Health Care Reform: Strategies For The Road Ahead

Presented by:
Luke Barnett

Agenda

- General Overview – What is already implemented?
- Major Upcoming Legislative Requirements
- The Rise & Advantage of Self-Funding
- Strategic Opportunities
- Closing Remarks & Questions

Reforms Currently in Place

Health Care Reform

Affordable Care Act

- Enacted in March 2010
- Makes significant changes to health care system
- Implemented over several years

Provisions that impact:

- Health care providers
- Government programs
- Health insurance issuers
- Employers/plan sponsors
- Individuals

Most employers that offer health plans will be impacted in some way

Effective Prior to 2013

- No lifetime limits/restrictions on annual limits (annual limits phased out entirely 1/1/14)
- Dependent coverage up to age 26
- Preventive care covered at 100% – no copays or cost sharing
- No pre-existing condition exclusions for children
- No rescissions
- No reimbursement for OTC medicine or drugs (without a prescription)
- Form W-2 reporting (250+ W-2 In Prior Year)
- Medical loss ratio rules
- Small employer tax credit

Preventive Care for Women

- New guidelines for preventive care for women on Aug. 1, 2011
- Must provide coverage for women's preventive health services without any cost-sharing
  - Applies to non-GF plans
  - No deductible, copayment or coinsurance
- Effective for plan years beginning on or after **Aug. 1, 2012**

Summary of Benefits and Coverage

- Generally provided to participants and beneficiaries
  - 1st day of **1st open enrollment period** on/after Sept. 23, 2012
  - 1st day of **1st plan year** on/after Sept. 23, 2012 (for other enrollment)
  - Must provide at various points thereafter
- Simple & concise explanation of benefits and costs
  - Template provided
  - Can provide in paper or electronic form
- Applies to:
  - Issuers and health plans (plan sponsors)
  - GF and non-GF plans
  - No duplication required: if issuer provides to enrollees, plan doesn't have to

60-Day Notice Rule

- Effective once SBC rule is effective for a plan
- Material modifications **not in connection with renewal** must be described in a summary of material modifications (SMM) or an updated SBC
  - Must be provided at least **60 days BEFORE** modification becomes effective
- Material modification:
  - Enhancement of covered benefits or services
  - Material reduction in covered benefits or services
  - More stringent requirements for receipt of benefits

2013 Compliance

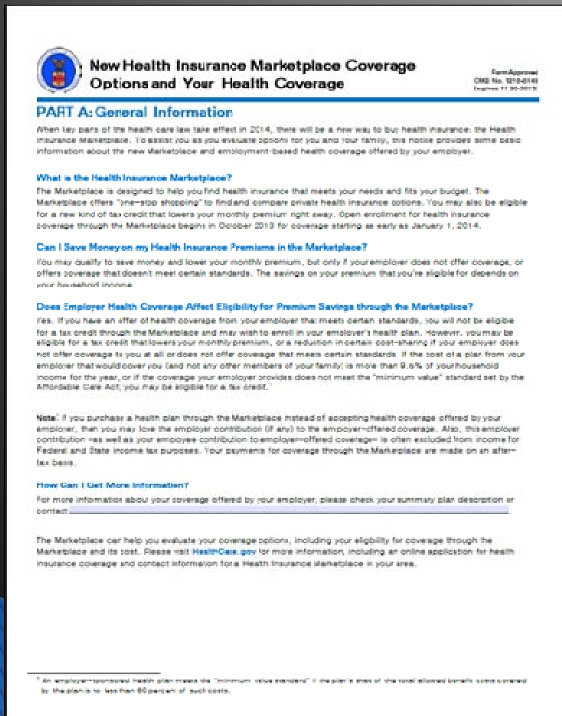
Health FSA Limits

- Before health care reform
  - No limit on salary reductions
  - Many employers imposed limit
- Beginning with 2013 plan year, limit is $2500/year – 2015 plan year limit is $2550
  - Limit is indexed for inflation for later years
  - Per FSA limit
- Does not apply to dependent care FSAs

Notice to Employees of Coverage Options on Exchange

Current employees:
by Oct. 1, 2013

New employees hired after Oct. 1:
within 2 weeks of hire



New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact ________________.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

- Employers subject to FLSA must inform all employees of Exchange information
- Include information on:
  - Exchange and services
  - Potential subsidy eligibility
  - Impact on employer contribution
- Model notices available

DOL: no legal penalties for failing to provide notice, but compliance encouraged

Increased Medicare Tax

- Medicare tax rate to increase for high-earners for 2013 tax year
  - 0.9 percent increase (from 1.45 percent to 2.35 percent)
- High-earner threshold
  - Single: $200,000
  - Married : $250,000
- Individual liability for tax depends on filing status and household income
- Employer responsibilities
  - Withhold additional amounts from wages in excess of $200,000
  - No requirement to match additional tax
  - No requirement to notify employees

Patient-Centered Outcomes Research Institute (PCORI) Fees

- Fee to fund research on informed health decisions
- Paid by issuers and self-funded plan sponsors
  - Special rules for multiple self-funded plans (including HRAs)
- Paying the fee
  - Using Form 720 by July 31 each year
  - Beginning with plan years ending on or after Oct. 1, 2012
  - Ending with the 2018 plan year

10/1/2013 plan year & later

$2 x average number of covered lives

10/1/2014 plan year & later

$2.08 x average number of covered lives

10/1/2015 and beyond

Increase based on National Health Expenditures

FINANCING FOR THE FUTURE
ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

2014 Compliance

2014 Compliance

- Individual Mandate – $695 or 2.5% of income for failure to comply in 2016
- Annual limits eliminated
- Preexisting condition exclusions prohibited
- Coverage for clinical trials (non-GF plans)
- Waiting period limitations (No more than 90 days)
- Insured small group and individual policies (non-GF plans) must provide essential health benefits package

Limits on Out-of-Pocket Expenses and Cost-Sharing

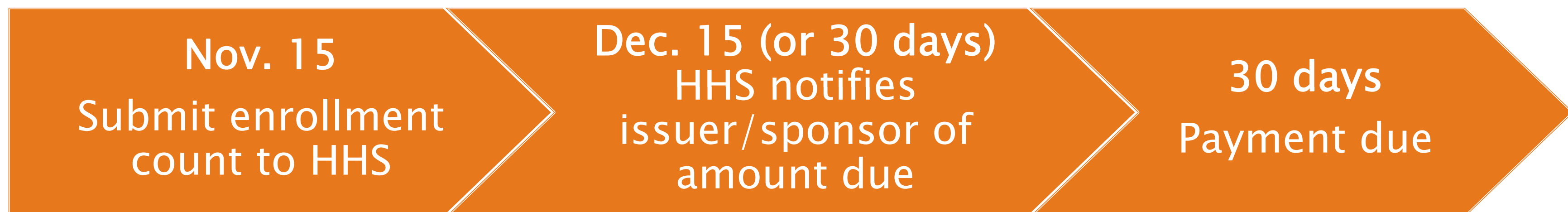
- Non-GF group health plans subject to limits on cost-sharing and out-of-pocket costs
- Out-of-pocket expenses may not exceed HDHP limits
  - 2015: $6,600/$13,200
  - Apply to all non-GF group health plans
- Deductibles must be $2,600 (single coverage) or $5,200 (family coverage)
  - Apply only to Embedded HDHP (HSA Qualified Plans)
- Limits indexed for inflation
- Out-of-pocket limits must include all cost sharing including deductibles, copayments (office visit, emergency room, etc.), & RX copayments.

