motion passed unanimously.

The vote was as follows:

Gerardo Sanchez, Chairman	Aye
Emma Torres, Vice-Chairwoman	Aye
Maria Sabori, Secretary	Aye
Gustavo McGrew, Board Member	Aye

3. B. Discussion and possible action on any and all matters regarding renewal of a broker agreement with Susan Posada Agency, Inc. and possible recommendations to City Council. ITEM CONTINUED FROM BOARD MEETING HELD APRIL 10, APRIL 24 AND MAY 8, 2019. (Glenn Gimbut, Assistant City Attorney)

Mr. Glenn Gimbut, Assistant City Attorney, informed that amendment to the Broker Agreement in accordance to the instructions given by Chairman Gerardo Sanchez, this agreement is a two (2) year renewal with a clause of automatic two (2) year renewals except that provides at least 60 days prior to the end of any term. This agreement also provided that the rate of compensation will always be the same unless approved by the board.

Board Member Gustavo McGrew stated that his understanding was that the agreement was going to be for one year.

Vice-Chairwoman Emma Torres mentioned that is agreed for a two-year renewal with an annual review before the agreement renews.

Mr. Gimbut replied that the annual review could be done; also, the board will have to give a 60-day notice for no reason, then the contract ends. Mr. Gimbut read an email to the trust, a copy of this email is filed with the complete agenda packet filed in the City Clerk's Office.

Board Member McGrew mentioned that automatic renewal is not recommended.

Mr. Gimbut replied that the automatic renewal was added at the recommendation of Mayor Gerardo Sanchez. He explained that the board would be meeting every three (3) months to review due diligence and fiduciary responsibilities of the Board on expenditures of public funds for employee health benefits package for fiscal year 2020-2021. Mr. Gimbut covered item 3. C. during this item. He read an email to the Board regarding the recommendation for the due diligence and fiduciary responsibilities of the Board for fiscal year 2020-2021.

Secretary Maria Sabori asked how soon staff can start looking into options.

Ms. Posada replied that the reason for being on against time frame is that the medical and other related insurances are based on claims, companies would not provide information until mid-March, because the claims for February to determine the rate. She added that the reason for every year is against the walls is because those are the conditions that the carries request. She mentioned is she provides the rates 30 days earlier they will not be accurate as the rates are based on the claims for February.

Vice-Chairwoman Emma Torres stated that since the board will be meeting in a quarterly basis, what will prohibit the board from receiving a quarterly report and not wait until the end to make a decision and be fair with the work done.

Ms. Posada replied that reports could be done on a quarterly basis, but in the end, that is when the rates will be determined. She informed that she provides a dashboard report to the city on a monthly basis.

Chairman Gerardo Sanchez mentioned that employees need to take responsibility for their actions and need to take care of themselves.

Ms. Posada stated that the services go out to bid when it is time for renewal, and there is a change in demographics or an increase. The only one that does not go out to bid is Blue Cross Blue Shield as they have the best network, but unfortunately, they increase their cost every year.

MOTION: Chairman Gerardo Sanchez/Vice-Chairwoman Emma Torres to approve the contract as presented. Motion passed unanimously.

The vote was as follows:

Gerardo Sanchez, Chairman	Aye
Emma Torres, Vice-Chairwoman	Aye
Maria Sabori, Secretary	Aye
Gustavo McGrew, Board Member	Aye

3. C. Discussion and possible directions to staff on any and all matters regarding the process for fiscal year 2020/2021 and due diligence and fiduciary responsibilities on Board to be certain of expenditures of public funds for employee health benefit package. (Glenn Gimbut, Assistant City Attorney)

This item was covered during the discussion of item 3. B.

4. ADJOURNMENT

MOTION: Chairman Gerardo Sanchez/Secretary Maria Sabori to adjourn the meeting at approximately 6:47 p.m. Motion passed unanimously.

The vote was as follows:

Gerardo Sanchez, Chairman	Aye
Emma Torres, Vice-Chairwoman	Aye
Maria Sabori, Secretary	Aye
Gustavo McGrew, Board Member	Aye

Maria Munoz

From: Glenn Gimbut
Sent: Thursday, June 6, 2019 2:49 PM
To: Janet Taylor
Cc: Maria Munoz; Tadeo A. DeLaHoya; Kay Macuil; Sposada@sposadaagency.com; Gerardo Sanchez; Monica Castro
Subject: Upcoming meeting of Employee Benefit Trust

This will confirm the "brainstorming" session so that the Trust Board and due its fiduciary duty next year and NOT run into the problems we had this year.

Through the Mayor, Kay and I were instructed that the Board wants to do what is right by the city and wants to be certain that city money is being wisely spent on behalf of the employees.

Monica expressed that her fear is that we seem to take the package recommended by Susan and not have real time to be certain it is a wise use of money. The desire to be certain is a good one. The method of simply looking to see if there are other brokers in the world does NOT address this problem. If one is just accepting a package at the last moment at a time where one cannot really change it if one wanted to, simply getting someone else to give you something at the last moment without an ability to change anything does not solve the problem.

Susan does an extraordinary amount of work. More than anyone else I have ever experienced. I welcome the Board getting educated and asking questions of Susan of what she does how she does it and why certain things are being recommended and others not and how she got to her conclusions. The problem is this is being done in a short "sprint" between December/January and finishing up around the end of February. During this time Monica is stretched thin as all get out between Audit, Budget, and regular business. Despite all appearances there is not a Red \$ on Monica's blouse. (Superwoman).

There are two components here. First is the process by which Susan is going through to choose the various components of the health benefits package. To use the exchange between Chico Marx and Groucho Marx in Coconuts, "Over here we have the Viaduct". "The what?" "The Viaduct". "Why a Duck? Why a no Chicken?" Line by line the Board should be asking Susan why a duck, why a no chicken. What we should be doing is alerting Susan that this is coming so it is not sprung as a surprise. She should be asked in December what would be a good time after she has started but before she is finished to meet and ask these kinds of questions such that it is not too late to change a vendor or a benefit. I anticipate that this would take place sometime in mid-February, but it is best to let Susan pick the date. Then there is a meeting with the Board and all questions can be asked and the Board can satisfy itself that the elements of the package have been properly "shopped" and that it can have effective input should change be desired.

The second component is how can we be certain that being a self insured is better than not and that we are providing better benefits at lower cost.

This becomes a Maria chore. Olivia's instinct of wanting to do her own checking and not take someone's word for it was a good one. It was her execution and approach that left a lot to be desired.

Rather than call the vendors selected by Susan or calling other brokers, what should be done is call other political subdivisions like Somerton, Gadsden Elementary School District, Yuma School District No. 1, Crane School District, and Yuma County. Ask the following questions:

- 1) How many employees?
- 2) What is the health benefit package?

- 3) Who is supplier – i.e. are you self insured or are you buying from a carrier, and if from a carrier, who?
- 4) What is your cost per employee?

This will give hard data to compare what we are offering our employees and what it costs us versus what others are offering their employees and what it costs them.

This is what I am proposing to improve the process going forward. It meets Monica's standards for due diligence and doing one's fiduciary duty, is data based, and takes personalities out of it. If one talks about this now, there is plenty of time to do it right and it should not end up as a form of last minute surprise. The proposed timing is to talk about this now and let the Board think about it. Then at the September meeting the Board decides whether to pursue something like this and establish the timing as well as weigh in on just what info they might need from Susan. Then in the December meeting set up the "Why a Duck" meeting and how far in advance of that to get materials or a report from Susan so the Why a Duck meeting can be an intelligent/meaningful one, and when they want the info on what other local subdivisions are doing and experiencing as a comparison.

My language for this meeting this week is:

"Discussion of process for fiscal year 2020/2021 and due diligence and fiduciary responsibilities of Board to be certain of expenditures of public funds for employee health benefit package."

Minutes
City of San Luis Employee Benefit Trust
Council Chambers – City Hall
1090 E Union Street
San Luis, AZ 85349
Wednesday, September 11, 2019
5:30 P.M.

1. **CALL TO ORDER/ROLL CALL** Chairman Sanchez called the meeting to order at approximately 5:37 p.m.

THOSE PRESENT

Board Member Maria Gonzalez
Board Member Gustavo MacGrew
Secretary Maria Sabori
Vice-Chairman Emma Torres
Chairman Gerardo Sanchez

OTHERS PRESENT

Kay Marion Macuil, City Attorney
Tadeo A De La Hoya, City Manager – arrived at 6:05 p.m.
Monica Castro, Director of Finance
Susan Posada, Benefits Consultant, and Broker
Rob Flunker, EBSO Representative – by phone
Maria Munoz, Benefits Coordinator
Edgar Carbajal, Acting Human Resources Director
Jorge Mungaray, IT Technician
Janet Taylor, Legal Secretary, Clerk of the Board

2. **CONSENT AGENDA**

All matters are considered to be routine by the Employee Benefit Trust Board and will be enacted by one motion. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.

- 2.A. **MINUTES OF:**

- Regular Meeting held on June 12, 2019

Consent Agenda was not approved due to the fact that the minutes were not posted on the website 24 hours prior to the meeting.

3. **DISCUSSION AND POSSIBLE ACTION ITEMS:**

- 3.A. Discussion and possible action on any and all matters regarding the approval and ratification of Stop Loss Carrier's renewal offer with Symetra Financial. (Susan Posada, Consultant and Broker)

Susan Posada, Consultant and Broker, stated that the initial presentation rates with Stop Loss Carrier were incorrect and that they were actually 317.52 less the prior year than originally presented to the trust.

Kay Macuil City Attorney stated that the contract was signed and that the city definitely wanted the insurance that the Stop Loss affords us and to get the board's approval with that error would be ok.

Chairman Sanchez asked the board if there were any questions and repeated that the rate is less than what was originally presented.

MOTION: Chairman Gerardo Sanchez and Vice-Chairman Emma Torres to approve the ratification of and renewal of Stop Loss Carrier's offer with Symetra Financial.

The Vote was as follows:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

3.B. Discussion and possible action on any and all matters regarding the annual review of the benefit plan. (Susan Posada, Consultant, and Broker)

Ms. Posada referred to the blue packets she had given out and stated that the plan 2018-2019 made 947,000.00 (nine hundred, forty-seven thousand) dollars more than the administrative claims and administrative fees that were saved or made last year because the claims were lower. Ms. Posada continued with the bad news that there were eleven (11) large claims, there were two (2) claims that exceeded the 50,000.00, and there are several that could hit hard.

Ms. Posada continued with the employee biometric results that showed 55% had some form of hypertension and that 45% are obese. Ms. Posada stated she is looking into a wellness program and to present some nutrition visits.

Mayor Sanchez asked if there was a certified dietician here or in Mexico that could provide some counseling.

Ms. Posada stated that the plan only pays for it if there is a critical illness.

Ms. Torres asked Ms. Posada what the large claims were if they were for heart disease or diabetes. Ms. Posada responded they were for a variety of different reasons.

Ms. Sabori asked if there was any way to compare to last year how we are doing with annual physicals.

Ms. Posada responded yes and that we were way down.

Mayor Sanchez emphasized that to have lower premiums, everyone needs to be healthier.

Ms. Sabori stated that maybe we could set-up different premiums for people who get their annual physicals and for those who don't.

Ms. Gonzalez commented that Ms. Posada mentioned the obesity rate and asked if we provided a dietician. Ms. Gonzalez commented further that Ms. Posada said we do not, but if someone has cardiac disease or diabetes, then one is provided to you.

Ms. Posada stated that not everyone is submitting their "other insurance" information into HR and suggested possible penalties for that.

Mayor Sanchez stated that we do need to look into penalties.

Ms. Torres commented that there does need to be responsibility on the employee part, but sometimes employees do not respond well to punishment. Continue with the wellness program. We should offer this and then this is what will happen. However, include this as wellness overall.

DISCUSSION ONLY NO ACTION NECESSARY

3.C. Discussion and possible action on any and all matters regarding Focus Imaging, preferred vendor, in City's Incentive/Win-Win plan. (Susan Posada, Consultant Broker)

Ms. Posada stated that at the time of the open enrollment Focus Imaging was a free-standing facility, but as of now, they have been purchased by Yuma Regional Hospital and that being a part of the hospital costs are higher. At that time, the Win-Win plan was discussed, and going to Phoenix or Tucson employees would save a lot of money, but now she doesn't feel that will work in the long run because she has seen some questions come in. Ms. Posada stated that after much research they found a company that we can contract with that doesn't cost us anything to contract with them initially but does cost us at the back-end. The company is E-Surgeries, and they contracted with Focus Imaging. So instead of paying the Blue Cross contracted rates they would pay an average of 140% of what Medicare pays as opposed to 200% & 500%. So what that means is that we are paying the lower rate.

Rob Flunker, by phone, stated that basically with E-Surgeries they have taken the Win-Win and ramped it up. Mr. Flunker explained how E-Surgeries contracts with ambulatory surgery centers/facilities that are not in the hospital realm avoiding the over cost that

hospitals charge and all for one rate. E-Surgeries contracts with facilities/surgery centers and anesthesiologists in Yuma so employees will not have to go to Phoenix, and the deductible and copay are still waived. There is no research on the part of the employee because EBSO captures it during the precertification process; then, a representative will contact the employee and let them know their options.

Ms. Posada continued that this will require the approval of their contract and that there is no fee initially until the claim comes in and does require a change in the plan document in order to waive deductible and copay. It will be a lot better for the employee. This year we removed the preauthorization for MRI's and CAT scans. We would have to add that back as a preauthorization, so when they call in they can be captured and sent to one of these facilities where they can choose to save money. It will be up to the employee.

Rob Flunker stated that they can still waive the cost of that to the employee by going to a facility with the contracted rate.

Mayor Sanchez replied that it sounds good on paper and it really is a good idea, but I see a couple of the employees as patients, and I asked them what they thought of going to Phoenix for an MRI, and out of the four (4) I asked none of them liked the idea. One, because they would lose a day or two of work and one, has severe back pain and not able to travel. But now that you mention we have affiliations or facilities that can do the work here in Yuma, that is a very good incentive as long as we know which facilities they are.

Ms. Posada stated that at this moment, we wouldn't know what facilities they are until we sign the contract. However, here is what we can do, sign the contract, and if we don't like the facilities, we do not have to use them.

Rob Flunker replied they contract based on surgery success rates, how often patients are re-admitted, and the amount of infection that occurs within those settings so ambulatory surgery centers nationwide have less than 1% infection rate. Also, if someone has a particular surgeon, they are set on using they will reach out to that surgeon and offer a contract to them. A lot of surgeons are looking to get out of the hospital setting.

Mayor Sanchez stated not to give up hope on Focus Imaging. Several providers are not happy about the hospital buying them. Also, when providers get involved, things are going to change.

Ms. Posada stated that she recommends keeping the Win-Win to see if people are going to use it. Once they see that it is more convenient, and it is a better option, we would have to change the plan document; we would have to get pre-authorization for MRI's and CAT scans and surgeries. That's the only way it is going to work is for them to call in, and then they can be directed. Then they are going to be able to say no copay no deductible no co-insurance I like that.

Mayor Sanchez stated that he did not think that we should remove it. Leave it there as an incentive, and see how it works once employees start seeing the benefits. But make sure in an acute setting if they need that study today or tomorrow we do have the option of doing it here. Let's keep that option open. If it is selective or a knee or a shoulder that can be done there, why not. I want to see a list of providers who are on the contracted list not everyone in Yuma is a great surgeon or family practice, or pediatrician people are always asking me whom do you recommend?

Ms. Posada requested that Rob Flunker provider that to her by tomorrow.

