Focus

November 13, 2017

HEALTHCARE/INSURANCE & BENEFITS

INSIDE

Growing healthcare option

Aaron Monson of Riverton & Zenith Family Health Centers explores a healthcare insurance option that eliminates the third party and allows the free market to determine what is a fair market value for medical services. The process, known as "direct primary care," is gaining popularity in a complicated healthcare world.

page F5

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Uh-oh! It's open enrollment season

Every fall, the leaves in the Salt Lake Valley change colors to signal many things — colder nights, shorter days, and approaching deadlines to purchase health insurance.

Because open enrollment began Nov. 1, now is the time to get serious about researching your options, comparing plans and prices, and locking in health coverage for the coming year.

If you are a freelancer, small-business owner or sole proprietor, chances are you purchase health insurance through the individual market. Unlike your friends and colleagues who gain coverage through an employer-based plan, you must hustle to buy your own health insurance each year.

And ever since the arrival of the Affordable Care Act, also called Obamacare, in late 2013, the process has become more complex. For instance, most Utahns can access subsidies to reduce premium costs, and insurers can no longer bar people because of pre-existing conditions, but the choices on Utah's marketplace have dwindled in recent years just as most premiums have increased.

Here are several key points to keep in mind as you shop for health insurance this month:

• Despite many congressional repeal attempts this year, Utah's individual market is open for business at www.healthcare.gov. Plus, you can "window-shop" for plans in a few minutes by going to www.healthcare.gov/see-plans.

• Two Utah-based health insurers — Select Health and University of Utah Health Plans — will sell plans in all 29 counties. Most Utahns will have a choice of up to 28 plans, including several plans linked to health saving accounts, also called HSA-qualified plans.

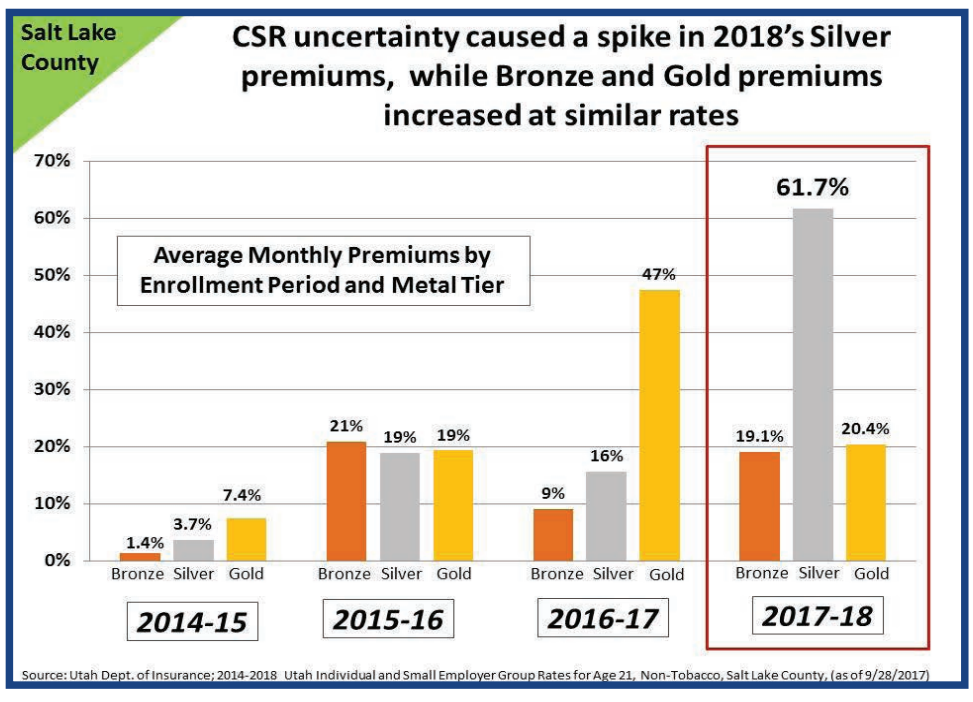
• Molina Healthcare is leaving Utah's individual marketplace at the end of 2017, causing about 70,000 consumers to choose a new plan for next year. Molina will maintain its offerings for Medicaid, CHIP and Medicare in Utah.

• Open enrollment began Nov. 1 and ends Dec. 15. This year, open enrollment lasts only 45 days, half has long as during previous years.

• Both the premium subsidies (tax credits) and the lower deductibles and co-pays created by cost-sharing reductions (CSRs) are intact for Utah's 2018 marketplace. Nothing has changed for Utah consumers.

• Sliding-scale premium subsidies are available to Utahns earning between 100 percent and 400 percent of the federal poverty level. For 2018, that means a family of four earning between $24,600 and $98,400 can qualify for subsidies to reduce their monthly premiums.

• While premiums for Silver plans (the most popular plan choice in Utah) increased significantly due to uncertainty over the Trump administration's refusal to pay CSRs, more robust



The biggest challenge for marketplace shoppers for 2018 plans will be the spike in the cost of Silver plans — the choice of 72 percent of last year's buyers.

see ENROLLMENT pg. F10

Choking On Your Health Care Premiums?

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	Present Situation		Cost Saving Configuration	
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Plan Details	Deductible / Unshared portion	$3,000 deductible	ZDC None	HCS $1,500 unshared
	Coverage	80% after deductible	Most primary care	100% after unshared
	Out-of-pocket maximum	$10,000	Not applicable	$1,500
	Monthly premium / Membership fee	$1,507.22	$129.75	$449.00
	Co-pay / Visit fee for one visit	$40	$10	None
	Annual fee	None	None	$125 (Yr. 1) $75 thereafter
	Initial (one time) enrollment fee	None	$50 per person	None
Annual Costs	Annual premium / Membership	$18,086.64	$1,557	$5,388
	Est. co-insurance cost for 4 visits	$96	Not applicable	Not applicable
	Co-pay / Visit fee on 4 visits	$160	$40	None
	HCS subsidy for ZDC membership	Not applicable	($900)	Not applicable
	Annual fee	None	None	$75
Potential Savings	TOTAL Annual Costs	$18,343	$6,160	
	Annual Savings		$12,183	
	Savings Percentage		☑ 66%	

NOTE: There is a one-time enrollment fee of $50 per person. Minor children must be accompanied by at least one adult membership.

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**Not available with all providers.*

BUSINESS INTERRUPTION INSURANCE

Save the day when disaster strikes

Have you thought about what you would do if your business were damaged by fire? Since you have insurance, you'll be able to rebuild. But, have you considered the impact on sales during the reconstruction? Depending on how long your business needs to be closed, will the revenue stream be stable enough to keep business going until the doors are reopened?

After a disaster, 40 percent of businesses don't reopen at all and another 25 percent fail within one year, according FEMA. Business interruption insurance is essential to help cover the gap so operations can resume quickly.