Wellness Program Changes

- Current rules for wellness program rewards:
  - Reward must be no more than 20% of the cost of coverage
  - Program must be designed to promote health/prevent disease
  - Opportunity to qualify for those with health issues (and notice)
- 2014 health care reform changes:
  - Reward increased to 30%
  - Reward up to 50% for programs to reduce/prevent tobacco use
  - Small business grants to establish new wellness programs (on hold)

Reinsurance Fees

- Fee to fund reinsurance program to stabilize individual insurance market
  - Program to operate 2014-2016
- Paid by health insurance issuers and self-funded plan sponsors (with some exceptions)
- Fees based on annual national contribution rate
  - 2014: **$5.25/month ($63/year)** x average number of covered lives



ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

Health Insurance Providers Fee

- Annual fee on health insurance providers
  - Effective in 2014
  - Due Sept. 30 each year
  - Allocated according to market share: $8B in 2014 – $14.3B in 2018 (based on premium growth in later years)

Applies to:
- Covered Entities
- Including health insurance issuers and HMOs

Does not apply to:
- Companies with $25M or less in net premiums
- Self-insured employers
- Government and non-profit entities
- VEBAs

Employer Responsibility

- Large employers subject to "Pay or Play" rules
  - Originally effective for 2014 – Delayed for one year, until 2015, until 2016 for employers 50 – 99 employees.
- Applies to employers with 50 or more full-time equivalent employees in prior calendar year
  - FT employee: employed for an average of at least 30 hours of service per week
- Penalties may apply if the employer:
  - Fails to offer minimum essential coverage to all FT employees (and dependents) OR
  - Offers coverage that is not affordable or does not provide minimum value
- Penalties triggered if any FT employee gets subsidized coverage through Exchange

Impending Compliance

Community Rating & Transitional Relief

- Does not apply to employers with over 100 Average Total Number of Employees.

- Employers with 2 – 50 – Probably early renewed your policy on 12/1/13.
- Employers with 51 – 99 – Have the opportunity to early renew 10/1/15.
  - Many carriers providing special renewal terms. (BCBS of IL & UHC)
  - Early renewing in the 51 – 99 segment retro-actively applies the employer mandate to 1/1/15.
- 10/1/15 – Last opportunity to make plan design changes.
- 10/1/16 – Last opportunity to renew “non community rated”
- 10/1/17 – All organizations with less than 100 ATNE will be offered Community Rated ACA Metallic Plans.

Community Rating & Transitional Relief

Is Community Rating bad for my organization???

- Some employers may see a discount relative to their non-community rated program. Less than 20%.
- Most will see a decrease in benefits and an increase in cost.
- Relatively healthy employers will be hardest hit.
- Non-composite rated metallic (Platinum, Gold, Silver) plans.
- D.C. Update – negotiations are underway to redefine a small group to 2-50 employees.

FINANCING FOR THE FUTURE
ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

ACA Reporting Requirements

- The Affordable Care Act ("ACA") created new reporting requirements under Internal Revenue Code ("Code") §§ 6055 and 6056.
- Under these new reporting rules, certain employers must provide information to the IRS about the medical plan coverage they offer (or do not offer) to their employees.
- Code § 6055 requires insurers, self-insured health plan sponsors, government agencies that administer government-sponsored health insurance programs and any other entity that provides minimum essential coverage ("MEC") to report information on that coverage to the IRS and covered individuals.

ACA Reporting Requirements Summary of Forms

- The forms operationalize the information reporting requirements under IRC §§ 6055 and 6056.
- The draft forms issued include:
  - **1095-B** – Health Coverage. Insurers and self-insured plans will provide one to each enrollee.
  - **1094-B** –Transmittal of Health Coverage Information Returns. Transmittal form insurers and self-insured plans will file with IRS along with all the Forms 1095-B.
  - **1095-C** – Employer-Provided Health Insurance Offer and Coverage. Large employers will provide one to each enrollee.
  - **1094-C** – Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns. Transmittal form insurers and self-insured plans will file with IRS along with all the Forms 1095-C.

FINANCING FOR THE FUTURE
ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

2018 – Cadillac Plan Tax

- 40 percent excise tax on high-cost health plans
- Based on value of employer-provided health coverage over certain limits
  - $10,200 for single coverage
  - $27,500 for family coverage
- To be paid by coverage providers
  - Fully insured plans = health insurer
  - Self-insured plans/FSAs = employer
- More guidance expected

Nondiscrimination Rules May Apply

Prohibit discrimination in favor of highly-compensated employees

Prohibited group and specific rules vary by type of benefit

Discrimination has negative tax consequences

Automatic Enrollment Rules

- Will apply to large employers that offer health benefits
  - Applies to GF and non-GF plans
  - Large employer = more than 200 employees
- Must automatically enroll new employees and re-enroll current participants
- Adequate notice and opt-out option required
- DOL:
  - Regulations will not be ready to take effect by 2014
  - Employers not required to comply until regulations issued <u>and</u> applicable

Strategic Opportunities & Advantages of Self-Funding

Opportunity

Walgreens joins Sears Holding, Darden Restaurants and other firms in pushing its workforce into the private exchanges, part of what employee benefit analysts call a historic shift in **health-care benefits accompanying the implementation of the Affordable Care Act**, known as Obamacare. -Michael Fletcher, Washington Post

General Electric Co. (GE) last year said it, too, would curb benefits in a move that may send some former employees to the public insurance exchanges created under the 2010 Affordable Care Act.

-Alex Nussbaum, Bloomberg

Partly blaming the health reform law, United Parcel Service is set to remove thousands of spouses from its medical plan because they are eligible for coverage elsewhere.

-Jay Hancock, Kaiser Health News

What makes up the ideal employer provided health plan?