Rob Flunker stated that unless we have a contract with them, they are not going to provide that list, it would be like giving away their secrets. That they only contract with the best based on the data of re-admission and infection rates. If an employee has a particular surgeon, they want than if not already contracted, E-Surgeries can reach out to that person and set up a contract if that surgeon is willing. However, we are asking them to open up their books and provide their secrets to us without having a contract they won't do that.

Ms. Posada stated that she recommends that we try it. She said that she spoke to Justin with Yuma Regional, and what he talked about is moving in the direction of value-based programs, and that is exactly what Rob is talking about. Reducing infections and improving the outcomes of any surgery. They are working with a consortium out of Yuma. Ms. Posada asked Justin if we could direct a contract with Yuma Regional, and his response was that he did not know, but they already do it for their plan the Yuma Hospital Plan for their medical. Ms. Posada said she would continue this dialog with Justin. This is how we will come up with ideas to reduce our costs.

Mayor Sanchez stated that the hospital has concerns, and they are working on different plans and different incentives. Mayor Sanchez also commented that the hospital plan is excellent, and you don't pay certain copays if you use the hospital facilities. Mayor Sanchez directed Susan Posada to continue talking and to continue the dialogue.

Rob Flunker commented that value-based pricing or reference-based pricing as it is also known as is the direction most of the country is going in terms of self-funding their medical plan in place of a PPO Network.

Mayor Sanchez asked about the motion

Ms. Macuil replied that she had drafted one, but she wanted to be sure and asked Susan does the Trust need to contract with E-Surgery>

Ms. Posada replied, yes.

Ms. Macuil stated, but we don't have that contract.

Ms. Posada responded, correct. I gave you a copy of the agreement for review today, and I also gave you a copy of the verbiage for the plan document.

Ms. Macuil stated that the board cannot approve the contract, but I was going to recommend that the board approve staff taking steps towards that.

Mayor Sanchez stated that we could not vote on something that does not exist.

Ms. Macuil responded right you cannot say you approve this contract when you don't have it.

Mayor Sanchez stated we could motion for staff to continue working or continue with the dialogue or to execute a contract.

Ms. Macuil replied, correct. I was confused because they make contracts with the facilities and with the doctors, so I didn't know if we were left out, but apparently, there is a contract.

Mayor Sanchez stated we could recommend staff to execute a contract with

Ms. Macuil stated they couldn't approve

Mayor Sanchez said you tell us, legal counsel. I don't know if you have any questions, but I see it as an advantage to our plan, and we should have that choice. It is another benefit. It's another perk. Let me be very clear; we did not say you could not use local facilities because that is what people want to say.

Ms. Posada stated that we need the hospital, and she agrees with Justin. Also, we need them as much as they need us. They provide other services community-wide.

Mayor Sanchez stated there is going to be a lot more outreach, nutritional, and wellness programs coming out, and we will start introducing them to San Luis, which has, for many years, been lacking.

Ms. Macuil stated this is what she came up with; I move to direct staff to take steps to prepare a contract to provide to the board as soon as possible.

MOTION:

Mayor Sanchez and Vice-Chairman Emma Torres to approve to direct staff to take steps to prepare a contract to provide to the board as soon as possible.

Motion passed unanimously

The vote was as follows:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye

Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

4. ADJOURNMENT

Mayor Sanchez and Board Member Maria Gonzales approve to adjourn.

The vote was as follows:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

Meeting adjourned at approximately 6:32 p.m.

Employee Benefit Trust Board Meeting

3. A.

Meeting Date: 12/11/2019

Department Head: Maria Munoz, HR Technician, Human Resources Department

Submitted By: Maria Munoz, HR Technician, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding changes to the contract renewal date for Healthiest You. **(Susan Posada, Consultant and Broker).**

SUMMARY:

Healthiest You contract renews on 01/01/2020 and is seeking approval from Trust Board members to have current contract amended to have it renew on 07/01/2020 so it can align with other benefits offerings.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE THE AMENDMENT OF CURRENT HEALTHIEST YOU CONTRACT AS PRESENTED.

Fiscal Impact

Fiscal Impact:

FISCAL IMPACT:

N/A

Employee Benefit Trust Board Meeting

3. B.

Meeting Date: 12/11/2019

Department Head: Maria Munoz, HR Technician, Human Resources Department

Submitted By: Maria Munoz, HR Technician, Human Resources Department

ITEM:

Discussion and action on any and all matters regarding the contract approval of ESurgeries Network.
(Susan Posada, Consultant and Broker)

SUMMARY:

ESurgeries Network is only available in the employer market, making it a unique voluntary surgical management program. They contract with top area surgeons to perform many surgical procedures in ambulatory surgical centers rather than in outpatient hospitals. This program will have the same principles as the Incentive/Win-win program but with greater savings because of the direct rates with TPA and not Blue Cross Blue Shield. If an employee was to utilize ESurgeries, the following would be waived: Deductible, Co-insurance & Co-pays

If ESurgeries is approved, Plan Document would need to be changed to add prior authorization to Complex imaging and effective date of changes would be 02/01/2019.

Staff is currently working on negotiating changes to the form of contract ESurgeries provided.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO CONTINUE THIS ITEM TO THE NEXT MEETING OF THE BOARD.

Fiscal Impact

Fiscal Impact:

Fiscal Impact:

No program set-up fee. Plan sponsor shall pay ESurgeries an amount equal to 20% of the total amount payable for services provided pursuant to a Single Case Agreement.

Attachments

- ESurgeries proposal agreement
 - ASC Common Elective Procedures
 - ASC cost savings material
 - ASCs Material
-

PARTICIPATION AGREEMENT

This Participation Agreement (the “Agreement”), dated _____, 2018 (the “Effective Date”), is between _____ (the “Plan Sponsor”), and Exclusive Surgeries Solutions LLC, an Arizona limited liability company (“ESS”).

RECITALS

- A. Plan Sponsor has established and currently sponsors a Benefit Plan for Plan Participants.
- B. ESS provides administrative services to employers by connecting medical providers, facilities (e.g., ambulatory surgery centers, surgical hospitals, and hospitals), physical therapists, allied health professionals, or other medical care providers who provide medical services with Plan Participants pursuant to a single case rate negotiated by ESS on behalf of such employers.
- C. Plan Sponsor desires to contract with ESS for ESS to provide such administrative services to Plan Sponsor.
- D. Pursuant to the terms and conditions herein, ESS agrees to provide such administrative services to Plan Sponsor.

AGREEMENT

NOW THEREFORE, based on the premises and terms and conditions herein, the parties hereby agree as follows:

- 1. Defined Terms. As used herein, the following terms will have the meanings assigned below.
 - 1.1 “Benefit Plan” means an employee welfare benefit plan offered by Plan Sponsor to Plan Participants.
 - 1.2 “Payor” means a Plan Sponsor or a third party administrator working on behalf of Plan Sponsor and pays for Services rendered to a Plan Participant.
 - 1.3 “Plan Participant” means a person who is entitled to receive certain benefits with respect to health care services under a Benefit Plan.
 - 1.4 “Provider” means a physician, surgeon, anesthesiologist, physical therapist, physician assistant, and other medical professional, as well as facilities under contract with ESS to provide services to Plan Participants.
 - 1.5 “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 Code of Federal Regulations Section 160.103.
 - 1.6 “Required by law” shall have the same meaning as the term “required by law” in 45 Code of Federal Regulations Section 164.103.

1.7 “Services” means the medical services that are delivered by a Provider to Plan Participant.

1.8 “Single Case Agreement” is an agreement for a particular set of medical services entered into by the authorized representatives of Plan Sponsor and ESS, the form of which is provided in Exhibit A.

2. ESS Services.

2.1 ESS Services. ESS will arrange for a single case rate for particular medical procedures with Providers for Plan Participants. ESS pre-negotiates all expenses for particular medical procedures. When a Plan Participant has elected to have a certain procedure performed by a Provider, ESS may enter into with a Single Case Agreement among the Plan Sponsor, the Provider and ESS to provide for the negotiated rate for the Services to be provided to the Plan Participant. Payment will either be made by Plan Sponsor to the Provider or Providers or payment will be made to ESS for ESS to deliver payment in accordance with the Single Case Agreement. If applicable, all Providers shall be responsible for the collection of the co-payment, coinsurance or deductible required to be paid by a Plan Participant under the applicable Benefit Plan. Providers have sole discretion for medical services delivered to Plan Participants.

2.2 Acknowledgement Regarding Marketing. Plan Sponsor understands that, while the intent of this Agreement is to permit ESS to create a provider solution panel that appropriately responds to identified health care needs of the Plan Participants, Plan Sponsor hereby grants ESS a license to use and authorizes ESS to identify and publish Plan Sponsor’s name, address, logo and available services in ESS’s information materials and website for distribution to Plan Participants and in marketing materials for distribution to Payors and potential Payors of ESS.

2.3 Records. Plan Sponsor shall maintain accurate financial books and records, including electronic records, concerning Services provided to each Plan Participant, including any charges to and payments received from the Plan Participant by Plan Sponsor (“Records”). Upon ten (10) business days’ advance notice, or such shorter notice as may be required by law, Plan Sponsor shall permit ESS or its designee and/or the applicable Payor to inspect, audit and copy those Records maintained by the Plan Sponsor during regular business hours. Plan Sponsor shall maintain such Records and provide copies of such information to ESS and/or the applicable Payor upon reasonable request, at no charge.

3. ESS Credentialing. For the purposes of credentialing, ESS utilizes an internal proprietary credentialing process for all Providers. Plan Sponsor shall cooperate with and abide by the standards and the requirements of ESS’s credentialing programs.

4. Tracking System. ESS has a proprietary system that collects all claim and outcome data from day of surgery for ninety (90) days or per American Medical Association guidelines. This system, as well as the assignment of a care coordinator for each individual patient, is used for the patients scheduling, surgical, and if necessary rehabilitative needs. Plan Sponsor shall provide ESS with such information as requested by ESS for purposes of utilization of the ESS tracking system.

5. Payment. Plan Sponsor shall pay ESS, the ESS administrative fees for services provided to Plan Sponsor for medical services provided to Plan Participants, as provided on Exhibit C. All pricing is calculated as a bundled price which includes Provider fees, anesthesia, facility, and ESS administrative fee, as well as other fees, including, but not limited to, implants and other medical devices/procedures that may be necessary during the surgical process. All ESS pricing will be handled with a Single Case Agreement that will be signed prior to the delivery of medical services. Plan Sponsor shall remit separate

payments for Providers, facilities, and ESS to ESS for distribution to the various entities, within (7) business days of the provision of medical services. For services rendered to a Plan Participant per Single Case Agreement, ESS will prepare completed medical billing forms for services rendered by Providers to Plan Participant. For purposes of the Employee Retirement Income Security Act of 1974 (“ERISA”) and any other applicable state or federal laws, ESS shall not be deemed the “Administrator” or “Named Fiduciary” of any Benefit Plan. Plan Sponsor waives and Plan Sponsor shall have no cause of action, at law or in equity, against ESS, its employees, agents, officers and directors, and hereby releases each of the foregoing parties of and from any claims, demands, obligations, liabilities, and causes of action of every nature whatsoever, relating to, arising out of, or resulting from the enforcement of and compliance with ERISA and this Agreement.

6. Term and Termination.

6.1 Term. The initial term of this Agreement shall be for three (3) years commencing on the Effective Date and shall automatically renew for consecutive one year terms, unless either party provides written notice of intent not to renew at least ninety (90) days prior to the expiration of the then-current term.

6.2 Termination. This Agreement may be terminated in the event of a breach by either party, provided that the non-breaching party provides the breaching party with sixty (60) days’ prior written notice of the breach and of its intention to terminate this Agreement and an opportunity to cure the breach within such notice period. If the breaching party fails to cure such breach during the sixty (60) day period, then this Agreement shall terminate and be of no further force or effect.

6.3 Use of De-Identified. Notwithstanding anything herein, regardless of termination of this Agreement, ESS shall be entitled to indefinitely use any de-identified PHI for ESS’s own purposes.

6.4 Insurance. ESS shall maintain insurance with respect to ESS’s obligations under this Agreement reasonably satisfactory to Plan Sponsor and provide from time to time as requested by Plan Sponsor proof of such insurance.

7. Limitation of Liability. In no event whatsoever shall either party be liable for indirect, inconsequential, incidental, exemplary, punitive, or special damages including but not limited to lost profits or interruption of business. The liability of ESS for any claim arising out of this Agreement (whether based in contract, on negligence, on strict liability or otherwise) regardless of the form of bringing such action, shall not exceed in the aggregate, the total amount of fees received by ESS for the services which gave rise to the claim. ESS shall only be responsible for any undisputed fees actually received by ESS.

8. Indemnification. Plan Sponsor shall indemnify, defend, protect and hold ESS and its employees, agents, partners, shareholders, directors, officers or affiliates and assigns harmless for, from and against any and all liabilities, harm, claims, proceedings, lawsuits, damages, attorneys’ fees and costs arising out or related to: (a) this Agreement, (b) any breach of this Agreement, (c) any negligence, gross negligence or intentional misconduct by Plan Sponsor or any officer, director, employee, agent, successor, affiliate or assign, and/or (d) the delivery of Services by a Provider to a Plan Participant.

9. Miscellaneous

9.1 Survival. The respective rights and obligations of the parties under Sections 5, 6.3, 7, 8, and 9 of the Agreement shall survive indefinitely.

9.2 Amendments and Waiver. This Agreement constitutes the entire agreement between the parties with respect to its subject matter. It may not be modified, nor will any provision be waived or amended, except in a writing duly signed by authorized representatives of the parties or when required by regulatory agencies. A waiver with respect to one event will not be construed as continuing, or as a bar to or waiver of any right or remedy as to subsequent events.

9.3 Assignment. Except as otherwise expressly provided herein, neither this Agreement nor any rights or obligations hereunder may be transferred or assigned by either party without the other party's prior written consent. Any attempted assignment in contravention hereof shall be null and void. Notwithstanding the foregoing or any provision herein to the contrary, a party may assign this agreement, in its entirety, without the other parties written consent, to any legal entity that acquires all or a major portion of the assets or business of such party, whether by merger, sale of stock, reorganization, recapitalization or other form of business consolidation provided that any such assignee delivers to the other party a signed notice evidencing its agreement to be bound by the terms and conditions of this agreement and is not a competitor of the non-assigning party. This Agreement shall be binding on any permitted successors, and assignees of the parties

9.4 Non-Solicitation. During the term of this Agreement and for three years thereafter, Plan Sponsor will not directly or indirectly, without the express written consent of ESS, solicit or assist in solicitation of any Providers to discontinue participation in ESS's panel or to join another competing network of healthcare providers within ESS's panel and thereby avoiding, evading or bypassing ESS.

9.5 No Third-party Beneficiaries. Except as provided, nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors and permitted assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

9.6 Notices. Any notice to be given under this Agreement to a party shall be made via U.S. Mail, commercial courier or hand delivery to such party at its address given below, and/or via facsimile to the facsimile telephone number listed below, or to such other address or facsimile number as shall hereafter be specified by notice from the party. Any such notice shall be deemed given when so delivered to or received at:

If to ESS: Exclusive Surgeries Solutions, LLC
8671 West Union Hills #503
Peoria, Arizona 85382
Facsimile: (623) 321- 1095

If to Plan Sponsor: _____

9.7 Confidentiality. Each of the parties and its respective employees, contractors and agents shall maintain in confidence during the term of this Agreement and thereafter, except as otherwise required by law: (1) all Plan Participant information including medical information, learned through the operation of this Agreement; (2) all confidential Plan Sponsor information, including information disclosed as part of any peer review processes; (3) quality assurance and utilization review information; (4) all financial and business information related to this Agreement or either party's respective operations, including, but not limited to, either party's earnings, volume of business, methods, systems, practices, plans, discounts and contract terms, and other commercially valuable proprietary information; and (5) any other information required to be maintained in confidence by applicable law and regulation (collectively "Confidential

Information”), unless disclosure of a specific part of the Confidential Information is otherwise required to accomplish the purposes of this Agreement or is required by applicable law and regulation. Each of the parties and its respective employees, contractors and agents shall use best efforts to safeguard and protect Confidential Information against any unauthorized disclosure by any person and shall refrain from using or allowing any other person to use Confidential Information in any way that is considered detrimental to the other party. Each party shall provide immediate notice to the other of any *subpoena duces tecum* served on it for the production of records. The parties hereby agree to the terms and conditions of the Business Associate Agreement, attached as Exhibit B.