Types of insurance available

Business interruption insurance can be added to a property insurance policy or included in a package policy. Covered risks may include disasters such as fire, hurricane, hail, lightning, windstorm, explosion and vandalism. There are typically three types of coverage:

• **Business income coverage:** Provides compensation for lost employee income if a business suffers property loss or damage from a covered peril. Coverage remains in place until restoration of the lost or damaged property is complete. In addition, the policy will cover operating expenses, such as utilities, that continue while a business has temporarily halted activity.

• **Extra expense coverage:** During the restoration period, a business may incur extra expenses. This coverage reimburses a company for money it spends during the restoration period over and above the normal operating expenses. These expenses would help the business avoid having to shut down. Extra expense coverage may also cover payroll for key employees until a business is back up and running.

• **Contingent business interruption insurance:** Reimburses expenses and lost profits affecting a supplier or manufacturer. For example, the massive earthquake and tsunami that hit Japan in March 2011 led to supply chain disruptions around the world. Companies that were affected and that had contingent business interruption insurance used this coverage to reimburse expenses and lost profits during the shipment delays.

Be aware that damages due to a flood or earthquake are usually excluded from a business interruption policy. There is generally also a 48-hour waiting period after the loss before coverage can take effect.

Why business insurance is essential

Disasters can have a variety of effects on a business. A fire may only destroy part of a building, but it could take a few weeks or months for repairs. Broken windows and roof damage after a hailstorm may leave a lot of water to clean up. A major hurricane, such as hurricanes Maria, Irma and Harvey, which all struck in 2017, could hit one of your suppliers and significantly impact your business. From lost income compensation to coverage for fixed and disaster-related expenses, business interruption insurance is essential to any business' survival.

How much is needed?

The amount of coverage needed depends on a few different factors: annual sales revenue, repair time before reopening, temporary relocation operating costs and ongoing payroll. It's a good idea to work with your accountant to correctly forecast the next 12 months of income and expenses. The cost of business interruption insurance will further vary depending on your business type, the amount of coverage needed and potential risks of your geographic location.

Protect your business with a recovery plan

In addition to having business interruption insurance, it's important to have a recovery plan in place. Develop a plan with these tips:

• Identify risks: What disasters and emergencies are likely to occur in your area? How will your business be impacted and how will you respond to them? Identify a plan of action as well as materials and supplies needed to ensure you and your employees are safe.

• Client retention plan: Decide on a communications strategy to prevent loss of customers. Post notices on social media, your company website and outside your premises. Contact clients by phone, text, email or regular mail. Place a notice in local newspapers.

• Backup resources: Consider the resources needed during an emergency, such as a back-up power source, communications system and digital information security plan.

• Business-to-business coordination: Even if your business escapes the physical damage of a disaster, operations may suffer significant losses due to delivery challenges or decreased customer demand. Businesses should communicate with their suppliers and markets (especially if they are a business supplier) about their disaster preparedness and recovery plans to promote confidence and ensure that everyone is prepared.

• IT recovery plan: Develop a specific information restoration strategy to get back online faster and decrease the chance of sensitive data getting into the wrong hands. Include procedures and requirements pertaining to networks, hardware, applications and wireless devices. To lessen potential damage, take steps to secure any equipment that could shift or fall over during a disaster. Keep computers above the flood line and away from large windows.

• Protect your building: Conduct regular inspections of the business property to identify potential hazards and risks. Look for signs of defective electrical wiring, leaky gas connections and structural defects. Reduce the threat of injury or death and minimize property damage in the event of a disaster by identifying hazards ahead of time and making the necessary repairs.

• Continued business activity: Identify critical business activities and the resources needed to support them. If you cannot afford to shut down operations, even temporarily, determine what would be required to operate the business from another location.

As you assess risks and make plans, consider having at least one employee train as a volunteer in FEMA's Community Emergency Response Team (CERT). Having someone trained in the CERT program means you'll have someone in-house with fire safety training, light search and rescue, team organization and disaster medical operations. Your CERT-trained employee(s) can help advise you about your disaster plans and can also serve as a liaison with first responders and other emergency preparedness groups in your area.

• For guidance on generating a business recovery plan, visit https://www.fema.gov/preparedness-checklists-toolkits for preparedness checklists and toolkits. Consult with your insurance advisor for the right amount of coverage to protect your business.

This article was supplied by Mountain America Credit Union, a full-service insurance agency offering a wide range of products for auto, home, family and business.

Five tips to help prepare for open enrollment and save on healthcare costs

Many Utahns will soon select or switch their health benefits plan during open enrollment, so now is the time to prepare for that important decision that usually happens once a year.

More than 70 percent of Americans say they are prepared for open enrollment, yet most people struggle to understand basic health insurance terms, according to a recent UnitedHealthcare survey. Only 9 percent of survey respondents could successfully define all four basic health insurance concepts: plan premium, deductible, co-insurance and out-of-pocket maximum.

Here are five tips can help you make the most out of your health benefits and better understand how to use your healthcare dollars.

1. Know your open enrollment dates. Open enrollment isn't the same or at the same time for everyone, so there are key dates to keep in mind depending on your situation:

• For the more than 177 million Americans with employer-provided coverage, many companies set aside a two-week period between September and December when employees can select health benefits for the following year.

• For the more than 58 million seniors and other people enrolled in Medicare, their Open Enrollment runs from Oct. 15 to Dec. 7 each year.

• Health insurance marketplace or individual state exchange open enrollment runs from Nov. 1 to Dec. 15.

For most people, changes made to coverage during open enrollment take effect Jan. 1, 2018.

2. Take time to review your options. Every person or family has unique health and budget needs, so there is no one-size-fits-all approach to selecting a health plan. Take the time to explore your options, and understand the benefits and costs of each plan so you can find the coverage that works best for you and your family members.

• Check if your current coverage still meets your needs and if your benefits will change next year.

• Determine if the plan is a good fit for your budget, and pay attention to more than just the monthly premium. You should also understand the other out-of-pocket costs, including deductibles, copays and coinsurance.

• Make sure your medications are covered. Even if you don't expect to change plans, it's important to ensure your drugs will still be covered next year.

3. Make sure your doctor is in your plan's care provider network. Even if you don't make any changes to your health insurance this year, it's still a good idea to ensure that any doctor you see regularly — or plan to visit in the coming year — is in your benefit plan's care provider network. If you plan to visit a doctor or hospital outside of the network, be sure to understand how your costs will differ from a network care provider because those costs will most likely be higher.

