BARRIERE CONSTRUCTION

Healthcare for Contractors

Lessons in Managing Risk and Cost

B MEETING OBJECTIVES

- Barriere Intro and Setting Stage
- Strategy #1: Foundation
- Strategy #2: Health Care Networks & Managed Care Evolution
- Strategy #3: Health Risk
- Summary & Open Discussion

B

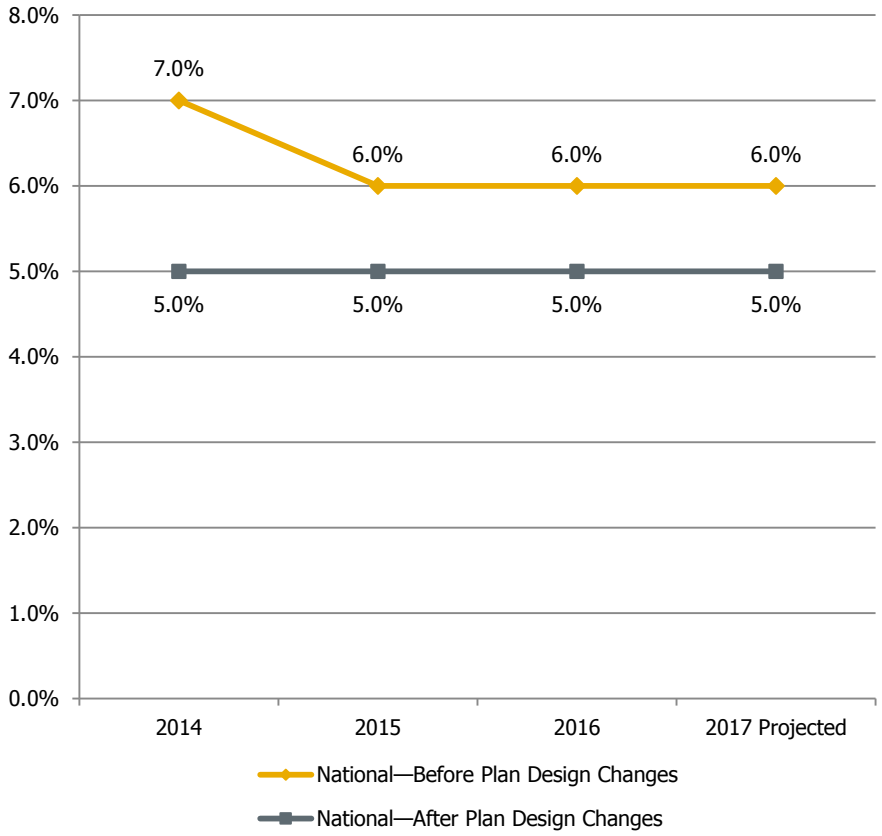
REGULATORY OUTLOOK

PPACA REMAINS

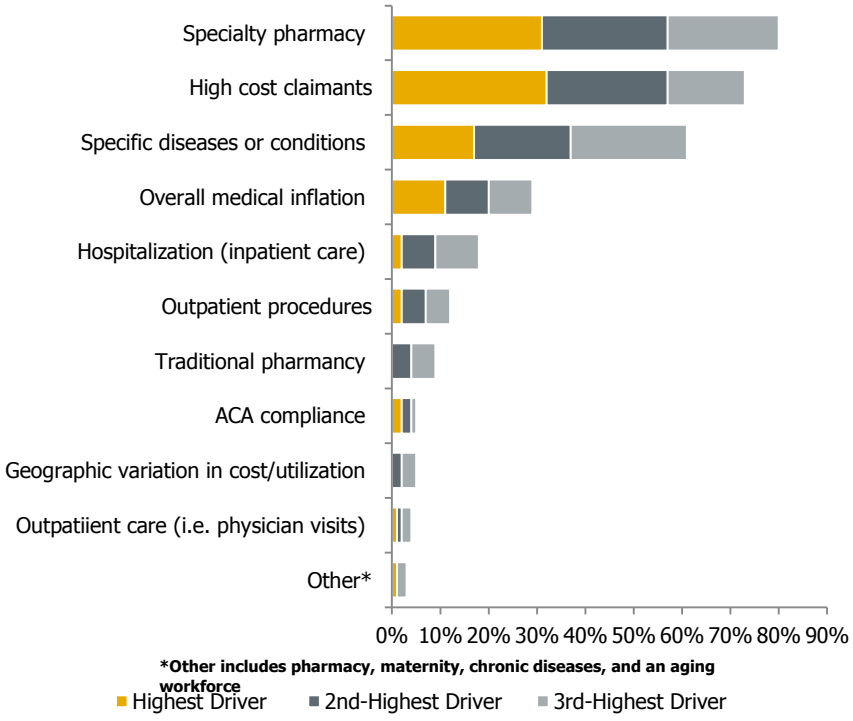
- The individual mandate continues
- No lifetime maximum continues
- The employer mandate continues
  - The parsing of FTEs and non-FTEs
  - Affordability issues, including safe harbor issues
  - Wellness credits, opt-out incentives, and effect on affordability
  - Employer reporting, all the coding and safe harbor rules
- Pass-through taxes on health insurers
- Benefit mandates
  - Waiting periods
  - Prohibition on dollar limits and pre-existing conditions
  - Adult children to age 26
  - Preventive care rule
  - Nondiscrimination rule
- Limits on health FSAs and reimbursement of OTC Rx
- Marketplace notices

MEDICAL TREND CONTINUES TO OUTPACE CPI

Medical/Rx Trend is Outpacing CPI by 2-3X



Top Cost Drivers of Rising Healthcare Costs



Source: National Business Group on Health 2017 Large Employer Health Plan Design Survey

TWO STRATEGIC AREAS OF FOCUS

SUPPLY SIDE

- Bricks and mortar
- Own the physicians (i.e. HMO)
- "Single Payer" systems
- Gatekeepers
- Specialty pre-certifications

DEMAND SIDE

- Wellness programs
- Disease management
- Some Preventative Medicine
- Second surgical opinion services
- Some Managed Care tools

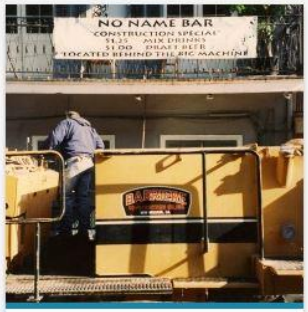
BARRIERE INTRO AND SETTING STAGE

BARRIERE CONSTRUCTION

BARRIERE CONSTRUCTION

HISTORY OF FAMILY

WE ARE A **FOURTH-GENERATION**, FAMILY-OWNED INDUSTRIAL, HIGHWAY AND CIVIL CONSTRUCTION, ASPHALT AND CONCRETE PAVING COMPANY.



1980s

BARRIERE THRIVES UNDER BETTY'S COMMITMENT TO SAFETY AND INTEGRITY. SERVICE EXPANDS INTO HIGHWAY AND HEAVY CIVIL CONSTRUCTION.

1989

GEORGE H. WILSON JR. BECOMES CHAIRMAN AND CHIEF EXECUTIVE OFFICER.

1990s

BARRIERE CELEBRATES 50 YEARS OF OPERATION. THE 3 WILSON BROTHERS – GEORGE, PETER AND BERT – TAKE OVER DAY-TO-DAY MANAGEMENT OF THE COMPANY.

1998

BARRIERE OPENS ASPHALT PLANT IN BOUTTE, LA.

2000s

BARRIERE COMPLETES LARGER-SCALE INFRASTRUCTURE PROJECTS THAT INCLUDE BOX CULVERTS, CURB & GUTTER, DRAINAGE, AND MORE.

2001

BARRIERE OPENS ASPHALT PLANT IN FRANKLINTON, LA.

2005

HURRICANE KATRINA DEVASTATES LOUISIANA'S GULF COAST.

2009

GENERATION 4 WILSON FAMILY MEMBERS BEGAN WORKING AT BARRIERE.

