TRANSFORMING YOUR COMPANY HEALTH PLAN:

PROVEN SOLUTIONS FOR COST CONTROL AND BETTER CARE

THE MAHONEY GROUP®

INTRODUCTION

Enough is enough. The American healthcare system isn't just broken — it's breaking the backs of workers and their employers. Despite outspending every other developed nation on healthcare, the U.S. lags behind on critical health outcomes such as life expectancy, infant mortality, and preventable deaths.

For businesses, rising healthcare costs eat into profits, stunt growth, and leave both employers and employees feeling trapped in a system where they are paying more but getting less.

Companies are faced with impossible choices: reduce benefits, shift costs to employees, or risk financial instability. This, in turn, fuels employee dissatisfaction, creating a vicious cycle where both business success and employee well-being suffer.

Meanwhile, families are squeezed between rising premiums, higher deductibles, and unpredictable out-of-pocket costs. Medical bills remain one of the leading causes of personal bankruptcy in the U.S.

And despite these costs, the quality of care often suffers due to administrative waste, inefficiencies, and misaligned incentives undermining the system's effectiveness.

Why is a nation that spends so much on healthcare delivering such poor results? The answer is complex, and we know our politicians can't be counted on to fix things. But for employers, there are ways to challenge the status quo and turn the tide.

In the following pages, we'll dive into three major pain points — affordability, cost transparency, and outcomes — and show you how innovative strategies like reference-based pricing, data-driven insights, cash payment options, and Centers of Excellence can make a real difference.

If you're an employer, each of these solutions will require work on your part. But it's that or year after year of 8% or higher premium increases. Choose your hard.

THE GROWING AFFORDABILITY CRISIS

When we talk about the rising costs of healthcare, the conversation often centers around premiums, copays, and deductibles. But the reality is much more dire than a simple discussion of dollars and cents. The American healthcare system has created what we call a "sick plan," not a true "health plan." Instead of proactively managing their health, most people only seek medical attention when they are seriously ill. Why? Because regular doctor visits and preventive care are simply too expensive for many individuals and families to afford.

For employers, this is a serious problem. When employees delay or skip routine care, their minor health issues often escalate into costly, major health crises. Not only does this drive healthcare costs up for the company, but it also reduces productivity, leading to more absenteeism, longer sick leaves, and even long-term disability. And for the employees, this "sick plan" approach leads to financial strain, higher stress, and deteriorating health over time. It's a vicious cycle that hurts both the employer and the workforce.

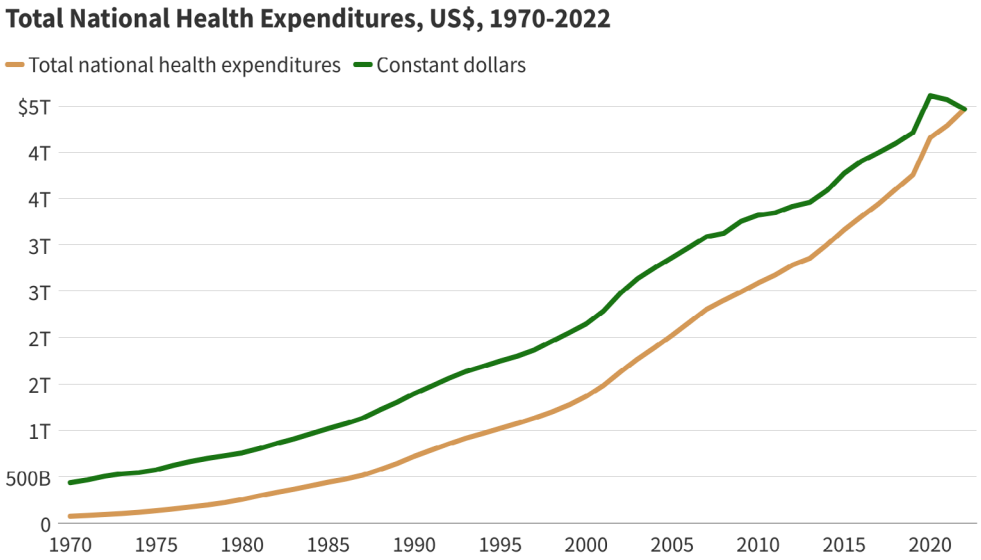
In the meantime, all of the major health care stock indexes have seen more than healthy increases over the past five years, including the S&P 500 Health Care Index, which has climbed by nearly 70%.