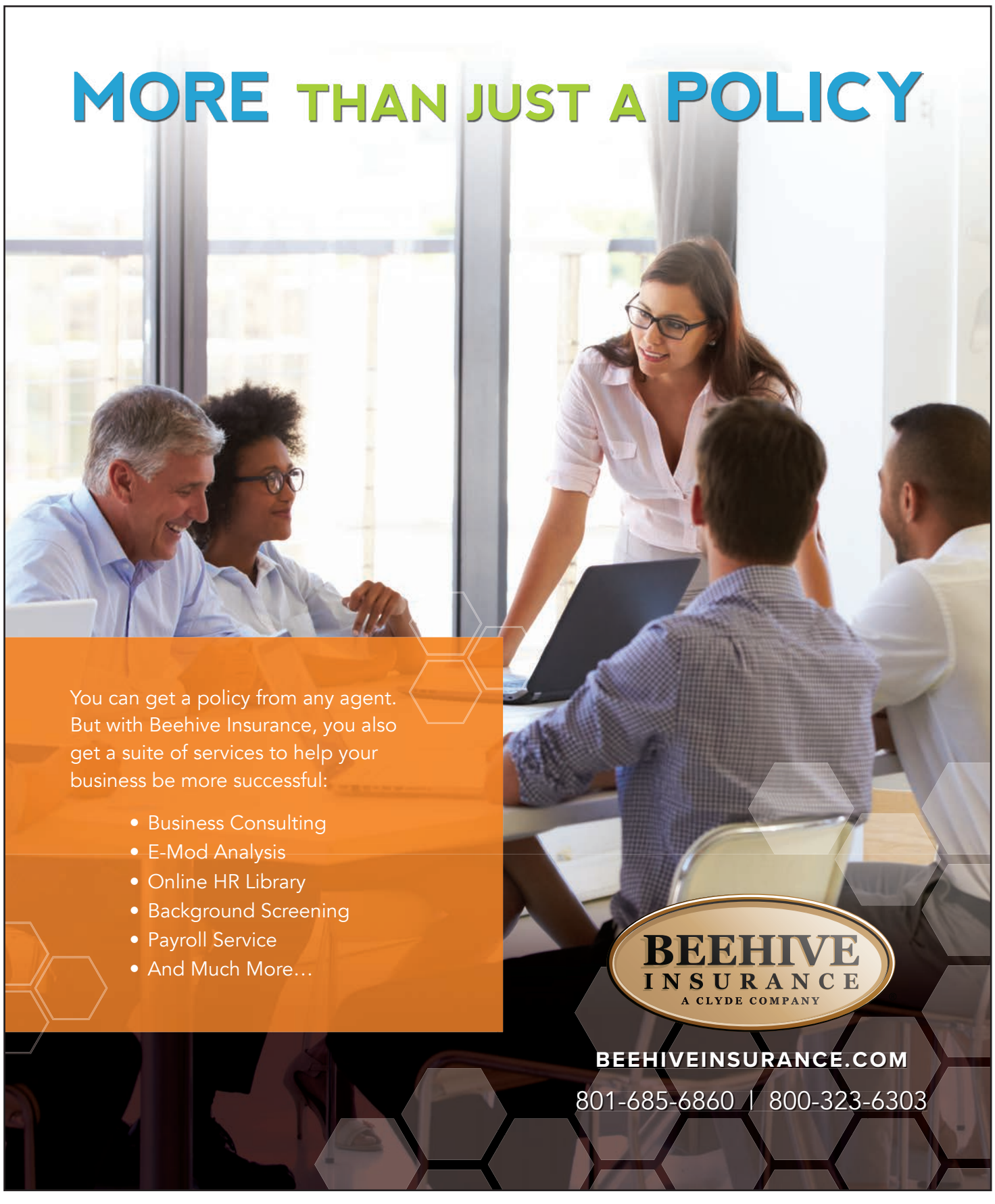
Also, check if your plan includes 24/7 telehealth services for consultations on minor health issues. Often, telehealth — defined as online, or virtual, visits with a doctor over a computer, tablet or mobile phone — is available to people enrolled in employer-sponsored health plans and group Medicare Advantage plans, as well as select individual Medicare Advantage plans. Virtual visits may provide convenient and affordable access to care for minor medical issues, including allergies, bronchitis and seasonal flu.

4. Don't forget about additional benefits. Additional benefits such as dental, vision, accident or critical-illness insurance are often affordable options that can protect you and your family from head to toe. For people enrolled in Medicare, many are surprised to find that Original Medicare doesn't cover prescription drugs and most dental, vision and hearing services. But many Medicare Advantage plans do, often at a no-cost premium beyond the premium for Original Medicare.

5. Take advantage of wellness programs. Some health plans offer discounts on gym memberships and provide financial incentives for completing health assessments, signing up for health coaching programs, lowering your cholesterol, losing weight, meeting walking goals, or stopping smoking. Programs are designed to reward people for making healthy choices and being more engaged in improving their health.

For help navigating open enrollment, visit UHCOpenEnrollment.com for articles and videos with easy-to-understand information about health benefits and health insurance terms.

Marc Briggs is the CEO of UnitedHealthcare Medicare and Retirement Utah.



direct primary care:

An out-of-the-box look at healthcare options

Inevitably this time of year, many are taken up with thoughts about healthcare. Open enrollment, when the news of health insurance rate hikes hits the fan, is a time when all must wonder how long can this go on before only the wealthy can afford healthcare?

This seemingly difficult issue demands that we look outside the box for solutions, a new perspective in which to frame the problem. With that in mind, we pose the question, is health INSURANCE the same thing as healthCARE? Our well-meaning politicians would have us believe that they are the same. If health insurance and healthcare are in fact the same thing, then one could argue that things are better if viewed solely on the basis of how many people are now "covered" by some form of insurance.

But saying so doesn't make it so. Good care is still available, but the promise of receiving it because you have insurance coverage is increasingly becoming less of a sure thing. For most Americans, the passage of the Affordable Care Act (ACA) has led to higher premiums, higher deductibles, fewer items covered, shrinking networks, etc. Not to mention greater challenges to care providers to render the care itself, in the form of tighter requirements to participate with the insurers. We have more health *insurance*, but not more health*care* — let alone better or more "affordable" healthcare.

The value proposition of insurance is that unexpected and large expenses will be covered in the event of an unforeseen or catastrophic event. We accept this for other aspects of our existence, such as in the case of car insurance, homeowners and life insurance. We are happy to pay a relatively small amount for someone else to bear the risk for us. The insurance companies profit from it and most of us do not mind that fact.

But does it make sense where basic and general healthcare is concerned? Health insurance companies also exist to make a profit, and paying for the care of their members reduces that profit. Simply put, the economic incentives of the health insurance companies do not align with the priorities of the doctors and their patients.

As it now stands, insurance company involvement in the care transaction goes way beyond the coverage of unforeseen or catastrophic events. Adding insurance into the basic healthcare picture not only complicates the process, but it increases costs in the form of overhead brought to the transaction — and, of course, the insurance company profit margin. When viewed through this lens, it makes little sense to put this third party between the two participants (doctor and patient) to a care transaction that is NOT unforeseen or catastrophic.

With the proliferation of higher-deductible health plans, health insurance is becoming useful only in catastrophic situations anyway. Ironically, it is, by default, returning to where it should have stayed to begin with. So why not embrace this fact and remove health insurance altogether from basic, routine healthcare? Let the two participants (doctor and patient) in a simple care transaction determine what is fair market value, trade money for services directly between each other, and let the free market settle the issue without government-forced insurance?

