

WHEN YOU'RE CONSIDERING SELF-FUNDING



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This is a general information pamphlet and discussion guide on self-funding health care benefits. Its intended use is as an informative tool, not for the marketing of goods and/or services.

This pamphlet and the information it contains does not constitute legal, financial or tax advice, nor does it serve as a substitute for legal, financial or tax advice. Federal and state insurance laws and regulations are complex; we recommend consulting with a specialist on these matters.

Self-Funding Overview

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Introduction

A growing number of employers are discovering that a self-funded health plan can be a cost-effective alternative to the traditional fully insured approach. Employers who opt for self-funding generally seek a better option for managing rising health-care costs that continue to consume an ever-growing share of the bottom line.

Consider these facts:

- Employers have experienced a 36% increase in health care costs in the past five years, from \$6,245 per employee in 2006 to \$8,516 per employee in 2011, according to the 2011 Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care. Meanwhile, employees have seen their share of the costs increase by 45%, from \$1,834 in 2006 to \$2,660 in 2011. Overall, costs have increased by 38%, rising from \$8,079 in 2006 to \$11,176 in 2011.
- They estimate that seven years from now the annual cost for single coverage will double from its 2009 rate of \$4,860, while the cost of family coverage will quadruple from its 2009 rate of \$14,244.

While rising costs are a major source of concern, employers also express frustration with the limitations of fully insured plans offered by commercial insurers. Employers may complain that plan design is inflexible, cost containment efforts are lacking, customer service is inferior or data about employees' health needs is inaccessible.

Self-funded solutions that offer opportunities to address these issues are often regarded as the exception, rather than the rule. Yet nationwide, 60% of all covered workers in the U.S. benefit from some form of self-funded medical plan, according to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.

Self insuring a benefit program can provide cost savings, an opportunity to significantly impact plan design, and utilization controls. Achieving these benefits requires learning more about the rules that govern self-funded plans, risk management, vendors who provide support services and related issues.

The Alliance has developed this discussion guide to help you understand vital self-funding concepts and terms. Insights and information have been gathered from various industry resources, including the Self Insurance Institute of America, Health Insurance Association of America (HIAA) and Duncanson & Holt Group Reinsurance Managers. The Alliance has also drawn on its considerable expertise as an employer-owned, not-for-profit cooperative that began serving self-funded employer groups in 1990.

This guide focuses on the major issues related to self-funding a group medical plan, which typically represents the largest cost within an employers' benefit package. Employers may also choose to self-fund other health-related benefits, such as dental, vision, prescription drug or short-term disability coverage.

How Self-Funding Works

In a self-funded or “self-insured” health plan, the employer accepts responsibility for the risk of health care for enrollees. The employer **self-funds** the plan rather than paying a premium to a commercial insurer. Employers may choose to be partially or fully self-funded.

Typically, employers work with an agent, broker, consultant or Third Party Administrator (TPA) to structure their self-funded plan. Steps required to create a self-funded plan include:

1. Secure stop loss coverage to protect the employer against extreme losses. The amount of risk to be insured will be determined by the employer’s size, nature of business, location, plan of benefits, financial resources and cash flow, prior claims experience and risk tolerance.
2. Prepare a health benefit plan document. This document will address the various plan provisions, including eligibility, coverage and termination. The TPA may assist with plan development by preparing Summary Plan Descriptions (SPDs), identification cards and other materials required for plan operation.
3. Obtain a contract with a TPA. The TPA administers the plan for the employer. Responsibilities may include maintaining proper funding so claims can be paid; paying the claims; and preparing claim reports and other data for the plan, the stop loss carrier and required government reports. The TPA may also bill and collect any premium and administrative fees for the plan.
4. Choose a network that has good health care provider coverage and claims savings.

Advantages of Self-Funding

In theory, a self-funded plan will be more cost-effective in the long run than a fully insured plan because many expenses associated with a fully insured plan are eliminated. The savings achieved from lower than expected claims belong to the employer and do not become the “profit” of the insurer. Employers that choose to self-fund their health benefit programs enjoy the following advantages:

A. Employer Control

An employer is allowed more control over their health benefit program.