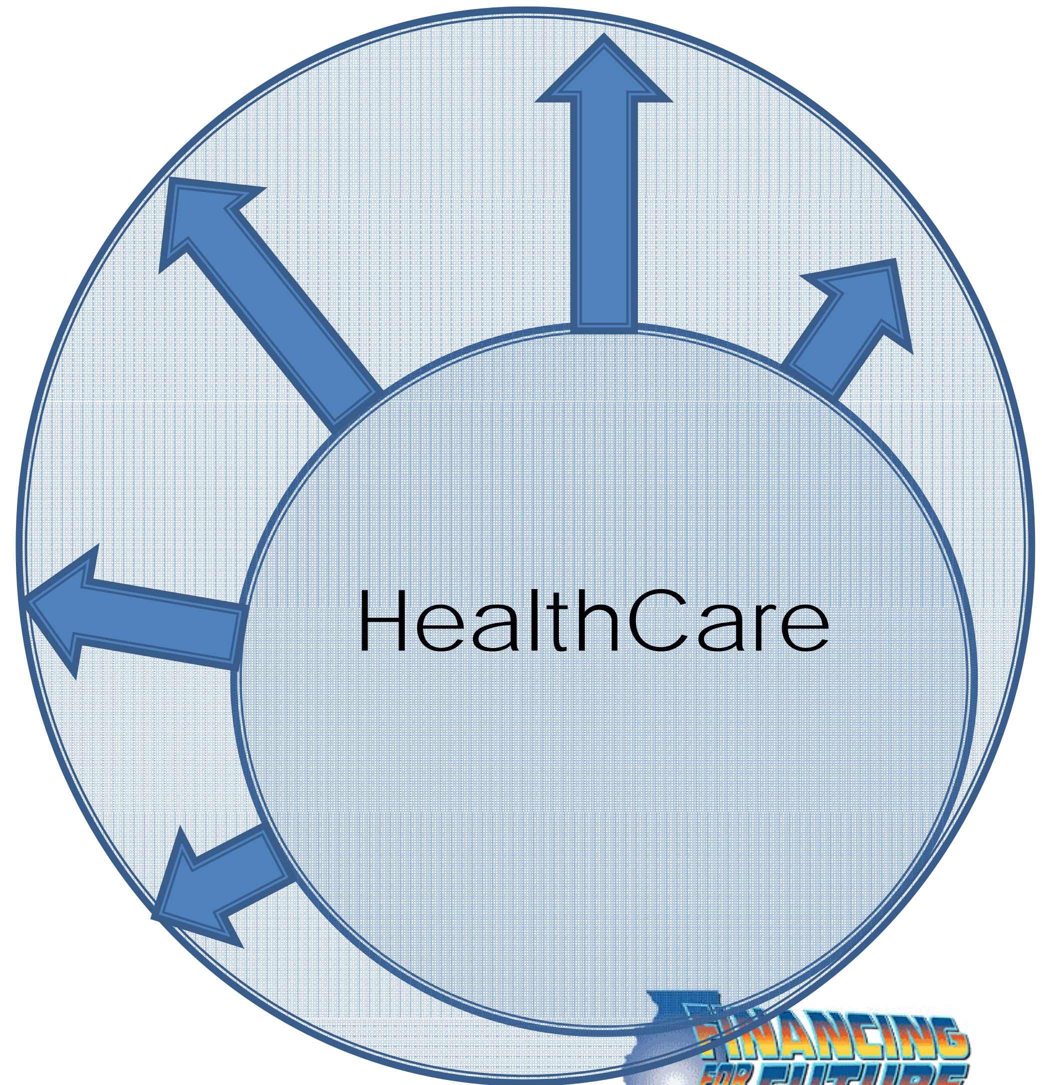
- Below average costs.
- Better than average benefits.
- Provider access.
- Engaged employees…
  - Provider Cost
  - Own health and health of family (prevention & chronic condition management)
- Employees want it to be easy to enroll, easy to understand & have confidence they have the right coverage.
- Easy to manage for Human Resources.

The Cost Problem

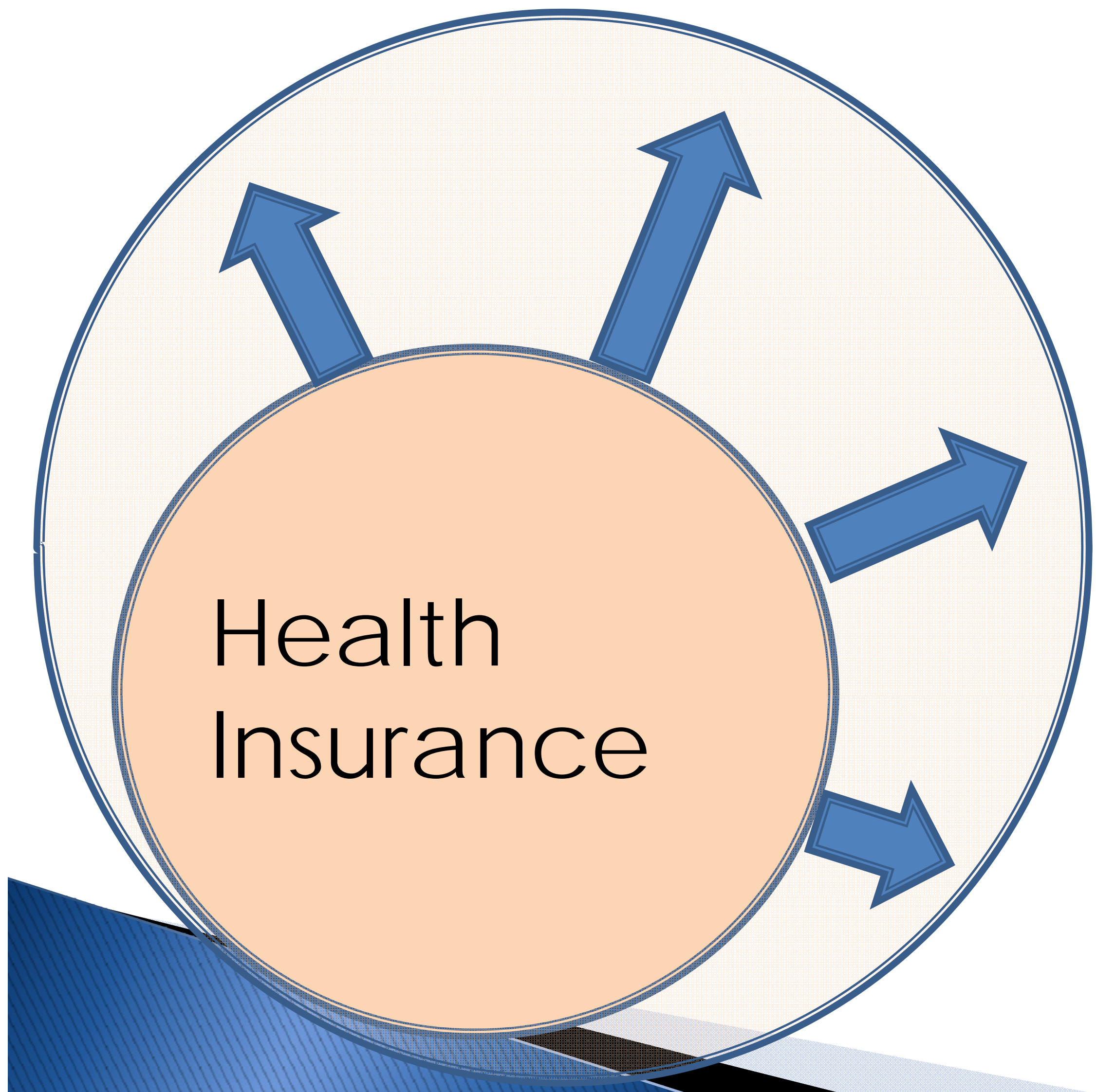
1. **Demographics**
   - Number of Americans over the age of 65 will double by 2025 (US Census Bureau)
2. **Government Regulation – Medical Device Tax**
   - 2.3% on ***GROSS SALES***