There is a growing voice for this concept, something called direct primary care (DPC). While insurance still makes sense in catastrophic and unforeseen circumstances, basic primary care can easily leave it out. A car insurance plan doesn't cover wiper blades, oil changes, or flat tires — those things are covered directly by the car's owner, not an insurance company. Primary care is like that, mostly routine and predictable — and as such could easily be covered directly by the consumer.

Returning basic primary care to a direct transaction (without health insurance in the middle) realigns the two parties' (doctor and patient) motivations, without the interference of a third party (insurance) with differing motivations. In the end, the care transaction is not only more cost-effective, but it is better for BOTH parties.

Consider also that under the present system, doctors only get paid when their patients are in the doctor's office receiving care. This negatively aligned incentive means that the doctor gets paid only when you are sick. Sick people are good for a doctor's business. Well people are not good for business. Unfortunately, a narrow, bureaucratic view of this issue has added to the problem.

Washington bureaucrats have issued edict after edict requiring healthcare providers to participate in increasingly onerous reporting and compliance burdens that are supposed to make healthcare better.

Government created "value-based" healthcare programs, largely enforced through a care provider's participation in government insurance programs, are supposed to fix the issue. While the idea that "anything that can be measured can be improved" is sound in many industries, it doesn't work well in healthcare.

The reasons are easy to understand when reduced to the basic components in a care transaction. In simple economic terms, the care transaction is an exchange of money for a doctor's time, focus and expertise. Any requirement imposed on a doctor that takes away time and focus from the patient, means the patient is getting less care in the long run. The road to healthcare hell is indeed paved with the many good intentions of the multiple bureaucrats, government officials and insurance companies that wish to enforce their ideas of "value" on the care transaction. These good intentions are so costly and time-consuming that they hurt, rather than help, the consumers they pretend to help.

So how can doctors be incentivized to keep their patients healthy, rather than practicing reactionary care and profiting when they are sick — *without* government involvement? Forcing compliance with a third party's ideas about value gets in the way of the two-party free-market exchange that should be allowed to happen in healthcare. Fortunately, this is a problem with a solution, one that is already in practice and growing exponentially across the United States.

In the direct primary care model, patients pay a monthly membership to their primary care doctor for any care that might be needed in the future. Doctors are paid whether the patient is sick or not, with the promise to render basic care as needed in exchange for a small monthly fee. Consider the economic realities in this arrangement: If a doctor has already been paid, the incentive is to keep the patient healthy, happy, and willing to continue to pay that monthly amount. In other words, the doctor is incentivized to practice pro-active and better (more valuable) care. Better for the doctor, and better for the patient, with market forces (and not the government) ultimately determining value.

This arrangement is being quietly adopted and promoted by numerous independent Utah physicians. Based on an in-depth review of Internet-only sources as of September, there are 77 healthcare providers in 33 clinic locations across 15 primary care groups in Utah that are either already practicing this way or moving in this direction. Because the field is relatively new, with a still largely undeveloped voice and marketing strategy, many of these entities are barely noticeable, even if you are looking for them.

Freedom-loving, entrepreneurial healthcare providers are not waiting for Washington to decide how to fix healthcare. They are creating their own healthcare landscape, and it is changing primary care as we know it. Consumers, business managers, business owners, HR directors and indeed anyone who might be involved in healthcare in any way would do well to sit up and take notice.

Aaron Monson is the COO for Riverton & Zenith Family Health Centers, a Utah primary care medical group, and manager for Zenith Direct Care, a growing network of direct primary care clinics.

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Some HIPAA basics and takeaways for your business

Many of those working in healthcare are all too familiar with the HIPAA requirements. However, more and more companies in other industries are seeing the HIPAA requirements as a framework to structure internal functions or analyze their own privacy and security policies and needs as they relate to IT and data security.

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, was created and exists to create national standards for electronic healthcare records, transactions and security, allowing for proper protection while facilitating the proper flow of information required to provide a high level of care. A few of the most commonly discussed HIPAA rules are the Privacy Rule, Security Rule and Enforcement Rule.

• The Privacy Rule requires all *covered entities* (health plans, healthcare clearinghouses and healthcare providers) follow the national standards on individually identifiable health information transmitted electronically. The Privacy Rule also grants individuals an enforceable right to request and obtain copies of their general health records held by providers. The Privacy Rule focuses data dissemination around "minimum necessary" disclosure and use, requiring a covered entity to make reasonable efforts to disclose and request the minimum necessary amount of protected information necessary.

• The Security Rule outlines protections surrounding the availability, confidentiality and integrity of electronically transferred or held health information. The Security Rule is designed to ensure the integrity and confidentiality of the protected health information and requires the proactive steps to protect against reasonably anticipated threats or impermissible uses or disclosures of the protected information.

• The Enforcement Rule governs the standards for the enforcement of the HIPAA rules.

Why do we need HIPAA?

Prior to HIPAA, no nationally accepted standards were required for the security and protection of health information — in spite of the growing reliance of electronic health records. As a result, Health and Human Services (HHS) implemented and has continued to evolve HIPAA in order to create a standard policy that can adapt to the changing technologies. More and more providers are using tablets and laptops from check-in through the visit. There are many possible opportunities for a data hack: having the actual device stolen, transmission between the tablets to the data warehouse or cloud or once the data is stored, etc. While anyone with a technological device or network should be considering their security and protection measures, the type of information contained is of greater interest and has potentially more damaging implications and therefore is a bigger target for hackers.

What information is protected?

The Privacy Rule defines this as all individually identifiable health information. This information is information received through a covered entity and 1. Relates to the past, present or future mental or physical health or condition of an individual; provision of health care to that individual; or payment for such health care; and, 2. Identifies the individual or that the information, under a reasonable belief, would lead to the identification of the individual.

How is information protected?

The Security Rule requires covered entities to maintain a reasonable effort in being proactive by creating a secure environment and proactively anticipating threats and impermissible use or disclosure of protected information and ensuring compliance in the workplace. Under the Security Rule, a covered entity is to protect the integrity and availability of protected data — "integrity" referring to the information not being altered or destroyed and "availability" being defined as accessible by an authorized individual.

The Security Rule requires covered entities to perform a risk analysis of its systems. This analysis is not limited to, but should contain an evaluation of, the likelihood of potential risks to the protected information and the impact of such potential risk; implementation of security measure to address the risks uncovered in the risk evaluation; documentation of the results of the analysis and the measures taken; and "maintain continuous, reasonable and appropriate security protections."

While the Security Rule does not specify what measures are to be taken, the rule does require the covered entity to consider its size and complexity; technical, hardware and software infrastructure; costs of available security measures; and the likelihood and possible impact of risks to protected information.