OUR SOLUTIONS

Start with Self-Funding

We believe affordability shouldn't be a barrier to good health. One of the ways we address this is by offering solutions that step outside the fully insured traditional insurance carrier model. Rather than being locked into high-priced agreements negotiated by insurance giants, we help employers and their employees take control of costs through self-funding.

At its core, a self-funded health plan allows employers to take on the financial responsibility of paying for their employees' healthcare claims directly, rather than paying fixed premiums to an insurance carrier. This approach offers significant advantages, especially for mid-to-large-sized businesses that want more control over both costs and plan design. Instead of paying for coverage that may not align with their employees' needs, companies can create custom benefits that better match their workforce.



Note: Health spending is shown in terms of both nominal dollar values (not inflation-adjusted) and constant 2022 dollars (inflation-adjusted based on the personal consumption expenditures (PCE) annual index).

Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF Health System Tracker

Also, with self-funding, businesses have direct insight into how healthcare dollars are being spent. Employers pay only for actual claims incurred by their employees rather than paying a carrier for projected claims.

Further, self-funding provides an opportunity for businesses to retain any unspent healthcare funds. Rather than padding an insurer's profit margin, excess funds can be reinvested into the company or the health plan itself, further reducing costs over time.

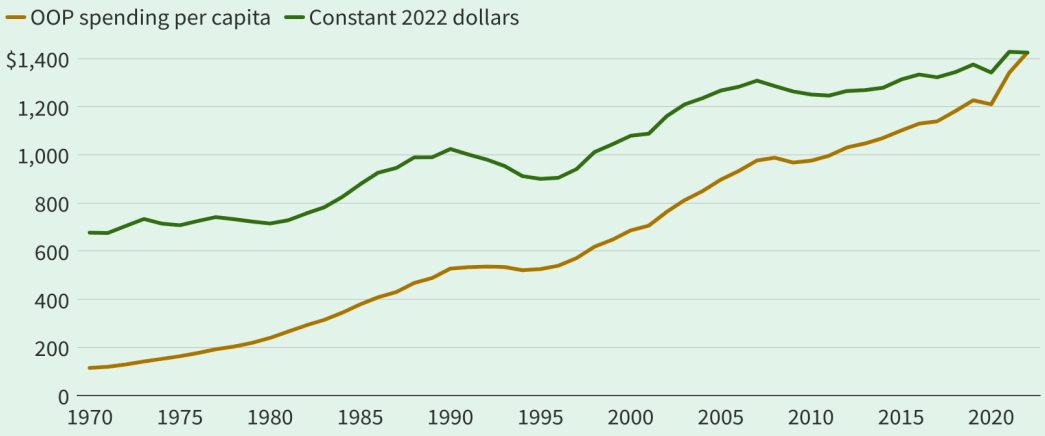
Self-funding also offers the ability to avoid some of the taxes and fees associated with fully insured plans, allowing employers to further maximize their healthcare budget.

Cash Payment for Services

In a system where insurance costs and reimbursement rates are often inflated, paying cash for healthcare services – as the self-funded model allows – can be a game-changer.

By negotiating directly with doctors, hospitals, and clinics, we help employees pay less for their care and often significantly less than they would under a traditional health plan.

Per Capita Out-of-Pocket Expenditures, 1970-2022



Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF Health System Tracker

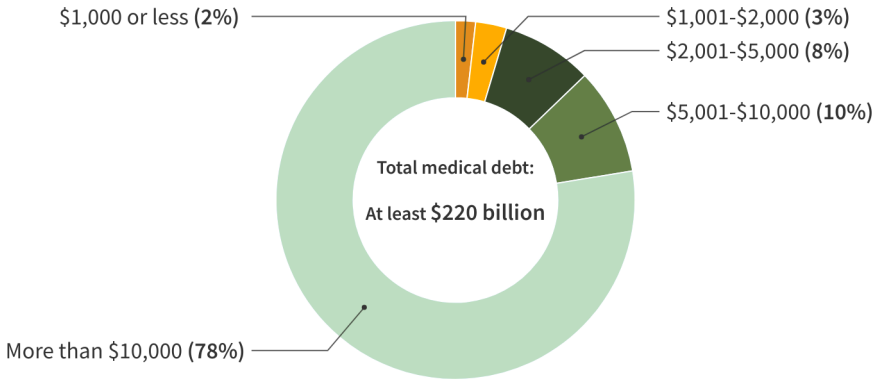
This empowers employees to seek care when they need it, instead of waiting until an emergency arises. And for employers, this leads to a healthier, more productive workforce, with fewer catastrophic claims that drive up costs.

