



The BRMS Approach to Health Care

**Managing your Employee Benefits
& Getting the Most from your Plan**

**A business white paper
January 2006**

The Current Health Care Environment

In today's business climate, many employers have found that benefits have lost much of the value for which they were originally intended and are now viewed as an entitlement.

This environment, coupled with the complex nature of the market and the ever-increasing cost of offering employee benefits, has driven many employers to focus on the contribution they will make, losing sight of the real value of offering employee benefits.

Employee benefits were originally introduced to recruit, retain and protect the welfare of an employer's most valued asset — their employees. Falling into the trap of managing this tool solely by cost, is leading to a market controlled by the carriers and providers. This model misses the connection between the plan sponsor, member and provider, which has fostered the acceleration of the current environment of increased costs.

The current market of rapidly increasing benefits costs is reminiscent of the market in the early 80's. During this time, we were coming off a decade of expansion in the employee benefits world and the pressures of increasing provider costs along with excessive administrative costs from big insurance companies led to a rapid search for different approaches to offering employee benefits.

There were two market forces at work at this time. In the private sector, we saw a significant reduction in the number of insurance companies willing to offer employee benefits. We saw a very rapid increase in outsourcing of the administration to third party administrators to reduce administration cost function, and in employers self insuring a portion of the benefits offered to get a better handle on the loss function of the benefits offering.

In the public sector, we saw the introduction of legislation that allowed for the formation of Health Maintenance Organizations (HMO) which, in certain sectors of the country, have become the dominate delivery system. It is this delivery system, which has shifted the risk component predominately to the providers, that is in jeopardy and seeing the highest rate of increase. While the HMO model remains viable, it is the management of the model that has led to the rapid increases.

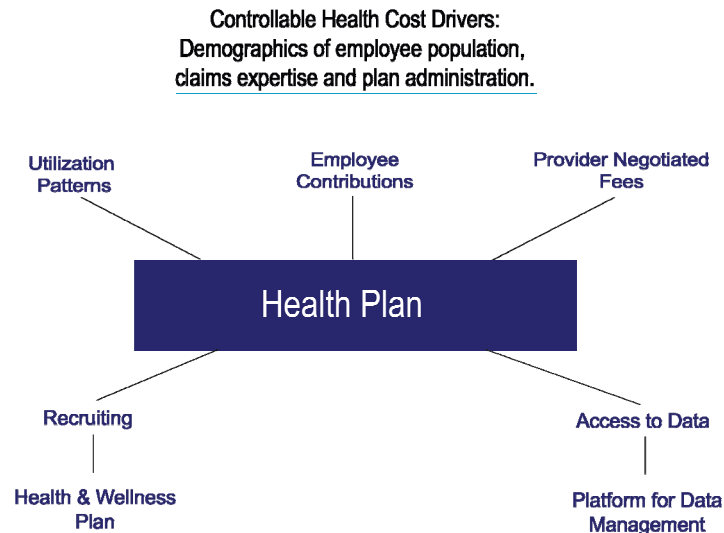
The HMO model was afforded incentives in the early years that encouraged the formation of these programs. These incentives, along with attractive equity markets for the stocks of managed care organizations and a virtual land rush for members, created a model that was again focused on cash flow and truly not on wellness and cost management. With some exceptions, this created was a big insurance company model reminiscent to the one that existed in the late 70's and early 80's. Once the dust settled, and the incentives were gone, the providers began negotiating increases. With the large overhead of the HMO's, we have seen double-digit increases in the past few years.

Developing a Successful Healthcare Plan

BRMS believes that plan sponsors should begin with a business approach to offering employee benefits. To the extent that the sponsor is able, they should try to rebuild the concept of offering benefits to recruit, retain and protect the welfare of its most valued assets — its employees.

To begin this process, we feel it is important that the sponsor look back on recent employee benefit's history and build a new model that takes away the financial incentives from third-party carriers, and rewards the member, providers and plan sponsor.

The illustration below shows the controllable cost drivers of an employee benefit plan. The key elements to underwriting an employee benefit plan are demographics (age, sex, zip, etc) of the group, historical claims experience and plan administration cost. Building a new model requires that we look past those traditional elements and focus on the items that ultimately effect the cost of your plan.



An employee contribution is an obvious place to begin since this is the focus of many employers bargaining under the entitlement mentality of employee benefits. Obviously, employee contributions reduce the sponsor's cost of offering employee benefits; however, more importantly, having some element of employee participation is a key element to controlling utilization patterns and building informed consumers of health care.

Under our current system, health care is the only consumer good or service the consumer does not shop for. We go to our health care provider and say "fix me." When shopping for other consumer items, such as a car, we will shop dealers, models, service department, warranties and rebates until we settle for the product that we are satisfied with. This is our ultimate goal — to have participants shop providers based on price, quality and outcomes. As we work through the model we will see how this can be achieved.