3. **New Medical Technology**

4. **Increased Prescription Drug Cost – Specialty Medication**
   - Harvoni – Miracle Cure - $88,000 per treatment
5. **Provider Consolidation = Less Competition = Higher Prices**



The Multiplier Effect



1. **Affordable Care Act Taxes & Fees**
   - Health Insurer Tax (3 – 4%)
   - Reinsurance Tax ($62.50 PEPM per year)

2. **Medical Loss Ratio Rules**
   - Create reverse incentive for insurers – 85% on claims per year.

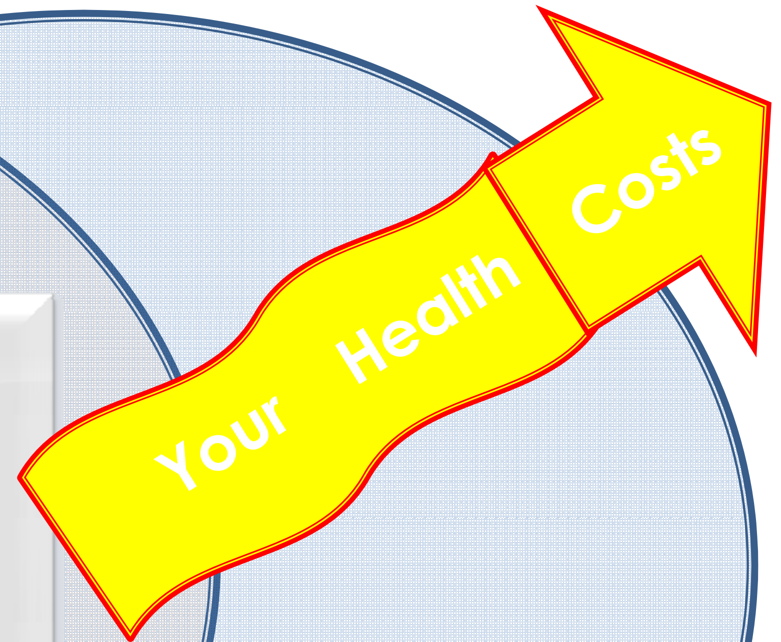
3. **Health Insurance Company Profits**

4. **Aging Health Insurance Pools**

5. **Influx of Previously Un-Insured probably Un-Healthy enrollees due to HCR.**

FINANCING FOR THE FUTURE
ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

Your Health Plan in the Middle



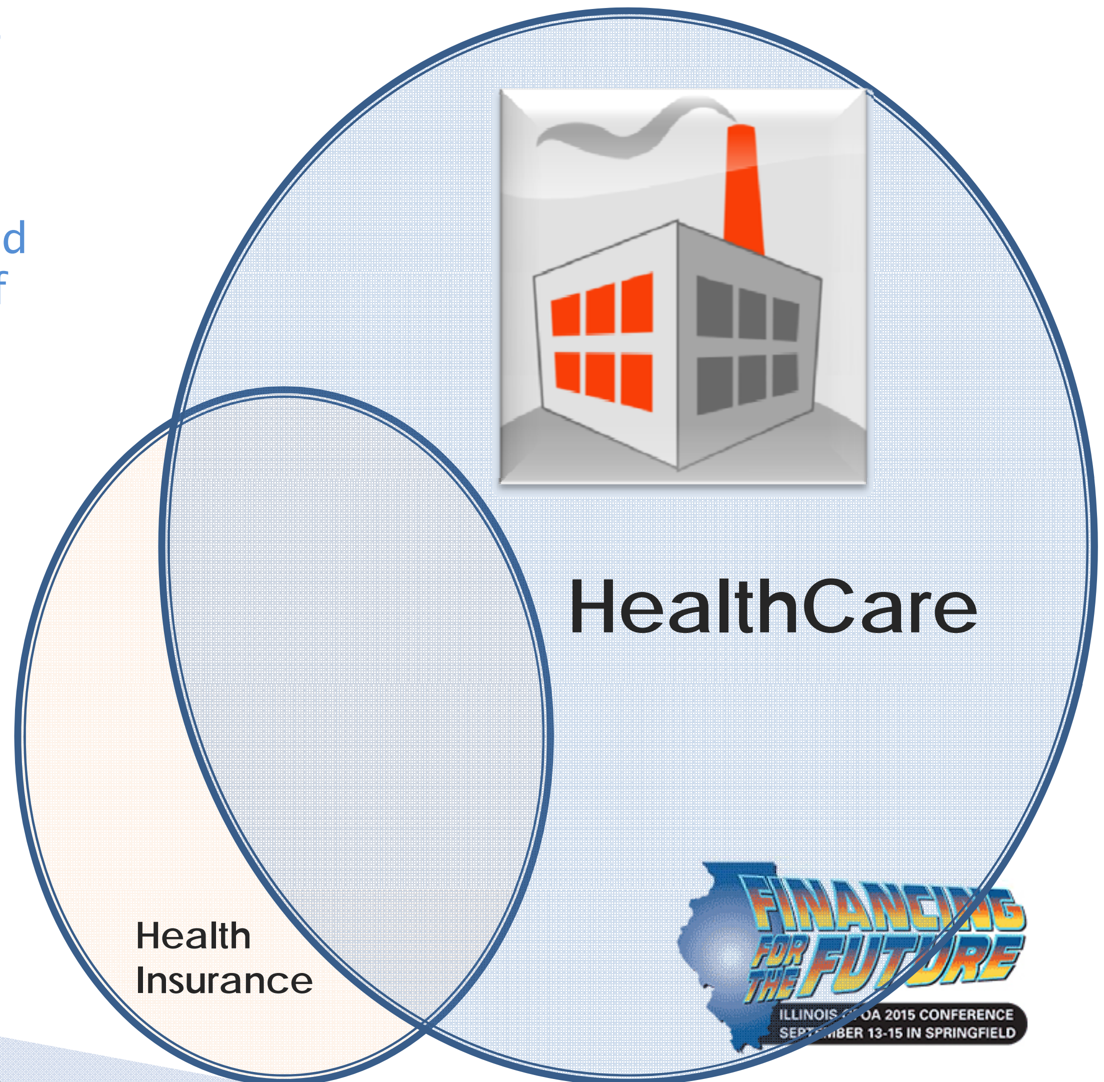
You can't eliminate health care costs – but you can stop funding health insurer profits!