1. Claims Process and Administrative Services

The self-funded employer chooses the TPA that is best suited for its needs and that will provide them with the greatest flexible service.

2. Cost and Utilization Controls

Under a traditional fully insured model, the employer is restricted to using cost and utilization control programs that are offered by the insurance company. With a self-funded program, the employer can choose cost and utilization control programs that best meet the needs of the health benefit program. A variety of programs are

available to self-funded employers, including but not limited to second surgical opinion programs, large case and disease management programs, pharmacy benefit programs, and access to employer cooperative networks and Preferred Provider Organizations (PPOs).

3. Cash Flow

The employer's cash flow is improved when the employer "frees" money that is paid and held by the insurance carrier in the form of reserves or pre-paid premium, for the employer's own use. Typically, a self-funded employer pays for expenses only after they have been incurred. Interest earned on reserves, which are established by the employer for the payment of claims, remain under the employer's control. In addition, a self-funded plan eliminates the premium tax, which can represent 2% to 3% of the fully insured premium amount.

4. Choice of service providers

Under a traditional fully insured plan, employees are limited to obtaining services from the service providers within the network offered by the insurance company. With a self-funded plan, the employer can choose a provider network that best fits with the needs of the employees.

5. Plan Design

Flexibility in designing a plan that best fits the employer's needs as well as the needs of its employees is very important to the self-funded employer. The Employee Retirement Income Security Act of 1974 (ERISA) regulates self-funded plans, which means that self-funded plan designs are exempt from requirements related to costly state-mandated benefits.

6. Data and Benchmarking

Self-funding typically offers access to data and benchmarking for the plan sponsor, which in most cases is an employer. Most sponsors want to see a twelve-month rolling or building summary of the most important indicators of the status of the plan. Among the more prevalent indicators are total charges, total payments, payments per enrollee, payments by various service code groupings (based on place of service, type of provider, and/or diagnosis), what providers receive the greatest number of dollars and why, and how effective the network is in terms of utilization and discounts. Simple summaries, however, are not enough. When an adverse trend is identified or a significant divergence from the norm is presented, the plan sponsor needs the ability to drill down to the details to find the reasons behind the changes. Access to data also enables plan sponsors to compare current performance against historical data for the employee group, as well as national benchmarks that indicate how the plan compares to national trends.

B. Elimination of Carrier Profit Margins

Generally, employers that self-fund a health benefit program do not look to the program to make a profit for the company. Self-funding eliminates insurer profit margin.

C. Lower Operating Costs

Employers frequently find that administrative costs for a self-funded program through a TPA are lower than those charged by an insurance carrier.

D. Risk Management

The employer is responsible for all claims. The employer may choose the amount of risk to retain and the amount to be covered by Stop Loss coverage.

E. Premium Tax

In most states, premium tax is not applicable under an employer's self-funded program and may result in an immediate savings of premium tax previously paid by the employer. However, premium taxes are not charged on HMO plans and are eliminated by some commercial insurers.

F. Uniform Regulations

One comprehensive federal law, ERISA, regulates self-funded plans. ERISA exempts self-funded plans from state laws. This uniformity of law substantially reduces administrative expenses as well as allowing employers the ability to offer uniform benefits, especially for multi-state employers.

Disadvantages of Self-Funding

Self-funding of the health benefit program is not the best solution for every employer. While companies with as few as 100 employees operate successful self-funded health benefit programs, employers must assess their ability to assume the risk of paying for the health care claim costs of their employees. Each employer must consider whether its work force stability and cash flow enables the organization to predict and cover the costs of claims incurred by its health benefit plan participants.

To be effective in attaining the advantages of self-funding, the employer must be willing to actively manage eligibility for benefits, payment of claims and incurring expenses. Self-funding may not reduce costs every year, or at all. While stop loss coverages limit the employer's liability, there is some risk that is assumed by the employer. The employer must be comfortable in trading the complete security of a fully insured plan for the possibility that actual cost could exceed the cost of a fully insured plan in any given year. Taking a long-term approach to self-funding can smooth out years when costs fall outside the norm.