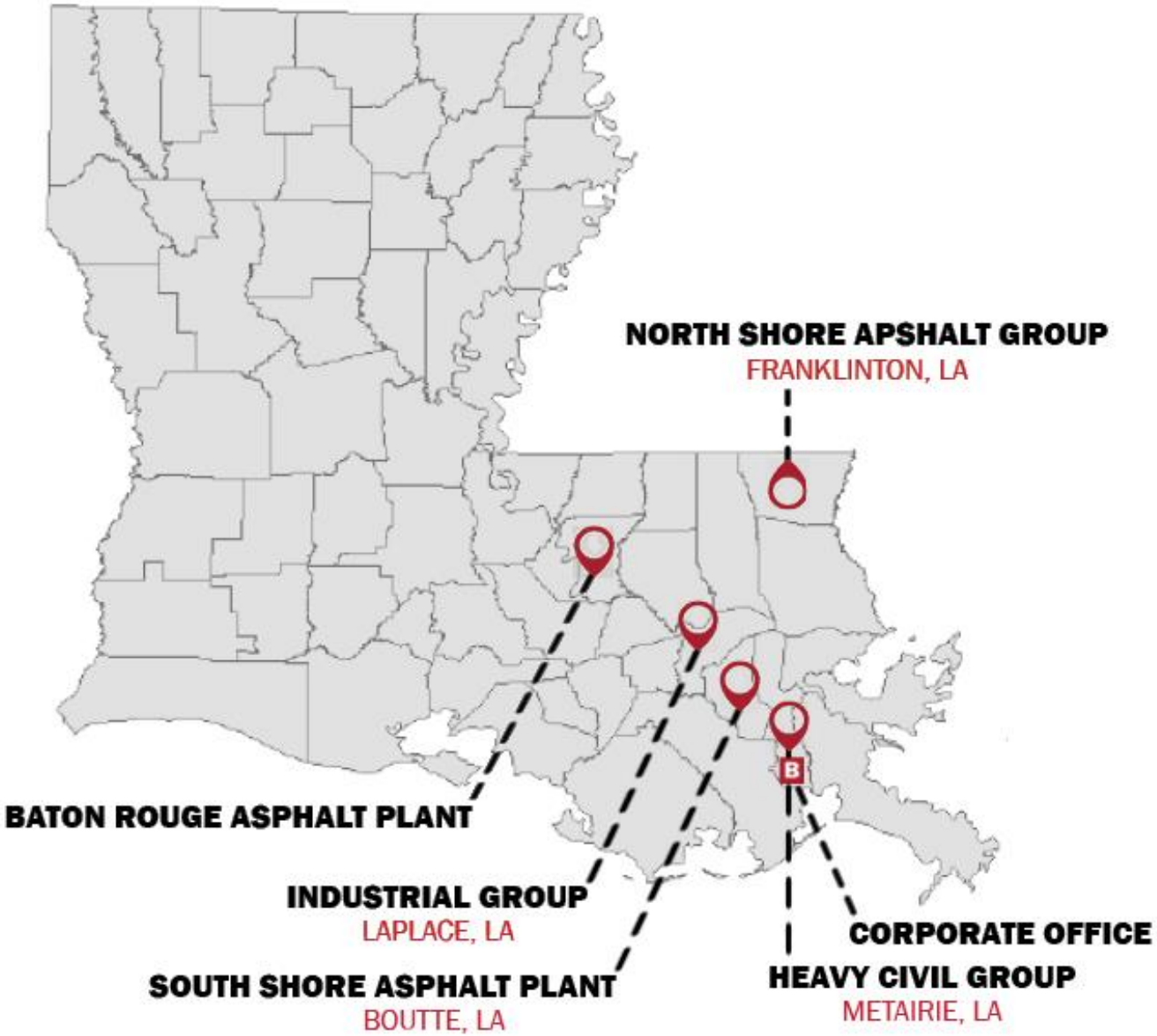
2016

PETER A. WILSON BECOMES PRESIDENT AND CEO OF BARRIERE. GEORGE H. WILSON, JR. TRANSITIONS TO CHAIRMAN OF THE BOARD AND BERT A. WILSON BECOMES PRESIDENT OF ASPHALT AND MATERIALS.

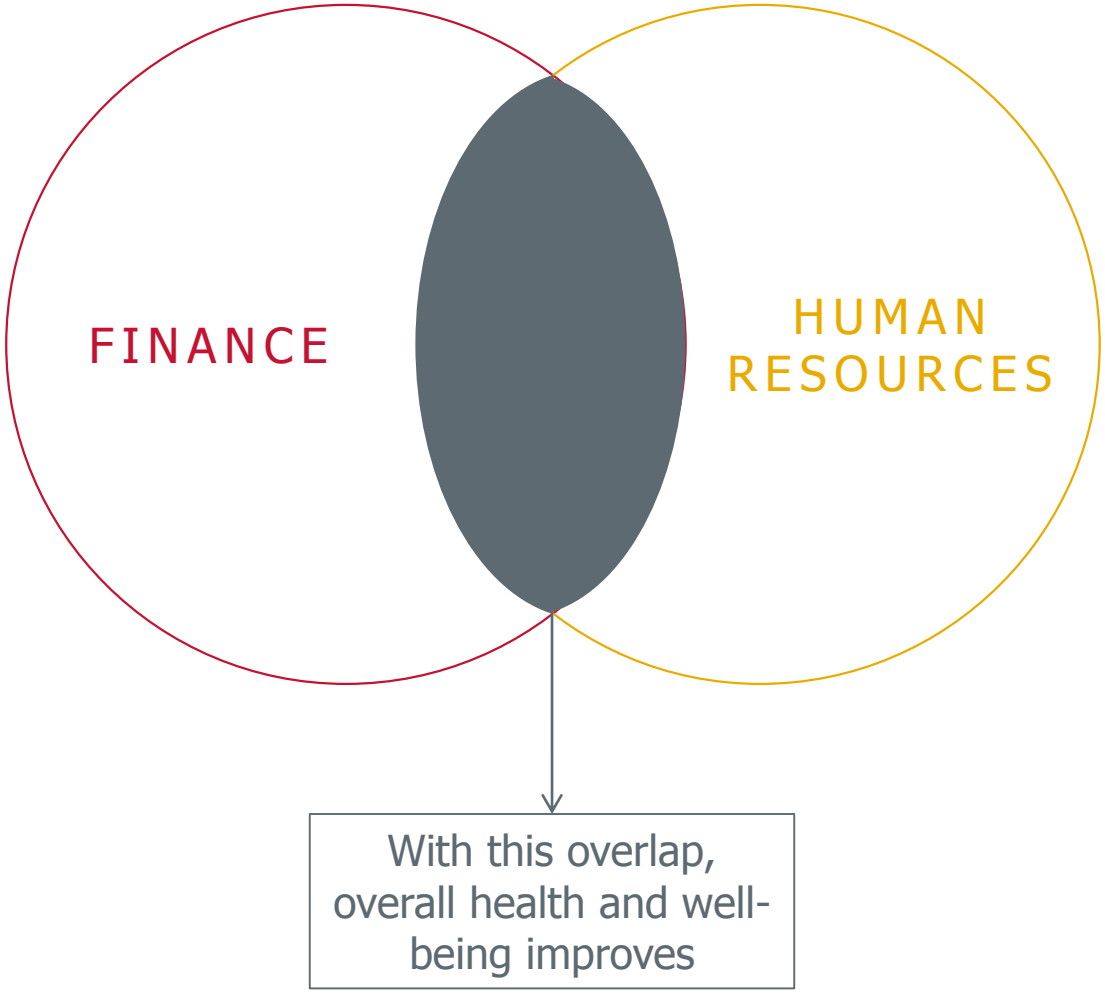
2016

BARRIERE OPENS THEIR THIRD ASPHALT PLANT IN BATON ROUGE.