9.8 Jurisdiction and Venue. This Agreement is governed by the laws of the State of Arizona. The parties consent to the jurisdiction of the courts of the State of Arizona and the United States District Court having competent jurisdiction over Maricopa County, Arizona for any dispute arising out of a breach in this Agreement.

9.9 Relation of Parties. In relation to the agreements herein contained ESS is defined as an independent contractor. The employees of ESS shall not be deemed at any time as employees, joint employees, or agents of Plan Sponsor. Plan Sponsor also affirms that it has no influence or directive authority over the management and operations of ESS employees.

9.10 Governing Law. This Agreement, and the rights and obligations of the parties hereto, shall be governed by and construed in accordance with the laws of the State of Arizona.

9.11 Entire Agreement. This Agreement supersedes any and all other agreements between the parties hereto with respect to the subject matter hereof and contains all of the covenants and agreements between the parties with respect hereto.

9.12 Counterparts. This Agreement may be executed in one or more counterparts, each of which will constitute an original and together will constitute one and the same instrument.

9.13 Attorneys’ Fees. In the event of any dispute arising out of this Agreement, the substantially prevailing party shall be entitled to recovery of its attorneys’ fees.

IN WITNESS HEREOF, the parties hereby agree to the terms and conditions herein as of the date first listed above.

EXCLUSIVE SURGERIES SOLUTIONS, LLC

PLAN SPONSOR

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

EXHIBIT A

Single Case Agreement: _____

Bill To: _____ **Date:** _____

Name _____ **Claim #:** _____

Company Name _____ **Patient Name:** _____

Street Address _____ **Patient Account #:** _____

City ST, Zip Code _____ **Authorization #:** _____

Phone # _____

Global Fee: _____ **DX Code:** _____
CPT Code: _____
CPT Code: _____

Breakdown of Fees:

Surgeon: _____ **EIN #:** _____
Anesthesiologist: _____ **EIN #:** _____
Facility: _____ **EIN #:** _____

Plan Sponsor shall pay the Global Fee listed above to the Providers listed above for the medical services to be provided to Patient listed above. Each Provider shall accept the fees listed above as complete payment for the medical services to be rendered to the Patient. Upon Plan Sponsor's execution and return of this Agreement, ESS will arrange for the scheduling of the medical services to be provided to the Patient. This form must be attached to Plan Sponsor invoice, along with such other forms as required by ESS, with detailed description of services rendered. Any changes in this procedure must be submitted to Plan Sponsor within 48 hours. Each Provider represents and warrants that the services rendered associated with this claim have not been previously assigned to any other organization for payment. Provider agrees not to balance bill the patient.

The undersigned hereby accepts the provisions outlined in this Single Case Agreement. Please return within 24 hours.

EXCLUSIVE SURGERIES SOLUTIONS, LLC
By: _____
Print Name: _____
Title: _____
Date: _____

PROVIDER
By: _____
Print Name: _____
Title: _____
Date: _____

PLAN SPONSOR
By: _____
Print Name: _____
Title: _____
Date: _____

EXHIBIT B

Business Associate Agreement

This Business Associate Agreement (the “**Agreement**”) is entered into between Exclusive Surgeries Solutions, LLC (“**Business Associate**”), and _____ (“**Plan Sponsor**”).

RECITALS

- A. Plan Sponsor and Business Associate are parties to a Participation Agreement (the “**Services Agreement**”), under which Business Associate provides services for or on behalf of Plan Sponsor.
- B. Plan Sponsor is a “covered entity,” as that term is defined in the HIPAA Standards for Privacy of Individually Identifiable Health Information and the Standards for Security of Electronic Protected Health Information, 45 C.F.R. Part 160 and Part 164, Subparts A, C and E (the “**HIPAA Regulations**”), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the “**HITECH Act**”) (collectively, the HIPAA Regulations and the HITECH Act are referred to as the “**Requirements**”), and, therefore, must comply with the Requirements.
- C. The Requirements require Plan Sponsor to enter into with its “business associates,” as that term is defined in 45 C.F.R. § 160.103, an agreement containing certain minimum safeguards. As a result of the Services Agreement, Business Associate will be a business associate of Plan Sponsor.
- D. The parties desire to enter into an agreement that complies with the Requirements.

AGREEMENT

For good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **Definitions.** Except as otherwise set forth in this Agreement, all capitalized terms have the same meaning as set forth in the Requirements, as such may be amended from time to time.
- a. “**Disclose**” has the same meaning as the term “disclosure” in 45 C.F.R. § 160.103.
- b. “**EPHI**” has the same meaning as the term “electronic protected health information” in 45 C.F.R. § 160.103, but limited to information created or received by Business Associate as a Business Associate of Plan Sponsor.
- c. “**PHI**” has the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, but limited to information created or received by Business Associate as a Business Associate of Plan Sponsor.
- d. “**Secretary**” means the Secretary of the Department of Health and Human Services or his or her designee.

2. **Business Associate's Obligations.** Business Associate will:

(a) Not Use or Disclose PHI except as permitted or required by this Agreement or as required by law;

(b) Use appropriate safeguards and comply, where applicable, with 45 C.F.R. Part 164, Subpart C with respect to EPHI, to prevent the Use or Disclosure of PHI, except as set forth in this Agreement;

(c) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of EPHI;

(d) Promptly report to Plan Sponsor: (i) any Use or Disclosure of PHI by Business Associate or a third party to which Business Associate Disclosed PHI that is not contemplated by this Agreement, including any Breach of Unsecured PHI; and (ii) any Security Incident, of which Business Associate becomes aware;

(e) Ensure that any subcontractors who create, receive, maintain or transmit PHI on behalf of Business Associate agree to the same restrictions and conditions in the Services Agreement and this Agreement;

(f) In accordance with Plan Sponsor's reasonable request, provide Plan Sponsor, in accordance with 45 C.F.R. § 164.524, access to PHI in a Designated Record Set;

(g) Make any amendment to PHI in a Designated Record Set that Plan Sponsor has agreed to pursuant to 45 C.F.R. § 164.526;

(h) Document any Disclosures of PHI necessary to provide an accounting of Disclosures in accordance with 45 C.F.R. § 164.528;

(i) To the extent Business Associate carries out any obligations of Plan Sponsor under the Requirements, Business Associate will comply with the Requirements that apply to Plan Sponsor in the performance of such obligation;

(i) Make its internal practices, books and records, relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining Plan Sponsor's compliance with the Requirements; and

(j) Mitigate, to the extent practicable, any harmful effects (known to Business Associate) from any Use or Disclosure of PHI by Business Associate not permitted by this Agreement.

3. **Permitted Uses and Disclosures.** Except as otherwise set forth in this Agreement, Business Associate may:

(a) Use or Disclose PHI to perform its duties and obligations under the Services Agreement and to report violations of the law to law enforcement; provided that, such Use or Disclosure complies with the Requirements;

(b) Use PHI for its management and administration or to carry out Business Associate's legal responsibilities; and

(c) Disclose PHI for the purposes in Section 3(b) of this Agreement, if (i) the Disclosure is required by law, or (ii) Business Associate obtains reasonable assurances from the persons to whom the PHI is disclosed that (x) the PHI will remain confidential and will not be Used or further Disclosed except as required by law or for the purpose for which it was Disclosed to the person, and (y) the person will notify Business Associate of any instances of which it becomes aware that the confidentiality of the PHI has been breached.

4. **Plan Sponsor's Obligations.** Plan Sponsor will notify Business Associate of any:

(a) Limitation in Plan Sponsor's Notice Of Privacy Plan Sponsors, as required by the Requirements, that may affect Business Associate's Use or Disclosure of PHI;

(b) Changes in or revocation of an individual's permission to Use or Disclose PHI, to the extent such change may affect Business Associate's Use or Disclosure of PHI; and

(c) Restriction regarding the Use or Disclosure of an individual's PHI that Plan Sponsor has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's Use or Disclosure of the PHI.

5. **Effective Date.** The terms and conditions in this Agreement will be effective as of the effective date of the Services Agreement and will continue until all PHI is destroyed or returned to Plan Sponsor.

6. **Termination.** Notwithstanding any provision to the contrary in this Agreement or the Services Agreement, if Business Associate breaches any of its obligations under this Agreement or the Requirements, Plan Sponsor may terminate this Agreement and the Services Agreement immediately upon providing notice to Business Associate or it may provide Business Associate with a reasonable opportunity to cure the breach or end the violation. If Plan Sponsor determines, in its sole discretion, that neither termination nor cure is feasible, Plan Sponsor will report the violation to the Secretary.

7. **Effect of Termination.** Upon termination of this Agreement, Business Associate will return to Plan Sponsor or destroy all PHI. If it is not feasible for Business Associate to return or destroy the PHI, (i) Business Associate will notify Plan Sponsor of such unfeasibility; (ii) Business Associate will limit Business Associate's Use and Disclosure of such PHI to the purpose which makes it unfeasible for Business Associate to return or destroy the PHI; and (iii) the terms and conditions set forth in this Agreement will continue with respect to the PHI for so long as Business Associate maintains the PHI.

8. **Indemnification.** Business Associate will indemnify, defend and hold harmless Plan Sponsor for, from and against any and all liabilities, costs, fees, fines, penalties and other expenses (including reasonable attorneys' and expert fees) arising from or related to Business Associate's breach of any of its obligations under this Agreement or the Requirements. The obligations under this Section will survive the termination of this Agreement.

9. **Amendment.** If the Requirements are amended and the amendments require an amendment to this Agreement to comply with the amendments to the Requirements, notwithstanding anything in the Services Agreement to the contrary, this Agreement will be amended automatically, without any signed, written amendment by Business Associate and Plan Sponsor, to comply with the amendments. All applicable Requirements, including all future applicable Requirements, are hereby incorporated in this Agreement by this reference, as if they were set forth herein in full. Otherwise, no modification, amendment, or cancellation or waiver of rights under this Agreement will be effective unless it is in a writing that is signed by both parties. No waiver of any breach of this Agreement will be construed as a waiver of any other rights under this Agreement.

10. **Entire Agreement**. This Agreement constitutes the parties' entire agreement with respect to the subject matter hereof. There are no restrictions, promises, representations, warranties, covenants, or understandings other than those expressly set forth herein. This Agreement supersedes all prior agreements or understandings between the parties with respect to the subject matter hereof, and may not be modified or amended in any manner other than as set forth herein.

11. **Governing Law**. This Agreement will be construed in accord with and any dispute or controversy arising from any breach or asserted breach of this Agreement will be governed by the laws of the State of Arizona.

12. **Third-party Beneficiaries**. There are no third-party beneficiaries of this Agreement.

EXCLUSIVE SURGERIES SOLUTIONS, LLC

PLAN SPONSOR

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Exhibit C

FEE STRUCTURE

Plan Sponsor shall pay ESS an amount equal to 20% of the total amount payable for Services provided pursuant to a Single Case Agreement. Payment due to ESS shall be due and payable no later than the time of delivery of the Services. All Single Case Agreements must be executed prior to any procedures being scheduled for Plan Participants.

EXCLUSIVE SURGERIES SOLUTIONS, LLC

PLAN SPONSOR

By: _____

By: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Example Procedures	
* This list of procedures are for review purposes only and a not gurantee of benefits.	
Procedures are provided on a case by case basis.	
<u>Gastroenterology</u>	<u>General Surgery</u>
Opening Of Esophagus	Gall Bladder Removal
Colonoscopy and EGD	Cyst Removal
Scope Of Colon With Biopsy	Inguinal Hernia
Colonoscopy	Ventral Hernia
Upper Stomach-Intestine Scope For Biopsy	Umbilical Hernia
Upper Stomach-Intestine Scope For Diagnosis	Pionidal Cyst Removal
<u>Urology</u>	Hemorrhoidectomy
Scope Of Bladder And Urethra, For Diagnosis	Laparoscopic Appendectomy
Prostate Needle Biopsy, Any Approach	Epigastric Hernia
Lithotrispy (Kidney Stones)	<u>Spine</u>
Scope Bladder, Insert Tube For Injection	Lumbar Laminectomy
Scope Bladder & Ureter, Insert Stent Into Ureter	Anterior Cervical Discectomy w Fusion
X-Ray, Urinary Tract Exam With Contrast Material	Microdiscectomy
Csto Calibration Dilat Urtl Strix/stenosis	(Includes Hardware)
Circumcision >28 Days	Disc Replacement
Scope Bladder, Simple Removal Stone, Stent	ACDF Disc Fusion (1 Level)
Scope Bladder & Ureter, Break Up Kidney Stone	ACDF Disc Fusion (2 Level)
<u>Ophthalmology</u>	<u>Orthopedics - Knee</u>
Cataract Removal, Insertion Of Lense	Medial& Lateral Meniscectomy (ascope)
Post-Cataract Laser Surgery	ACL Ligament Repair (arthroscopic)
Intravitreal Njx Pharmacologic Agt Spx	ACL Ligament with Allograft (ascope)
Blepharoplasty Upper Eyelid W/Excessive Skin	Posterior Cruciate Ligament Repair(arthroscopic)
Xcapsl Ctrc Rmvl Insj Lens Prosth 1 Stg	Medial Collateral Ligament Repair(arthroscopic)
Trabeculoplasty Laser Surg 1+ Sess	Chonodroplasty
Iridotomy/irdec Laser Surg 1+ Sess	Full Synovectomy(remove Inflamed Synovial tissue)
Rpr Blpos Levator Rescj/advmnt Xtrnl	Total Knee Replacement
Ciliary Bdy Dstrj Cyclopc Ndsc	Partial Knee Replacement
<u>OB/GYN</u>	<u>Orthopedics - Hip</u>
Uroscopy	Total Hip Replacement (includes Implants)
Bladder Sling	Arthroplasty
Ablations	Hip Arthroscopy (Simple)
Tube Tying	Hip Arthroscopy (Complex)
<u>ENT/ OTO</u>	<u>Orthopedics - Shoulder</u>
Speto	Arthroscopy Shoulder Rotator Cuff Repair
Child-Tubes in Ears	Arthroscopy Shoulder Surg Debridement Extensive
Endo-Nasal Turbinates	Arthroscopy Shoulder Distal Claviclectomy

Tonsils /Adneoids	<u>Orthopedics - Hands & Fingers</u>
<u>Plastic Surgery - Reconstruction</u>	Trigger Finger Release
Breast Cancer Reconstruction	Tendon Sheath Incision
Breast Reduction	Carpal Tunnel Release (open)
Masectomy	Dupuytrens Contracture
Gender Reassignment	Ganglion Excision
Orbital Rim Repair	Excision of Lesion of Tendon Sheath or Joint
Excisions	Fasciectomy, partial Palmar with release
Skin Cancer	Synovectomy -tendon sheath, radical, flexor, finger tendon
Z-Graph	Suspensionplasty- Carpometacarpal joints
Tissue Expander	<u>Pain Management</u>
Panniculectomy	Interventional Pain Nerve Blocks-Epiderals
Blepharoplasty	Intrathecal Pump Implants
<u>Vascular</u>	Electrical Stimulation
Vein Striping	Abalations
Ligation	Radiofrequency Rhizotomy
<u>Dermatology</u>	<u>Podiatry</u>
Mohs Procedure - Cancer	Bunectomy / Hammertoe
Lesions	Ingrown Toenail/Nailbed surgery
Biopsy	Plantar Facisitits - Tendon Repair
Cyst Removal	<u>Burns</u>
	Wound Debridement
	Burn Treatment
	Skin Biologic Therapy
	Fat Grafting

Commercial Insurance Cost Savings in Ambulatory Surgery Centers



Healthcare Bluebook™

ASCA

Ambulatory Surgery Center Association

HealthSmart®

Executive Summary

A review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than \$38 billion per year due to the availability of ambulatory surgery centers (ASCs) as an appropriate setting for outpatient procedures. More than \$5 billion of the cost reduction accrues to the patient through lower deductible and coinsurance payments. This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department (HOPD) prices for the same procedure in all markets, regardless of payer.