Negotiated Pricing

Beyond cash payments, self-funding also allows us to facilitate negotiated pricing outside the scope of what traditional insurance carriers arrange. These agreements provide transparency and predictability for both employees and providers. With clear, upfront pricing, there are no surprise bills or hidden costs that can blindside families.

Instead, employees know exactly what they are paying for each service, giving them the freedom to make informed healthcare decisions without the fear of crushing financial consequences.

Share of Aggregate Total Medical Debt in the U.S., by the Amount of Debt Individuals Owe, 2021



Note: To reduce the influence of the highest debt holders on the total, KFF used a conservative method to calculate medical debt for respondents with extremely high debt amounts. This approach removes the highest debt values from the calculation. This analysis is limited to those owing over $250 in medical debt.

Source: KFF analysis of the Survey of Income and Program Participation (SIPP)

Peterson-KFF Health System Tracker

THE LACK OF COST TRANSPARENCY

For most Americans, understanding the true cost of healthcare is a guessing game. Whether it's the price of a hospital stay, a prescription drug, or a routine medical procedure, patients are often left in the dark until the bill arrives.

The lack of transparency in the U.S. healthcare system has created confusion and frustration for employees and employers alike. For businesses, this opacity leads to unpredictable healthcare spending and contributes to skyrocketing costs. Employees, meanwhile, face a constant fear of the unknown — never sure how much they'll owe after receiving care.

This broken system has dire consequences. Without clear pricing, individuals can't make informed decisions about their care. In many cases, they avoid seeking treatment altogether, fearing the financial burden that may come with it. For employers, this lack of transparency makes it nearly impossible to plan for healthcare costs, leading to yearly budget surprises and premium hikes.

OUR SOLUTIONS

Transparent PBMs

Pharmaceutical costs are a major driver of rising healthcare expenses. The traditional model for pharmacy benefits management (PBM) often includes hidden fees, rebates from drug manufacturers, and opaque pricing structures. We take a different approach by partnering with PBMs that are fully transparent, passing savings directly to employees. These PBMs have sworn off drug company rebates, ensuring medication costs are clear and fair.

This approach helps employers save on prescription drug costs while providing employees with access to affordable medications. By removing the hidden incentives that have plagued the pharmaceutical industry for years, we bring integrity back into the equation — allowing employees to get the prescriptions they need without the financial burden.

Data-Driven Insights

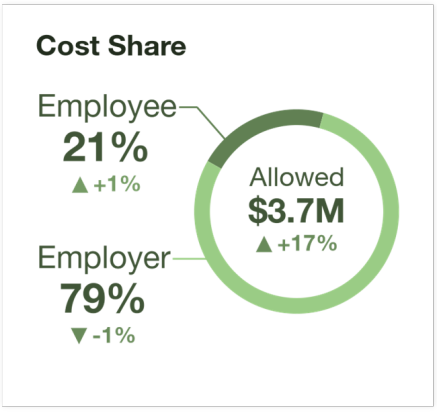
One of the greatest advantages to self-funding is that it provides employers with direct access to health claims data. However, raw data alone isn't enough. Partnering with health data providers as we do allows employers to get a detailed look at where healthcare dollars are being spent, uncovering inefficiencies, patterns, and potential cost savings.

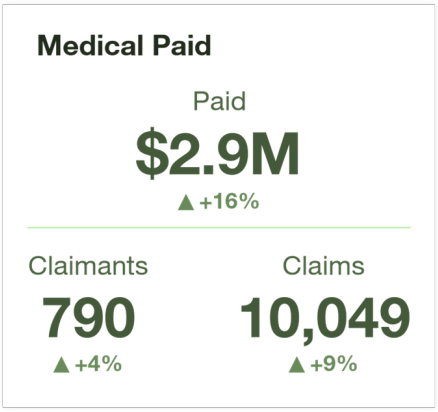
For instance, data can highlight which treatments or procedures are driving up costs, where employees may be over-utilizing certain services, or where preventive care measures could significantly lower long-term expenses.

