The Cigna Group - Former Broker Manager at Bright Health Group

Interview conducted on September 05, 2023

Topics

Health Insurance, Small Businesses, Brokers, Fully Insured Plans, Self-Funded Plans, Virtual Care Solutions, Cost Savings

Summary

The Tegus Client speaks with a former Broker Manager at Bright Health Group who has extensive experience in the health insurance/financing arena. The expert discusses their background, including their work with various insurance companies and their current role as a broker selling policies for small groups and Medicare. They emphasize the importance of assessing risk and getting individuals over 65 off the group's books. The expert explains that small businesses have options for funding their health plans, including fully insured and level funded/self-funded options. They recommend using a broker and discuss the different options available based on the size of the business. The expert also clarifies the underwriting process for self-funded plans and the role of third-party administrators. They mention the involvement of the owner, finance manager, and HR representative in the decision-making process. The expert notes the consolidation in the brokerage market and the addition of virtual care solutions by carriers. The conversation also touches on point solutions offered as benefits to employees and the revenue generation of virtual care providers. The expert explains the partnerships between virtual care providers and payers and the challenges of implementing a virtual primary care model.

Expert Details

Broker Manager at Bright Health Group, a health insurance platform. Expert is a broker working in the small group/individual u-65/Medicare markets. Has been dealing within the space for the past 20 years.

Employee Benefits Specialist at policyline.

Former Broker Manager at Bright Health Group, a health insurance platform. In this role, the expert is responsible for building a wholesaler broker channel of clients who then sell Bright Health's individual customized insurance. The expert works with brokers and agents to help consult on insurance logistics or any issues that arise for the broker's clients.

Prior to Bright Health, the expert was Sales Director at Sidecar Health, a customizable and cash incentivized insurance company, leaving in May 2021. In this role, the expert was responsible for working directly with brokers to build partnerships between their clients and Sidecar's product.

Additionally, the expert spent 17 years at United Health Care building relationships with agents, brokers, and consultants to facilitate the sale of UHC's small group health insurance products to groups with 99 employees or less.

Q: Do you have experience explaining different health insurance options + related pros and cons (e.g. fully insured, self funded, ICHRAs, HSAs, level-funded plans, PEPM benefits, etc.) for small / medium business?
A: Yes, 20+ years of experience

Q: Do you know the different options small businesses encounter vis a vis outsourcing insurance functions (claims processing, managed care / network management, brokers, etc.)?
A: Yes absolutely

Q: Have you been following recent trends in the small business insurance market re: self funding vs fully funded plan adoption?
A: Yes I have been watching these trends in great detail.

Tegus Client
Thank you for taking the time to talk about the market both of small businesses seemingly transitioning given rising costs to a self-funded model, whereby they would be more likely to evaluate a solution and pay for it as well as on the market side and how distribution of these types of benefits and any type of network solutions work for small businesses that are looking to self-fund on the broker side. Can you give us your background as a broker in the space?

Former Broker Manager at Bright Health Group
So I have been in the health insurance/financing arena since 2004. I got my start with Blue Cross and Blue Shield of North Carolina in the small group market as an inside wholesaler which all that means from a small market perspective at that time were groups that had employees less than 100 lives. The Affordable Care Act changed that definition in 2014 from one to 55. But still, when you're talking about small business as a whole, it's that market that's less than 100 lives.

So I cut my teeth with Blue, learning the ropes, meeting brokers, selling our product, becoming the subject matter expert through the broker channel. And then I transitioned from that in '07 over to UnitedHealthcare, where I obtained an outside role just doing the same thing, but just the official outside wholesaler responsible for a distribution channel, a list of brokers. And I stayed there until 2020. So I spent the bulk of my career at United learning the ins and outs of the industry, the changes that took place in that time frame were insurmountable and huge. So I was at the forefront of it all.

There really wasn't an opportunity to move up. And so I looked elsewhere where I transitioned over to a company called Sidecar Health in June of 2020, which was a ground floor opportunity with stock options in the individual market, looking at the cash price with regards to health insurance, having no network and utilizing their channels to purchase insurance.