The study also looks at the potential savings that could be achieved if additional procedures were redirected to ASCs. As much as \$55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.

Finally, the study explores additional cost savings that would result if certain inpatient procedures, such as total joint replacements, continue to migrate to ASCs.

This study supplements an earlier review of Medicare costs by researchers at the University of California-Berkeley that showed that ASCs reduce Medicare costs by \$2.3 billion annually. *Ambulatory Surgery Center Association, Medicare Cost Savings Tied to ASCs, (2013),* <http://www.advancingsurgicalcare.com/medicarecostsavings>.

Introduction and Purpose

The Medicare price differential for common outpatient services delivered in the hospital outpatient department (HOPD) vs. ambulatory surgery center (ASC) environment is well known and documented. On average, Medicare reimburses ASCs at 53 percent of the rate it reimburses HOPDs for the same procedure. The payment gap between services delivered at ASCs rather than HOPDs reduced the Centers for Medicare and Medicaid Services' (CMS) costs by more than \$7 billion between 2007 and 2011¹.

While CMS payment rates are publicly available, commercial carrier payment rates are not. Therefore, less is known about the price differences and associated savings that exist between the ASC and HOPD environments for those employers and patients covered by commercial insurance (employer-sponsored insurance or private insurance purchased on the public exchanges and elsewhere).

The following analysis provides an estimate of the significant savings that ASCs currently provide to commercially insured patients, along with potential savings available to the commercially insured population, when shifting care to an ASC setting. This analysis was conducted in a partnership between Healthcare Bluebook, the Ambulatory Surgery Center Association (ASCA) and HealthSmart, a leading provider

of third-party administrative services for self-funded employers.

Specifically, the paper discusses each of the following:

1. the estimated cost savings generated by ASCs in the commercially insured U.S. population;
2. the estimated additional cost reductions to be achieved if more cases were to be performed in ASCs;
3. the additional value created as traditional inpatient procedures migrate to ASC settings (e.g., total knee replacements); and
4. examples of HOPD and ASC price disparities within and across regions.

The ASC model was developed in 1970, and Medicare approved payments to ASCs for more than 200 procedures in 1982. Steady growth in the number of ASCs and the number of surgical procedures performed in the outpatient setting, including HOPDs, has continued since. This shift toward outpatient procedures has accelerated due to advancements in medical practice and technology that have reduced the need for overnight hospital stays.

¹ Department of Health and Human Services, Office of Inspector General. (2014, April). *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center Approved Procedures to Ambulatory Surgical Center Payment Rates.*

Retrieved April 11, 2016, from <http://oig.hhs.gov/oas/reports/region5/51200020.pdf>

Today, many common surgeries are performed as outpatient procedures, and most patients, except those with complicated health conditions, can be served in the outpatient setting. Common ASC procedures include colonoscopies, cataract surgeries, tonsillectomies and arthroscopic orthopedic surgeries. CMS currently approves and reimburses 3,837 procedure codes in the ASC setting, and commercial populations are constantly expanding these boundaries. In fact, some ASCs are performing total joint replacements and other traditionally inpatient procedures with excellent outcomes.

While all HOPDs are hospital owned, most ASCs are at least partially owned by physicians, often in conjunction with hospitals and/or management companies. Sixty-five percent of the more than 5,400 Medicare-licensed ASCs in the U.S. are wholly owned by physicians and operate as small businesses.

A study published in *Health Affairs* analyzed data from the National Survey of Ambulatory Surgery and discovered that procedures performed in ASCs are more efficient, taking 25 percent less time than those performed in hospitals². This efficiency, and corresponding cost-effectiveness, is due largely to the ASCs' focus on a limited number of procedures, their owner/operator culture and specialized nursing and support staff. Because ASCs specialize in providing outpatient surgery, they are able to deliver patient-care services efficiently and conveniently. For example, operating rooms are turned over quickly and are not interrupted by emergency cases. This enables physicians

to commence their procedures in a timely manner and use their time more productively. Consequently, ASCs tend to be more convenient and cost effective than HOPDs while still providing excellent care.

² Munnich, E. L., & Parente, S. T. (2014). Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Affairs*, 33(5), 764-769.

Patients Often Pay Dramatically Different Amounts for the Same Care in the Same Community

Healthcare prices vary dramatically even within the same insurance network and city. For example, in Charleston, West Virginia, the price of a cataract surgery, including payments to the anesthesiologist and physician, can vary from \$2,684 to \$8,662 depending on the facility where the surgery is performed (Figure 1). In this case prices vary by more than 300 percent, primarily due to the amount charged by the facility – not the physicians. These facility prices vary by almost 600 percent and total more than 70 percent of all dollars spent for cataract surgery in Charleston, WV.

Payments to anesthesiologists vary, partially due to the time component of anesthesia billing, but these payments are the smallest

portion of the total cost and are dwarfed by payments to facilities.

Payments to physicians are a more significant portion of total cost, but physicians performing the most expensive cataract surgeries are paid approximately the same as physicians performing the least expensive surgeries. Thus, it is the choice of facility that drives the total price variation.

The consistency of payments to physicians indicates that most physicians are unable to differentiate themselves when negotiating payment rates from insurance companies and, hence, are paid similar rates. Facilities, on the other hand, vary significantly in their service

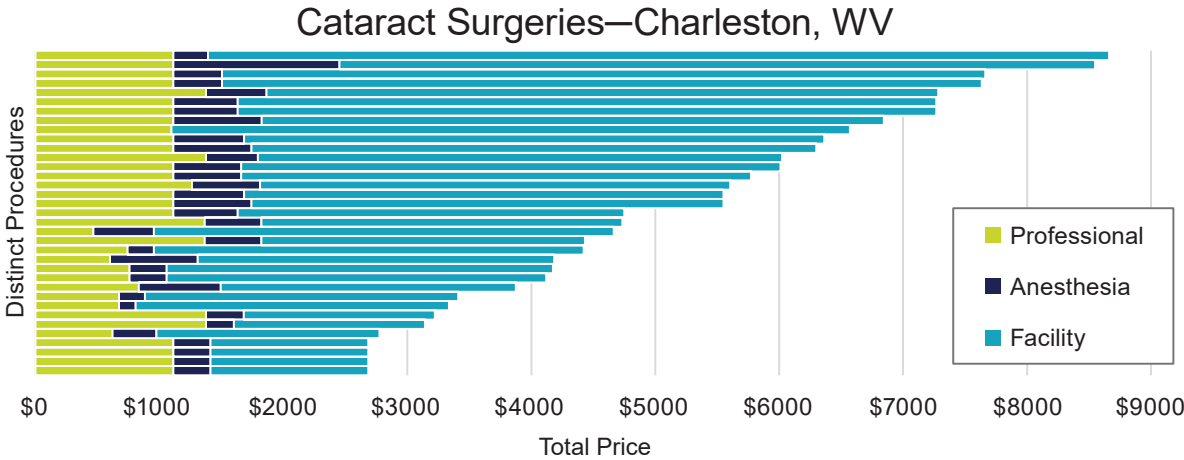


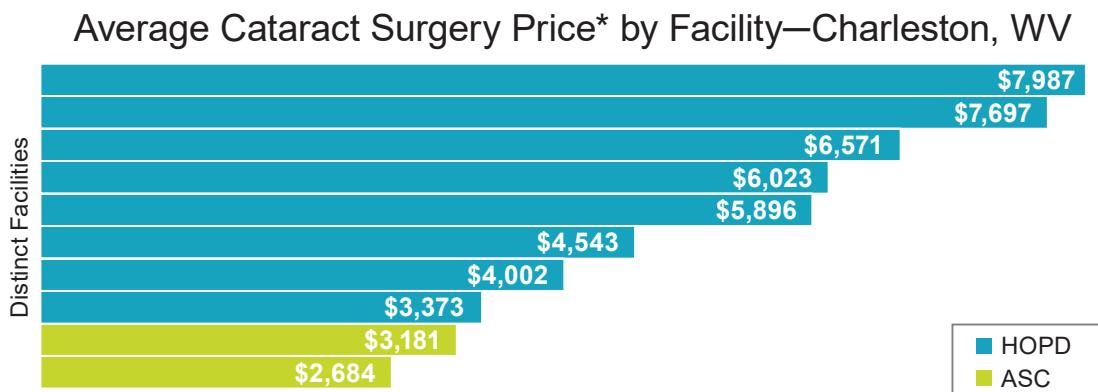
Figure 1

offerings and market power and, therefore, have significantly different negotiated rates with insurance companies.

For example, Hospital A provides emergency, inpatient and outpatient care. Hospital B offers everything Hospital A offers and also operates the only children's hospital in the metropolitan area. Due to this exclusive service line, Hospital B has better negotiating leverage with an insurance company. Importantly, this leverage applies not only to services uniquely performed in the children's hospital, but also to outpatient surgeries, such as cataract surgery, that are performed in other facilities in the area. Since the entire hospital is either in or out of network, all services are negotiated together, allowing Hospital B to demand higher reimbursement for procedures even though equally good, lower-priced alternative sites of service exist in that market area.

Since any ASC will offer fewer services than both Hospital A and B, those ASCs will have less negotiating leverage with commercial carriers and, therefore, often will receive lower reimbursement rates than either Hospital A or B if they want to be included in the insurer's network. While the efficiency inherent in the ASC model explains why ASCs can continue to exist when receiving significantly lower payments, it is the market power of hospitals that widens these price disparities^{3 4}.

As a result of these factors, the total price of a procedure performed at an ASC is generally significantly lower than the total price of the same procedure performed in an HOPD. For example, the average price of cataract surgery at an ASC in Charleston, West Virginia, is \$2,932, including the physician and anesthesiologist payments, while the average price at an HOPD is \$5,762 (Figure 2). In this example,



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 2

³ Neprash, H.T., BA, Chernew, M.E., PhD, Hicks, A.L., MS, Gibson, T., PhD, & McWilliams, M., MD, PhD, (2015, October). Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *Journal of the American Medical Association*.

⁴ The Robert Wood Johnson Foundation, Martin Gaynor, PhD & Robert Town, PhD. (2012, June). *The impact of hospital consolidation – Update*.

Retrieved April 20, 2016, from <http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.htm>

the average price for a cataract surgery at the least expensive facility was \$2,684, including the payments to anesthesiologists and physicians. At the most expensive facility, the average price was \$7,987. ASCs are at the low end of the spectrum and HOPDs are at the high end.

This commercial price differential between the ASC and HOPD environments is persistent across metropolitan areas (Figure 3), insurance carriers and procedure categories, with the degree of price variability related to local market factors.

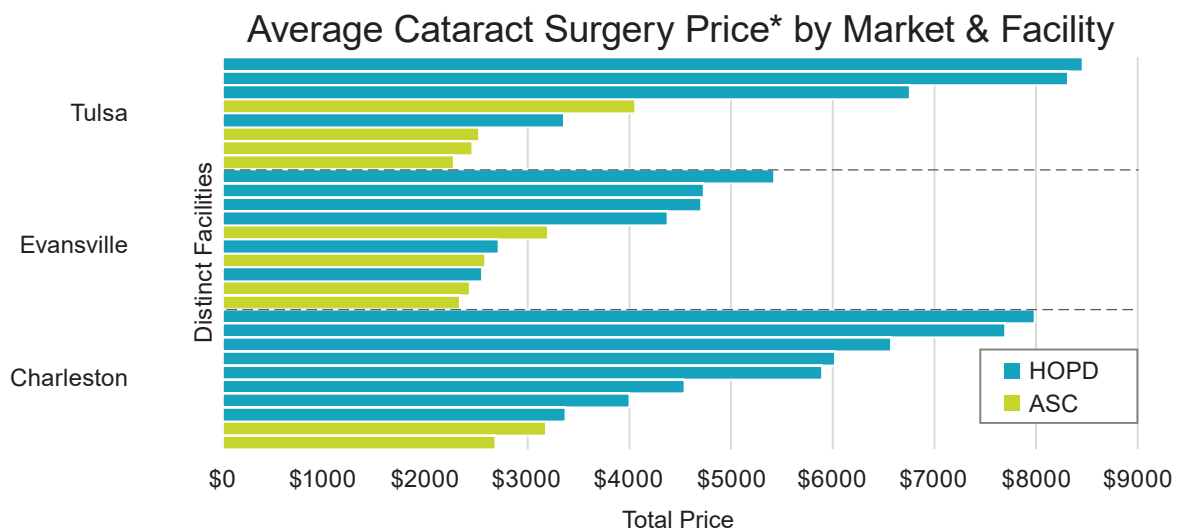
Summary of Methodology

All analysis was conducted using a sample of de-identified commercial claims data for calendar year 2014 from HealthSmart. This data represents more than 400,000 lives across all regions of the U.S. The CMS list of ASC-eligible procedure codes, with a few additions reflecting those prevalent in a

commercial population (pediatric-related codes, OB/GYN-related codes, etc.), was used to identify the spending on procedures that can be performed in an ASC.

Total price of service was included in the analysis (facility fees, professional fees and anesthesia fees, where relevant). Based on the commercial population considered, these services accounted for about 19 percent of total medical spend, or \$890 per person for the year. All prices are calculated using the “allowed” amount, which reflects the actual amount a provider received after any discounts were applied.

Thirteen high-volume outpatient procedures were used as proxies to analyze the price differential between the ASC and HOPD environments and estimate the percentage of spending that could be saved by performing the procedures in ASCs instead of HOPDs. An adjustment was made to account for the fact that some high-risk patients are not candidates



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 3

for ASC-based care (patients with high comorbidities are traditionally directed to an HOPD in order to be closer to critical-access care). This adjusted percentage was applied to the \$890 ASC-eligible spend per person and then scaled by the commercially insured U.S. population to estimate the national savings potential.

All estimates are based on the calendar year 2014 data. No adjustments were made to account for population aging or increasing utilization of ASC-eligible services. (See Appendix A: Methodology and Appendix B: Adjustments for ASC Ineligibility for a more detailed explanation of the methodology.)

Current ASC Use Reduces Private Healthcare Costs by \$38 Billion Annually

The lower cost of care in ASCs relative to HOPDs saves employers and consumers tens of billions of dollars a year. For the commercially insured population in the U.S., an

estimated \$37.8 billion is saved annually by using ASCs. Stated differently, if all of the procedures currently performed in ASCs for the commercially insured population in the U.S. were performed in HOPDs, the cost of those procedures would increase by \$37.8 billion in just one year.

Potential Cost Reductions Attributed to ASCs

Despite the savings detailed above, for commercially insured populations, only 48 percent of procedures commonly performed in ASCs are actually performed in ASCs. If the remaining 52 percent were performed at ASC price points, an additional \$41 billion in healthcare costs could be saved annually.