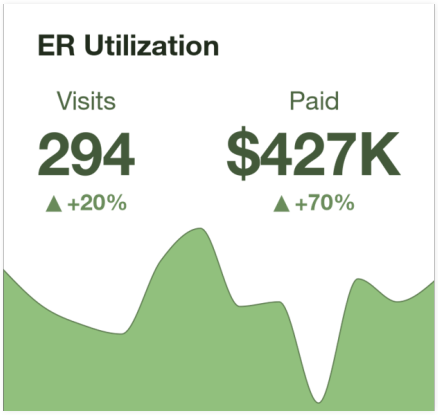
Employers can also gain insights into high-cost claims and chronic conditions, helping them design interventions that address specific health needs within their workforce.

With this level of transparency, companies can shift from reactive healthcare spending — paying bills after the fact — to a proactive approach, where they can take steps to reduce costs before they spiral out of control. It also allows for better communication with employees, offering them clarity about their benefits and how to best utilize the health plan for their needs.

By leveraging health data, companies can make more informed decisions about plan design, employee wellness initiatives, and vendor selection, ensuring that every dollar spent is driving value. This level of visibility is nearly impossible in a traditional plan, where insurers provide little more than summary reports.







Reference-Based Pricing

Another solution that is helping employers regain control of their healthcare spending is reference-based pricing (RBP).

In a traditional insurance model, healthcare costs are largely dictated by the contracts between insurers and providers, which often leads to highly inflated prices for routine procedures. RBP flips that script by setting a benchmark — often based on a multiple of Medicare rates — against which healthcare services are priced.

Instead of relying on negotiated rates between insurers and providers, RBP establishes a transparent, fair-market price for various medical services.

For example, instead of paying a hospital's inflated charge for a knee replacement, which could vary wildly depending on the provider, employers using RBP agree to pay a fixed percentage over the Medicare reimbursement rate for that procedure. This ensures that employees receive care at a reasonable cost, without the extreme markup that often accompanies hospital bills.

RBP empowers employers by capping what they will pay for a service, ensuring cost predictability and reducing the risk of surprise bills. It also puts pressure on providers to accept fair-market rates rather than taking advantage of the opaque pricing structures that dominate the healthcare industry. Employees benefit from this model as well, often with lower out-of-pocket costs for services and the peace of mind that they are not being overcharged.

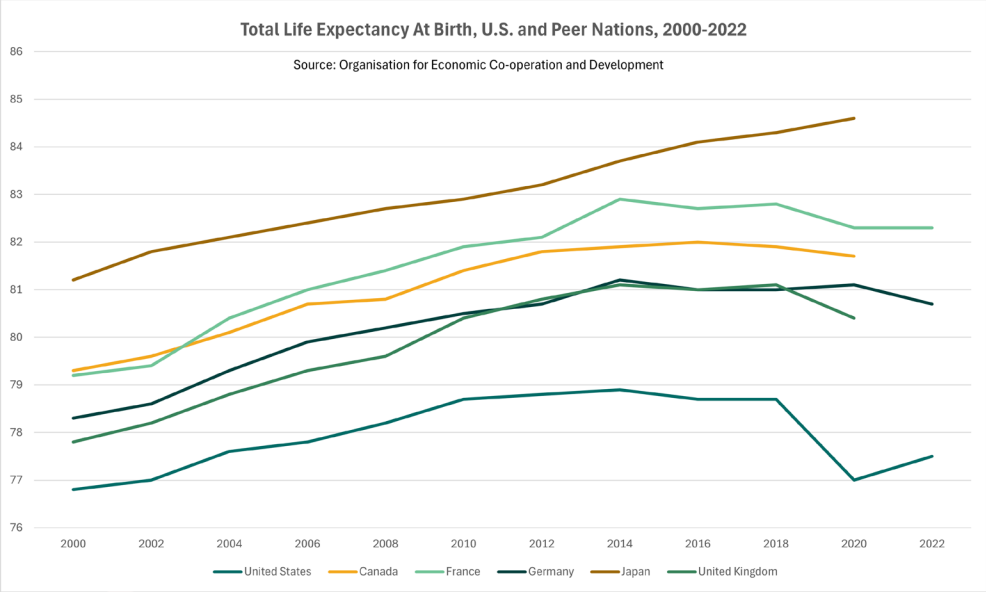
Real-Time Price Visibility

Another of the key tools we offer is access to real-time price information for medical services. With our partners, employees can check the cost of a procedure, doctor visit, or prescription before they step into a clinic or pharmacy. This enables them to compare prices, select the most cost-effective option, and avoid being hit with surprise bills after the fact.