BARRIERE'S LOCATIONS



B HOW HR AND FINANCE MEET IN THE MIDDLE



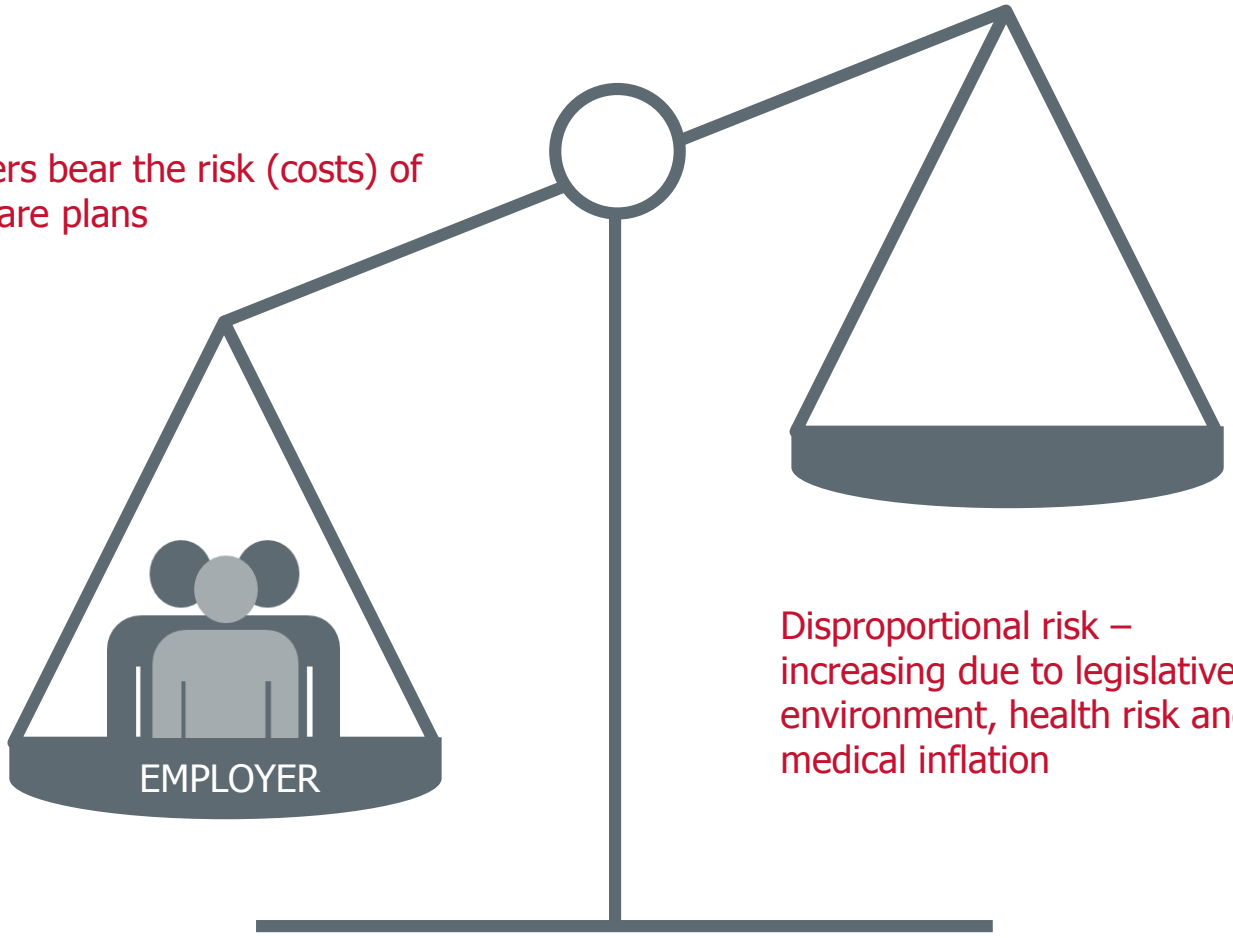
STRATEGY #1: FOUNDATION

RISK MANAGEMENT/RETENTION

BARRIERE CONSTRUCTION

B CONTRACTOR RISK

Employers bear the risk (costs) of health care plans

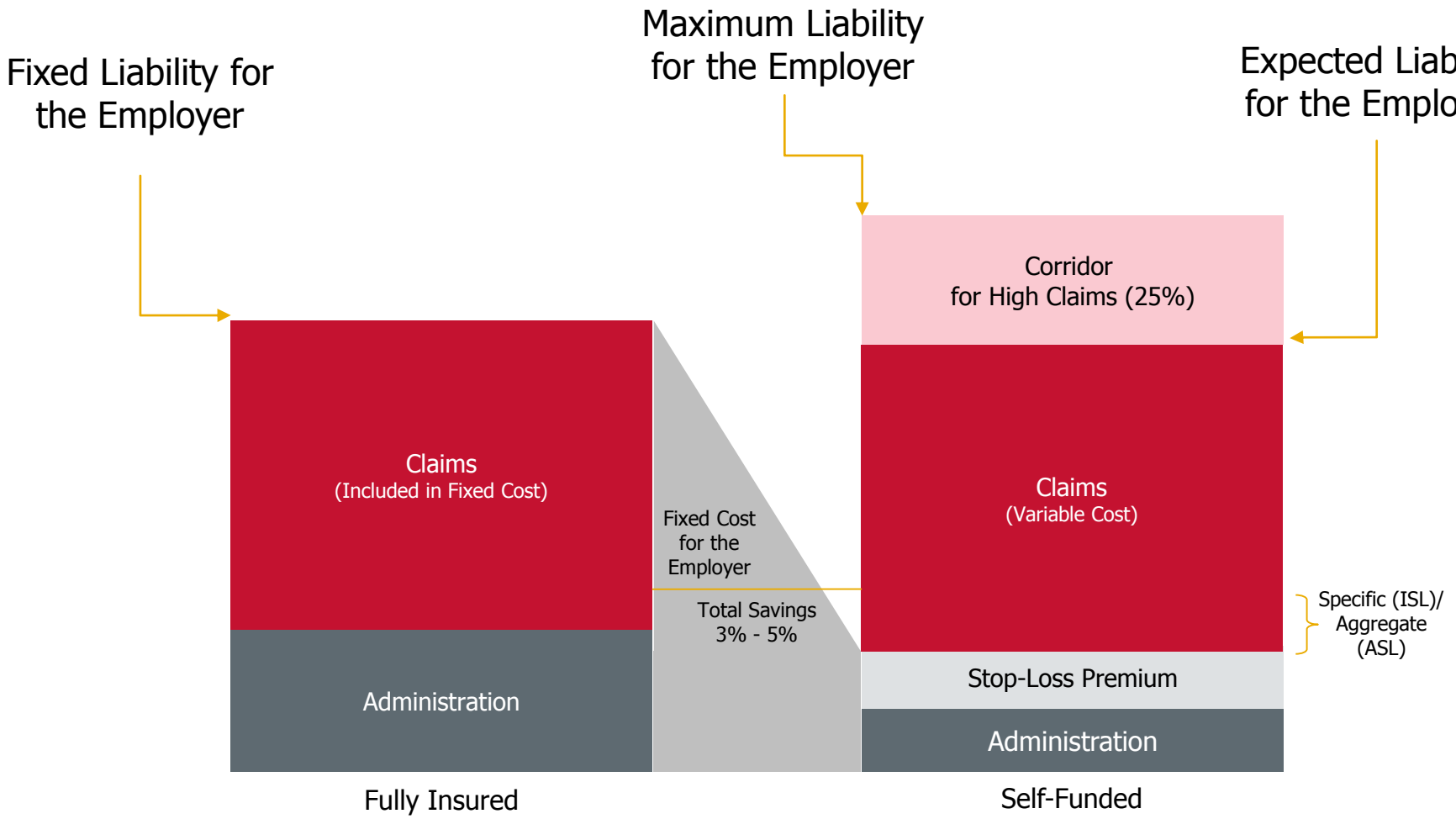


Disproportional risk – increasing due to legislative environment, health risk and medical inflation

B

RISK RETENTION VS. TRANSFER

FULLY INSURED VS. SELF-FUNDED



B STOP LOSS/RISK MANAGEMENT MARKET OVERVIEW

STATE OF THE 2016 MARKET

18%

Claims over $500K*

from 2014 - 2015

Severity and Frequency of Catastrophic Claims Continue To Increase**

- The two most common million-dollar claimant conditions were:
  - **Premature infant and live born complications**
  - **Cancers**
- Just 1.7% of claimants produced claims over $1 million, but those claimants accounted for a disproportionate 18.5% of the overall stop-loss claims reimbursements.

EMPLOYER RISK TRANSFER TRENDS

Employer Groups are evaluating risk transfer thresholds, but less than 20% of Plan Sponsors are taking on additional risk through plan design changes at renewal (Source: 2017 Lockton Book of Business)

Alternative ways to transfer risk, such as captive arrangements, are being discussed, but self-funding with traditional stop loss coverage remains the most prevalent approach to transferring risk for Plan Sponsors

Large employers who have previously declined stop loss coverage have been evaluating coverage at $750K or higher specific deductible thresholds

*Based on Lockton InfoLock reporting
**Statistics provided from 2016 Sun Life Top Ten Catastrophic Claims Report

B RISK MANAGEMENT OPTIONS

HOW HR AND CFOs MEET IN MIDDLE

TYPES OF STOP-LOSS FOR VARIOUS SIZE EMPLOYER GROUPS

<200

- Specific—Yes
- Aggregate—Yes
- Captive - Yes

200-999

- Specific—Yes
- Aggregate—Maybe
- Captive - Maybe

1,000+

- Specific—Yes
- Aggregate—No
- Captive - No

CONTRACT TERMS TO REVIEW

- Laser
- Run-in limit
- Run-out limit
- Disclosure required
- Mirroring
- Firm/illustrative
- Advance-funding accommodation
- Centers of excellence discount/requirement
- Independent review appeal exclusion

➔ WHY IT MATTERS/KEY CONSIDERATIONS

When self-funded, stop-loss insurance is a critical part of the employer's risk management strategy. It protects employers from unpredictable and catastrophic risks.

Better pricing may be achieved through a coalition/captive arrangement. Know what you are getting yourself into.

Understand the contract terms. Stop-loss contracts may include certain gaps that can result in significant exposure for an employer.

STRATEGY # 1 SUMMARY

- Questions to take to your CFO
  - How do we assess the financial performance of our plan?

- Key points
  - There are "half – steps" to self-funding platform that allow for much of the upside, with limited volatility
  - Know where your risk is.
  - The line for "fully insured" as only option has moved for mid-sized firms

STRATEGY #2: HEALTH CARE NETWORKS & MANAGED CARE EVOLUTION

BARRIERE CONSTRUCTION

EVOLUTION OF THE HEALTH CARE NETWORK

1920s

ROOTS OF MANAGED CARE AND "NETWORKS"

Baylor Hospital in Texas offers comprehensive coverage for fixed premium

B EVOLUTION OF THE HEALTH CARE NETWORK

1920s

1970s

HMOs BEGIN TO TAKE ROLE IN HEALTH CARE FINANCING

- Favorable legislative climate fuels growth in the 1980's
- The term "in network" becomes synonymous with "good"

B EVOLUTION OF THE HEALTH CARE NETWORK

1920s 1970s 1990s

HMO BACKLASH HAD BEGUN

Viewed as too restrictive in both access to care and size of networks

B EVOLUTION OF THE HEALTH CARE NETWORK

1920s 1970s 1990s 2000s

PPO AND POS PLANS EMERGE TO FILL THE VOID – AND EMPLOYEES OPT OUT OF HMOs

- Wider networks and unfettered access to care – at what cost
- The PPO model is seemingly undermining some of the principles of managed care
  - Unfettered access to care
  - Marketed based on size and inclusion of docs/facilities in network
  - Begs question: Is it really a network if 95% of all available hospital beds and 85% of all physicians are considered "in"? Or is it just a retail price with 3rd party financing?