The ACA has increased incentive for companies down to 50 employees to self-insure and the market is responding.

1. If you're over 200 lives you should strongly consider self-insuring. If that seems too risky then…

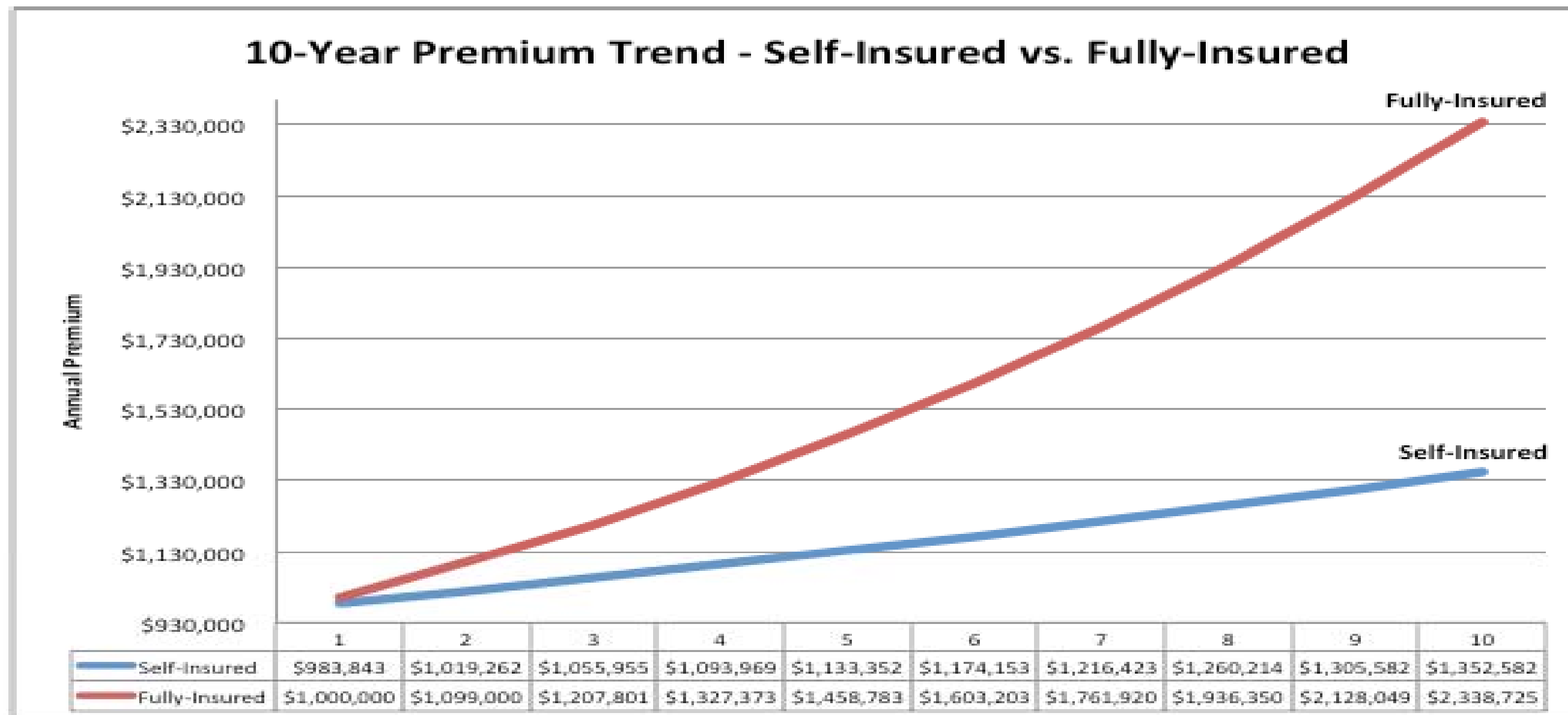
2. Employer's are pooling together through the use of group health captives to give themselves buying power and leverage in an improved risk pool with like minded employers.

3. Traditional insurance carriers are rolling out level-funded products down to 10 lives!



Advantages of Self-Funding

- According to a recent ADP study, larger employers pay approximately $1,400 less per employee per year than smaller companies.
- According to a recent Mercer study, larger employers are likely to have increases of 3.6% as compared to increases of 9.9% for smaller employers.