That didn't work. Then seven months after that, they said we're going to move in a different direction, which was fine because I knew what I was getting into. That moves a lot faster than they tell you. It's just based upon how much money you raised and how quickly the product takes flight. So then a transitioned to Bright HealthCare in May of '21. And that was a start-up as well on the individual side as a wholesaler as well, selling again through the broker channel.

They were five years down the road. So I thought they were much better fit for me. And it was selling just individual policies through a broker channel. So nothing really outside the box other than how they tried to distribute it in terms of the way they sold it. They end up going public in June of '21 after I came on. They had three quarters of negative earnings after starting out at $18 a share. This was Minnesota's unicorn. And then subsequently after that, after the down earnings when they went public, we ended up most of us losing our jobs in March '22.

And so now I've been a broker. Since that time, I came over to a buddy of mine's independent insurance practice. And I was his wholesaler for Blue Cross and United for 15 years. And so I'm still in a small group arena, selling anything under 100 lives. But I do individual under age 65 and heavily involved in Medicare as well just because of the aging population and how many people are turning 65 every single day.

Tegus Client
So are most of the policies for your groups under 100? Are these individuals employed by a business?

Former Broker Manager at Bright Health Group
Yes, so in terms of looking at the group market, my target market is 20 employees up to 250 lives, which gets out of that arena of small business, in that medium-sized business market. A lot of these groups will buy

the same way. They think about benefits the same way. Just different dynamics as far as what can go on based on where you fall within the markets based on the Affordable Care Act. But most of these folks in the group space, they work for the employers. So the employer provides the insurance for them.

Tegus Client
So in your case, these are older employees who are often eligible for Medicare plans. And you're helping sell to the brokers and the companies that cover these employees?

Former Broker Manager at Bright Health Group
I am the broker now as well. So besides trying to sell into a group, one of the value add is we don't farm out Medicare leads to other brokers because some group brokers just don't want to mess with it. One of our value add is, not only are we going to help you assess the risk on your group on the books, make it as good as we possibly can. One of the ways that we do that is those folks that are eligible for Medicare. You can't force anybody. And then, those folks that are under 65 as well too, in the individual market through the group, if it makes sense for them to go, then we'll assess that risk as well too.

But majority are looking at the bigger picture when you're working with the group is those folks that are 65 and over, you want them off your book because a lot of times what you're facing with them is they're on four to five different medications by that period. And they have two to three chronic conditions. So something is going to transpire, You don't want that claim on your group. So that's why we really push hard for Medicare. We'd rather then go there because we're probably going to have a better benefit as well too.

Tegus Client
So if I'm a business with sub-100 employees, how do I typically approach making an insurance decision? Do I engage a broker? Do I engage a consultant? How do I pick my TPA? How do I pick a PEO? What does the decision-making process from like an average small business with whom you work when it comes to understanding to how structure their health insurance program?

Former Broker Manager at Bright Health Group
So when you're looking at it from that vantage point, you have a group that's under 100 lives. First off, you must determine what market segment they fall in. This is all going back to when the Affordable Care Act came out in 2014. If they have less than 50 employees, then by definition they're a small business. 51 to 99, then they're considered large group.

When you're under 50 lives, you do have two different options to choose from as far as how to fund your health plan. You can look at fully insured, which is the tried-and-true measure. And then you can also look at what they call level funded or self-funded. And then in this instance, speaking for that market segment, you are going to go through a broker.

You're not going to go through a consultant because the consultant is not going to come down into that market segment because they're used to bigger revenue, more ways to shop to market, more tools at your discretion, you're really limited because of how things are regulated. So you're going to use a broker in that under 50 market.

And then what you're going to do first is you're going to say, I don't have to offer health insurance because by law, but I'm going to do it for two reasons. So I got to have it for me, and b, I got to have it because it's a retention tool. If I'm in a market segment that my business is in, then most other of my competitors have it because otherwise, I'm not going to attain or attract good employees.