Every company has some sort of sensitive information and a proactive approach *cannot be overlooked* or replaced by a reactive method. The importance of a proactive security policy is central to HIPAA due to the incredibly sensitive information held in health records. When companies decide to look at their own internal standards compared to HIPAA, much focuses around the requirements of the Security Rule. A frequent reader of my column will find the almost painfully repetitive theme surrounding around the necessity of proactive IT monitoring.

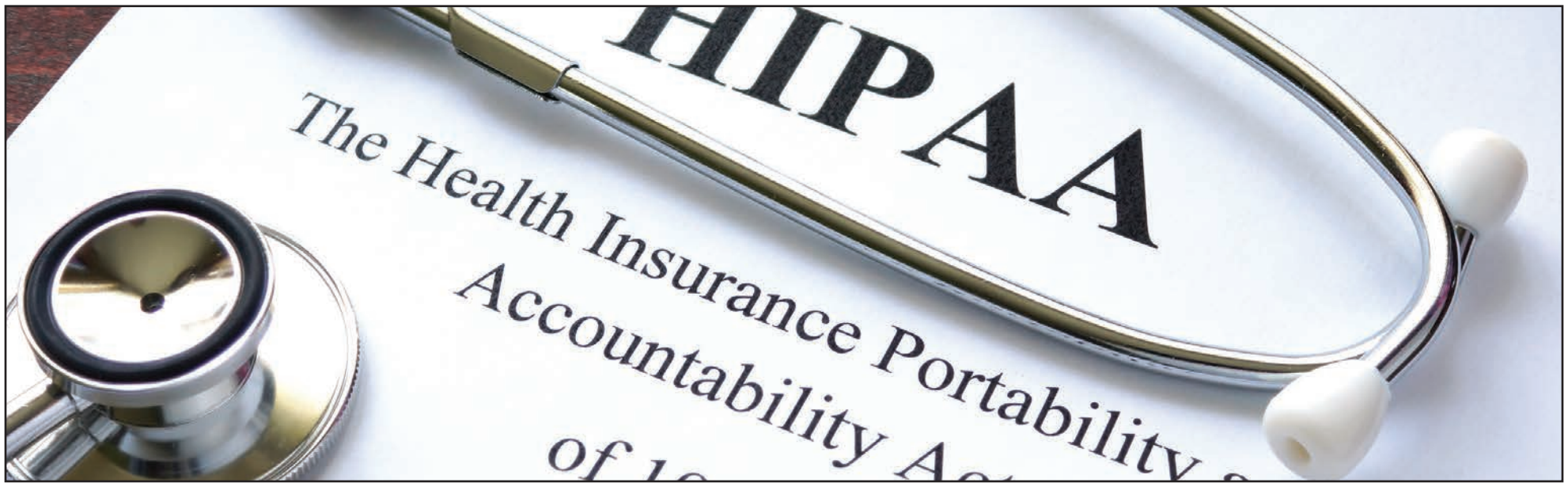
This is what the Security Rule in HIPAA requires. While it may not be necessary to go the full extent as required under HIPAA in your own business, deciding to take your own IT practices on the other end of the spectrum where you only react when there is a problem instead of creating and having a proactive, continuous watch on your system is likely to lead to some sort of loss. More likely than not, reactive maintenance will cost significantly more than being proactive from the start — and after factoring in any reputational damage, customer data loss, insurance premiums, etc., the amounts far exceed what a healthy, proactive IT plan would cost.

Takeaways

HIPAA requirements contain a level of complexity and importance suggested to be discussed with your legal professional and industry leaders. This article merely serves to create a general understanding of the issue.

While there are many specific requirements as a result of the sensitive information in healthcare, it is important to use this as a guideline for all industries. While many HIPAA elements will not be applicable, an increased emphasis on data security, accessibility rules, requirements of business associates (and employees) who touch sensitive information, etc., are all beneficial areas to strengthen in all industries. Most, if not all, companies all have some level of sensitive information. Do not avoid taking the proper precautionary measures merely because it may not be the most sensitive of information. While you cannot avoid all potential negative access, ensuring you take necessary steps to minimize your chances for information to fall into the wrong hands is key. Know your employees. Know your contractors. (Background and credit checks can be great tools — check with your attorney for any legal hurdles.) Know your network and environment. Know what data you must protect. Know how you are or aren't protecting this data. Know the negative outcomes if there is a data breach. You are only as strong as your weakest link. Know the weakest link and strengthen it — then reanalyze and repeat. Review your options and make an informed decision to help your business, and its reputation, succeed in the long term.

Bahar Sharifan is president of Wasatch I.T., one of Utah's largest providers of outsourced IT services for small and medium-sized businesses.