The employer must be willing to deal with several potential disadvantages:

A. Risk Assumption

The employer assumes the risk. If the employer has had historically worse than average claims experience, they should probably elect not to self-fund.

B. Administrative Responsibilities and Employer Involvement

Increased employer responsibility will be assumed to replace services typically and traditionally provided by an insurer under an insured plan. Most employers contract with a TPA to accomplish some of the additional administrative duties; other responsibilities may not be contracted away. These responsibilities include the employer's legal and fiduciary responsibilities. The viability of the benefit plan is now based on the financial stability of the employer rather than that of the insurer.

C. Asset Exposure

The employer's assets are exposed to any liability created by legal action against the self-funded plan.

Roles and Responsibilities

A self-funded plan requires a new structure for administering the health plan, from the regulations that govern plan administration to the professionals whose services may be retained to help administer it. Understanding these roles and responsibilities can help employers make appropriate decisions as they weigh the possibilities represented by a self-funded health plan.

Regulations

The federal ERISA law regulates self-funded plans and pre-empts state laws. Due to this ERISA preemption, self-funded employers are able to design their benefit programs without regard to state-mandated benefits. This uniformity of law substantially reduces administrative expenses as well as allowing employers the ability to offer uniform benefits, which can be especially useful for multi-state employers. In addition to ERISA, the Department of Labor (DOL) and the Internal Revenue Service (IRS) may have rules and regulations that apply to self-funded plans and programs.

Employer Role

Under a self-funded arrangement, employers fund their benefit programs and assume responsibilities that an insurance company would normally assume under a fully insured program. So instead of seeking traditional coverage from an insurance company, employers elect to fund the risk directly from their assets. The employer assumes liability for claims, including responsibility for the administrative functions customarily provided by an insurance company. In many cases, these functions are assigned to a TPA to handle on the employer's behalf.

The employer has the freedom to establish a benefit program that best fits its needs. Employers are no longer restricted to programs offered by insurers. This flexibility, combined with financial responsibility for plan expenses, provides employers with an incentive to both reduce health plan costs and offer the benefits that are best suited to their employees.

There are products and services available to assist employers in the administration of their self-funded programs as well as to protect them against catastrophic or unpredictable losses (see the “Risk Management” section on page 7 for a detailed discussion of these products and services).

TPA Role

Most employers do not have the capacity or the expertise to handle the day-to-day operation of a health benefit program. Those who choose to self-fund their benefit program generally contract to purchase administrative services from a TPA. The TPA plays a significant role in the administration of an employer’s self-funded benefit plan.

Basic TPA arrangements usually include:

- Development of forms necessary to administer the program
- Adjudication of claims and benefit processing
- Eligibility/enrollment determination and reporting
- Communications/customer service
- Employer and government report preparation and record keeping
- Acquisition of assistance with excess loss (stop loss) coverage

Additionally, TPA services or independent vendors can provide the employer with many services typically provided by an insurer, including:

- Consulting in design, preparation and printing of the Summary Plan Description (SPD)
- Actuarial/underwriting advice and cost projections for benefit changes and additions
- Consultation on state and federal benefit requirements and developments
- COBRA administration
- Cost containment services (precertification, large case management, utilization review, disease management, hospital bill audits, etc.)
- HIPAA compliance
- Claim reports
- Access to other services and vendors such as case management and disease management services

A contractual agreement, generally called an Administrative Services Only (ASO) agreement is established between the TPA and the employer. This agreement will specify the exact service(s) to be performed, performance guarantees and standards (accuracy of claims, timeliness of claims, etc.), the rights and obligations of both parties and the administrative fees.

The selection of the right TPA is critical to the success of an employer’s self-funded plan. Criteria that reflect the elements that are important to the employer should be established, followed by a detailed review and selection process that discloses the capabilities of the TPA. This detailed review should take place prior to signing an ASO agreement.

Risk Management

One of the most important considerations for self-funding an employee benefit plan is the employer's ability to purchase stop loss coverage. Other key issues to consider include the ability to evaluate the viability of the stop loss carrier and the benefits and programs that the carrier brings to the self-funding equation. The attached appendix, *Stop Loss Insurer Key Attributes Check List*, is designed as a tool to guide the employer that has decided to pursue a self-funded benefit plan.