So your broker is going to go to market for you and they're going to look at the fully insured space with the BUCA, so Blue Cross, United, Cigna, Aetna. And then they're also going to look at the level funded/self-funded arena. And what happens there as well too is that's pretty cookie cutter. You have your BUCAs that will roll over and offer level funded as well too.

And then on the occasion that you really don't want to look at them for that type of insurance, there are other TPAs out there that really started to come into the fold that will offer unbundled opportunities. And

what that means is, is that you'll have a company that will help you define what TPA to look at. Then we can go look at the taper, the stop-loss who's going to help ensure the group. And then we can even look at the bigger picture, which is Rx, pharmacy benefit managers because that's where the action is these days in terms of spend.

And that's what you're going to do in that 20 to 50 space. None times out of 10, eight times out of 10, I'll still tell you most folks just stay fully insured because it's easy. They must have the benefit. There's a pain associated with the market as far as how expensive it is, how convoluted it is, but they know what they're getting.

A lot of times when groups in that 20 to 50 space, they transition over to level-funded or self-funded. They're doing it because the risk on the group is really good. They're going to save a tremendous amount of money. And they're going to be able to see group-level claims over $5,000. You're going to see where their dollars go. And they'll be level-funded or self-funded for maybe a year or two because all it really takes is one claim. One claim and then your renewal is astronomical.

We had one recently that just happened. It had a high-cost claim. It costed over $100,000 to a 30 life case. They got popped 35%. So we ended up having to go back over to fully insured. So sometimes it doesn't happen right away. But eventually, you'll get back over to that side of the house. And you'll stay there for a couple of years. And you might try level-funded again as well too.

There's a lot of action in the two to 50 space because that's where the majority of our country is in terms of groups. 51 to 99, when you get outside of what they call small group or small group reform, you're considered a large group. And a 51-plus group or 51 to 99 groups going to buy 100 and over groups, so 100 to 250.

They have a little bit of cash on hand. But nine times out of 10, they're still going to look at fully insured through a broker, not a consultant. Not a lot of consultants are going to come down under 100 lives. It's just not worth it for them because of all the handholding that has to happen. And plus they have account management team, it's not worth their time to pay them to come downstream. They'd rather play in that 100, 250 or above market.

So a broker will be there as well. They'll look at all fully insured. They will look at level-funded. They'll have more freedom to look at that level funded or self-funded arena where they can actually level fund it. By definition it works just like fully insured. And that I'm going to fund my plans to the max liability.

And I'm going to spread that risk out over a 12-month period for the same premium every month. Because there's not a lot of cash on hand for some of these groups. So they need to be able to just pay the same amount of money so they can budget. But level funded, you get the ability to have a contract that allows you to see claims, see where your money is going, obviously the potential to get money back. But 51 to 99 as well, what ends up happening is they'll get out of that level funded opportunity.

And they'll go to what they call a partially self-funded, which means the only difference is, is that you're funding to what they call the expected claims cost. So you're adding in your administration costs plus expected. You still have a max liability that you'll see. But we only really technically have to fund to expect it.

You'll keep the max liability in a fund, separate just in case you end up having a high claims claimant or claimants or high claim month. But the thing with self-funding is by funding to expected costs, you do have months that go up and down, but you keep more of the money upfront rather than waiting to get it in arrears from the TPA or the carrier that you're utilizing level funded with.

So with 51 plus, you've got more leeway. You are using a broker. They still are quoting fully insured. They're going to look at level funded as best as possible and to assess that risk. You have more groups in that 51-plus space that will go level-funded or self-funded than you would underneath in that two to 50 space. But the rules of the road are the same. You have one large claimant, it's going to wreck your group and then you're going to have to go back to fully insured.

And the other thing to keep in mind too in this 51-plus market is everything is underwritten. So two to 50, it's

all guarantee issue, that the rates are filed with each state's department of insurance. 51-plus fully insured, you got to get underwritten, self-funded regardless of market segments is always going to be underwritten.