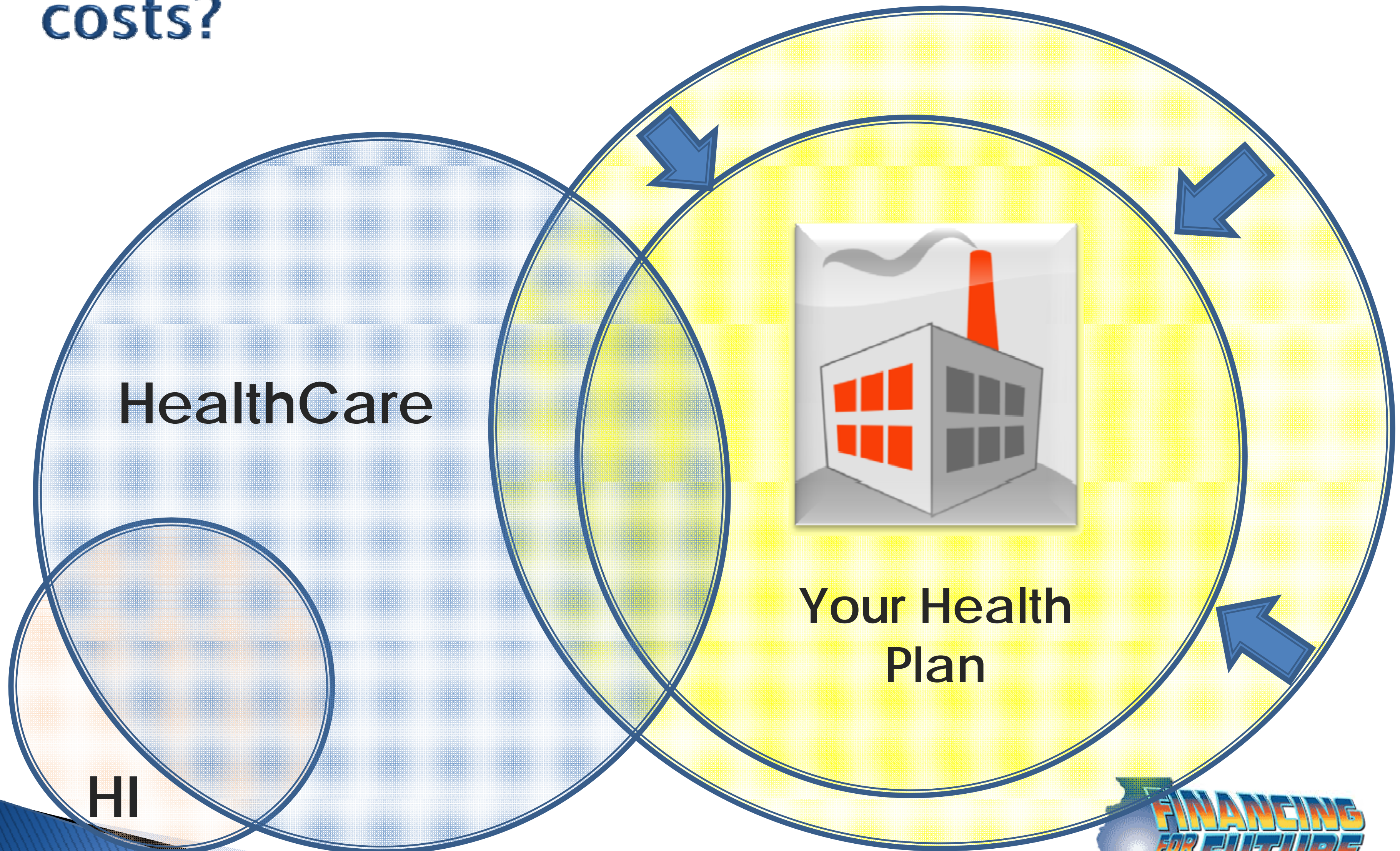


	1	2	3	4	5	6	7	8	9	10
Self-Insured	$983,843	$1,019,262	$1,055,955	$1,093,969	$1,133,352	$1,174,153	$1,216,423	$1,260,214	$1,305,582	$1,352,582
Fully-Insured	$1,000,000	$1,099,000	$1,207,801	$1,327,373	$1,458,783	$1,603,203	$1,761,920	$1,936,350	$2,128,049	$2,338,725

Advantages of Self-Funding

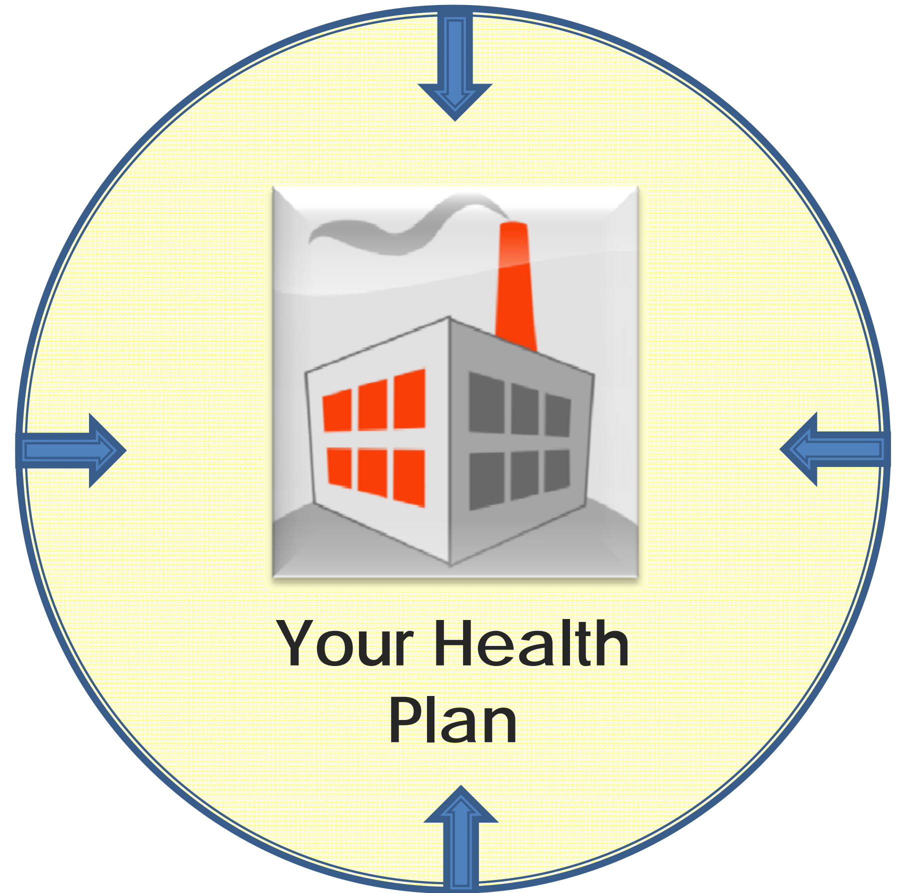
1. Avoid the ACA's Health Insurer Tax. Approximately 4% that only applies to fully-insured plans.
2. Remove yourself from insurer profits and their aging and adversely selected against risk pools.
3. Increased claims transparency gives employers the ability to breakdown & identify utilization trends and proactively implement appropriate adjustments.
4. Complete plan design flexibility allows for unlimited creativity and quick reaction.
5. Amplify the impact of your wellness program through plan design integration.

How do you reduce your "healthcare" costs?



How do you reduce your "healthcare" costs?

1. *Meaningful Wellness*
2. *Claim Utilization Analytics*
3. *Engaged Employees*
4. *Provider Access*



FINANCING FOR THE FUTURE
ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

Wellness – Which Programs do you offer?