Whether it's a routine checkup or a specialized treatment, they know exactly what to expect — eliminating financial guesswork and giving them confidence in their healthcare choices.

THE QUALITY-OF-CARE CRISIS

The United States may spend more on healthcare than any other country, but when it comes to outcomes, we lag far behind. Whether it's life expectancy, patient satisfaction, or the prevention of chronic diseases, the U.S. ranks poorly compared to other Western nations.



This isn't just a reflection of poor lifestyle choices; it's also a consequence of the uneven quality of care that permeates our healthcare system. The unfortunate reality is that many patients receive subpar care, often from providers whose primary incentive is volume over quality.

For employers, this means higher costs and worse health outcomes for their workforce. When employees receive ineffective or low-quality treatment, they end up needing more care, which only adds to the financial burden. Worse still, this poor care often results in long-term health complications that could have been avoided with timely and effective treatment. This not only increases healthcare costs but also impacts productivity and morale, as employees struggle with unresolved health issues that could have been better managed.

OUR SOLUTIONS

Direct Primary Care

While traditional healthcare often involves high costs, long waits, and limited time with providers, Direct Primary Care (DPC) offers a refreshing alternative that benefits both employers and employees. In a DPC model, patients pay a flat monthly fee directly to their primary care provider, bypassing insurance billing and allowing for more accessible, personalized care.

This flat monthly fee model covers a range of essential services, from routine checkups to chronic disease management, and allows employees to see their provider as often as needed without added costs. The result? More frequent and meaningful interactions with doctors, leading to better preventive care and early detection of health issues.

As a result, employees feel more supported in managing their health, and the simplified, predictable pricing structure eliminates much of the frustration associated with traditional healthcare. For employers, DPC offers a cost-effective option that can reduce downstream expenses by keeping employees healthier and out of the ER or urgent care for routine issues.

Centers of Excellence

Centers of Excellence are hospitals, clinics, and specialized medical centers that consistently deliver exceptional outcomes across a range of treatments and procedures. By partnering with these institutions, we provide our clients and their employees access to the best care available — often at a lower cost than traditional healthcare facilities. These centers are recognized for their expertise, high success rates, and commitment to patient care, ensuring that employees receive the most effective treatments without unnecessary complications or repeat visits.

What's more, care at Centers of Excellence often comes with no copays and no deductibles, meaning employees can receive top-tier treatment without worrying about the financial strain. This approach not only improves health outcomes but also reduces long-term costs for both employees and employers by ensuring that problems are solved the first time, eliminating the need for costly follow-up treatments.

Specialist Networks

Beyond Centers of Excellence, we also work with curated networks of specialists who are experts in their respective fields. These specialists agree to deliver care at significantly reduced costs, often with no out-of-pocket expenses for the employee. By focusing on networks with a proven track record of success, we ensure that employees are treated by physicians who prioritize quality, not volume. This means fewer misdiagnoses, fewer unnecessary procedures, and better overall outcomes.

For employers, these networks represent a critical tool in controlling healthcare costs. By directing employees to specialists who deliver high-quality care at lower prices, we help prevent the cascade of escalating medical expenses that often results from poor treatment. The result? Healthier employees, reduced absenteeism, and fewer costly claims for catastrophic conditions.

LET'S FIX YOUR HEALTHCARE PLAN — TOGETHER.

THE MAHONEY GROUP®

Contact us today to take the first step toward a healthier, more sustainable future for your business and your employees.

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About The Mahoney Group

Embracing a bold, innovative approach, the Mahoney Group's Employee Benefits Practice is committed to breaking away from conventional solutions. Our deep industry expertise, coupled with cutting-edge strategies, enables us to create tailored benefits packages that not only resonate with your employees but also save both you and them money.

Whether you choose a fully insured or self-insured plan, our comprehensive suite of services encompasses benefits plan design, implementation, administration, and unwavering support. Our aim is to deliver exceptional value at every step of the way.

Founded in 1915, The Mahoney Group is one of the oldest and largest independent insurance brokers in the U.S. But what really sets us apart is our unique employee-owned structure, which allows us to align directly with your interests, not those of distant shareholders or Wall Street pressures. This alignment empowers us to focus solely on what matters most: your success and peace of mind.