So you've got a bigger potential risk there, but 51-plus. The thing to note too is if the broker is able to save 15%, 20%, 25%. The group is going to take that because of just the sheer cost as we know health insurance is. They can save that money for at least a year, and then they have to go back. Then they'll take that risk just because of the cost.

Tegus Client
Does it become more economical to self-fund from your experience? Because we've read literature that suggests that the high costs of fully insured premiums are pushing smaller businesses towards a level-funded, self-funded model. So I would love to understand from your perspective where the breaking point is and how that shifted.

Former Broker Manager at Bright Health Group
Yes. Typically, it used to be 250 employees or more. We're starting to see more, so 100-plus. And so when you get underneath that number, there is the opportunity. We quoted with many groups as we can. But I'm not really seeing a tremendous shift in our block much less in the overall market that's saying level-funded or self-funded is a bigger play than fully insured.

It's an option. It's an alternative strategy. It's something for a broker to talk about to run, to explain. But again, you got to get underwritten. So some of these groups just doesn't meet the threshold to make sense. Or even though it's just explained properly, they still want their fully insured just because it's the safety that they've always known.

They've had relatively okay rate increases. And even though some of these groups are saving money, they don't want to rattle the cage. I don't have a specific percentage that I could give you in that sub-100 market or even sub-50. I would venture to go out and say that it's still heavily fully insured. So if you are one of these rare birds under 250 or 150 that wants to self-fund, when it comes to figuring out, what providers are in network and how are you going to process claims, is this all effectively outsourced to the broker? The broker figures all this out for you?

So if you're going self-funded, nine times out of 10, whatever TPA you're going to use, they're going to have one or two networks that you can offer. It's either Cigna or it's Aetna. UnitedHealthcare won't lend out their network. You'd have to go direct to United to get a self-funded quote. Same thing with Blue Cross and Blue Shield.

So the broker will effectively find the TPA that they're most comfortable with, that they have the best relationship with because there's a plethora of third-party administrators out there that can help self-fund and process claims. And then you'll have Aetna or Cigna. You'll start out probably at a 10% decrement,15% because that's what they're going to charge you to use their network. And then when you're underwritten from there based on your group.

However, whatever rating methodology they want to use, the biggest one now is just they call it GRx, which is looking at pharmacy benefit spend over the last five years and assessing a factor off that. Or you can use what I'm starting to see in the markets now, artificial intelligence or machine learning. So some of these TPAs will go out to Google. There's 1.5 billion data points. And based on all the information you've give me about a said person, I'm able to determine a risk tolerance for a group based on that information.

Tegus Client
And given in the self-funded instance, the employers bear the risk. What do you mean by underwritten? Who is underwriting them?

Former Broker Manager at Bright Health Group
So if I go through any of the carriers, to get my self-insured quote, then the carriers themselves are going to underwrite. You're going to give me a census based, it's called a member-level census. So I'm getting all

names of all belly buttons in the group, ZIP code, county, date of birth and gender. And I'm going to run that through a tool called GRx. GRx is owned by a company, an actuarial firm called Milliman. I'm not sure if you've ever heard of them.

United, the Blues, Aetna and Cigna, they'll send that information typically to them. And then they'll spread out information based on what they find, and then underwriting for each individual carrier will take a look. And from there, they'll assess the risk and then produce rates. If I go to a third-party administrator not a carrier, what I've seen now is they have their own underwriting team in-house.

And then they're really starting to use machine learning and artificial intelligence like I was describing, still based on member level census, but they're asking for a little bit more information like your street address, your phone number, how long you've lived there, if you can provide a social. So that way, they can try to dive deeper to price the business correctly. So there's no hiccups if it gets installed. So that's typically how it works.

Tegus Client
And they're underwriting the stop-loss?

Former Broker Manager at Bright Health Group
Yes. So when you go to a carrier, it's all cookie-cutter. So they have their own stop-loss, they have their own paper, they have their own third-party administrator. So once they get done underwriting the group, there's only one carrier for stop-loss. So they then give you the rates.