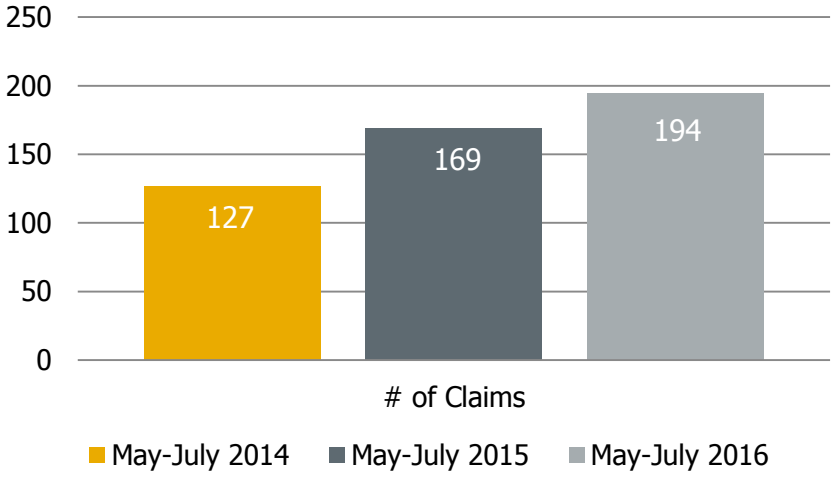
BARRIERE NETWORK EVALUATION

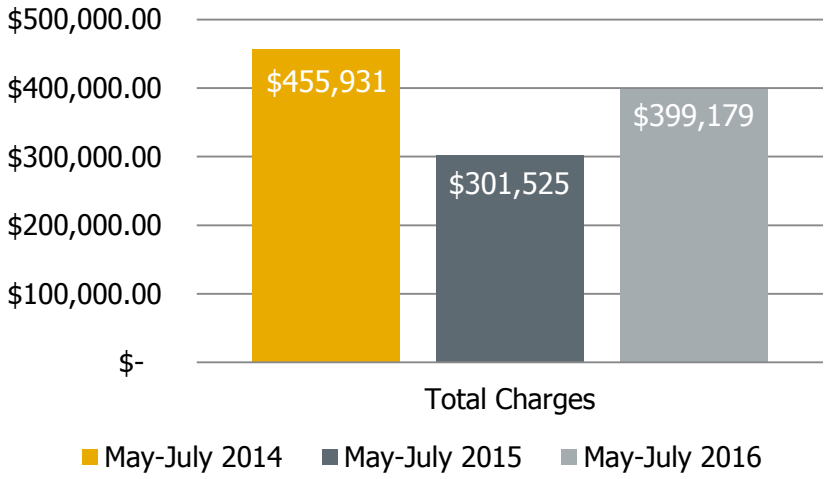
SELF REPORTED						
IN-NETWORK	BARRIERE UTILIZATION	PPOPLUS NETWORK AVG SAVINGS	BCBSLA	CIGNA	VERITY/HCH	UNITEDHEALTHCARE - CHOICE PLUS
Inpatient	35%	59%	57%	57%	58%	62%
Outpatient	43%	51%	68%	57%	57%	67%
Physician	22%	47%	56%	57%	45%	57%
Inpatient		$1,076,250	$1,131,375	$1,131,375	$1,102,500	$1,008,000
Outpatient		$1,580,250	$1,035,225	$1,399,650	$1,386,750	$1,061,025
Physician		$874,500	$719,400	$709,500	$907,500	$709,500
Total $		**$3,531,000**	**$2,886,000**	**$3,240,525**	**$3,396,750**	**$2,778,525**

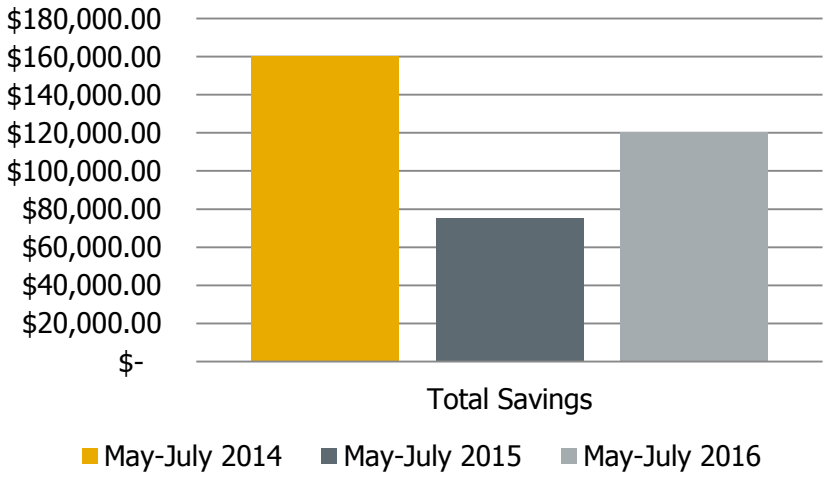
LOCKTON DISCOUNT TOOL						
IN-NETWORK	BARRIERE UTILIZATION	PPOPLUS NETWORK AVG SAVINGS	BCBSLA	CIGNA		UNITEDHEALTHCARE - CHOICE PLUS
Inpatient	35%	59%	59%	54%		59%
Outpatient	43%	51%	68%	53%		66%
Physician	22%	47%	54%	54%		55%
Inpatient		$1,076,250	$1,076,250	$1,207,500		$1,076,250
Outpatient		$1,580,250	$1,032,000	$1,515,750		$1,096,500
Physician		$874,500	$759,000	$759,000		$742,500
Total $		**$3,531,000**	**$2,867,250**	**$3,482,250**		**$2,915,250**
	$ Savings		**$663,750**	**$48,750**	**$134,250**	**$615,750**
	% Savings		**19%**	**1%**	**4%**	**17%**

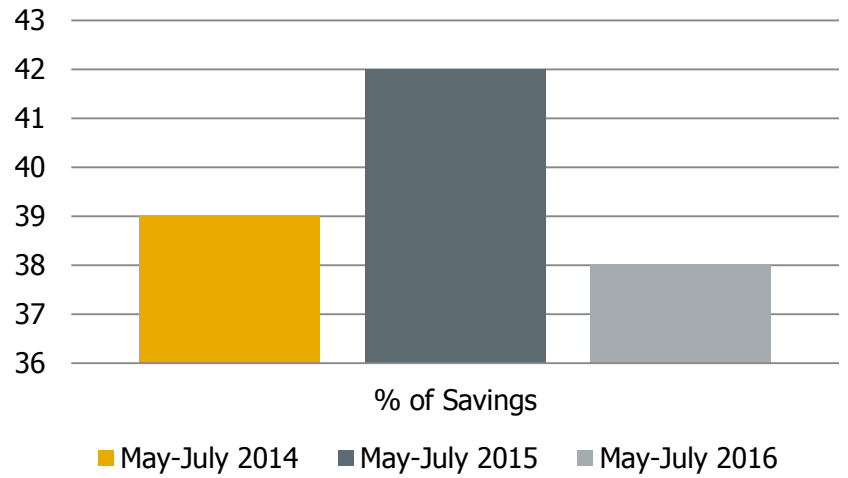
Total dollars based on 12 months Barriere Construction utilization

B OUTPATIENT HOSPITAL









B OUTPATIENT HOSPITAL

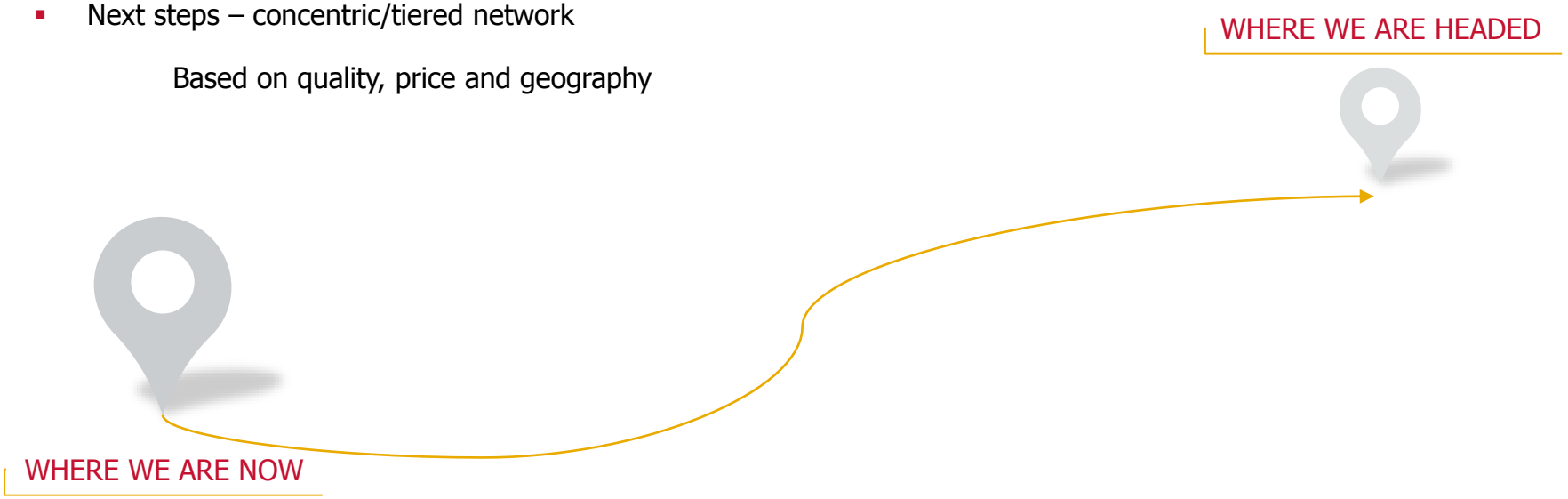
PROVIDER NAME	TOTAL SUBMITTED CHARGES	TOTAL SAVINGS
Ochsner Medical Center	$150,000	35%
Saint Tammany Parish Hospital	$25,695	50%
Riverside Medical Center	$20,551	32%
West Jefferson Medical Center	$18,708	41%
East Jefferson Medical	$15,789	58%
Children's Hospital	$10,055	39%
North Oaks Medical Center	$7,460	28%
Lakeview Regional Medical Center	$7,025	35%
St. Charles Parish Hospital	$3,985	31%
Slidell Memorial Hospital	$2,634	82%

B THE ROAD AHEAD – AND WHY

NETWORK AND PROCEDURE COST COMPARISONS

- Network move – from "local" to "national TPA"
- Next steps – concentric/tiered network

  Based on quality, price and geography



STRATEGY #2 SUMMARY

- Questions to take to your CFO
  - What savings would be reasonable (15% of premium?) for a 30% or 40% smaller network?
  - What are we willing to sacrifice for the savings of "X"?