As a practical matter, ASCs would not be the appropriate setting for a small percentage of patients (e.g., those with serious health issues) currently treated in HOPDs. For example, patients on dialysis (0.1 percent of Americans) are not ASC eligible for certain procedures. When ASC-ineligible cases are accounted for, the total potential annual savings from performing the surgeries in ASCs instead of HOPDs is \$38.2B. (This assumes 3 percent of relevant cases are ASC ineligible. See Appendix B: Adjustments for ASC Ineligibility.)

The average ASC price, however, is a blend of both lower-priced and higher-priced ASCs. The optimal migration of cases would shift cases from HOPDs to the local low-price ASCs. If patients were directed to low-price ASCs only, the potential annual savings increases from \$38.2 billion to \$55.6 billion.

Migrating a meaningful number of patients to lower-cost ASC settings would, undoubtedly, also have the added benefit of causing HOPDs

Annual Savings from Procedures Performed in ASCs

% of Common ASC Procedures Currently Performed at ASCs	48%
Current Annual Savings	\$37.8 B
Potential Additional Annual Savings	\$38.2 B
Potential Additional Annual Savings from Optimal Migration to ASCs	\$55.6 B

to consider price reductions in order to maintain their market share. While this study did not attempt to model the competitive reactions of HOPDs if confronted with a significant loss of patient volume, fundamental economic principles as well as a recent study that looked at the impact of reference-based pricing on patient choices concluded that hospitals did, in fact, lower their pricing for certain procedures in response to a loss of market share to competing ASCs⁵.

Potential Savings Can Grow if ASCs Can Perform More Complex Procedures

With advances in surgical techniques, pain management and post-surgical care, more procedures traditionally performed in the inpatient setting are being shifted to ASCs. This creates an expanding frontier for reducing healthcare costs. As an example, total hip and total knee replacements, which currently account for about 1.5 percent of total medical spend, are now being performed safely in ASCs in a limited number of markets. The potential savings are significant. Assuming that the price differential and the rate of ASC ineligibility due to comorbidities for total joint replacement will be commensurate with other outpatient procedures, \$3.2 billion could be

saved by moving total hip and knee replacements to ASCs. (See Appendix A: Methodology.)

Projected National Cost Reductions

To realize the potential cost reductions highlighted above, several things need to happen. On the supply side, ASC capacity will have to double in order to support the migration from HOPDs.

On the demand side, patients must be educated and incentivized to choose ASCs for their outpatient procedures. As premiums rise and adoption of high-deductible health plans increases, patients have greater incentives to reduce their costs by choosing ASC-based care, but education is lacking. Though healthcare transparency has made significant advancements in recent years, most patients are still unaware of the lower costs that ASCs offer.

Even modest changes in market share produce massive savings for the entire health system. For example, if an additional 5 percent of current HOPD cases were moved to ASCs annually over the next ten years, \$113.8 billion would be saved compared to current utilization rates (Table 1). This assumes that the annual potential ASC savings is currently \$41.4 billion:

Ten-Year Savings Projection

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Potential Savings	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$41.4 B	\$413.7 B
Percent of Savings Captured	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	28%
Savings	\$2.1 B	\$4.1 B	\$6.2 B	\$8.3 B	\$10.3 B	\$12.4 B	\$14.5 B	\$16.5 B	\$18.6 B	\$20.7 B	\$113.8 B

Table 1

⁵ Robinson, J., et. al. (2015, March). Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery. *Health Affairs*.

\$38.2 billion from current ASC-eligible procedures above plus \$3.2 billion from total knee and hip replacement.

For ASC eligible procedures in this study, patients were responsible for 15 percent of the cost on average. That would mean \$17.1 billion in reduced costs for patients over the next ten years (Figure 4). If 3 percent or 8 percent of HOPD cases were moved to ASCs annually, ten-year savings would be \$68.3 billion and \$182 billion respectively (Table 2).

Projected National Cost Reduction	
Plan Sponsor Savings	\$96.7 B
Patient Savings	\$17.1 B
Total Savings	\$113.8 B

Figure 4

These estimates do not account for inflation or upward trends in medical spending. They also do not take into account the potential that HOPD pricing will decrease in order to compete with ASCs, which would create further outpatient savings. As referenced above, in the CalPERS reference pricing program, high-priced providers will reduce prices to be competitive and attract price-sensitive consumers.

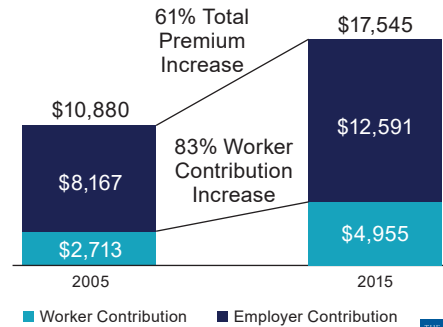
Ten-Year Savings Projections

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Savings at 3% Additional Capture	\$1.2 B	\$2.5 B	\$3.7 B	\$5.0 B	\$6.2 B	\$7.4 B	\$8.7 B	\$9.9 B	\$11.2 B	\$12.4 B	\$68.3 B
Savings at 5% Additional Capture	\$2.1 B	\$4.1 B	\$6.2 B	\$8.3 B	\$10.3 B	\$12.4 B	\$14.5 B	\$16.5 B	\$18.6 B	\$20.7 B	\$113.8 B
Savings at 8% Additional Capture	\$3.3 B	\$6.6 B	\$9.9 B	\$13.2 B	\$16.5 B	\$19.9 B	\$23.2 B	\$26.5 B	\$29.8 B	\$33.1 B	\$182.0 B

Table 2

⁶ Henry J. Kaiser Family Foundation. (2015, September). *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005–2015*. Retrieved April 10, 2016, from <http://kff.org/health-costs/report/2015-employer-health-benefits-survey/>

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2015



Reducing Costs for Employers and Employees

From 2005 to 2015, average health insurance premiums for employer-sponsored family coverage increased 61 percent, from \$10,880 to \$17,545 per year. To combat these rising costs, employers have increasingly adopted Consumer Driven Health Plans (CDHP) and account-based plan types, shifting costs to employees. This has driven the average employee’s share of healthcare spending up 81 percent in the same time period, from \$2,713 to \$4,955⁶ annually. This highlights the need for programs like price transparency that can help patients identify better value providers within their networks so that employers and their employees both can lower costs.

For example, in Charlotte, NC, the average ASC price for a knee arthroscopy was \$6,118, while the average HOPD price was \$12,493, more than twice as expensive. That means \$6,375 is saved on average in Charlotte, NC, when a patient chooses an ASC for a knee arthroscopy. How those savings are divided between the payer and the patient depends on the plan design.

For a knee arthroscopy in Charlotte, NC, if a patient has a Silver Plan as defined by the Affordable Care Act, with a \$2,700 deductible, 80 percent coinsurance and \$5,000 maximum out of pocket, the patient would save \$1,275—more than the median family's weekly income. The remaining \$5,100 would be saved by the payer. For self-funded employer-sponsored insurance, that is \$5,100 directly to the bottom line for the employer.

Applying the same plan design to the earlier example of cataract surgery in Charleston, WV, a patient would save \$566 by choosing an ASC instead of an HOPD. This is a significant savings in a geographic area where annual income per capita is less than \$35,000⁷. The payer would realize an additional savings of \$2,264.

Estimating Savings for Self-Insured Populations

For employers that self insure, it is reasonably straightforward to estimate the potential cost reductions from ASCs for their covered employees. With \$890 in ASC-eligible spending per commercially insured person and 20.6 percent savings opportunity from moving all

ASC-eligible cases from HOPDs to ASCs, \$183 in potential ASC savings exists per commercially insured person. A self-funded employer with 1,000 employees is normally covering more than 2,000 lives, when employees and dependents are counted, which means a potential ASC-based savings of more than \$366,000 for the employer and employees.

Conclusion

Billions of dollars spent each year on commercially insured outpatient surgeries and procedures can be reduced, without compromising quality, if more cases migrate to ambulatory surgery centers. While a small percentage of patients have health conditions that require outpatient care to be received in proximity to a full-service hospital should complications arise, most patients can receive the same level of care at lower cost by seeking treatment in an ASC. Advances in medical technology and pain control are allowing increasingly complex procedures, such as total joint replacements, to be performed in an outpatient setting.

Policymakers, insurers, employers and beneficiaries all have a shared interest in reducing healthcare costs, and the \$38 billion in annual savings identified in this study highlight the role that ASCs already play in controlling these costs. Strategies should be implemented to generate additional savings by ensuring that the most efficient site of service for outpatient care is selected whenever possible. In particular, innovative plan design and increased consumer awareness of the benefits of receiving care in an ASC can save thousands of dollars per procedure.

⁷ United States Census Bureau. (2014). *2010–2014 American Community Survey 5-Year Estimates*. Retrieved April 30, 2016, from <http://www.census.gov/>

About the authors/organizations

Ambulatory Surgery Center Association (ASCA)

ASCA is the national membership association that represents ASCs of all specialties and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to all the patients they serve.

Healthcare Bluebook

Healthcarebluebook.com, headquartered in Nashville, TN, is a leading provider of health-care price and quality transparency solutions to employers, third-party administrators (TPA), health plans and provider organizations. Healthcare Bluebook products help employers and employees save money by enabling consumers to understand local health-care prices, compare providers on price and quality and shop for care anywhere in the U.S.

HealthSmart

For more than 40 years, HealthSmart has offered a wide array of customizable and scalable health-plan solutions for self-funded employers. HealthSmart's comprehensive service suite addresses individual health from all angles. This includes claims and benefits administration, provider networks, pharmacy, benefit-management services, business intelligence, onsite employer clinics, care management, a variety of health and wellness initiatives and Web-based reporting.

Appendix A: Methodology

Data Source

All analysis was conducted using a national sample of de-identified commercial claims for calendar year 2014.

Estimating Potential ASC Savings for the Commercially Insured U.S. Population

The estimated potential ASC savings for the commercially insured U.S. population is calculated as:

Equation 1

Addressable Spend per Commercially Insured Person \$890	X	Percent Savings from ASCs 20.6%	X	Commercially Insured Population 208.6M
---	---	------------------------------------	---	---

Estimating the Addressable Spend per Commercially Insured Patient

The addressable spend is the expenditure on any procedure that could be performed in an ASC for an ASC-eligible patient, whether that patient is ASC eligible or not. (Adjustments for ASC ineligible are made later in the process. See Appendix B: Adjustments for ASC Ineligibility.) All prices are calculated using the allowed amount, which is the actual amount a provider receives after any discounts are applied.

CMS currently covers 3,837 procedure codes in the ASC setting. Procedure codes from select Healthcare Bluebook ShopSmart™ procedures were added to the CMS list to produce a complete ASC-eligible procedure code list. These procedure codes were used to identify procedures in one

year of medical-claims data. For each procedure performed in an ASC or HOPD, the total anesthesia, professional and facility payments were included as part of the procedure price. All office-based, inpatient-based and emergent care was excluded. When the total payments from this process were divided by the total members in the represented population, the annual addressable spend per person was \$890.

Estimating Percent Savings from ASCs

To estimate the percent savings from ASCs, thirteen high-volume procedures were used as proxies to represent all ASC procedures. These procedures were selected for their high volume and standardization. The average ASC price was calculated for each procedure in each metropolitan market across the U.S.

The potential ASC savings is the sum of the differences between the price of each HOPD case and the average ASC case price for that metropolitan market and procedure combination. Market and procedure combinations with limited data volume were excluded.

Equation 2

$$potential\ ASC\ savings = \sum_{m,p,h} cost_{m,p,h} - average_ASC_price_{m,p}$$

m = market
p = procedure
h = HOPD case

To produce the ASC savings as a percentage, the potential ASC savings was divided by the total spend for all analyzed markets and procedures and multiplied by one hundred.

Equation 3

$$percent\ savings\ from\ ASCs = \sum_{m,p,h} \frac{potential\ ASC\ savings}{total\ spend} \times 100$$

Estimating Potential Savings from Total Hip & Total Knee Replacements

To estimate potential savings from moving total hip and knee replacements to the ASC setting, Equation 1 from above was used, but with \$73.59 as the addressable spend per commercially insured person. This represents 1.5 percent of total medical spend per commercially insured person. The 20.6 percent savings opportunity was not changed because there are not currently enough markets offering ASC-based joint replacement to use as a representation of the entire U.S. However, the savings opportunity may be as much as double this estimate based on markets that currently have ASC-based total joint replacements.

Appendix B: Adjustments for ASC Ineligibility

Some patients will not qualify for treatment in an ASC setting due to comorbidities or other complicating factors. To account for this, potential ASC savings were estimated using three assumptions for what percent of the commercially insured population is ASC ineligible: 1 percent, 3 percent and 7

percent. These percentages were selected based on prevalence rates for three common conditions that may make patients ineligible for care at an ASC for some procedures (Table 3).

Seven percent ASC ineligibility is the upper limit of this sensitivity analysis since it is the sum of the prevalence rates of all three conditions, which are not independent and which don't necessarily disqualify patients from ASC-based care. For example, a patient with a body mass index (BMI) of 41 could still be cared for in an ASC for most if not all procedures performed in an ASC. However, a patient with a BMI of 45 would qualify for fewer procedures in an ASC setting.

Three percent was selected as the expected rate of ASC ineligibility in a commercially insured population. This, however, could still be an overestimation, so we have also included the one-percent ASC-ineligibility threshold.

For each of these ASC-ineligibility rates, a corresponding number of cases per market/procedure combination were assumed to be performed at the average HOPD price and excluded from the migration calculation. See Table 4 for the sensitivity impact on estimated savings.

Common Conditions that Effect ASC Eligibility

Condition	Prevalence (% of U.S. Population)	Notes
Latex Allergy	< 1%	Some ASCs are not equipped with a latex-free operating room.
CKD (with Dialysis)	0.1%	Not a disqualifying condition for all procedures performed in ASCs.
BMI > 40	6.3%	Patients with BMI > 45 are almost always ASC ineligible. Not all patients with BMI between 40 and 45 are ASC ineligible.

Table 3

Effect of ASC-Ineligibility on Potential Savings

	Savings as % of Total Addressable Spend	Potential Annual Savings
0% ASC Ineligible	22.1%	\$41.0 B
1% ASC Ineligible	21.6%	\$40.1 B
3% ASC Ineligible	20.6%	\$38.2 B
7% ASC Ineligible	18.6%	\$34.5 B

Table 4

Appendix C: Savings Examples

Procedure prices in most U.S. markets can vary by as much as 500 percent. In most cases, when present, ASCs provide the best value.

Procedure	Market	Lowest Price Provider Type	Lowest Price	Average ASC Price	Average HOPD Price	Average Price Difference
Cataract Surgery	Charleston, WV	ASC	\$2,684	\$2,932	\$5,762	\$2,830
Cataract Surgery	Evansville, IN	ASC	\$2,450	\$3,316	\$6,992	\$3,676
Cataract Surgery	Tulsa, OK	ASC	\$2,248	\$2,249	\$3,833	\$1,335
Knee Arthroscopy	Fayetteville, NC	ASC	\$5,924	\$7,658	\$11,575	\$3,917
Knee Arthroscopy	Charlotte, NC	ASC	\$5,664	\$6,118	\$12,493	\$6,375
Knee Arthroscopy	Tulsa, OK	ASC	\$2,627	\$2,844	\$4,807	\$1,963
Knee Arthroscopy	Phoenix, AZ	ASC	\$2,355	\$2,972	\$4,306	\$1,334

Ambulatory Surgery Centers

A Positive Trend in Health Care



Ambulatory surgery centers (ASCs) are health care facilities that offer patients the convenience of having surgeries and procedures performed safely outside the hospital setting. Since their inception more than four decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

A TRANSFORMATIVE MODEL FOR SURGICAL SERVICES

As our nation struggles with how to improve a troubled and costly health care system, the experience of ASCs is a great example of a successful transformation in health care delivery.