Stop-loss for individuals start out at $27,000 and go up from there. And then your aggregate, which is your corridor between your expected claims cost and your maximum funded liability claims cost is anywhere from 110% to 125%. Typically, it's 125%. If you can go 110%, you're getting quite aggressive. But this means that the opportunity to recruit funds is less. But obviously, your monthly rates are better.

When you go to a TPA and you're shopping, whether it's level funded or self-funded, then yes, you've got the TPA that you work with, and they'll go out to their markets of stop-loss carriers. There could be 10 or 12 of them sometimes. Although that's an abundant, but then they'll shop it along with underwriting the risk as well too.

So that way, you'll come back with an opportunity to look at multiple ways to fund your plan. Because in essence, you as the carrier being self-funded, you're paying for it. But you do by stop-loss on an individual basis and on a group basis to cover yourself, should something arise.

Tegus Client
So I'm going to play this back to you just to make sure I understand that before we go back. So the way that it would work, if I had a small business in North Carolina, an auto shop or something where, let's say it was a big auto shop and I got 50 employees. I'm going to engage with the broker. If I want a self-fund, or not, they're going to choose neither option, but I'll choose self-fund just for the purpose of this example. I'm in the minority, which in this case will really be a level fund.

Former Broker Manager at Bright Health Group
It will be a level fund, I guess.

Tegus Client
The broker is going to intro me to a TPA who is going to be connected to a stop-loss carrier. The stop-loss carrier is going to give me the opportunity to effectively purchase into their network of providers to offer to each of my employees. And then the TPA is going to process my claims, should they arise. But I will pay the premium both to reserve against future claims losses as well as to pay for my stop-loss premium each month. And that's the workflow. Am I understanding that correctly?

Former Broker Manager at Bright Health Group

Yes. You will have premium payments to your admin cost plus your maximum funded liability spread out over 12 months, equal 12-month payments. And then you will also utilize the TPA's network. Whether that's going to be Cigna or Aetna, whichever one may have a contract to be able to sell or rent out as they call it.

Tegus Client
So how do you engage who's the stakeholder, who's engaging? How long does the process take?

Former Broker Manager at Bright Health Group
So typically, you're going to find in the most markets that I deal in. The owner because they're small businesses, they wear the hat or a lot of hats. Occasionally, you'll have a finance manager, a director of finance. They will be involved. If they're able to hire human resources people or person, they could be involved.

So those are the three key stakeholders. When you buy benefits, you're working anywhere from 30 to 90 days out. It depends upon how quickly your carrier that you're with gets you your renewal. By law, you have to get it 45 days in advance in today's market that doesn't work because it doesn't give you enough leeway. So carriers will get that renewal anywhere from 60 to 90 days out to you. 60 is more like the number. So when I said 30, it's if you're not the existing broker, if you're somebody else that's getting in a group to have a health review because you prospected in.

You didn't know when the renewal was. And they want to make sure that the current broker they're working with is doing their job. That's the 30-day window. But for the most part, it's safe to say that's 60 to 90 days. And then you got those three stakeholders that are involved.

Tegus Client
Is it usually one independent person who is making the decision from the perspective of the owner of the small business? Or do families get involved? Or are there other stakeholders? Or is there someone with a designated title, not the owner of the business themselves directly?

Former Broker Manager at Bright Health Group
Besides those three, I have seen it where they'll go to key employees that have been around for a very long time with the business to make sure that they're comfortable with the change or the benefits. So family members do sometimes get involved. You might have a head of a department other than those three key stakeholders, not so much a family member, maybe the manager, all the employees. They might run benefits by them because they can get an idea of what the employees are thinking about existing benefits and things of that nature.

For the most part though, those three owners, either director of finance, a CFO or human resources, together if they're all three in the business, they're going to make that decision or it could be the CFO with the owner. But they will take info from those other folks that I just explained. I've seen that happen plenty of times.