An employer offering a self-funded health plan often purchases stop loss coverage through an insurance company as protection against catastrophic or unpredictable large losses. Under stop loss coverage, the insurance company providing the stop loss coverage becomes liable to the employer for losses that exceed certain dollar limits. And, usually, the stop loss company reimburses the employer for the covered loss. So, stop loss coverage protects the employer; it does not insure employees.

Many reinsurance carriers will discount their premiums based on the utilization of a network. Reinsurance carriers have evaluated The Alliance's network, savings and methodology, yielding discounts off of premiums in the range of 18% to 45% for members of The Alliance.

Typically, stop loss coverage may be purchased on a specific and aggregate basis.

Specific Stop Loss

Specific Stop Loss limits an employer's exposure for eligible medical expense costs associated with each covered individual during a plan year.

The Specific Stop Loss level is set at a pre-determined dollar amount. If eligible medical expenses incurred by a covered individual exceed the Specific Stop Loss limit, the stop loss company reimburses the employer as specified in the contract.

Example:

The employer purchases stop loss coverage with a \$20,000 specific stop loss limit. Payable claims are received for a covered individual during a policy year totaling \$35,000. The employer pays the covered charges of \$35,000 and in turn the stop loss carrier reimburses the employer \$15,000 for the claims paid in excess of the specific stop loss limit.

Variations of Specific Stop Loss: Incurred and Paid

Specific Stop Loss contracts are generally offered on an incurred and paid basis. Only eligible medical expenses that were both incurred and paid during the contract period are covered. However, variations as to the incurred period (months) and paid period (months) offer

employers flexibility in plan design and contracts. Below are examples of two variations of Specific Stop Loss found in contracts:

Incurred in 15 months and paid in 12 months (15/12). This contract provides coverage for expenses that are incurred in the three months prior to the carrier's initial effective date and paid during the first contract period.

Incurred in 12 months and paid in 15 months (12/15). This contract provides coverage for eligible services incurred during the contract period and paid by the employer within the contract period (12 months) or the three months immediately following the contract period. This variation provides greater protection to the employer for events occurring at the end of the contract period.

Premiums for Specific Stop Loss coverage are typically charged as a rate per covered employee per month and a rate per covered dependent unit per month. However, individual stop loss carriers may use different rate designs. Obviously, Specific Stop Loss coverage amounts and rates are established at the time of contracting and again at renewal.

Specific Stop Loss may be purchased without the purchase of Aggregate Stop Loss.

Aggregate Stop Loss

Aggregate Stop Loss coverage limits the employer's exposure for eligible medical expense costs associated with all claims for all covered individuals during the entire plan year. When eligible expenses paid during a contract period exceed the aggregate level, the employer is reimbursed as specified in the contract.

Issues to examine on Aggregate Stop Loss coverage include the annual aggregate deductible and the contract basis.

Annual Aggregate Deductible

The employer is expected to be able to fund the normal expected claims plus an additional amount. The Aggregate Stop Loss coverage generally commences after claims reach an "expected amount" plus 20-25% (or claims exceed 120-125% of expected). There are, however, numerous variations and coverage options, attachment points and determinants available from stop loss carriers.

Contract Basis

Aggregate contracts are typically offered on an incurred and paid basis. Only eligible expenses that are both incurred and paid while under contract are covered. Specific Stop Loss may be purchased along with aggregate coverage to provide protection before the aggregate is met.

Conclusion: Next Steps

Self-funding can offer many opportunities for employers willing to take an active role in managing their employee health benefit expenditures. While self-funding clearly offers both advantages and disadvantages, many employers can benefit from learning more about their options and exploring the possibilities that self-funding may offer to their organization and their employees.

Glossary

Aggregate Attachment Point

The aggregate “deductible” that sets the point above which the stop loss insurance company begins reimbursing the Plan Sponsor. Aggregate attachment points are calculated by multiplying for each month, the single census times the single aggregate factor, plus the family census, times the family aggregate factor.