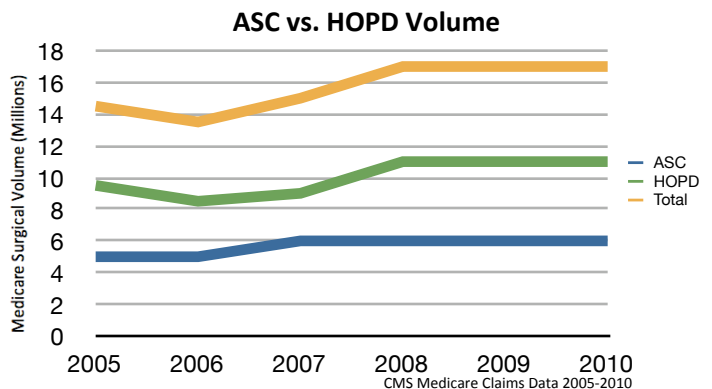
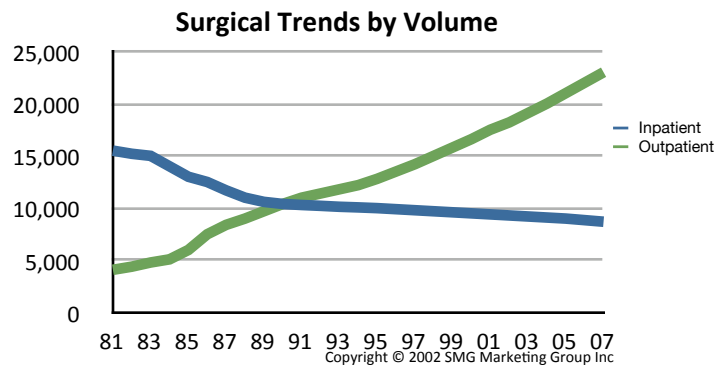
Forty years ago, virtually all surgery was performed in hospitals. Waits of weeks or months for an appointment were not uncommon, and patients typically spent several days in the hospital and several weeks out of work in recovery. In many countries, surgery is still performed this way, but not in the US.

Physicians have taken the lead in the development of ASCs. The first facility was opened in Phoenix, Arizona, in 1970 by two physicians who saw an opportunity to establish a high-quality, cost-effective alternative to inpatient hospital care for surgical services. Faced with frustrations like scheduling delays, limited operating room availability, slow operating room turnover times, and challenges in obtaining new equipment due to hospital budgets and policies, physicians were looking for a better way—and developed it in ASCs.

Today, physicians continue to provide the impetus for the development of new ASCs. By operating in ASCs instead of hospitals, physicians gain increased control over their surgical practices.¹ In the ASC setting, physicians are able to schedule procedures more conveniently, assemble teams of specially trained and highly skilled staff, ensure that the equipment and supplies being used are best suited to their techniques, and design facilities tailored to their specialties and to the specific needs of their patients. Simply stated, physicians are striving for, and have found in ASCs, professional autonomy over their work environment and over the quality of care that has not been available to them in hospitals. These benefits explain why physicians who do not have ownership interest in an ASC (and therefore do not benefit financially from performing procedures in an ASC) choose to work in ASCs in such high numbers.

Given the history of their involvement in making ASCs a reality, it is not surprising that physicians continue to have at least some ownership in virtually all (90%) ASCs. But what is more interesting to note is how many ASCs are jointly owned by local hospitals that now increasingly recognize and embrace the value of the ASC model. According to the most recent data available, hospitals have ownership interest in 21% of all ASCs and 3% are owned entirely by hospitals.²

ASCs also add considerable value to the US economy, with a 2009 total nationwide economic impact of \$90 billion, including more than \$5.8 billion in tax payments. Additionally, ASCs employ the equivalent of approximately 117,700 full-time workers.³



ASCs PROVIDE CARE AT SIGNIFICANT COST SAVINGS

Not only are ASCs focused on ensuring that patients have the best surgical experience possible, they also provide cost-effective care that save the government, third party payors and patients money. On average, the Medicare program and its beneficiaries share in more than \$2.6 billion in savings each year because the program pays significantly less for procedures performed in ASCs when compared to the rates paid to hospitals for the same procedures. Accordingly, patient co-pays are also significantly lower when care is received in an ASC.

If just half of the eligible surgical procedures moved from hospital outpatient departments to ASCs, Medicare would save an additional \$2.4 billion a year or \$24 billion over the next 10 years. Likewise, Medicaid and other insurers benefit from lower prices for services performed in the ASC setting.

Currently, Medicare pays ASCs 58% of the amount paid to hospital outpatient departments for performing the same services. For example, Medicare pays hospitals \$1,670 for performing an outpatient cataract surgery while paying ASCs only \$964 for performing the same surgery.

This huge payment disparity is a fairly recent phenomenon. In 2003, Medicare paid hospitals only 16% more, on average, than it paid ASCs. Today, Medicare pays hospitals 72% more than ASCs for outpatient surgery. There is no health or fiscal policy basis for providing ASCs with drastically lower payments than hospital outpatient departments.

In addition, patients typically pay less coinsurance for procedures performed in the ASC than for comparable procedures in the hospital setting. For example, a Medicare beneficiary could pay as much as \$496 in coinsurance for a cataract extraction procedure performed in a hospital outpatient department, whereas that same beneficiary's copayment in the ASC would be only \$195.

Without the emergence of ASCs as an option for care, health care expenditures would have been tens of billions of dollars higher over the past four decades. Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentivize the movement of patients and procedures to the ASC setting.

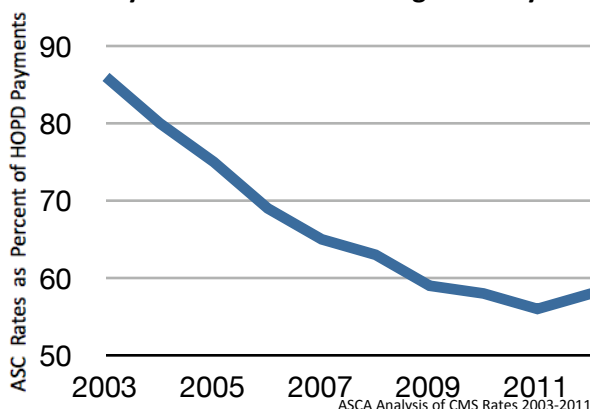
The long-term growth in the number of patients treated in ASCs, and resulting cost savings, is threatened by the widening disparity in reimbursement that ASCs and hospitals receive for the same procedures. In fact, the growing payment differential is creating a market dynamic whereby ASCs are being purchased by hospitals and converted into hospital outpatient departments. Even if an ASC is not physically located next to a hospital, once it is part of a hospital, it can terminate its ASC license and become a unit of the hospital, entitling the hospital to bill for Medicare services provided in the former ASC at the 72% higher hospital outpatient rates.

**Cost Comparison:
ASC v. Hospital Outpatient Department**

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	\$193	\$490	\$964	\$1,670
Upper GI Endoscopy	\$68	\$139	\$341	\$591
Colonoscopy	\$76	\$186	\$378	\$655

ASCA Analysis of CMS Rates Effective 1 Jan. 2012

**The Gap Between ASC and HOPD
Payments Has Widened Significantly**

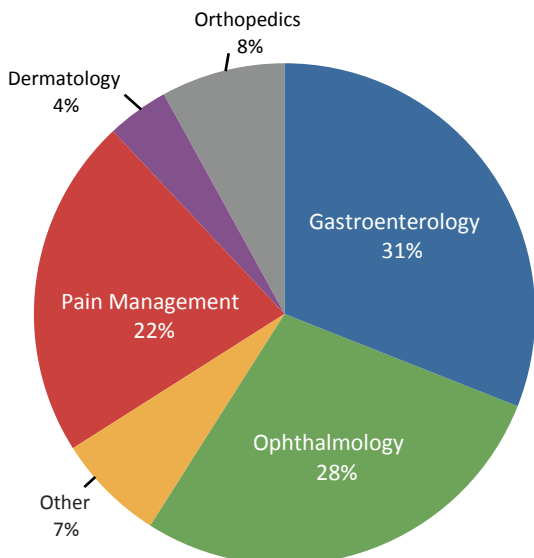


THE ASC INDUSTRY SUPPORTS DISCLOSURE OF PRICING INFORMATION

Typically, ASCs make pricing information available to their patients in advance of surgery. The industry is eager to make price transparency a reality, not only for Medicare beneficiaries, but for all patients. To offer maximum benefit to the consumer, these disclosures should outline the total price of the planned

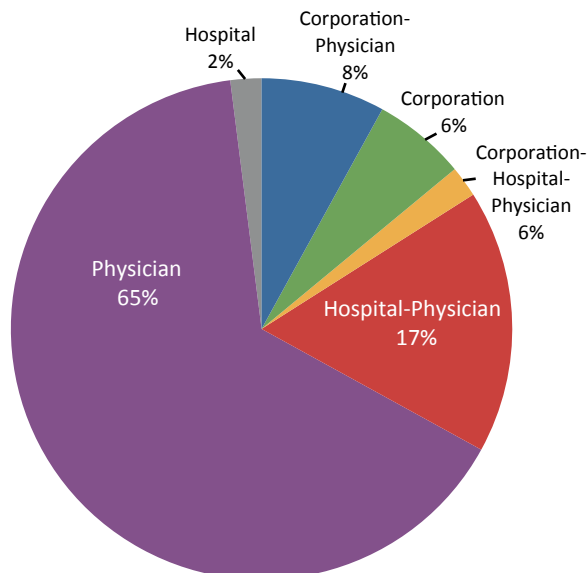
surgical procedure and the specific portion for which the patient would be responsible. This will empower health care consumers as they evaluate and compare costs for the same service amongst various health care providers.

Medicare Case Volume by Specialty



ASCA Analysis of CMS Claims Data 2010

ASC Ownership



ASCA's 2011 ASC Employee Salary & Benefits Survey

ASCs = Efficient Quality Care + Convenience + Patient Satisfaction

The ASC health care delivery model enhances patient care by allowing physicians to:

- Focus exclusively on a small number of processes in a single setting, rather than having to rely on a hospital setting that has large-scale demands for space, resources and the attention of management
- Intensify quality control processes since ASCs are focused on a smaller space and a small number of operating rooms, and
- Allow patients to bring concerns directly to the physician operator who has direct knowledge about each patient’s case rather than deal with hospital administrators who almost never have detailed knowledge about individual patients or their experiences

Physician ownership also helps reduce frustrating wait-times for patients and allows for maximum specialization and patient–doctor interaction. Unlike large-scale institutions, ASCs

- Provide responsive, non-bureaucratic environments tailored to each individual patient’s needs
- Exercise better control over scheduling, so virtually no procedures are delayed or rescheduled due to the kinds of institutional demands that often occur in hospitals (unforeseen emergency room demands)
- Allow physicians to personally guide innovative strategies for governance, leadership and most importantly, quality initiatives

As a result, patients say they have a 92% satisfaction rate with both the care and service they receive from ASCs .⁴ Safe and high quality service, ease of scheduling, greater personal attention and lower costs are among the main reasons cited for the growing popularity of ASCs.

ASCs ARE HIGHLY REGULATED TO ENSURE QUALITY AND SAFETY

ASCs are highly regulated by federal and state entities. The safety and quality of care offered in ASCs is evaluated by independent observers through three processes: state licensure, Medicare certification and voluntary accreditation.

Forty three states and the District of Columbia, currently require ASCs to be licensed in order to operate. The remaining seven states have some form of regulatory requirements for ASCs such as Medicare certification or accreditation by an independent accrediting organization. Each state determines the specific requirements ASCs must meet for licensure and most require rigorous initial and ongoing inspection and reporting.

<

All ASCs serving Medicare beneficiaries must be certified by the Medicare program. In order to be certified, an ASC must comply with standards developed by the federal government for the specific purpose of ensuring the safety of the patient and the quality of the facility, physicians, staff, services and management of the ASC. The ASC must demonstrate compliance with these Medicare standards initially and on an ongoing basis.

In addition to state and federal inspections, many ASCs choose to go through voluntary accreditation by an independent accrediting organization. Accrediting organizations for ASCs include The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) and

ASCs: A COMMITMENT TO QUALITY

Quality care has been a hallmark of the ASC health care delivery model since its earliest days. One example of the ASC community’s commitment to quality care is the ASC Quality Collaboration, an independent initiative that was established voluntarily by the ASC community to promote quality and safety in ASCs.

The ASC Quality Collaboration is committed to developing meaningful quality measures for the ASC setting. Six of those measures have already been endorsed by the National Quality Forum (NQF). The NQF is a non-profit organization dedicated to improving the quality of health care in America, and the entity the Medicare program consults when seeking appropriate measurements of quality care. More than 20% of all ASCs are already voluntarily reporting the results of the ASC quality measures that NQF has endorsed.

Since 2006, the ASC industry has urged the CMS to establish a uniform quality reporting system to allow all ASCs to publicly demonstrate their performance on quality measures. Starting on October 1, 2012, a new quality reporting system for ASCs will begin and will encompass five of the measures that ASCs are currently reporting voluntarily.

the American Osteopathic Association (AOA). ASCs must meet specific standards during on-site inspections by these organizations in order to be accredited. All accrediting organizations also require an ASC to engage in external benchmarking, which allows the facility to compare its performance to the performance of other ASCs.

In addition to requiring certification in order to participate in the Medicare program, federal regulations also limit the scope of surgical procedures reimbursed in ASCs. Even though ASCs and hospital outpatient departments are clinically identical, the Center for Medicare & Medicaid Services (CMS) applies different standards to the two settings.

Reporting Measures

Measure	Data Collection Begins
Patient Burn	Oct 1, 2012
Patient Fall	Oct 1, 2012
Wrong Site, Side, Patient, Procedure	Oct 1, 2012
Hospital Admission	Oct 1, 2012
Prophylactic IV Antibiotic Timing	Oct 1, 2012
Safe Surgery Check List Use	Jan 1, 2012
Volume of Certain Procedures	Jan 1, 2012
Influenza Vaccination Coverage for Health Care Workers	Jan 1, 2013

Specific Federal Requirements Governing ASCs

In order to participate in the Medicare program, ASCs are required to meet certain conditions set by the federal government to ensure that the facility is operated in a manner that assures the safety of patients and the quality of services.

ASCs are required to maintain complete, comprehensive and accurate medical records. The content of these records must include a medical history and physical examination relevant to the reason for the surgery and the type of anesthesia planned. In addition, a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and the procedure to be performed. Prior to discharge each patient must be evaluated by a physician for proper anesthesia recovery.

CMS requires ASCs to take steps to ensure that patients do not acquire infections during their care at these facilities. ASCs must establish a program for identifying and preventing infections, maintaining a sanitary environment and reporting outcomes to appropriate authorities. The program must be one of active surveillance and include specific procedures for prevention, early detection, control and investigation of infectious and communicable diseases in accordance with the recommendations of the Centers for Disease Control and Prevention. Thanks to these ongoing efforts, ASCs have very low infection rates.⁵

A registered nurse trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever a patient is in the ASC. To further protect patient safety, ASCs are also required to have an effective means of transferring patients to a hospital for additional care in the event of an emergency. Written guidelines outlining arrangements for ambulance services and transfer of medical information are mandatory. An ASC must have a written transfer agreement with a local hospital, or all physicians performing surgery in the ASC must have admitting privileges at the designated hospital. Although these safeguards are in place, hospital admissions as a result of complications following ambulatory surgery are rare.⁵

Continuous quality improvement is an important means of ensuring that patients are receiving the best care possible. An ASC, with the active participation of its medical staff, is required to conduct an ongoing, comprehensive assessment of the quality of care provided.