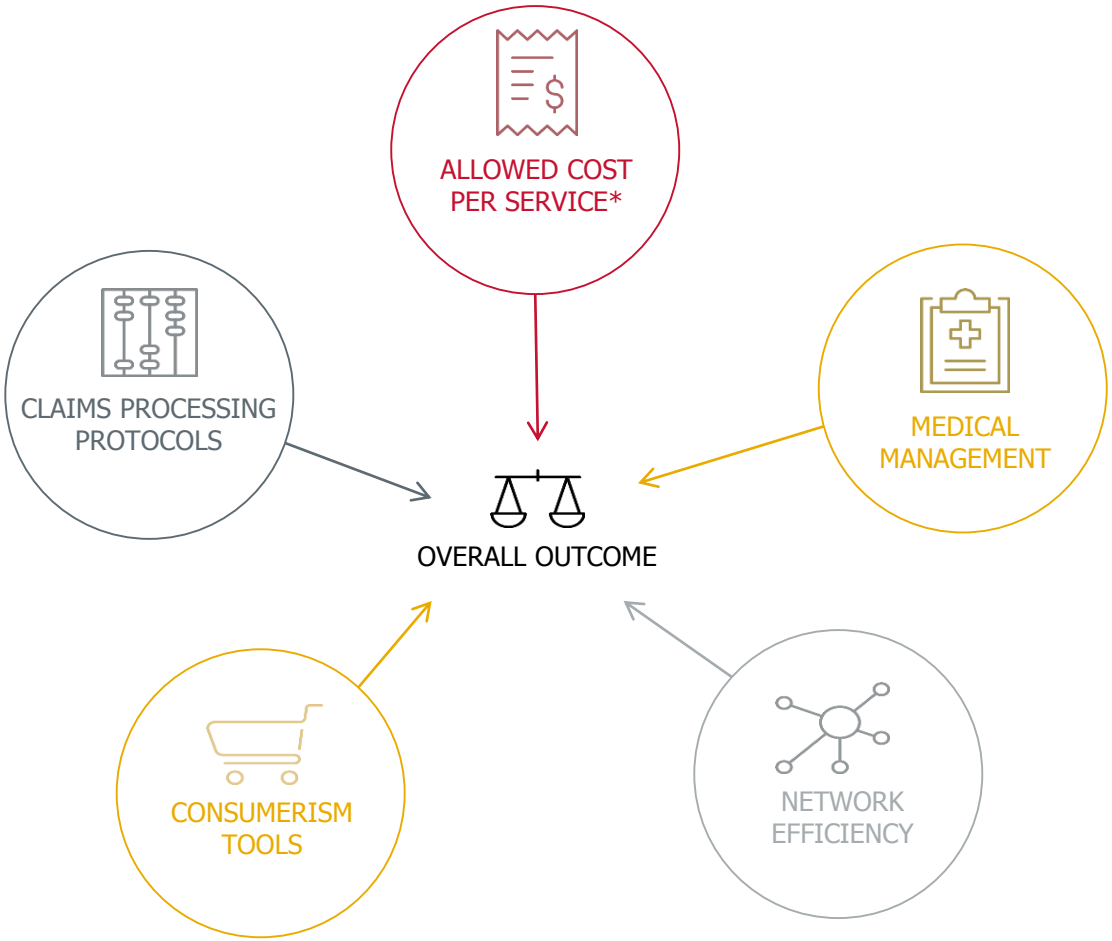
- Key takeaways
  - Know your network.
  - Know where your is "leverage" point is in the network.
  - Ask the carrier/TPA for the options – they rarely bring them up on their own.

SUPPLY SIDE – WHERE IS IT HEADED?

BARRIERE CONSTRUCTION

B TOTAL COST OF CARE

WHERE WE ARE HEADED



Total Cost of Care standardizes evaluation criteria and makes comparing networks easier to understand, allowing companies to see what is driving the base unit cost values.

* Discounts are the only focus here and do not get to a cost per service – only a discount off billed.

B THE ANALYSIS CAN'T STOP AT THE DISCOUNTS

TRADITIONAL DISCOUNTS

	HOSPITAL A	HOSPITAL B
Retail Price	$4,100	$3,200
Discount	60%	50%
Net Paid Per Day	$2,460	$1,600

MORE MUST BE CONSIDERED

	HOSPITAL A	HOSPITAL B
Admits Per/1000	65	50
Average Length of Stay	4.0	4.6
Actual Cost	$639,000	$368,000

B TOTAL COST OF CARE
POTENTIAL GAME CHANGER

OLD WORLD DISCOUNT COMPARISON

Allowed/ Billed -1

A

50M/110M-1 =
55% discount
1.00 med decrement

B

100M/200M =
50% discount
1.11 med decrement

Carrier A has a better risk than the norm so have to increase it to the norm of 1.0

A WINS DISCOUNT GAME

TOTAL COST OF CARE CALCULATION

Allowed/MM * Risk Adj^

A

50M/155k mm =
$323PMPM
* 1.10RA

=$355PMPM
1.00 med decrement

B

100M/300k mm =
$333PMPM
* 0.97RA

= $323PMPM
0.91 med decrement

B WINS LOWEST-COST GAME

^Technically, this is: Allowed/MM*Risk Adjustment + Capitation/MM

STRATEGY #3: HEALTH RISK

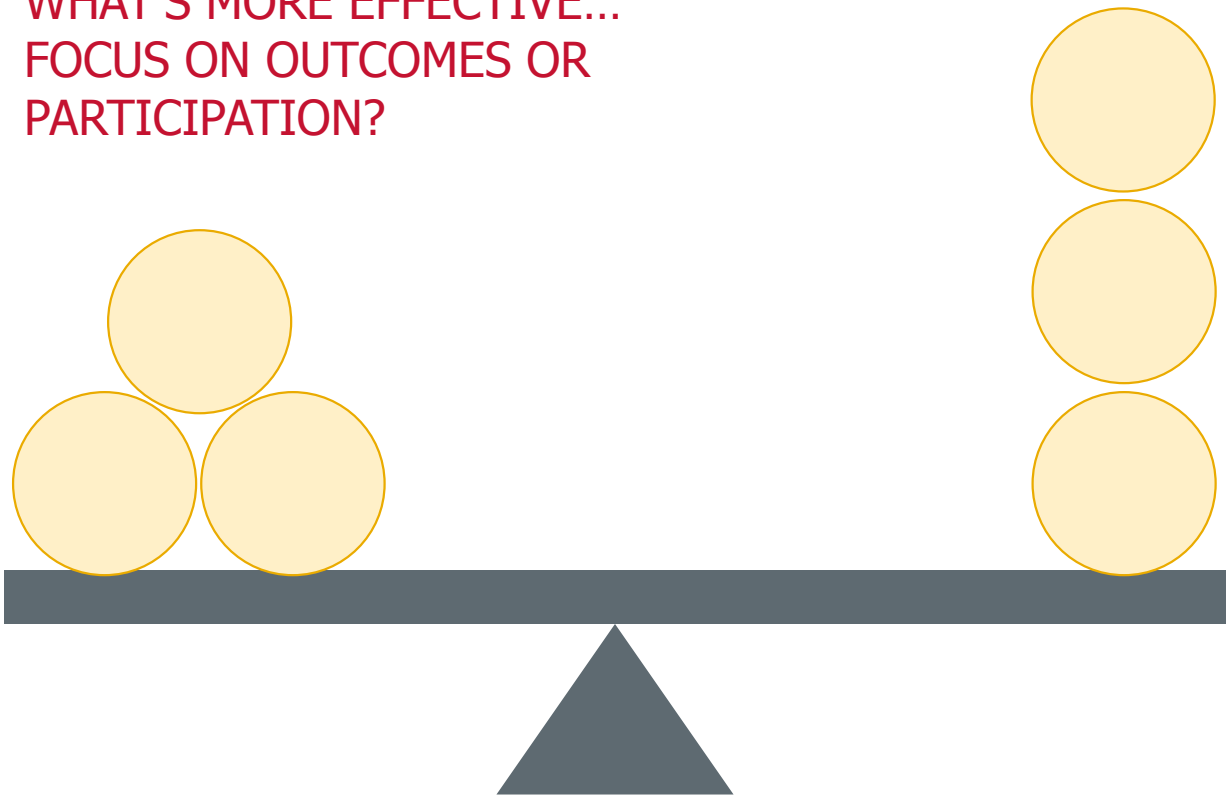
BARRIERE CONSTRUCTION

B COMPLEX PROBLEM

COMPLEX FACTORS IMPACT MEMBER HEALTH AND WELLNESS CHOICES. WHAT CAN BARRIERE INFLUENCE?

HEALTH RISK & CONTRACTORS – DOES IT MATTER?