Tegus Client
So how consolidated is the brokerage for small business or small group, whatever the right terminology is? Is it a lot of independents? Is it a lot that are affiliated with a larger brokerage like a Marsh or an Aon? Is it just a hodgepodge? What is the fragmentation of that market?

Former Broker Manager at Bright Health Group
So since the Affordable Care Act came into play in '14, there has been a tremendous consolidation in the marketplace. There are very few independent agnostic agencies that I currently work for that are still actively involved. The firms that really came in and purchased were OneDigital, USI Insurance, and NFP and then The Hilb Group. And so we've seen a tremendous, like you said, consolidation.

The other thing too is that brokers today, they're not young. The average age is 57 years old. So when you're getting paid, if I had to take a guess, four times your book of business, they were jumping all over that.

These are huge paths. But the rug with it is you've got to stay on and help make sure that business gets validated. And for some of them, they were willing to stay on and become an employee and then have a production requirement and then only a percentage of the new business sold. So most of them just went ahead and sold, stayed on, validated their contracts because they didn't get all that money upfront, right? It was a two-pronged approach, and then left.

I've been in the business for 20 years, I was a wholesaler. So I know a ton of these guys. And a lot of them really weren't happy about that changeover once they did it. One thing was said and then another thing transpired. There's a few of the firms out there that did it the right way, but there's a few out there that some of these folks went to that they just shake their head and go, should have never done that.

Tegus Client
So there are these group now that offer virtual primary care like Teladoc. There are groups that offer modern advanced direct primary care like One Medical. And they seem to have grown, TBD how much of that growth has been small business versus large business. If you're a broker advising a small business on their benefits, how would you or how has that market of advisory with these specific solutions evolved? Do they touch the brokers at all? Is it largely direct to the companies? What is your experience with these types of solutions and how they sell into small companies?

Former Broker Manager at Bright Health Group
So when these point solutions came out initially, they were add-ons. No real carrier in the marketplace had decided to go the virtual care route because of claims. They just had formulated how they were going to get in this world. They knew they needed to because they were losing claims, they were losing dollars, revenue.

So a lot of times in the beginning, seven years ago, they really started to take hold. You would go directly to one of those carriers. So Teladocs, the MDLIVEs of the world, 1-800-Medicine. HealthiestYou comes to mind. So you adjust on a per employee per month basis. You buy this for your employees, and you'd want them to go there because the small stuff, you want those claims off the books. Plus it will help with productivity.

You don't have to take a day off, take your child and see the doctor and then go get the script. You just visually have that type of a meeting. But then the carriers got smart, and then they either partnered with one of these carriers that you're speaking of or they just created their own. And so then what you have now is that it's all baked in. So it's part of the package, whether I buy it fully insured or level-funded or self-funded, I'm going to have a virtual care access for my employees for those small minor type of claims.

So there's not really a one-off anymore unless you're dealing in the bigger markets and you really trying to push more of that virtual primary care type of solution rather than just for the minor aches and pains. Instead of going to your PCP, you can just use the board-certified physician network of Teladoc to handle your skin lesion or handle your strep throat or handle your sinus infection.

Tegus Client
So, these point solutions would be sold as incremental cash outweighs directly paid by SMBs to offer as a benefit to their employees. Now because so many of these point solutions have partnered with payers, they are wrapped into the monthly level funded payments, which include the stop-loss premia from the carriers who have these who have these solutions in network.

Former Broker Manager at Bright Health Group
Yes. So they give you an either/or based on where you live. So they've really dived deeper into it because they don't want to miss those claims in that revenue.

Tegus Client
So the idea is they charge PEPM, just a Teladoc or a One Medical or Health E-Solutions. But the difference is you offer your employees a benefit, whereby they go to the clinic. And the paramedics and the nurses to take your readings and to check you in, are present physical. But the doctors who you see for, it could be anything. Could be just primary care, could be a specialist visit.