The excellent outcomes associated with ambulatory surgery reflect the commitment that the ASC industry has made to quality and safety. One of the many reasons that ASCs continue to be so successful with patients, physicians and insurers is their keen focus on ensuring the quality of the services provided.

Medicare Health and Safety Requirements

Required Standards	ASCs	HOPDs
Compliance with State licensure law	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Governing body and management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Surgical services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assessment and performance improvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Environment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Medical staff	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Nursing services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Medical records	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pharmaceutical services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Laboratory and radiologic services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Patient rights	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Infection control	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Patient admission, assessment and discharge	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

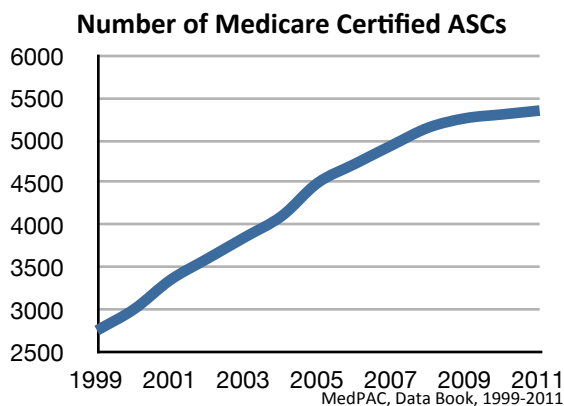
Source: 42 CFR 416 & 482

CONTINUED DEMAND FOR ASC FACILITIES

Technological advancement has allowed a growing range of procedures to be performed safely on an outpatient basis (unfortunately, however, Medicare has been slow to recognize these advances and assure that its beneficiaries have access to them). Faster acting and more effective anesthetics and less invasive techniques, such as arthroscopy, have driven this outpatient migration. Procedures that only a few years ago required major incisions, long-acting anesthetics and extended convalescence can now be performed through closed techniques utilizing short-acting anesthetics, and with minimal recovery time. As medical innovation continues to advance, more and more procedures will be able to be performed safely in the outpatient setting.

Over the years, the number of ASCs has grown in response to demand from the key participants in surgical care—patients, physicians and insurers. While this demand has been made possible by technology, it has been driven by patient satisfaction, efficient physician practice, high levels of quality and the cost savings that have benefited all.

However, in a troubling trend, the growth of ASCs has slowed in recent years. If the supply of ASCs does not keep pace with the demand for outpatient surgery that patients require, that care will be provided in the less convenient and more costly hospital outpatient department.¹²



ASCs CONTINUE TO LEAD INNOVATION IN OUTPATIENT SURGICAL CARE

As a leader in the evolution of surgical care that has led to the establishment of affordable and safe outpatient surgery, the ASC industry has shown itself to be ahead of the curve in identifying promising avenues for improving the delivery of health care.

With a solid track record of performance in patient satisfaction, safety, quality and cost management, the ASC industry is already embracing the changes that will allow it to continue to play a leading role in raising the standards of performance in the delivery of outpatient surgical services.

As always, the ASC industry welcomes any opportunity to clarify the services it offers, the regulations and standards governing its operations, and the ways in which it ensures safe, high-quality care for patients.

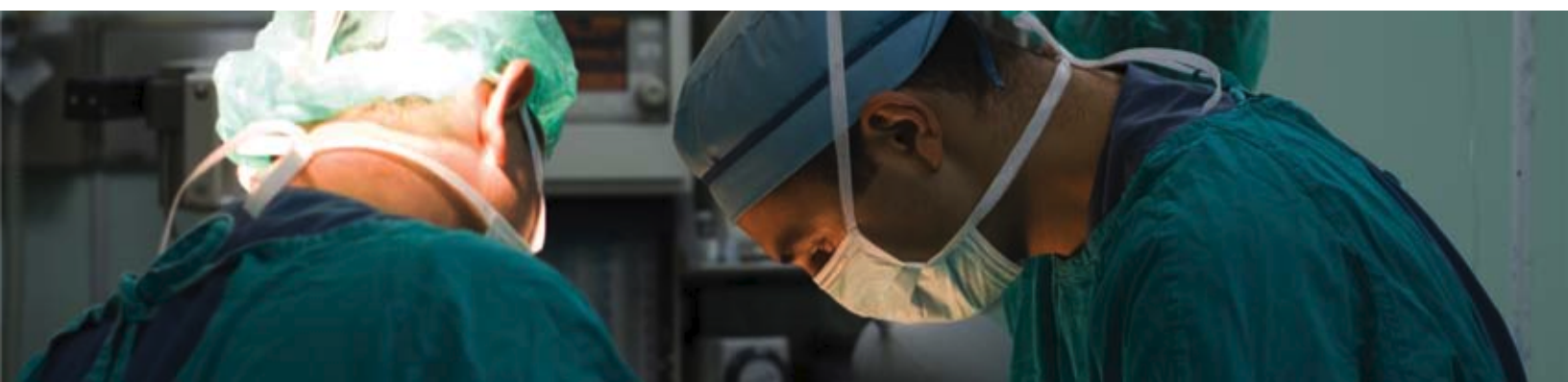
POLICY CONSIDERATIONS

Given the continued fiscal challenges posed by administering health care programs, policy makers and regulators should continue to focus on fostering innovative methods of health care delivery that offer safe, high-quality care so progressive changes in the nation's health care system can be implemented.

Support should be reserved for those policies that foster competition and promote the utilization of sites of service providing more affordable care, while always maintaining high quality and stringent safety standards. In light of the many benefits ASCs have brought to the nation's health care system, policymakers should develop and implement payment and coverage policies that increase access to, and utilization of, ASCs.

END NOTES

- 1 "Ambulatory Surgery Centers." Encyclopedia of Surgery. Ed. Anthony J. Senagore. Thomson Gale, 2004.
- 2 2004 ASC Salary and Benefits Survey, Federated Ambulatory Surgery Association, 2004.
- 3 Oxford Outcomes ASC Impact Analysis, 2010.
- 4 Press-Ganey Associates, "Outpatient Pulse Report," 2008.
- 5 ASCA Outcomes Monitoring Project, 3rd Quarter 2011.



Employee Benefit Trust Board Meeting

3. C.

Meeting Date: 12/11/2019

Department Head: Maria Munoz, HR Technician, Human Resources Department

Submitted By: Maria Munoz, HR Technician, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the increase to budgeted expense for SIARMED's audit. **(Susan Posada, Consultant and Broker).**

SUMMARY:

SIARMED's audit will be concluded by Health Claim Auditors, Inc. (HCA). The audit was designed to look at the carrier's ability to pay claims accurately and timely and involves a look at the system as well as the processed utilized.

Total cost for audit will be \$16,200, a difference of \$2,200 from the budgeted amount of \$14,000.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO _____ THE INCREASED BUDGETED AMOUNT FOR SIARMED'S AUDIT.

Fiscal Impact

Fiscal Impact:

FISCAL IMPACT:

Audit expense increased from the budgeted amount of \$14,000 to \$16,200

Attachments

Audit proposal

CONFIDENTIAL

THE INFORMATION CONTAINED HEREIN IS
CONFIDENTIAL AND INTENDED FOR USE BY
THE CLIENT OFFICIALS LISTED BELOW OR
AUTHORIZED AGENTS ONLY

Auditing Proposal *for*

City of San Luis

Susan Posada Agency

Submitted By:
Health Claim Auditors, Inc.

November 2019

TABLE OF CONTENTS

Page(s)

<i>1</i>	<i>HCA Background</i>
<i>2 - 6</i>	<i>Claims and Systems Audit</i>
<i>7 - 9</i>	<i>Qualifications</i>
<i>10</i>	<i>Fee Schedule</i>
<i>11</i>	<i>Audit Timetable</i>

Health Claim Auditors, Inc. Background

HCA conducts over two hundred and fifty (250) independent audits annually with a national client base of over one thousand (1,000) clients. HCA does not have direct business connections within the industry as to provide a total independent third party audit.

The training received by the auditors with Health Claim Auditors, Inc. (HCA) consist not only of extensive backgrounds of claims operation systems and claim adjudication, but current updates of inside knowledge of the procedures utilized in billing practices by hospitals and physicians as well as system enhancements to combat medical inflation. The auditors at HCA must have previous experience in both systems and claims. HCA will not hire an auditor with just systems knowledge or claims adjudication knowledge, they must have both. For this reason, 55% of all cost containment opportunities recommended by HCA comes from the extensive system knowledge of our auditors.

To provide a thorough audit, HCA has developed and engages a unique process in which a “national best practices approach” database is utilized.

HCA takes pride in providing comprehensive audits that identify claims issues, hidden costs and profits, trends, policies, procedures and system’s analysis for cost containment. Listed below are some of the types of services rendered to businesses by HCA.

- * Comprehensive Medical Claims;
- * Utilization Review/ Cost Control;
- * Prescription Drug/ Benefit Manager;
- * Test audits on potential or finalist Carriers, Third Party Administrators and Prescription Benefit Managers;
- * Mental/Nervous Carve Outs;
- * Long Term Disability Carve Outs;
- * Vision Carve Outs;
- * Dental Carve Outs;
- * Durable Medical Equipment/ Home Health Carve Outs;
- * Diabetes Provider Carve Outs;
- * Repricing/ Discount specific issue;
- * Hospital Provider/ Bill;
- * Workers Compensation;
- * Re Insurance for Aggregate, Specific and Timeliness;
- * Termination of Carrier;
- * Re-Audits.

CLAIMS AND SYSTEMS AUDIT

Health Claim Auditors, Inc. (HCA) has developed a unique approach to the underlying question, “Is my carrier performing at an adequate level of service concerning the claims payments and administration of my health care program?”. The answer to this question is to have a Manual Claims Audit and a Systems Capabilities Audit completed by HCA.

This audit is designed to look at the carrier’s ability to pay claims accurately and timely, and involves a look at the system as well as the process utilized.

The Manual System Audit is performed at the carrier's location, and includes the following elements.

A. A complete review of the claims processing system being utilized which includes researching abilities to perform in the following areas:

1. Edits being utilized in the system to flag claims for medical review.
2. Membership updating and procedures for eligibility requirements including administration of COBRA Benefits.

3. Coordination of Benefits in the areas of both research and processing.

4. Proper Usual, Customary and Reasonable application.
5. Procedures utilized for subrogation processing.
6. Turnaround time for clean claims and claims under review.
7. Ability to identify duplicate payments and fraudulent claims.
8. Medical necessity of specific professional services.
9. Quality assurance programs and claim production adequacy.
10. Processing of claims secondary for Medicare.
11. Ability to identify unbundling and code creeping in billing submissions.

12. Ability to systematically identify a claim that is related to a pre-existing condition.

13. Analysis of cost containment software being utilized such as Patterns of Care and Outpatient Hospital Surgical Indexing to determine how effective your Carrier/T.P.A. is, in regards to cost containment.
14. Systematic editing for necessary benefit and cost containment analysis. Examples are Coordination of Benefits, full-time student status, rental price of durable equipment, provider discounting, including prompt pay discounting, and coding discrepancies.
15. Analysis of any hospital audit program(s) currently being utilized.
16. Ability to serve City of San Luis through Customer Service Operations.
17. Communication between Utilization Review Department and Claims Processing Department.

- B. Individual claims will be selected to be audited for accuracy in the following areas:
 1. Coordination of Benefits.

2. Subrogation and Workers Compensation duplication.
3. Accuracy of CPT and ICDA codes.
4. Administration of benefits including deductibles, co-payments, benefit maximums and any special benefit requirements.
5. Provider or subscriber location and reimbursement amount to that provider.
6. Proper review performed by the medical department when required.
7. Eligibility of claimant to receive benefits.
8. Comparison of amount paid on a claim to an invoiced amount.
9. Turnaround time of each individual claim.
10. System maximums totaled correctly.

HCA

Page 5

Audit Proposal

C. Following the final review of the abilities of the claims processing system and the individual claims audit, HCA will provide City of San Luis the following reports for your review.

1. A comprehensive report on each of the previously mentioned overall system capabilities including any possible deficiencies.

2. Results of an extensive individual claims audit, which will give you a full analysis of accuracy and the following statistical information.
 - A. Data entry, error ratios.

 - B. Payment error ratios, including overpayments and underpayments.

QUALIFICATIONS

The training received by the auditors with Health Claim Auditors, Inc. (HCA) consist not only of extensive backgrounds of claims operation systems and claim adjudication, but current updates of inside knowledge of the procedures utilized in billing practices by hospitals and physicians as well as system enhancements to combat medical inflation.

The auditors at HCA must have previous experience in both systems and claims. HCA will not hire an auditor with just systems knowledge or claims adjudication knowledge, they must have both.

The auditing staff conducting the projects will consist of three (3) individuals with a combined experience of forty three (43) years of experience in the areas of Systems, Claims, and Cost Containment programs as well as financial auditing.

Account Manager, William A. Carr:

- Fourteen (14) years in the insurance business.

- Major Account representative working with accounts ranging in size from 500 to 8,000 employees, both statewide and nationally.
- Supervisor of claims operation.
- Knowledgeable in the areas of claims administration, systems, benefit structure and cost containment options.
- Degree in Computer Science.

Auditor, Irma Espejel:

- Seventeen (17) years in the insurance business.
- 4 years claims management experience.
- 10 years claims processing experience.
- Claims Manager and coordinator of major claims system conversion.
- 3 years of internal audit and analysis experience.
- Experienced in group presentations and training sessions.
- Initiated Claim Processor auditing and performance standards.
- Developed a Detailed Conversion Plan.
- Responsible for providing updates and outlining planning strategies to senior management.

Auditor, Margaret Kohler:

- Twelve (12) years of claims management experience.
- Extensive background in CPT-4/ICD-9 codings and computer programming and operations of health benefits.
- Promoted as a Benefits Specialist Department which handles the most difficult and complex claims.
- Extensive training and experience in multiple system implementations, diverse Health plans, Stop Loss, FSA Administration, Case Management, Retirement Benefit plans, claims administration and system adjudication.

The aforementioned associates also have multiple years experience auditing with Health Claim Auditors.

FEE SCHEDULE

The fee for HCA to perform Claims and System Audit(s) for City of San Luis would be as follows:

- Comprehensive Medical and Dental Audit - \$16,200.00. Travel expenses will be included in the aforementioned fixed cost.

This audit includes a comprehensive review of randomly selected medical and dental claims stratified by dollar volume, a full audit of specific claims selected (large and potential error claims) to detail payment errors and opportunities of additional cost containment through system enhancement and procedures followed. To provide a thorough audit, HCA has developed and engages a unique process in which a “national best practices approach” database is utilized

HCA conducts over 250 audits annually with a national client base of over 1,200 clients.

Respectfully submitted, the quoted fees listed above for this group will remain in effect through December 31, 2019.

HCA

Page 10

Audit Proposal

AUDIT TIMETABLE

It has been a pleasure to discuss the services provided by Health Claim Auditors, Inc. (HCA) and submit the proposal for audit. As per your request, we have assembled a typical timetable for the audit. The following exhibit displays the timetable expectations to conduct the HCA Claims and System Audit with full cooperation of the audited parties.

Week One

- Request of required data for the Claims and System Audit made to the TPA;
- Administrative staff conducts all Business Associate Agreements, Confidentiality Agreements and TPA required documents;
- Scheduling of the appropriate Audit Team.