Aggregate Stop Loss

Insurance coverage to self-funded employers that provides a ceiling on the dollar amount of eligible expenses that an employer would pay, in total, during a contract period. Coverage is written on a paid claim basis, one year at a time. The carrier reimburses the employer after the end of the contract period for Aggregate claims.

ASO (Administrative Services Only)

An ASO plan is a contract with an insurer to provide a fully self-insured employer with certain administrative services only; no insurance protection is provided.

Attachment Point

Same as Annual Aggregate Deductible. That point above which the liability of the stop loss carrier is attached.

Benefit Booklet

A booklet for the employee that contains a general explanation of benefits and related provisions of the health plan.

Employee Retirement Income Security Act of 1974 (ERISA)

This federal legislation allows for and sets guidelines regarding a group’s ability to self-fund their benefits.

Expected Paid Claims

An estimate of the dollar value of claims to be paid during a plan year or contract period.

Exposure

The state of being exposed to the chance of loss (risk). The extent of exposure as measured by participation, proportion of female or male lives in a group, amounts or units of insurance at risk, etc.

Fiduciary

- Indicates the relationship of trust and confidence where one person (the fiduciary) holds or controls property for the benefit of another person. For example, the relationship between a trustee and the beneficiaries of the trust.
- Under ERISA any person who (a) exercises any discretionary authority or control over the management of a plan or the management or disposition of its assets, (b) renders investment advice for a fee with respect to the funds or property of a plan, or has the authority or responsibility in the administration of a plan.

- One who acts in a capacity of trust and who is therefore accountable for whatever actions may be construed by the courts as breaching that trust. Under ERISA, fiduciaries must discharge their duties solely in the interest of the participants and beneficiaries of an employee benefit plan. In addition a fiduciary must act exclusively for the purpose of providing benefits to participants and beneficiaries in defraying reasonable expenses of the plan.

IBNR

Incurred but not reported. Claims that have been incurred but have not been reported to the administrator as of some specific date.

Incurred Claims

Those claims (paid or unpaid) for which a liability (the insurer's) has arisen under provisions of an insurance contract.

Lag

The usual delay between the actual occurrence of a claim and its payment. Made up of both incurred but unreported claims, as well as reported but not yet paid claims. A function of benefit design, geographic location and administrative efficiency as well as human procrastination.

Mandated Benefits

A specific coverage that an insurer or plan sponsor is required to offer by law. Mandated benefits in insurance contracts vary from state to state according to each state's insurance laws.

Paid Claims

The dollar value of all claims paid, i.e., hospital, medical, surgical, etc., during the plan year, regardless of the date that the services were performed.

Plan Document

Explains the provisions of a plan, usually including the benefits provided by the plan and the rights of those who are covered under the plan.

Plan Participant

An employee or dependent covered by the health plan.

Plan Sponsor

1. The employer, in the case of an employee benefit plan maintained by a single employer.
2. The employee organization, in the case of a plan maintained by an employee organization.
3. The association, committee, joint board of trustees or other similar group of representatives of the parties involved, in the case of a plan maintained by one or more employers, and one or more employee organizations.

Policyholder

The employer, trust or other entity with which the insurance company has a contract to provide insurance coverage.

Specific Stop Loss

The form of excess risk coverage that provides protection for the employer against a high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Specific Stop Loss is also known as Individual Stop Loss.

Stop Loss Carrier

The insurance company that provides specific and aggregate protection for the Plan Sponsor. This carrier can be changed without disrupting to the health plan.

Stop Loss Insurance

Contract established between a self-insured group and insurance carrier providing carrier coverage if claims exceed specified dollar amount over a set period of time.

Summary Plan Description (SPD)

The written statement of a plan required by ERISA. It must be provided in an easy-to-read form, including a statement of eligibility, coverage, employee rights and appeal procedure.

Third Party Administrator (TPA)

The party to an employee benefit plan that may collect premiums, pay claims and/or provides administrative services. Usually an out-of-house professional firm providing administrative services for employee benefit plans.