They teleconference into the room so that any physical limitations that would arise if you just did a Zoom call on your phone would be avoided because you have someone there taking measurements for the doctors directly. They can draw your blood, they can take your height and weight, whatever.

And then the doctor can consult with you virtually while you're sitting in the room. And so these guys are selling to brokers today. And so as someone that spent a lot of time in this channel, would love to know what else you would want to know or how you would think about this. Or is it just a nonstarter given what you've told us about the payer community adopting these point solutions?

Former Broker Manager at Bright Health Group
So this would be like a carrot or the stick mentality. You would still have access to whatever carrier you went with their network?

Tegus Client
Yes. If you were paying for a solution like a Teladoc, this replaces it. But for broader care delivery, you continue as you've informed us. You would continue with Cigna and Aetna?

Former Broker Manager at Bright Health Group
And then this would be for a play instead of being on, seeing your existing doctors or the doctor in the network. This would be more of a longer type of care visit, more empathy, more emotions, I guess, brought into instead of just being a number. Is that what I'm thinking as well too?

Tegus Client
I think for the initial use case, you can think of this as just going to a doctor for a checkup. It's literally just replacing a normal primary care visit that would sit in network with the Cigna or Aetna. But you're going to go to this. And from the patient's perspective, it's faster because it is tied up talking to multiple clients and shifting between offices because the doctors just Zooming in from wherever they're sitting.

And there won't be as many delays. But the real benefit is to the healthcare team because as I said, the doctor's time is made more efficient because they don't have to physically go between rooms. So the value proposition to the patient is just minimal waiting time. But other than that, it should be exactly the same as just going to the doctor.

Former Broker Manager at Bright Health Group
I would say just listening to that feedback, if patients don't have a primary care doctor already, and this was something for those that wanted something faster. I could see a play for that there. But I don't see the overall value in it if somebody already has a doctor and they're happy. They like going into a brick-and-mortar office there.

The only change I could see with it is if they weren't happy or they didn't have a doctor, this was a way for them to have one. Provides all the benefits, much faster turnaround time, relatively close to their house or the area that they're in, then I could see the value in that with the networks being as robust as they are. Unless it's sold in a really aggressive way, people are just going to go log in and utilize what's already available to them and go about it from that vantage point. I'm trying to see how to really put this into a solution in a small group, and it's not coming to mind that it would be really worth anything.

Tegus Client
The only scenario I could see is an A/B test. And I don't know if this is even possible. So I'd love to know if it's ever been tried or if you've ever heard of this. So if you had a business to keep the numbers within the 100 employees, today I went through my broker, I contracted with a TPA who was connected to Cigna, and my employees all have access to Cigna's local network in our city.

So I could see an instance in which if these guys are charging less PEPM because they think they can provide care more effectively than Cigna's network, then if it's cheaper for me as the business, I can say, you know what, let me try 25 employees with you. Especially because you can also do the specialist care. They should

cover just about everything. Emergency room, maybe not. Some of the more expensive claims, maybe not.

But they should cover vast preponderance of your canines. And so let me carve out 25 employees when open enrollment starts at the beginning of the year and scale back my Cigna exposure on my level funded plan to 75. And then maybe that's cheaper for me. I don't know if that's possible to segment your employee population in terms of coverage. I don't even know how you would do it. But have you ever heard of that offering different programs to different employees? Or is that just hare brained?

Former Broker Manager at Bright Health Group

No, it's not hare brained at all. I have seen different programs, different employees, but that's overall. This hourly group is going to have this plan, this salary group is going to have this type of plan. In terms of what you're referring to is it wouldn't be allowed because Cigna and the stop-loss carrier, particularly the TPA and the stop-loss carrier, they're going to assess the risk of the entire group with Cigna or Aetna as the network. So those 25 employees that you're saying will segment out and run everything through this virtual primary care.

The only way you're going to see the fruits of that is at the next renewal, should the group run well based on carving out 25 folks and saying, let's try to get you to go here, you don't have a primary care doctor, why don't you use these guys and let's see how it goes. You got to get them even to accept it because you can't force it. That's the only way I see that would work. They're still going to underwrite the entire risk of the group.