Provider contracting is another key element to controlling employee benefit costs. Initially providers were reluctant to contract directly with plan sponsors. This has changed dramatically with the increase in PPOs and level of sophistication of third party administrators. Providers, as well as many HMO/PPOs, are willing to approve TPA access, via a proprietary panel on behalf of their clients, for a simple access fee.

Additionally, TPAs are able to contract directly with providers on behalf of the plan sponsor. We feel that this is the best form of contracting as it links providers directly to sponsors as well as participants. Our ultimate goal is to gather enough data that we can understand an outcome by provider. Again, the initial price for a service is not necessarily what the total cost will become. Having access to claims history allows a plan sponsor and participant to select providers based on outcomes.

Utilization patterns are another key element to controlling the cost of employee benefits. With access to claims data you can understand member utilization patterns and develop strategies to impact utilization patterns.

The Four key elements to this equation are (1) disease management, (2) health and wellness programs, (3) plan design and (4) recruiting. With advance claim data mining tools, plan sponsors can identify patterns and modify plan design to provide disease management to control costs from a proactive basis, measure the success and quantify the value of health and wellness programs.

Recruiting is an often overlooked item in controlling costs and utilization patterns for a plan sponsor and should be considered as a factor in controlling utilization patterns.

A Business Strategy Approach to Employee Benefits

Below is a practical outline on how to start managing your own employee benefits program.

- I. Define your Vision
 - a. Vision: To arrange and participate in cost-effective, comprehensive benefits that protect our most valuable asset — the employees and families of the ABC plan sponsor.

- II. Define your Mission
 - a. Mission: To find solutions to increase the quality and delivery of health care in the participants with better management, and maximization and reallocation of resources, while promoting health and wellness and assuring a stable long-term funding structure.

- III. Define your Objectives:
 - a. Provide Quality Health Care
 - Provide a high quality and affordable benefits plan with reliable coverage and delivery.
 - Work with organizations that support our vision and mission.
 - Continually improve the effectiveness of all our programs and services through process and quality evaluation.
 - Maintain a high level of professional competence and expertise in our staff through progressive education and staff development.

- Comply with all state, federal privacy regulations to ensure security of personal information.
- Benchmark against other similar plans and align our plan with the best-in-class.

b. Promote Health & Wellness

- Offer access to comprehensive services to improve, maintain and restore people's health.
- Through leadership and collaboration, promote, maintain, and improve the health of our participants.
- Initiate and participate in activities directed towards the promotion and maintenance of health and prevention of illness.

c. Maintain a fiscally viable and responsible organization.

- Ensure an appropriate and affordable health care system.
- Plan and deliver services to maximize quality and cost effectiveness.
- Improve access to services, providing appropriate service, and using existing resources in the most efficient/effective manner.
- Preserve effective processes and procedures in our existing system while working together to make required changes.
- Utilize technology to improve processes and increase efficiencies as well as maintain data that will foster informed decisions.

The Benefits of Self-Insurance

Premiums for employer-sponsored health insurance rose at about five times the rate of inflation. For the fourth consecutive year, we have seen double-digit growth, according to a study released June 2005 by UC Berkeley researchers.

These annual premium increases have ranged from 15 to nearly 45 percent, leaving many employers pondering how they can continue to offer their employees health benefits.

“Employers continue to look for ways to control the rising costs of health insurance, with more than half shopping around for a better option and one in six actually changing insurance carriers,” said Gary Claxton, Vice President and the Director of the Health Care Marketplace Project at the Kaiser Family Foundation.

With insurance premiums continuing to increase, you may be tempted to cut back on your company’s benefits or cut your carrier.

Before you renew plans with increased co-pays, higher deductibles or reduced benefit coverage, learn how self-funding your company benefits can be more effective and more affordable.

Self-funding has become a viable health care option for employers who are unable to meet the rising costs of HMO plans. With self-insurance, employers predetermine and pay a portion or all of the medical expenses of employees, similar to that of traditional health care providers.

Funding is established with a trust or a simple reserve account. As with other health care plans, the employee may pay a portion of the cost in premiums.

The difference is that employers maintain control over the amount of funds paid into the plan and manage costs directly, and catastrophic coverage (added protection against abnormal claims for any covered participants in the plan) is provided through a stop-loss policy.