Appendix

Stop Loss Insurer Key Attributes Check List

<i>Stop Loss Insurer</i> <i>Key Attributes</i>	Candidate 1	Candidate 2	Candidate 3	Candidate 4
1 Allows dual choice of employer plan design				
2 Lasering practices				
3 Any employer class restrictions				
4 Employer size restrictions				
5 Stable insurer: service rating				
6 Purchase of other insurance products required				
7 Minimum specific level				
8 Will they take The Alliance network into consideration when preparing pricing				
9 Pooling experience				
10 Any access requirements, preferred TPAs or other restrictive arrangements				
11 Cost containment products offered				
12 Efficiency of claims reimbursement				
13 Direct stop-loss insurer access				
14 Rates quoted				
Total Score				

Key Attribute Definitions

- 1. Allows dual choice of employer plan designs**
This attribute measures degree of flexibility of the stop loss plan; attribute to consider if you offer an HMO along with your self-funded program.
- 2. Lasering Practices**
Determine if lasering and application of new underwriting standards are a common practice at renewal of existing accounts for this reinsurer.
- 3. Employer Class Restrictions**
Does the reinsurer underwrite businesses in your SIC?
- 4. Employer Group Size Restrictions**
Does your business fit the reinsurer's size requirements?
- 5. Stable Insurer**
Insurance companies receive ratings from independent rating services, such as: Standard & Poor's, Weiss Research, A.M. Best Co., Duff and Phelps, and Moody's Investor Services. Each service providers ratings based on a letter scale. Be aware, however, that the letter scales may mean different ratings and each rating service has different rating schemes and manners.
- 6. Purchase of other insurance products required**
Some stop loss carriers require purchasers to also purchase their life, short-term or long-term disability products. No requirement for other purchases should be made.
- 7. Stop Loss minimum levels**
Do the stop loss levels offered meet the needs of your group?
- 8. Premium takes into consideration The Alliance Network**
The Alliance's network provides significant claims savings for employer members. Due to the depth and breadth of this network it is appropriate that stop-loss premium should take this "savings" into consideration.
- 9. Pooling Experience**
If yes, the stop loss carrier should be able to explain how rates were determined and what type or sort of credit or "savings" the pool realized due to pooling. Was the pricing tiered? For example, was the base rate the pool rate plus some credit or debit for your group? Was your agent/broker/consultant allowed to be involved? What are the agent/broker/consultant commissions? Are first year commissions the same as renewal? Does the pool need to have a "preferred TPA?" What is the commission paid to the TPA? Does the TPA retain the percentage of "Claims savings?" Claims savings is the percent of premium given back to the TPA and sometimes shared with the agent/broker/consultant for claims management/utilization.

10. Access requirements, Preferred TPAs or other restrictive arrangements

Stop loss carriers have particular needs that must be fulfilled by the TPA. These needs include accuracy in reporting, billing, notification, maintenance of enrollment information, shock loss notification, monthly aggregate reporting and claim submission to name a few. Is the reinsurer willing to work with your current TPA? How can your current TPA obtain “preferred” status?

11. Cost Containment products

Is there a premium consideration for additional programs offered under your benefit design that manage health care dollars or benefit plan risk?

12. Efficiency of Claims Reimbursement

Stop loss carriers reimburse the employer after the employer pays a claim that exceeds the specific level. It is important that the reinsurer provide timely and efficient reimbursement.

13. Direct stop-loss insurer Access

Are you able to communicate with the stop loss carrier directly with regard to claim, underwriting concerns, enrollment, billing or invoices?

14. Rates Quoted

Are rates quoted competitive for the services provided?



Who is The Alliance®?

The Alliance is an employer-owned, not-for-profit cooperative whose mission is to move health care forward by controlling costs, improving quality and engaging individuals in their health. On behalf of members, we:

- Maintain a broad network of health care providers so Alliance members have the freedom to choose their own doctor and hospital.
- Pool the purchasing power of our members to negotiate a fair price to pay for health care services.
- Provide information and resources to help employers develop and implement their health benefit strategy.
- Offer resources and support to help employees and their family members stay healthy or manage illness.
- Create tools, such as our *QualityCounts*[™] reports which help employees and their family members be informed consumers of health care.

The Alliance serves more than 160 member employers that provide coverage to 83,000 employees and dependents in Wisconsin, Illinois and Iowa.

Want to learn more about self-funding and The Alliance? Contact us today:

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