Program	Percent
Health risk assessments	60%
Weight management/weight loss programs	59%
Health/wellness newsletter	58%
Smoking cessation programs	50%
Nutrition counseling/education	43%
Web-based resources for healthy living	40%
CPR/first aid	39%
Health fair	35%
Healthier foods in cafeteria/vending machines	41%
Safety/accident prevention program	34%
Worksite speaker on health topics	34%
Subsidized gym memberships	34%
Stress management education	29%
On-site workout facilities	21%
Personal health coaching	21%
Healthy back education	17%
Other	9%
Medical self-care	5%
None at this time	2%

0% 10% 20% 30% 40% 50% 60% 70%

Wellness – Awareness to Results

Implementation Timeline

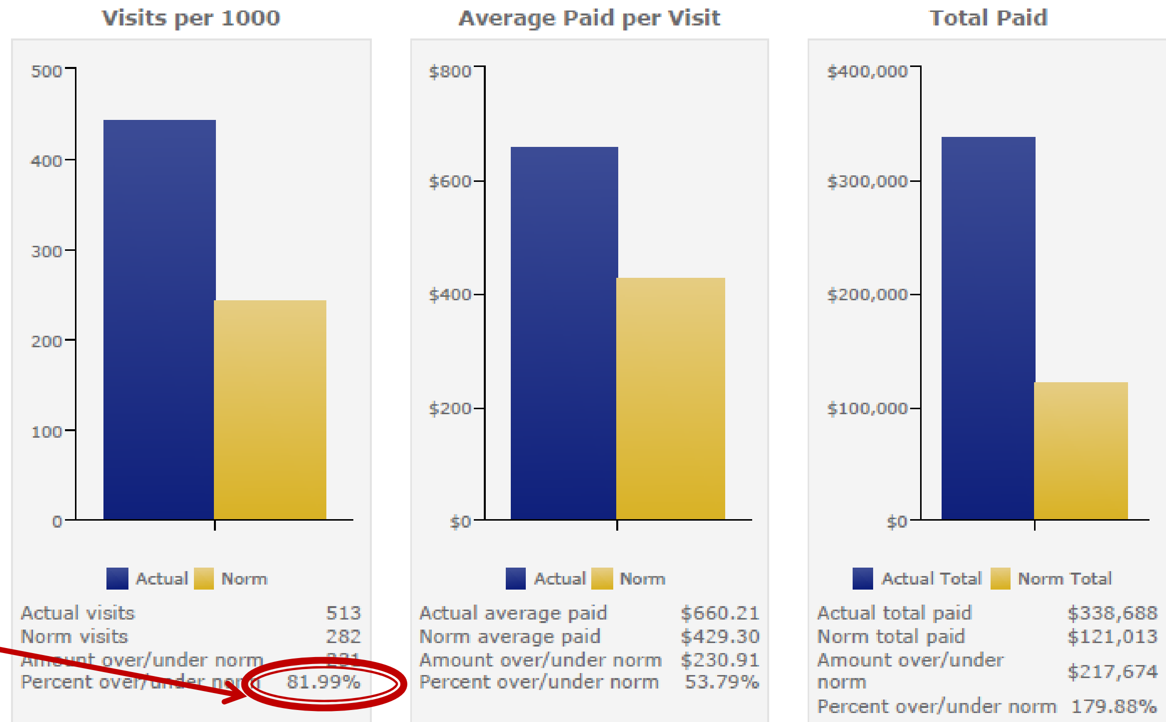
Year 1	Year 2	Year 3
CREATE AWARENESS	**EFFORT BASED**	**RESULTS BASED**
Health Risk Assessment Biometric Screenings Tobacco Cessation Program Walking Program Newsletters Coaching	Health Risk Assessment Biometric Screenings Tobacco Cessation Program ***EXTEND TO SPOUSES*** Incentives through Payroll Contributions to participate	Establish a "Results and Rewards" Program Incentives through Payroll Contributions based on results Calculates an individual health goal for each member Measures the health of an individual based on avoidable & preventable risk factors - Blood Pressure, Cholesterol, Glucose, Triglycerides, BMI, & Tobacco Use

Claim Analytics – Step 1) Benchmark

- Benchmark your Health and Rx claims data against national norms from Truven Health Analytics and Kaiser Family Foundation

- Compare your data to other employers of similar size, industry and region

EMERGENCY ROOM UTILIZATION IS HIGH



ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

Claim Analytics – Step 2) Dig Deeper

- Identify and analyze cost and utilization problem areas

Page layers:

Drop members here to create page layers

Ascending

Descending

Don't Sort

Context filter: Emergency

Emergency Room

Emergency Room

	Charges	Paid	People	Visits	Charges per Person
Alcohol/Drug Use	$937.00	$366.39	2	2	$468.50
Blood and Blood-forming Organs	$3,067.49	$2,077.68	5	5	$613.50
Burns	$1,862.00	$1,650.36	3	3	$620.67
Circulatory System	$106,868.70	$64,476.74	38	55	$2,812.33
Digestive System	$124,541.51	$67,633.89	54	71	$2,306.32
Ear, Nose, Mouth and Throat	$46,506.50	[illegible]	53	59	$877.48
Endocrine, Nutritional and Metabolic	$12,879.63	$5,603.55	10	12	$1,287.96
Eye	$3,272.50	$1,720.78	6	6	$545.42
Factors Influencing Health Status	$6,644.90	$3,746.69	15	15	$442.99
Female Reproductive System	$8,417.20	$3,500.05	5	7	$1,683.44

	Charge							
ACUTE PHARYNGITIS	$8,93	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DIZZINESS AND GIDDINESS	$14,50	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UNSPECIFIED OTITIS MEDIA	$2,89	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE	$1,87	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES	$1,92	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
STREPTOCOCCAL SORE THROAT	$2,37	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DYSFUNCTION OF EUSTACHIAN TUBE	$1,02	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SIALOADENITIS	$6,38	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UNSPECIFIED SINUSITIS (CHRONIC)	$1,27[illegible]	[illegible]	2	2	[illegible]	[illegible]	[illegible]	[illegible]
ACUTE SINUSITIS UNSPECIFIED	$280.00	$89.43	1	1	$280.00	$280.00	$89.43	$89.43
ACUTE TONSILLITIS	$327.50	$178.24	1	1	$327.50	$327.50	$178.24	$178.24
ALLERGIC RHINITIS CAUSE UNSPECIFIED	$790.70	$478.22	1	1	$790.70	$790.70	$478.22	$478.22
CLOSED FRACTURE OF NASAL BONES	$0.00	$415.75	1	1	$0.00	$0.00	$415.75	$415.75
DENTAL CARIES PIT AND FISSURE	$637.00	$0.00	1	1	$637.00	$637.00	$0.00	$0.00
EPISTAXIS	$255.00	$178.94	1	1	$255.00	$255.00	$178.94	$178.94

Claim Analytics – Step 3) Explore Solutions

Actuarial Modeling

Model Comparison: Demo - Do Not Edit

Total Paid Comparison	Current	Low Impact w/ER	High Impact
Value of Medical Plan Changes		-3.56%	-18.86%
Value of Rx Plan Changes		-10.62%	-45.70%
Total Value of Plan Changes		-4.62%	-22.89%
Total Medical Paid	$5,577,297.14		
Total Rx Paid	$489,932.00		
Total Projected Paid	$6,067,229.14	$5,786,923.15	$4,678,440.39