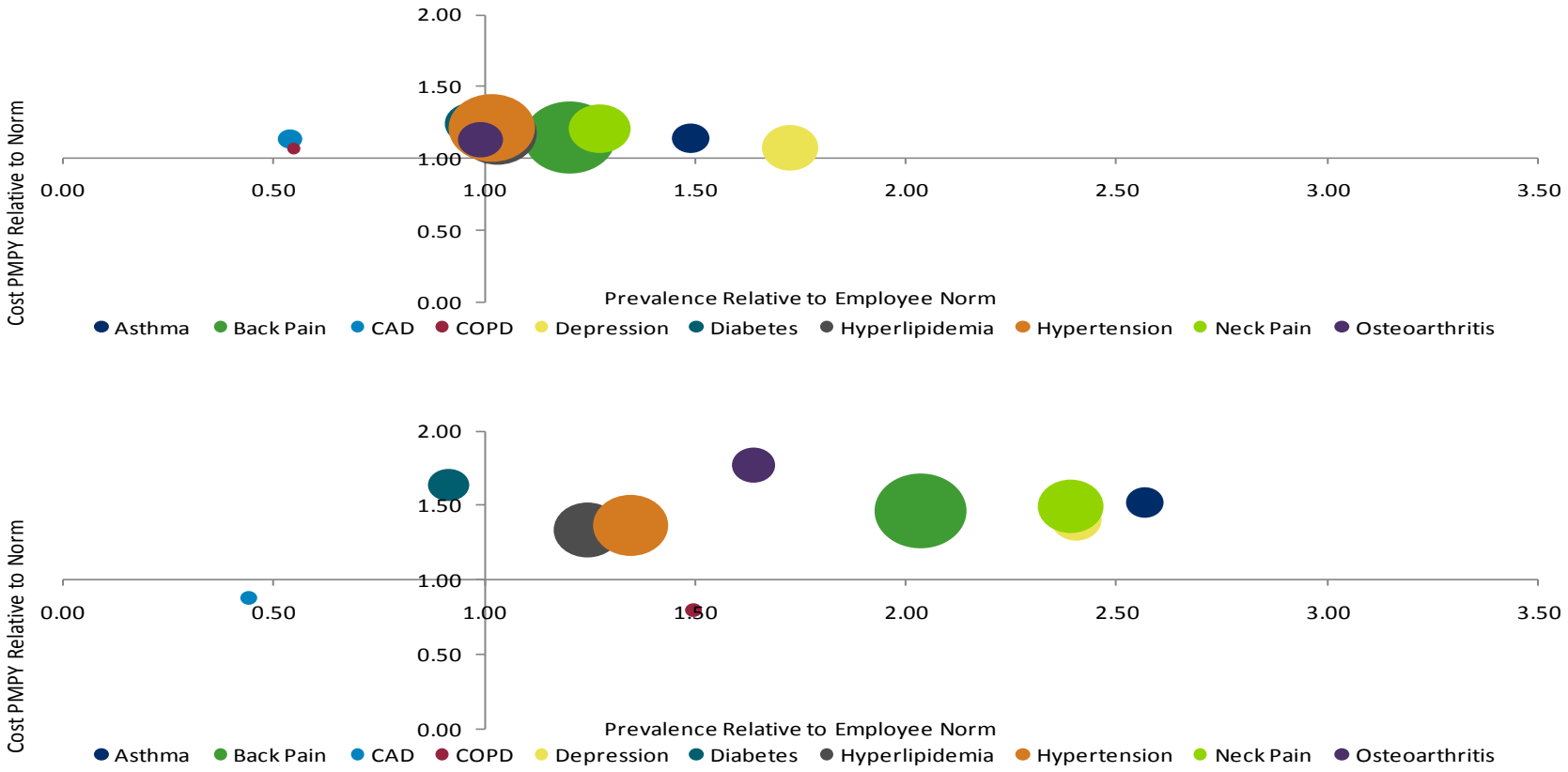
WHAT'S MORE EFFECTIVE…
FOCUS ON OUTCOMES OR
PARTICIPATION?



B WELLNESS FOR CONTRACTORS

Incentive	Employee Engagement How are you driving participation?	Disincentive
No	Tie to Employee Contributions Are you linking to your health plan?	Yes
<10% of the cost of the health plan	Incentive/Disincentive How large is your incentive/disincentive?	>10% of the cost of the health plan
Participation	Participation/Outcomes How are you measuring success?	Achieving healthier outcomes

B MULTIPLIER OF COST AND RISK FOR CONTRACTORS



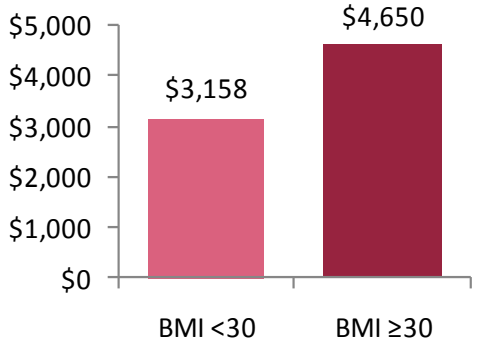
Size of bubble is based on number of employees within population. Employee Norm from Lockton InfoLock® Book of Business. Chronic Conditions based on full cycle period.

B MULTIPLIER OF COST AND RISK FOR CONTRACTORS

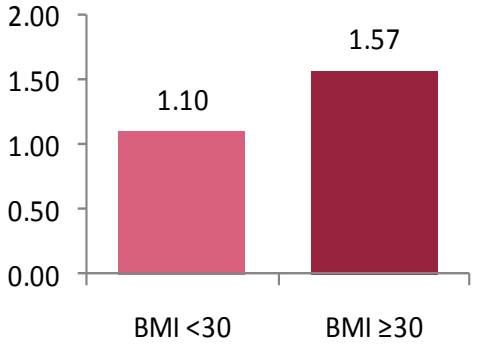
72% of enrolled employees have self-reported BMI data available