UTAH HOSPITALS

Ranked by Number of Beds

THE List

List Development Laneace Gregersen | laneace@slenterprise.com

	Company Name Address	Phone Web	Total No. Beds	No. Employees	No. Physicians	For Profit?	Specialties	Administrator	Owner
1	**University of Utah Hospitals and Clinics** 50 N. Medical Drive SLC, UT 84132	801-581-2121 healthcare.utah.edu	680	10,068	1,380	N	Multiple	David Entwistle	University of Utah
2	**Intermountain Medical Center** 5121 S. Cottonwood St. Murray, UT 84107	801-507-7000 intermountainhealthcare.org	504	4,480	1,458	N	Cardiovasular, neurosciences, oncology, trauma, women's, newborn ICU, medical, surgical, emergency medicine, transplant, orthopedics	Joseph N. Mott	Intermountain Healthcare
3	**Utah Valley Hospital** 1034 N. 500 W. Provo, UT 84604	801-357-7850 intermountainhealthcare.org	395	2,113	532	N	Level II trauma center, newborn ICU, heart & cancer care, obstetrics, surgery	Kevin Brooks	Intermountain Healthcare
4	**McKay-Dee Hospital** 4401 Harrison Blvd. Ogden, UT 84403	801-627-2800 intermountainhealthcare.org	321	1,859	823	N	Level II trauma center, heart & cancer care, newborn ICU, obstetrics, surgery	Timothy Pehrson	Intermountain Healthcare
5	**St. Mark's Hospital** 1200 E. 3900 S. SLC, UT 84124	801-268-7111 stmarkshospital.com	317	1,500+	600+	Y	ER, heart services, cancer services, imaging & surgery centers	Steven B. Bateman	Mountainstar Medical Group
6	**Primary Children's Hospital** 100 N. Mario Capecchi Drive SLC, UT 84113	801-662-1000 intermountainhealthcare.org	289	2,531	900	N	Pediatric Level I trauma center, heart services, cancer services, organ transplants	Katy Welkie	Intermountain Healthcare
7	**LDS Hospital** 8th Ave. & C St. SLC, UT 84143	801-408-1100 intermountainhealthcare.org	250	1,069	1,134	N	Medical, surgical, bone marrow transplant, orthopedics, women & newborn, psychiatry, chemical dependency	Jim Sheets	Intermountain Healthcare
8	**Dixie Regional Medical Center** 1380 E. Medical Drive St. George, UT 84790	435-251-1000 intermountainhealthcare.org	245	2,102	305	N	ER, neurosurgery, heart surgery, newborn ICU, surgery, cancer therapy, LiVe Well Center	Terri Kane	Intermountain Healthcare
9	**Ogden Regional Medical Center** 5475 S. 500 E. Ogden, UT 84405	801-479-2111 ogdenregional.com	239	1,000+	300+	Y	Level II trauma center, certified stroke center, maternity care	Mark Adams	Mountainstar Medical Group
10	**Jordan Valley Medical Center** 3580 W. 9000 S. West Jordan, UT 84088	801-561-8888 jordanvalleymc.com	183	783	492	N	Cancer, woman's services, orthopedics, general surgery, pediatrics	Steven M. Anderson	IASIS Health Care
11	**Salt Lake Regional Medical Center** 1050 E. South Temple SLC, UT 84102	801-350-4111 saltlakeregional.com	158	700+	500+	Y	Emergency medicine, heart care, cancer care, diagnostic imaging, etc.	Dale Johns	Physician-owned
12	**Logan Regional Hospital** 500 E. 1400 N. Logan, UT 84341	801-627-2800 intermountainhealthcare.org	146	761	200	N	ER, obsterics, surgery, cancer center	Kyle Hansen	Intermountain Healthcare
13	**Lakeview Hospital** 630 E. Medical Drive Bountiful, UT 84010	801-299-2200 lakeviewhospital.com	128	597	226	Y	Orthopedics, chest pain, women's services, behavioral health, wound care & ER	Troy Wood	Mountainstar Medical Group
14	**Jordan Valley Medical Center West Valley Campus** 3460 S. 4155 W. West Valley City, UT 54120	801-964-3100 jordanvalleywest.com	102	439+	492	N	Orthopedics, general surgery, women's services, behavioral health	Jon Butterfield	IASIS Health Care
15	**Riverton Hospital** 3741 W. 12600 S. Riverton, UT 84065	801-285-2010 intermountainhealthcare.org	97	400	670	N	Women & newborns, ER, pediatric services, medical, surgical, outpatient, diagnostic imaging	Blair Kent	Intermountain Healthcare
16	**American Fork Hospital** 170 N. 110 E. American Fork, UT 84003	801-855-3300 intermountainhealthcare.org	90	540	200+	N	ER, women & newborn, surgery, diagnostic imaging, cancer treatment	Jason Wilson	Intermountain Healthcare
17	**Alta View Hospital** 9660 S. 1300 E. Sandy, UT 84094	801-501-2600 intermountainhealthcare.org	71	374	247	N	Women & newborn care, medical & surgical services, imaging, ER	Bryan Johnson	Intermountain Healthcare
18	**Brigham City Community Hospital** 950 S. Medical Drive Brigham City, UT 84302	435-734-9471 brighamcityhospital.com	49	*	*	Y	Acute-care hospital	Richard Spuhler	Mountainstar Medical Group
19	**Cedar City Hospital** 1303 N. Main St. Cedar City, UT 84721	435-868-5000 intermountainhealthcare.org	48	332	57	N	ER, obstetrics, surgery, cancer services, cardiology, spine & pain services, diognostic imaging	Eric Packer	Intermountain Healthcare
20	**Sevier Valley Hospital** 1000 N. Main Richfield. UT 84701	435-893-4100 intermountainhealthcare.org	40	120	81	N	ER, diognostic imaging, dialysis, lab, family medicine, general surgery, obstetrics, sleep lab	Gary Beck	Intermountain Healthcare

THE Enterprise UTAH'S BUSINESS JOURNAL

*Did not disclose. Please note that some firms chose not to respond, or failed to respond in time to our inquiries.

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ENROLLMENT

from page F1

premium subsidies will ease these increases for most Utah consumers.

The biggest challenge for the Utah marketplace in 2018 is the specific increase in premiums for Silver plans. Since 72 percent of Utahns with marketplace insurance selected a Silver plan in 2017, many will be affected by these increased prices. In Salt Lake County, the average Silver premium increased 61 percent for 2018 — three times more than it did in 2017 — while average Bronze and Gold premiums increased 19 percent and 20 percent, respectively.

Why did Silver premiums spike in Utah? Because the Utah Insurance Department advised the state's two marketplace insurers to increase Silver premiums to offset the potential cut in CSR funding from the federal government. And on Oct. 14, the Trump administration cancelled CSR payments for 2018, making the state's insurance department seem very prudent in their advice (other states did not take precautions and were caught short by the CSR cancellation). As a result, the Utah Insurance Department calculated that almost 50 percent of 2018's premium increase in Utah was caused by political uncertainty emanating from Washington, D.C.

The 86 percent of Utah marketplace consumers who qualify for premium subsidies will be mostly insulated from these premium increases. This is because premium subsidies rise in relation to the second-lowest Silver plan, also called the benchmark plan. If Silver premiums go up, so do the subsidies. But about 50,000 Utahns who purchase individual market insurance either don't qualify for subsidies or don't realize these subsidies are available. Many entrepreneurs and small-business owners fall in to this category. These consumers will face much higher Silver premiums without the cushion of the subsidies to offset them.

What are your options if you earn more than 400 percent of the poverty level ($48,240 for a single person, and $115,120 for a family of five) and don't qualify for premium subsidies?

Here are three strategies to find affordable insurance for 2018:

• First, look Silver plans sold off the marketplace. Health insurance today is sold on the marketplace (at healthcare.gov where premium subsidies are available), and off the marketplace (directly purchased from an insurer where subsidies are not available). Because the CSR uncertainty caused Utah insurers to increase premiums for on-marketplace Silver plans, this means that very similar Silver plans sold off the marketplace have premiums that are $95 (age 30), $101 (age 40) and $146 (age 50) cheaper per month.

If you earn too much to qualify for a subsidy, off-marketplace plans should be on your shopping list. In Utah, off-marketplace Silver plans can be purchased directly from these four insurers: Select Health, University of Utah Health Plans, Regence BlueCross and BridgeSpan.

• Second, consider Enhanced Bronze plans. A new plan type offered in 2018 is the Enhanced Bronze plan, with average premiums that are $121 (age 30), $129 (age 40) and $185 (age 50) cheaper per month than average Silver plans. Keep in mind, however, that both Bronze and Enhanced Bronze plans have higher deductibles and co-pays than Silver plans — approaching $13,000 for a typical family plan. To reduce those out-of-pocket costs, consider purchasing an HSA (health savings account)-qualified plan to lock in pre-tax savings on your predictable healthcare spending.

• Third, some Gold plans will be cheaper than Silver plans in 2018. The upside-down world created by the CSR uncertainty means that monthly premiums for the lowest-priced Gold plan are $18 cheaper (age 30) than the most expensive Silver plan with similar deductibles and co-pays.

If health insurance so complex, why go through the hassle of signing up for health insurance this month?