Week Three, obtain detail claims report(s) for all claims;

- HCA technical personnel prepare data for match with HCA claim programs;
- Administrative staff conducts a Valid Random Selection with internal electronic program;
- Technical staff researches data for specific (bias selected) claims that will be researched for creative billing issues found in previous auditing utilizing the HCA national database;
- Administrative staff conducts a manual selection of large dollar claims for bias audits;
- Random/ Bias selections are sent to the TPA for retrieval from their system;

Week Six

- (Provider dependent), on-site claims review is initiated;
- Random and Bias Selected claims are audited with an addition of historical file review for disclosure of possible additional error trends;
- Comprehensive overview of system edits for cost containment, policies and procedures for all adjudication, customer service, disaster recovery, etc.;

Week Seven

- If needed, Consultation of specific professionals is conducted to confirm or verify for individual claim error findings or dispute resolutions;
- Construction of the rough draft audit report for TPA responses;

Week Nine

- HCA receives TPA responses/comments to the audit reports;
- Consultation with appropriate professionals (if required) of additional disputed claims is reviewed;
- Construction of the presentation report;

Week Ten

- Professional presentation to City of San Luis.

CONTACT INFORMATION

Name of Corporation: Health Claim Auditors, Inc.

Tax Identification Number: 88-0420540

Contact individual: Bill Carr

Telephone Nos.: (512) 619-4400 / (702) 617-4801

Desk E-Mail: wcarr@hcauditors.com

HEALTH CLAIM AUDITORS, INC.

Established 1987

*Henderson, NV * Cleveland, OH*

Employee Benefit Trust Board Meeting

3. D.

Meeting Date: 12/11/2019

Department Head: Maria Munoz, HR Technician, Human Resources Department

Submitted By: Maria Munoz, HR Technician, Human Resources Department

ITEM:

Discussion and possible direction to staff on any and all matters regarding informational update on Employee claims status report. **(Susan Posada, Consultant and Broker)**

SUMMARY:

To date there are 5 large claims totaling \$65,209.29 all of which are under \$20,000.00. Claims continue to be below what was expected and analyzed at 9.41% below last year's claims which were under expected by \$1 million.

RECOMMENDATION / SUGGESTED MOTION:

NO ACTION TO BE TAKEN, ITEM IS FOR INFORMATIONAL PURPOSES ONLY

Fiscal Impact

Fiscal Impact:

NO FISCAL IMPACT

Attachments

Dashboard for Nov. 2019/October 2019 claims

Dashboard 2018-2019



Medical and Dental Membership	July	August	September	October	November	December	January	February	March	April	May	June	2019 Yr to Date	2019 Monthly Avg	2019 Annualized	2018 Comparison	% Change
US & Mexico Med - Employees	126	123	118	126	120	122	120	123	127	129	131	134	1499	125	1499	1583	
US & Mexico Med - Spouse	8	9	8	6	6	6	8	5	7	7	6	6	82	7	82	89	
US & Mexico Med - Children	41	43	42	42	43	42	41	42	40	40	40	40	496	41	496	581	
US & Mexico Med - Family	24	24	26	25	24	24	23	22	22	22	22	22	280	23	280	269	
Mexico Med - Employee	1	1	1	1	1	1	1	1	1	1	2	2	14	1	14	15	
Mexico Med - EE + Spouse	5	5	5	5	5	5	5	5	5	6	4	4	59	5	59	48	
Mexico Med - Child(ren)	11	10	10	10	10	11	10	10	10	10	9	9	120	10	120	130	
Mexico Med - Family	23	23	23	24	23	23	24	24	23	23	22	22	277	23	277	333	
Dental US & Mexico - Employees	125	122	122	125	126	124	124	127	129	131	133	136	1524	127	1524	1571	
Dental US & Mexico - Spouse	4	7	7	4	4	4	5	5	5	4	4	4	58	5	58	77	
Dental US & Mexico - Children	27	25	25	28	28	29	28	28	28	28	28	28	330	28	330	585	
Dental US & MX - Family	23	23	23	23	23	24	24	23	23	23	23	23	278	23	278	257	
Dental Mexico Only - Employee	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	49	
Dental Mexico Only - EE + Spouse	8	8	8	8	9	9	9	9	9	9	9	9	103	9	103	47	
Dental Mexico Only - Child(ren)	19	15	15	18	17	18	16	16	16	16	15	15	196	16	196	131	
Dental Mexico Only - Family	33	35	35	32	30	28	29	29	28	28	27	27	361	30	361	333	
Plan Contributions																	
US & M - EE \$636.67	\$80,220.42	\$78,310.41	\$75,127.06	\$80,220.42	\$76,400.40	\$77,673.74	\$76,400.40	\$78,310.41	\$80,857.09	\$82,130.43	\$83,403.77	\$85,313.78	\$954,368.33	\$79,530.69	\$954,368.33	\$959,796.93	
US & M - SP \$1,321.22	\$10,569.76	\$11,890.98	\$10,569.76	\$7,927.32	\$7,927.32	\$7,927.32	\$10,569.76	\$6,606.10	\$9,248.54	\$9,248.54	\$7,927.32	\$7,927.32	\$108,340.04	\$9,028.34	\$108,340.04	\$112,560.65	
US & M Child(ren) \$1,321.22	\$54,170.02	\$56,812.46	\$55,491.24	\$55,491.24	\$56,812.46	\$55,491.24	\$54,170.02	\$55,491.24	\$52,848.80	\$52,848.80	\$52,848.80	\$52,848.80	\$655,325.12	\$54,610.43	\$655,325.12	\$731,644.25	
USM Sp Child(ren) \$2,021.09	\$48,506.16	\$48,506.16	\$52,548.34	\$50,527.25	\$48,506.16	\$48,506.16	\$48,506.16	\$44,463.98	\$44,463.98	\$44,463.98	\$44,463.98	\$44,463.98	\$565,905.20	\$47,158.77	\$565,905.20	\$518,659.58	
Mexico Med EE \$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$232.00	\$3,248.00	\$270.67	\$3,248.00	\$3,374.51	
Mexico Med - SP \$481.39	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$2,406.95	\$28,402.01	\$2,366.83	\$28,402.01	\$22,006.56	
Mexico Med - Child(ren) - \$481.39	\$5,295.29	\$4,813.90	\$4,813.90	\$4,813.90	\$4,813.90	\$5,295.29	\$4,813.90	\$4,813.90	\$4,813.90	\$4,813.90	\$4,332.51	\$4,332.51	\$57,766.80	\$4,813.90	\$57,766.80	\$59,517.74	
Mexico Family - \$702.95	\$16,167.85	\$16,167.85	\$16,167.85	\$16,870.80	\$16,167.85	\$16,167.85	\$16,870.80	\$16,870.80	\$16,167.85	\$16,167.85	\$15,464.90	\$15,464.90	\$194,717.15	\$16,226.43	\$194,717.15	\$222,754.25	
Dental	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Dental US & Mexico EE \$37.60	\$4,700.00	\$4,587.20	\$4,587.20	\$4,700.00	\$4,737.60	\$4,662.40	\$4,662.40	\$4,775.20	\$4,850.40	\$4,925.60	\$5,000.80	\$5,113.60	\$57,302.40	\$4,775.20	\$57,302.40	\$57,338.18	
Dental US & Mexico SP \$75.19	\$300.76	\$526.33	\$526.33	\$300.76	\$300.76	\$300.76	\$375.95	\$375.95	\$375.95	\$375.95	\$300.76	\$300.76	\$4,361.02	\$363.42	\$4,361.02	\$5,654.18	
Dental US & Mexico Ch \$75.19	\$2,030.13	\$1,879.75	\$1,879.75	\$2,105.32	\$2,105.32	\$2,105.32	\$2,180.51	\$2,105.32	\$2,105.32	\$2,105.32	\$2,105.32	\$2,105.32	\$24,812.70	\$2,067.73	\$24,812.70	\$24,685.09	
Dental US & Mexico Fam \$93.85	\$2,158.55	\$2,158.55	\$2,158.55	\$2,158.55	\$2,158.55	\$2,252.40	\$2,252.40	\$2,158.55	\$2,158.55	\$2,158.55	\$2,158.55	\$2,158.55	\$26,090.30	\$2,174.19	\$26,090.30	\$23,459.26	
Dental Mexico Only EE \$16.78	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$16.78	\$0.00	\$16.78	\$1.40	\$16.78	\$799.69	
Dental Mexico Only SP \$33.55	\$268.40	\$268.40	\$268.40	\$268.40	\$301.95	\$301.95	\$301.95	\$301.95	\$301.95	\$301.95	\$301.95	\$301.95	\$3,455.65	\$287.97	\$3,455.65	\$1,527.83	
Dental Mexico Only Ch \$33.55	\$637.45	\$503.25	\$503.25	\$603.90	\$570.35	\$603.90	\$536.80	\$536.80	\$536.80	\$536.80	\$503.25	\$503.25	\$6,575.80	\$547.98	\$6,575.80	\$4,263.71	
Dental Mexico Only Fam \$44.73	\$1,476.09	\$1,565.55	\$1,565.55	\$1,431.36	\$1,341.90	\$1,252.44	\$1,297.17	\$1,297.17	\$1,252.44	\$1,252.44	\$1,207.71	\$1,207.71	\$16,147.53	\$1,345.63	\$16,147.53	\$14,450.35	
Actual Contributions	\$229,139.83	\$230,629.74	\$228,846.13	\$230,058.17	\$224,783.47	\$225,254.91	\$223,480.89	\$220,746.32	\$222,620.52	\$224,450.45	\$222,392.41	\$224,431.99	\$2,706,834.83	\$225,569.57	\$2,706,834.83	\$2,547,484.89	6.26%
Plan Distributions																	
Medical Claims US & MX			-\$11,851.70	-\$107,648.90	-\$61,119.06	-\$62,496.73	-\$30,819.72	-\$84,001.14	-\$126,784.02	-\$91,931.03	-\$66,420.33	-\$78,112.91	-\$721,185.54	-\$60,098.80	-\$721,185.54	-\$934,387.64	-22.82%
Medical Claims Mexico Only				-\$53.00	-\$8,708.25	-\$591.40	-\$16,565.75	-\$28,064.20	-\$11,254.47	-\$11,550.53	-\$4,582.34	-\$5,824.71	-\$87,194.65	-\$7,266.22	-\$87,194.65	-\$360,768.00	-75.83%
RX US & MX	-\$3,141.62	-\$9,469.55		-\$21,531.46	-\$5,389.84	-\$12,855.86		-\$9,350.66	-\$9,289.40	-\$11,106.44	-\$9,832.20	-\$9,140.14	-\$101,107.17	-\$8,425.60	-\$101,107.17	-\$202,802.18	-50.14%
RX Mexico Only								-\$27,027.85	-\$14,487.54	-\$6,835.75	-\$4,815.68	-\$11,854.40	-\$65,021.22	-\$5,418.44	-\$65,021.22	\$0.00	
Dental US			-\$795.40	-\$8,344.57	-\$1,266.08	-\$770.20	-\$4,063.40	-\$2,412.15	-\$4,122.90	-\$3,102.49	-\$2,164.24	-\$5,874.31	-\$32,915.74	-\$2,742.98	-\$32,915.74	-\$88,951.64	-63.00%
Dental Mexico				-\$6,331.50	-\$3,503.70	-\$2,660.00		-\$9,257.30	-\$2,059.00	-\$2,704.69	-\$3,923.91	-\$4,155.50	-\$34,595.60	-\$2,882.97	-\$34,595.60	-\$17,564.73	96.96%
Total Claims Paid	-\$3,141.62	-\$9,469.55	-\$12,647.10	-\$143,909.43	-\$79,986.93	-\$79,374.19	-\$51,448.87	-\$160,113.30	-\$167,997.33	-\$127,230.93	-\$91,738.70	-\$114,961.97	-\$1,042,019.92	-\$86,834.99	-\$1,042,019.92	-\$1,604,474.18	-35.06%
EBSO TPA Medical fee \$24.50	-\$5,855.50	-\$5,806.50	-\$5,708.50	-\$5,855.50	-\$5,684.00	-\$5,733.00	-\$5,733.00	-\$5,757.50	-\$5,855.50	-\$5,953.50	-\$5,782.00	-\$5,880.00	-\$69,604.50	-\$5,800.38	-\$69,604.50	-\$56,773.42	22.60%
EBSO Dental Admin \$3.00	-\$621.00	-\$717.00	-\$687.00	-\$720.00	-\$702.00	-\$708.00	-\$708.00	-\$711.00	-\$723.00	-\$735.00	-\$714.00	-\$726.00	-\$8,472.00	-\$706.00	-\$8,472.00	-\$17,130.65	-50.54%
BCBS Network Fee \$16	-\$3,184.00	-\$3,168.00	-\$3,104.00	-\$3,168.00	-\$3,088.00	-\$3,104.00	-\$3,104.00	-\$3,120.00	-\$3,200.00	-\$3,232.00	-\$3,168.00	-\$3,248.00	-\$37,888.00	-\$3,157.33	-\$37,888.00	-\$39,843.82	-4.91%
Starmed Admin Fee \$4.25	-\$1,028.50	-\$1,020.00	-\$977.50	-\$1,020.00	-\$994.50	-\$1,003.00	-\$1,003.00	-\$1,007.25	-\$1,024.25	-\$1,041.25	-\$1,011.50	-\$1,028.50	-\$12,159.25	-\$1,013.27	-\$12,159.25	-\$12,972.55	-6.27%
ACA Reporting \$3.00	-\$717.00	-\$711.00	-\$699.00	-\$717.00	-\$696.00	-\$702.00	-\$702.00	-\$705.00	-\$717.00	-\$729.00	-\$708.00	-\$720.00	-\$8,523.00	-\$710.25	-\$8,523.00	-\$10,682.45	
Stop Loss/Reinsurance Premium	-\$41,886.36	-\$41,880.52	-\$41,690.92	-\$41,886.36	-\$41,065.28	-\$41,249.04	-\$40,757.80	-\$41,518.84	-\$40,996.76	-\$41,720.12	-\$40,187.36	-\$40,554.88	-\$495,394.24	-\$41,282.85	-\$495,394.24	-\$484,858.23	2.17%
Reinsurance Fees (PPCORI)																\$0.00	
Healthiest You	-\$1,896.00	-\$1,840.00	-\$1,840.00	-\$1,880.00	-\$1,856.00	-\$1,864.00	-\$1,848.00	-\$1,880.00	-\$1,872.00	-\$1,920.00	-\$1,816.00	-\$1,920.00	-\$22,432.00	-\$1,869.33	-\$22,432.00	-\$24,392.73	-8.04%
EAP Preferred	-\$415.80												-\$415.80	-\$34.65	-\$415.80	-\$5,498.18	-92.44%
Adjustments Prior Period																\$0.00	
Other	-\$7,812.00	-\$5,683.50	-\$5,671.50	-\$13.50	-\$9.00	-\$13.50	-\$10.50	-\$7.50	-\$10.50	-\$15.00	-\$6.00	-\$349.66	-\$19,602.16	-\$1,633.51	-\$19,602.16	-\$17,672.73	
Consultant Comp	-\$8,470.00	-\$8,400.00	-\$8,050.00	-\$8,400.00	-\$8,190.00	-\$8,260.00	-\$8,260.00	-\$8,295.00	-\$8,435.00	-\$8,575.00	-\$8,330.00	-\$8,470.00	-\$100,135.00	-\$8,344.58	-\$100,135.00	-\$102,510.70	-2.32%
Total Fixed Costs	-\$71,886.16	-\$69,226.52	-\$68,428.42	-\$63,660.36	-\$62,284.78	-\$62,636.54	-\$62,126.30	-\$63,002.09	-\$62,834.01	-\$63,920.87	-\$61,722.86	-\$62,897.04	-\$774,625.95				