Tegus Client

So effectively, Cigna or Aetna isn't going to let you do that. If you want to do that, you're going to have to pay for both.

Former Broker Manager at Bright Health Group

Exactly. Even 51 plus, when you get out of small group reform and you're a large group, they're still going to do the same thing as far as assessing risk. It's just up to you to try to get them to go over there, kind of like that carrot and the stick mentality. Come up with some value proposition that makes sense saying, hey, if you go over here to this virtual primary care, you get these types of care faster, we'll spend more time with you.

You're not a number, you're not going to have to wait if the appointment's at 10:30. You don't get seen until 11:00. How many times does that happen, just to get it off the ground, that could work? But that's the only way I see it. And then not only that, but you're paying for it too. So you're paying the premium based on having that network and then you're also paying the additional PEPM for the virtual primary care. And then you'll still have baked in. You still have virtual care baked in because most carriers today in the TPA, they already have it included.

I don't think you can write it or not. You probably could. But most I've seen with level-funded, it's all baked in because it's all a package these days. But there might be some out there that you can just say, I don't want that virtual care or Teladoc. We're going to try something else on our own. They'll be able to take that up. They're still not going to have that big of a savings on the premium because it's such a small PEPM these days.

Tegus Client

So so these virtual care providers, like Teladoc, it's got hundreds of millions of revenue. They must just be indexed largely to much larger groups to enterprise clients. Because how could a business like that have grown if this is the dynamic in the small group market. They're never going to pay double unless you tell me differently. I can't see why a small business that's already getting squeezed on rising health costs, why they would choose to pay for both.

Former Broker Manager at Bright Health Group

So these are on a grander scale, so they only partner with the payer. So they're built in that way, so they get access to all the groups across the country. And then you're right, and they need bigger enterprise

corporations Teladocs are involved there, the MDLIVEs of the world. HealthiestYou is another one. So they'll contract directly at that point. So they're making it on a grander scale. The only way I see virtual primary care working like you're describing, and it has not taken off, and I don't see a lot of it, well, in my market.

So reference-based pricing takes into account Medicare as the baseline rate instead of working from a top-down approach like you do now, which takes into account MSRP. Think of Sears, when you have a discount from a carrier or a payer rather, you come in the network, we'll discount that 30%, 40%. And then here's your final number as far as your surgery goes or your MRI goes.

But that final number, especially with stuff done in the hospital, it's probably 200% to 600% of Medicare. So who cares what the discount is. That just touches the surface. So what happened here a couple of years ago is some of these TPAs got smart. They said, we're going to use Medicare as the baseline rate. We're going to go from a bottom-up approach.

And so we'll throw out 140% or 170%. If the hospital doesn't take it, they won't get our lawyers involved, then we'll go up to 200%. But they're still making money. So a lot of times, then what you can do is in Novant and CNC have caught on to that here. And they don't even play that because the member is still responsible for such claim. And if the hospital doesn't get what they want, they go after the members.

And then the members are in the middle while the lawyers talk. And then they go out to collections. It's just a bad play all the way around, and it just caused us a lot of stress. Where I see a virtual primary care model is envisioned with something like that, because you have some savings. You're still not really using a network per se. You're just offering up a discount. But then you could go and say, here's this virtual primary care. If you go here not only we'll pay for it, but you have no out-of-pocket cost at all.

That's negotiated then, when you do the contract. So there's a lot of moving parts. But you go here, you have no deductible, no out-of-pocket. They do all your virtual care stuff. They take all your blood work. And then if they do contract with a network instead of using the network, because you can still do that as well too. You can still have a Cigna or an Aetna involved.

So that's the care agnostic mentality. That's why I really see something like this really working. But until there's enough pain in the market, and plus everything is built in like we've talked about, I just don't see a fit for this.

Tegus Client
Perfect. Thank you for the time. Have a great day.