First, if you don't sign up before Dec. 15, you will be out of luck for the rest of the 2018. Open enrollment (Nov. 1-Dec. 15) is the only time of year you can sign up, re-enroll or switch plans without a life-qualifying event like a birth, marriage, death or loss of coverage. In addition, the federal government is making it harder for people to sign up for health insurance outside of the open enrollment period by requiring additional documentation that a qualifying life event has occurred.

Second, despite what you may think, getting sick or having an accident is not a life-qualifying event that enables you to enroll in coverage. If a lab test comes back abnormal next May and your doctor recommends additional and expensive testing, you won't be able to sign up for insurance to cover it. To encourage year-round coverage and prevent people from gaming the system, the Affordable Care Act restricts open enrollment a specific time period each year — and that period is happening right now.

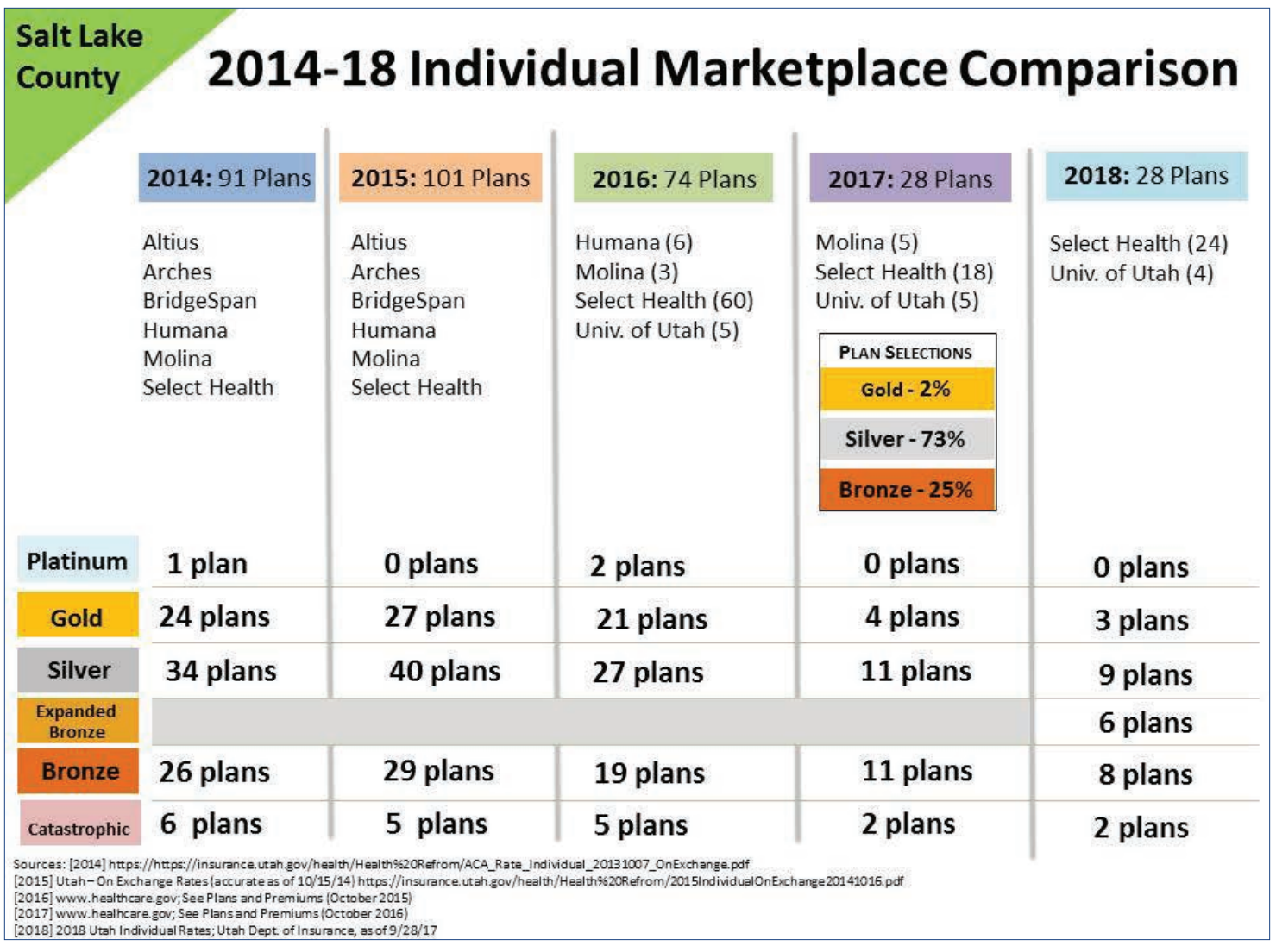
Third, the U.S. healthcare system is geared toward health insurance as the primary payment model. Self-pay is feasible for many routine medical tests, but the Affordable Care Act also made many of these procedures — including vaccinations, physical exams, mammograms, colonoscopies and well-child checks — free of charge. Health insurance opens doors to medical care that is beyond the reach of self-pay, from intensive testing to medications to appointments with specialists. For instance, the cost of a normal delivery at LDS Hospital in Salt Lake City is $7,000, while the cost of a C-section is $10,700. One day in the NICU for a baby that needs extra care costs about $3,000 a day.

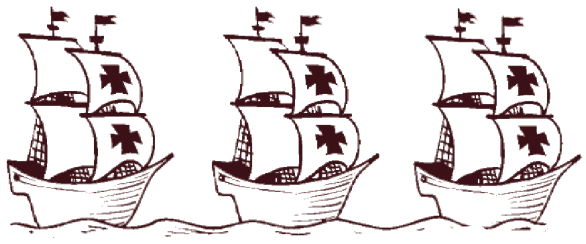
Fourth, having health insurance doesn't just protect you from unpayable medical bills. It also allows you to access the discounted rate for medical services and procedures. You've probably seen this on insurance bills: The sticker price for an MRI scan might be $2,000, but your insurance company has negotiated a discounted price of $1,200. Without insurance, chances are you would pay the full sticker price unless you spend a few hours on the phone convincing the doctor or hospital to lower their fee.

Fifth, you don't have to do it alone. Health insurance is complicated. After all, what is the difference between a deductible and an out-of-pocket maximum if they both mean the same thing? (Hint: Your insurance starts to pay a large portion of your expenses once you hit your deductible, typically 80 percent, and your coverage pays for 100 percent of expenses after you hit your out-of-pocket maximum.)

Fortunately, Utahns can access free help from Take Care Utah's network of navigators and brokers. Take Care Utah is the official nonprofit navigator in Utah, and their trained experts have helped tens of thousands of Utahns sign up for insurance since 2013. Find the nearest assistor by going to www.takecareutah.org or calling 2-1-1 from anywhere in the state.

Jason Stevenson is education and communications director at Utah Health Policy Project.