29.6% of those have BMI greater than or equal to 30

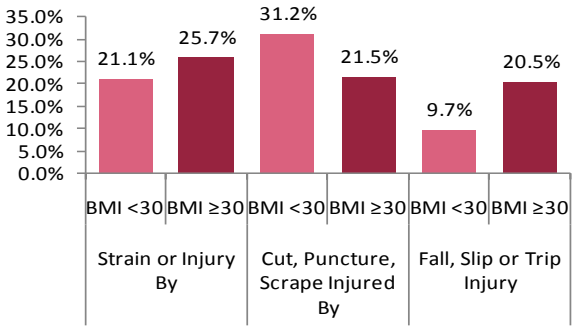
Paid Medical and Rx PMPY



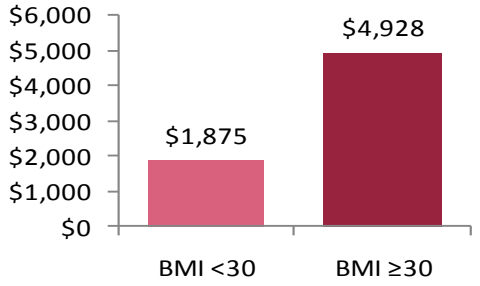
Avg RRS



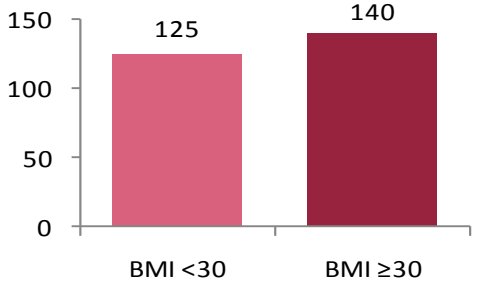
Top Causes of WC Injury



Avg Cost per WC Claim



Avg Duration per WC Claim

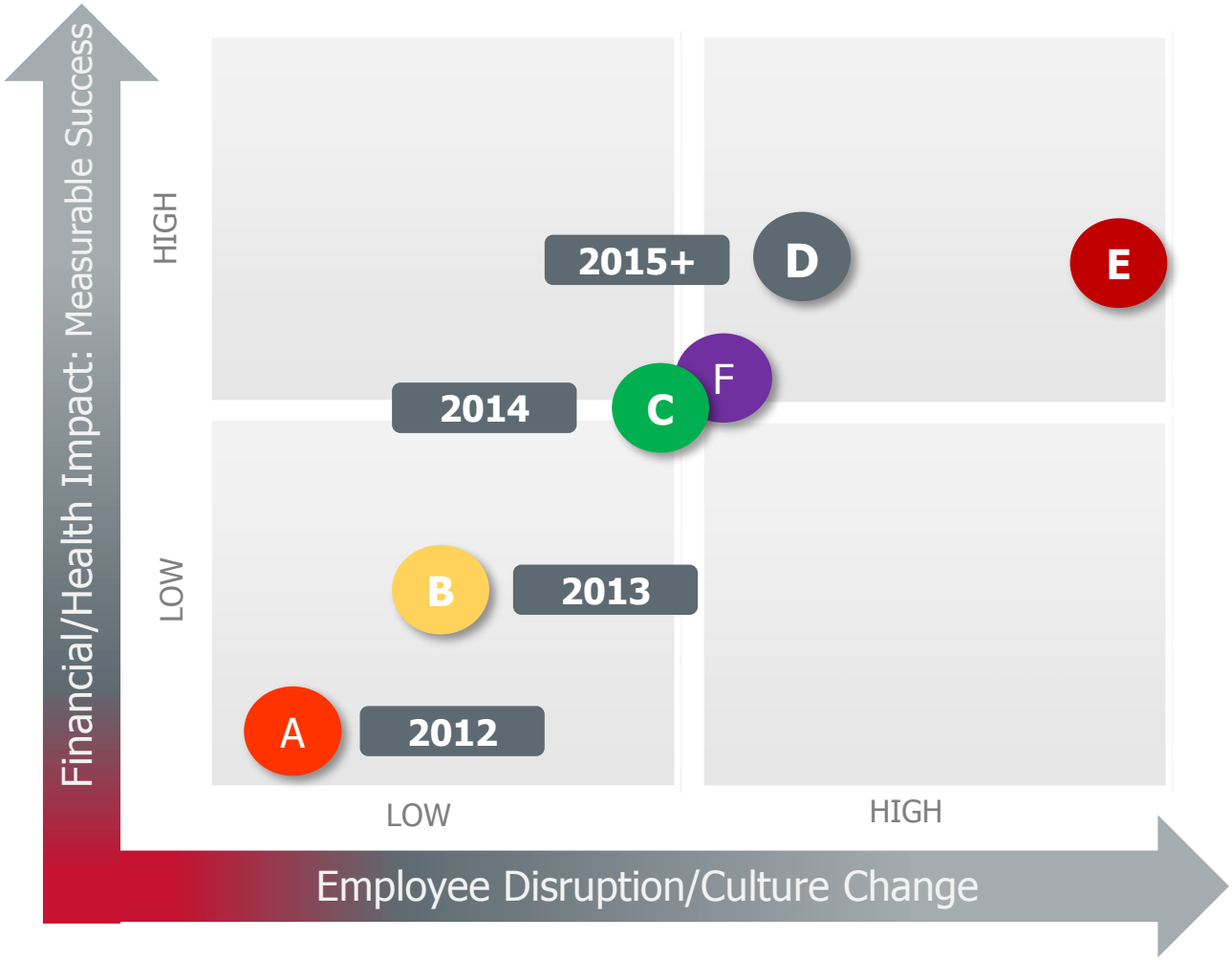


B WELLNESS PROGRAM UNIVERSE

PROGRAM TYPES AND IMPACT

Wellness Program Options

A. 2011 Barriere program
B. Moderate program
C. Hybrid program
D. Barriere's current program
E. "Scotts" type program
F. Manufacturuing industry benchmark



B INCENTIVE DESIGN

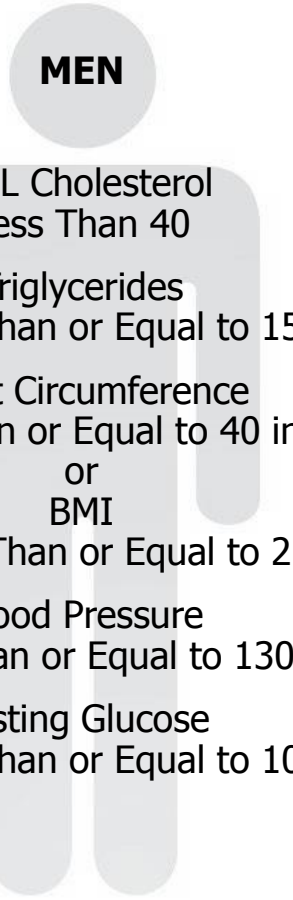
Health & Wellness Plan	2017	2018
Incentive Program Open	December 15, 2016	September 1, 2017
Incentive Deadline	March 25, 2017	March 13, 2018
Incentive Effective	May 1, 2017	May 1, 2018
Level 3 Non-Wellness* Participant	<20 Points	<40 Points
Level 2 Wellness* Participant	20-49 Points	40-69 Points
Level 1 Wellness* Champion	50+ Points	70+ Points
Lab Work & Biometrics †	20 Points	20 Points
Annual Wellness Exam † Sterling to monitor insurance claims data ‡	N/A	20 Points Visit to take place May 1, 2017 – March 13, 2018
Wellness Outcomes	10 Points/Outcome or 10% Improvement ▪ Blood Pressure <130/85 mmHg ▪ HDL Men >40mg/dL; Women >50 mg/dL ▪ Triglycerides <150 mg/dL ▪ Glucose <100 mg/dL ▪ Waist Circumference Men ≤40”; Women ≤35”	10 Points/Outcome or 10% Improvement • Blood Pressure <130/85 mmHg • HDL Men >40/mg/dL; Women >50 mg/dL • Triglycerides <150 mg/dL • Glucose <100 mg/dL • Waist Circumference Men ≤40”; Women ≤35”
Tobacco Surcharge $50 monthly/EE and SP	Electronic Affidavit *Alternative: Nicotine Cessation eCourse*	Electronic Affidavit *Alternative: Nicotine Cessation with Sterling Health Coach or eCourse provided in Health Park*

* Tier Achievement is contingent upon spouse participation.
† Component is a required activity of program year.
‡ Visits that take place within 45 days of the wellness incentive deadline may require additional documentation

WHAT BARRIERE MEASURES

BARRIERE CONSTRUCTION

METABOLIC SYNDROME RISK FACTORS



MEN

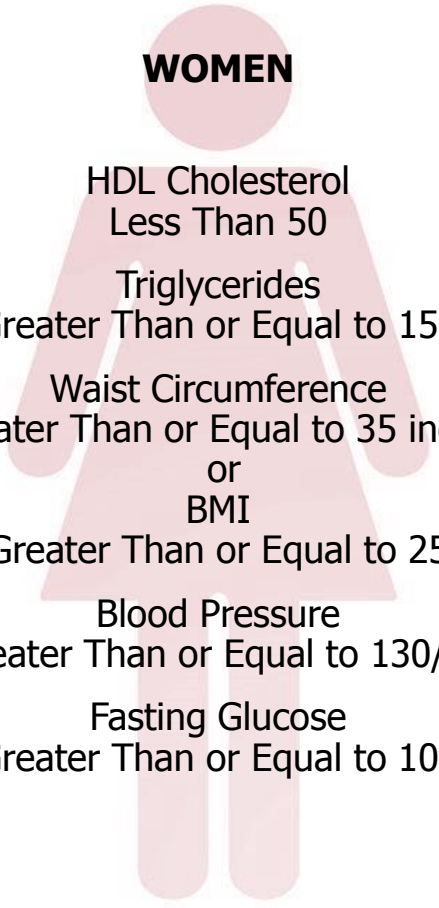
HDL Cholesterol
Less Than 40

Triglycerides
Greater Than or Equal to 150

Waist Circumference
Greater Than or Equal to 40 inches
or
BMI
Greater Than or Equal to 25

Blood Pressure
Greater Than or Equal to 130/85

Fasting Glucose
Greater Than or Equal to 100



WOMEN

HDL Cholesterol
Less Than 50

Triglycerides
Greater Than or Equal to 150

Waist Circumference
Greater Than or Equal to 35 inches
or
BMI
Greater Than or Equal to 25

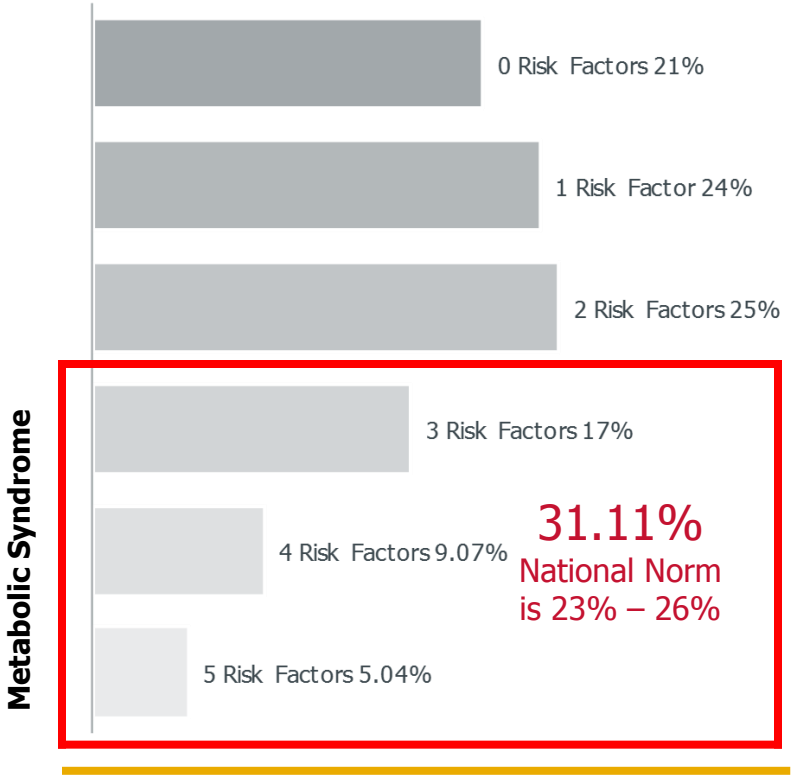
Blood Pressure
Greater Than or Equal to 130/85