Members Affected Comparison

Total Claimants 1006

Total Enrolled 934

	Current		Low Impact w/ER		High Impact	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	1000	2000	1000	[illegible]	1500	3000
Members affected			0		-501	-44
% of total claimants			n/a	n/a	-49.80%	-4.37%
% of total enrolled			n/a	n/a	-53.64%	-4.71%
Primary Care Copay	20	40	25	50	40	80
Members affected			-416	-152	-416	-152
% of total claimants			-41.35%	-15.11%	-41.35%	-15.11%
% of total enrolled			-44.54%	-16.27%	-44.54%	-16.27%
Specialist Copay	30	50	40	60	60	100

The consultant can enable the employer to weigh the impact on personnel against potential savings to make the best choice for them

- Model potential plan design changes to see financial impact

Claim Analytics – Step 4) Implement Solutions

- Ultimately develop targeted solutions for saving money on your health plan

ILLINOIS GFOA 2015 CONFERENCE
SEPTEMBER 13-15 IN SPRINGFIELD

Plan Design – Network Access

- The Affordable Care Act mandates many things, but surprisingly provider access is completely unaddressed. The market is responding…

Insurance Carriers – Creating new “Narrow” networks for both the public exchange and employer markets.

Third Party Administrators – The Targeted Approach

- Have developed policies with no network and base provider reimbursements off of Medicare.
- Have developed policies where they pay at the “deepest” provider discounts with no active network.
- Have developed policies that revert to Medicare reimbursements when certain limits are reached – $50,000 on inpatient and $10,000 on out-patient.

Provider Access

Medical Tourism

- Dollars & Sense
  - No Hassles, no bills, no employee cost
  - Savings are between 30 and 80%, based on procedure
- First-Class Medical Quality
  - Facilities and International Hospitals equal or exceed US Standards
  - Affiliated with Harvard, John Hopkins, Cleveland Clinic, Columbia University
  - Surgeons are Board Certified & speak English
- First-Class Features
  - Luxurious 4-star hotel, airfare & chauffeur
  - 24/7 personal medical concierge

Provider Access

Telemedicine

Avg. time spent with a Doctor during traditional visit- 4 mins
Avg. time spent with a Telemedicine MD – 15 mins

24/7 Access to Doctors

Licensed and reside in the US

Credentialed using NCQA standards

Available by phone, video, or email

Diagnose, prescribe, inform

Service available in all 50 states (cannot prescribe in OK)

Over 300 doctors in the network

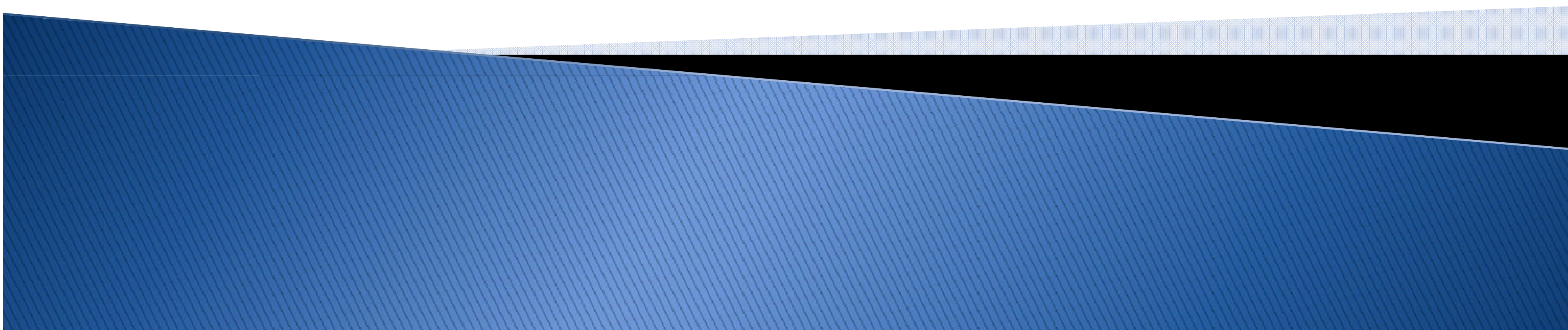
Waiting lists in most states for Doctors

Most Common Calls

1. Allergies
2. Bronchitis
3. Earache
4. Sore Throat
5. Pink Eye
6. Sinusitis
7. Strep Throat
8. Upper Respiratory Infections
9. UTI

Provider Access

- Shared Primary Health Clinics
  - Traditional Healthcare doesn't address key issues
  - Onsite or Near-site clinic solutions can help transform your group's healthcare
  - Communities can come together so that employers of all sizes can benefit from Full-Time dedicated staff
  - Improve quality of care and lower costs with objective referrals, innovative pharmaceutical options, and lower lab costs
  - Benefits both the employer and employee. Employees often refer to the onsite clinic as the #1 most appreciated benefit at their employer.



Engaged Employees

Empower your employees to be better Consumers of insurance

Provider Cost Comparison

(details on next page)

	Option 1	Option 2	Option 3
Employer Estimated Responsibility	$1,121.07	$873.76	$1,439.67
Your Estimated Responsibility	$780.27	$718.44	$859.92

$2,400
$2,000
$1,600
$1,200
$800
$400
$0

Don't waste your opportunity to create the "Ideal Health Plan"

- Below average costs.
- Better than average benefits.
- Provider access.
- Engaged employees…
  - Provider Cost
  - Own health and health of family (prevention & chronic condition management)
- Easy to manage for Human Resources.
- Employees want it to be easy to enroll, easy to understand & confidence they have the right coverage.

Connor & Gallagher

Property & Casualty

With an unrivaled stable of insurance markets to approach on your behalf our seasoned experts will ensure the most competitive & secure placement of your business coverage. We specialize in the following commercial lines of business:

Property, Casualty, Bonding, Workers' Compensation, Professional Liability, & Alternative Risk.

Employee Benefits

Our strategic carrier partnerships and focus on innovative plan design help you provide the most cost effective solutions for your company and the best possible benefits for your employees. We go beyond brokerage to be your HR department's right hand.
We specialize in:

Group Health, Dental, Disability, Life, Vision, Executive Benefits & all Voluntary Lines.

Retirement Planning

Delivering turn key solutions for your companies retirement plan through fiduciary guidance, investment monitoring, employee education, and best in class provider partners is the key to your successful retirement plan. Our focus is:

Qualified Plans: 401k & 403b
Buy-Sell Plans
Individual Life Insurance

Contact Information

- **Connor & Gallagher Benefit Services, Inc.**
  - Phone: 630-737-9370
  - **Luke Barnett** x 124: lbarnett@congalins.com

Securities offered through LaSalle St. Securities LLC (LSS), member FINRA/SIPC. Advisory services offered through LaSalle St. Investment Advisors LLC (LSIA), a Registered Investment Advisor. Connor & Gallagher is not affiliated with LSS or LSIA. LSS is affiliated with LSIA.