THE EXPLORATION HAS BEEN DONE

Maybe group captive insurance is a fit for your company

In 1492, Christopher Columbus set sail from Spain to find an all-water route to Asia. To his surprise, 12 months into his voyage, he found America. Today, setting sail on the ocean of the captive insurance world may seem more treacherous than the perils faced by Columbus but the good news is that someone has already blazed the trail. While there may be much to learn for most business owners looking into a group captive alternative, the following may be helpful as you navigate the captive insurance world.

First, the definition of "group captive" insurance is an insurance company that is owned and operated by a another company (or multiple companies or group of companies) to insure itself. This article will specifically discuss how group captives have emerged as a mainstream alternative within the commercial insurance arena over the past 10-20 years. The concept of captive insurance structures is not new and captive insurance alternatives have been around for over 50 years.

Is captive insurance something you should consider? If so, how do you know which option is the best fit for you? Are all captives the same? If you're already in a group captive, how do you know if you're in the right group? When Columbus sailed across the ocean, not everyone could do what he did. Today, group captives are not for everyone and every business. There are certain risks involved and should always be properly and thoroughly reviewed before entering into any group.

What are some of those risks? With hundreds of groups captive options available and not knowing how to navigate that marketplace it can be a daunting task for any business owner.

The following are some key factors to consider when looking at the options:

Expenses. One easy way to measure one group versus another is the expense costs shared by the members. One of the easiest ways to compare which group is the right group for your company is found mainly in comparing the expense factor of the group you are considering. This is the part of the premium used to run the captive and is paid by every member on a pro-rata basis. It is usually expressed in a percentage. This is a sunk cost and won't ever be returned to any member of the group. The key is to find the lowest percentage possible. A good percentage is under 33 percent.

Group size and composition. The size of the group can go from as few as 15 members to over 400. The smaller the group, the more control each member of the captive will have to run the captive. It is easier to choose who you'd like to do business with in a smaller group. The larger captives can feel more like being insured with a standard insurance company. They can and will add whomever they want. Also, what type of companies are you choosing to do business with? There can be advantages to working with other companies in the same industry. For example, contractors can work together with other contractors to share best practices. These are called homogenous groups. Heterogeneous groups will have a wide variety of industries included as members.

Risk sharing amount. Every group captive will have risk sharing to all the members. This can happen when one member has multiple claims that exhaust their funds set aside to pay claims. The IRS has determined that this is a key factor for any company that operates as an insurance company. (That's why all groups have this element.) The key is to review the past history to see how much risk sharing happens annually. This amount should typically be less than 5 percent.

Tail fund. At some point, you may decide it's time to move to a different insurance structure. In order to do that, you'll need to have a "tail fund" set up. The tail fund uses the final residual amounts of each policy year and sets them aside for the possibility of paying claims that come in on a delayed basis. Every large insurance company today has a small amount of its active claims that arose from policies that are over 10 years old. These claims in the captive setting should be handled by the tail fund. By doing that, each owner can rest assured that they won't have potential liability that goes on forever. The amounts set aside in the tail fund should be less than 1 percent of your actual premium. If there isn't a tail fund set up, it's either because the group is too new and the issue hasn't been addressed or it's because the group hasn't been managed properly.

There are many benefits of group captives. One benefit is gaining control of the insurance marketplace that has historically brought uncertainty to their clients. It's not unusual to see premium fluctuations flatten out for members of group captives. As the best and most profitable companies leave the standard insurance marketplace and go to the captive arena, standard insurers will be forced to raise prices on those companies that remain. This is the principle of "adverse selection." If the best, most profitable companies leave, all that is left are those that aren't profitable (in theory).

Christopher Columbus put it this way: "You can never cross the ocean unless you have the courage to lose sight of the shore." Sailing across unknown waters is not for everyone, but for those who do, you just might find a place better than you had before. If you are willing to take a little risk, there can be big rewards. In the insurance world, a captive can be that world that can create a new profit center. This is how you can be rewarded for paying attention to safety and quality. Finding the right group can make all the difference.

Graden Marshall is vice president of Cobb, Strecker, Dunphy & Zimmermann Inc., a commercial and professional insurance agency in Salt Lake City.

Save time and money by knowing where to go for medical care

People who experience an injury or illness often have to decide where best to seek medical attention, with some patients often heading to the emergency room (ER). Because ERs prioritize life-threatening emergencies, patients who are experiencing non-emergencies often have to wait hours to be seen by a doctor.

Visits to the emergency room can also cost patients up to 10 times more than a visit to urgent care or other care settings, so comparing where to go for care could save $1,500 or more per treatment. In fact, families could save $4.4 billion annually by choosing an urgent care, a doctor's office or even a virtual environment — depending on the medical issue — instead of an ER when seeking non-emergency care, according to the National Institutes of Health.

People who experience a significant or serious medical issue should go to the ER, but for people who need non-emergency care, here are some tips to consider:

Know your options: There are several different care settings to consider depending on the nature or severity of your illness or injury:

• *Emergency room:* For serious or critical conditions that require immediate medical attention, including persistent chest pains, broken bones and head or eye injuries.

• *Urgent care center:* For non-life-threatening injuries or illnesses that require immediate care, such as ear pain, persistent diarrhea, a minor sprain or shallow cut.

• *Primary care physician:* For wellness check-ups, diagnostics, management of long-term conditions and some urgent and non-urgent treatments.

• *Virtual visits*: For online access to a doctor for minor health needs or to obtain certain written prescriptions.

• *Convenience care clinic:* For non-urgent medical conditions such as sprains, skin rashes, sore throats and upset stomachs, often staffed by nurse practitioners.

Understand your coverage: Read your health plan's summary plan description to understand what is covered so you're aware of potential out-of-pocket costs, including premiums, co-payments, deductibles and co-insurance. Visit an online glossary to understand what those terms mean. According to a recent UnitedHealthcare study, just 9 percent of Americans could successfully define all of these terms. Knowing this information can help prepare you to ask questions that may avoid surprises in your medical bills.

Comparison-shop based on quality and cost: There are many online and mobile resources offering healthcare quality and cost information that enable people to comparison-shop for healthcare as they would with other consumer products and services. Nearly one-third of Americans have used the Internet or mobile apps during the last year to comparison-shop for healthcare; up from 14 percent in 2012, according to a recent survey. Public websites, such as www.uhc.com/transparency and www.guroo.com, offer market-average prices for hundreds of medical services in cities nationwide, including Salt Lake City.

Identify your go-to resources: In addition to online and mobile resources, people can call their health plan to discuss quality and cost transparency information and talk with their doctors about alternative treatment settings. Some health plans provide a 24-hour nurse line for information about care options and can help locate the nearest network facility.

As people take greater responsibility for their healthcare decisions and costs, understanding treatment settings can be important to help people get care and avoid surprise medical bills.

Dr. Laurine Tibaldi is the chief medical officer for United Healthcare's Health Plan of Nevada/Sierra Health and life and market medical director for United Healthcare in Nevada, Utah and Idaho.

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