Fasting Glucose
Greater Than or Equal to 100

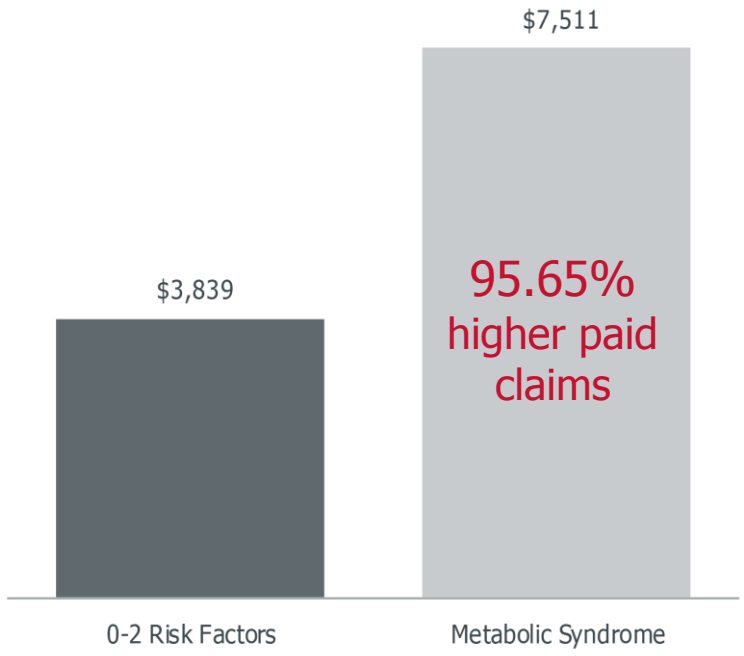
Source: National Heart Lung and Blood Institute and National Institutes of Health

B BIOMETRIC RISK FACTORS PER MEMBER

NUMBER OF BIOMETRIC RISK FACTORS PER MEMBER



PLAN PAID PMPY

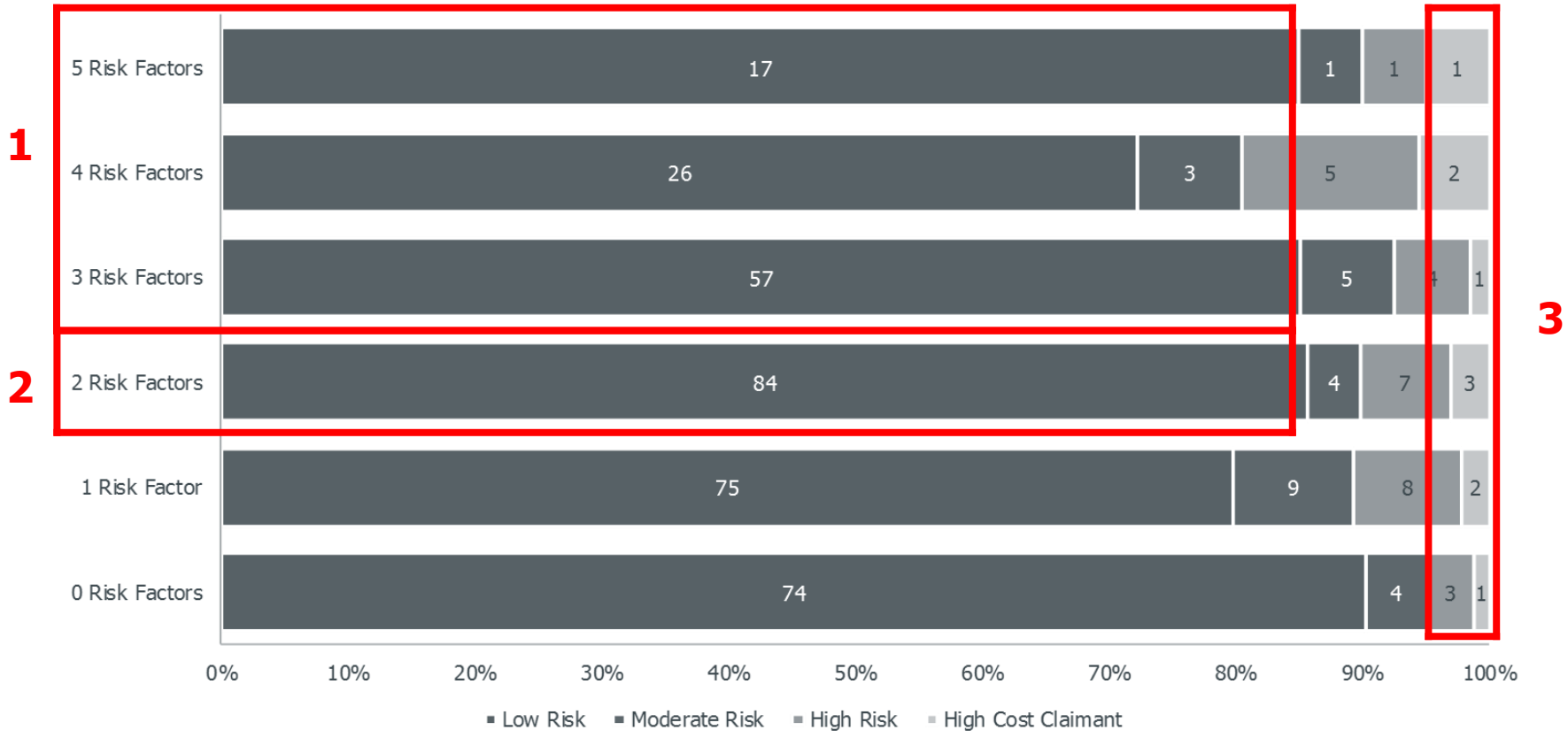


METABOLIC SYNDROME

Metabolic syndrome is a name for a group of biometric risk factors that occur together and increase the risk for coronary artery disease, stroke, and type 2 diabetes. In this report, metabolic syndrome is defined as members with three or more biometric risk factors.

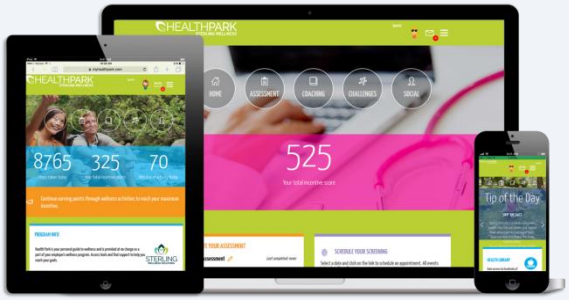
B BIOMETRIC RISK FACTORS AND CLAIMS-BASED RISK PER MEMBER

CLAIMS-BASED RISK CATEGORIES BY NUMBER OF BIOMETRIC RISK FACTORS PER MEMBER



1. 100 members have metabolic syndrome, but have been identified as low risk from claims. Target this population with preventive care and pre-diabetes programs.
2. This group has both low metabolic risk and low claims risk. 84 members have two metabolic risks and may potentially migrate to metabolic syndrome without some targeted intervention. Last year, 26% of those with 2 risk factors migrated to Metabolic Syndrome.
3. Coordination with disease or case management to ensure proper focus on care is occurring.

HEALTHPARK
STERLING WELLNESS



Get started in Health Park.

Do Wellness. Anytime, Anyplace.
With full mobile access you can log on to your wellness portal day or night. Track incentive progress, participate in challenges, connect with buddies—the possibilities are endless! Search Health Park in your app store or log on today to get started:

www.MyHealthPark.com

Your Member ID is your BAR + the last six digits of your SSN. Spouses use BARSP + the last six digits of the employee's SSN.
Registering for the first time? Click 'New User.'

Connect with your Health Coach

Angela Hertz, RN, CWC
Primary Care Nurse
Email: Ahertz@sterling-wellness.com
Phone: 225.218.3737
Office: Galleria

Your Sterling Wellness Health Coach is available to help you stay motivated and set attainable health goals to improve your well-being. Visit the Coaching page on MyHealthPark.com or call 225.218.3737 to connect with Angela today!

COACHING
- √Tip of the Day
- √Health eCourses
- √Connect with a Coach
- √Health Library

CHALLENGES
- √Track Healthy Habits
- √Participate in Challenges
- √Sync a Fitness Device

SOCIAL
- √Connect with a Buddy
- √Share Testimonials
- √Event Calendar

HOME
- √Program Overview
- √Incentive Points
- √Incentive Forms
- √Upcoming Events

ASSESSMENT
- √Health Assessment
- √Appointment Scheduling
- √Offsite Screening Voucher
- √Screening Results

2017-18 program deadline:

TUESDAY, MARCH 13, 2018

Barriere Construction's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored programs that seek to improve health or prevent disease. All health information gathered through the wellness program is completely confidential and will not be disclosed without your written authorization. If you think you may be unable to meet a standard for a reward under this program, contact Sterling Wellness at 1-800-838-0337 to find out if you are eligible to receive the same reward through an alternative standard. Download the full disclosure at MyHealthPark.com.

B
BUILDING HEALTHY LIVES

STRATEGY #3 SUMMARY

- Questions to take to your CFO
  - How should/do we account for health risk translating into workers comp exposures?
  - Are we willing to shift risk costs off of health plan based on health status?

- Key takeaways
  - Wellness isn't about "do stuff get stuff" – at least not for contractors
  - Data points to health outcomes program as being the most likely to improve health risk of population.
  - May take 2 years or more to implement and have culture re-adapt.

SUMMARY & OPEN DISCUSSION

BARRIERE CONSTRUCTION

B SUMMARY AND DISCUSSION

1 Plan Funding Alternatives

Understand the plusses and minuses of fully insured vs self funding.

Measure the point at which risk vs. cash flows matters to your organization.

Create risk sharing roadmap for CFO discussions – informed with financial tradeoffs.

2 SUPPLY VS DEMAND MANAGEMENT

If 90% of all Dr's and hospital beds are "in-network", it is really a network? Or is it just retail pricing using employers?

Evaluate the alternative network offerings in your area/with your TPA – and measure savings.

Measure labor impact (recruit retain) – and savings offset. Can you create concentric network – reference based pricing?

3 Health Risk

HR and Finance can think "win – win". Health outcomes programs can show "culture of care" and financial efficacy.

Tie program into the care and safety cultures of your organization.

Create a roadmap and measurable data points for program (i.e. biometric improvements, contribution $$ shifted)