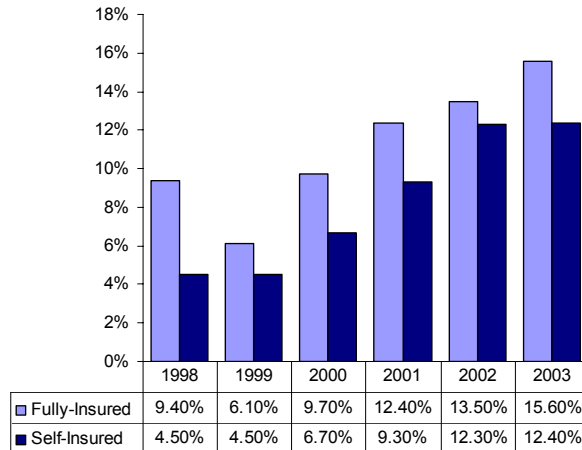
With cash flow advantages, self-funded plans are an effective way to provide health coverage while saving money and collecting interest income on claim reserves. In addition, self-funded plans are exempt from mandated benefit laws and state insurance premium taxes.

This self-funded plan has several other benefits. Plans are customizable — designed to meet the employee's specific needs — and administration is more efficient with a licensed TPA who uses the latest technology advancements to streamline processes and control your costs.

With all of these combined benefits, over time, this self-funded plan will save you significant dollars.

With one specific deductible, cost-saving benefits, additional protection and plan choices on first dollar benefits to comprehensive coverage with state-of-the-art online administration, self-funding can help your organization and your employees lower health care costs.

Fully-Insured and Self-Insured Cost Increases '04



Advantages of self-funding include:

- Better customer service
- Enhanced reporting
- Increased plan control
- Tailored administration
- Controlled Costs
- Greater control over plan management

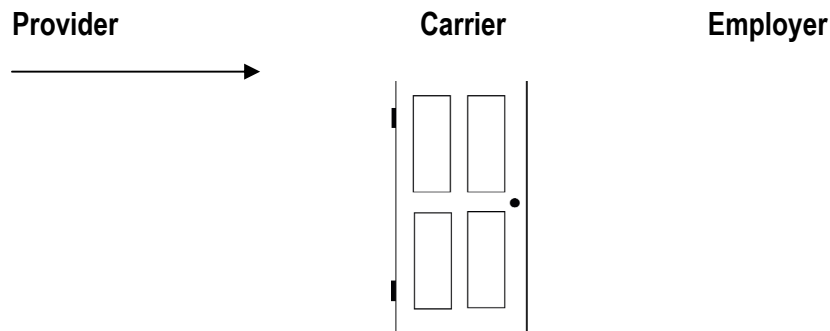
Self-funding has proven to increase cash flow and enable corporations to fund other important resources, such as increased salaries and retention programs.

As the state increases more costly mandates, more and more California employers are discovering the cost advantages of federally regulated self-funding plans. The flexibility and control over plan design allowed self-funded employers to insure 68% of the US workforce in 2003.

Currently, everyone is focusing on employee contributions, but a key element to consider is access to your data. The best way to obtain this access is to self-fund.

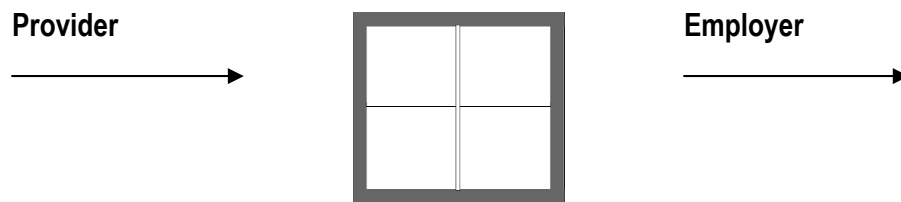
HMO

With an HMO, the carrier acts as a barrier, or closed door, to the employer.



Self-Funded Plan

With a self-funded plan, the employer has direct access, or an open window, to the provider.



About Benefit & Risk Management Services

Founded in 1994, Benefit & Risk Management Services, Inc. (BRMS) is a leading health care benefit administrator and risk management firm managing over \$600 million in employee benefits annually.

Redefining the value of Third Party Administration, BRMS provides the latest technologies and most advanced solutions that help control rising health care costs.

From plan creation and underwriting, to online management of your benefits and claims — we do it all — efficiently and cost effectively. With a management team that holds over 20 years of individual experience in employee benefits, BRMS can help design a customized program tailored to your needs. With proprietary technology — Virtual Benefits Administration System (Vbas[®]) — your health plan is administered efficiently and effectively.

Online plan enrollment, management and termination, claims processing and payment, compliance with federal HIPAA standards, managed care protections, utilization review, data warehousing, consolidated billing, reporting and customer support.

With one secure online system, your insured data is housed, protected, analyzed and consolidated. All employee benefit information is available via the Internet any time of the day or night and updated in real-time.

For more information on Benefit & Risk Management Services, contact info@brmsonline.com.