AIMS Insurance Program Managers, Inc.

THE AIMS SMART HEALTH STRATEGY

What is the AIMS Smart Health Strategy?

The AIMS Smart Health Strategy is a plan of action combined with an ART approach to insurance that allows a small or mid-size business to negotiate and price employee health insurance plans in much the same way, and with the same cost-containing elements, that businesses with thousands of employees have been doing for decades. The Strategy replaces the traditional year-by-year bidding process with a long-term plan to control costs by de-coupling the basic components of any health insurance plan so that they can be negotiated and priced independently. For example, claim processing can be separated from claims themselves, and even claims can be broken down into predictable and unpredictable strata. De-coupling also allows employers to take advantage of ERISA rules – that are generally more liberal than state rules and that are not subject to the HHS rulemaking for ObamaCare – to design plans that fit their particular needs better than the one-size-fits-all plans generally available to smaller companies.

The overall Strategy is designed for companies that are ready and willing to make a 3-to-5-year commitment to break the cycle of ever-increasing premium with no explanation other than that medical costs "trend" upward every year. It allows companies that have relatively healthy populations with at least 15 enrolled employees, and that are willing to work with their employees to make them even healthier, to keep costs well below trend while at the same time providing superior plans that better meet employees' real needs.

Between 2003 and 2011, medical premiums have increased 62%[1], or by an average annual compound growth rate of 6.22%. At that rate of increase[2], over 5 years the cost of a plan will increase 35%. If the employer can hold increases to 3% a year, the plan's cost will increase less than half as much, or about 16%. It is entirely conceivable that a properly constructed and managed plan could decrease cost modestly over the same period, say to 95% of what it was. In that case, the employer would have a 40 percentage point advantage in health care costs over a competitor that stuck with the traditional approach. Adopting the Strategy could well make the difference between continuing to provide a health insurance benefit to employees and opting out of the system, thereby forcing employees into Obamacare's state- or federally-run insurance exchanges.

Health Insurance Challenges Faced by Small Businesses

Until now, companies with fewer than 100 employees have been at a tremendous disadvantage in the marketplace because they have not been able to obtain data about the underwriting performance of

[1] Scientific Blogging, 12/12/12.
[2] The cost of small-employer plans has increased at a higher rate, and current increases appear to be averaging 8% or more.

their plans. Because of the lack of data, and unlike larger companies, small employers find themselves in extremely weak negotiating positions. They don't know what their actual costs are as a percentage of premium, they don't know which plan elements are being utilized and which are not, they don't know whether employees take advantage of potential cost savings, such as for generic v. name-brand drugs, and so they have no idea where potential cost savings might lie, whether coverage adjustments will increase or decrease actual costs, or what types of health problems besetting their employees could be alleviated by specific wellness programs and/or employee incentives. This kind of information is routinely available to larger employers and certainly to employers who self-insure their healthcare risks. It is the healthcare equivalent of property/casualty insurance program data that are routinely available to even the smallest companies.

In 1981 and in a 1986 revision, Congress passed and then expanded the Risk Retention Act that permits companies to form Risk Purchasing Groups or Risk Retention Groups through which independent companies can band together to make group purchases of insurance or to self-fund their risks. The 1981 act applied only to general liability risks such as product and professional liability, but the revision broadened the permission to essentially all casualty lines of insurance, including Workers' Compensation. Many readers will be familiar with the Act and may even be participants in an RRG, RPG, group captive or other P&C risk management funding vehicle. But such arrangements are rare in the employee benefit field due to the regulations applying to Multiple Employer Welfare Associations [MEWAs] and HIPPA rules. MEWA rules effectively prohibit groups from forming across state lines because – unlike RRGs and RPGs – they have to comply with both Federal rules and the rules of each state within which they have participants. The cost of compliance makes them uneconomical for most trade associations and similar groups. Until recently, ERISA rules have also effectively prevented companies from forming single-parent and group captives to reinsure benefit programs.

In the P&C world, Alternative Risk Transfer vehicles such as captives, RRGs and RPGs came into being because insurers essentially abandoned the market for certain lines of coverage [see for example: medical malpractice and the rise of "bedpan" mutual insurance companies]. Health insurers did no such thing; they just kept raising premiums to keep up with cost increases and state-mandated coverage expansions. And they have no incentive to support alternatives to the current system. That is one very good reason why it has been so hard to create workable alternatives.

States, too, have an interest in preventing small employers from forming such groups because the premium tax revenue generated by small-employer health plans is critical to them. Businesses with 500 or fewer employees employ roughly 100 million people. We estimate that they generate about $14 billion in annual premium tax revenue for the states. 50% or more of that revenue would disappear if businesses would just take a $25,000 deductible on the healthcare claims of their employees[3].

Before Obamacare, under the McCarran-Ferguson Act (1945), states were the arbiters of what coverages had to be offered in their states. Consequently, rules and regulations vary significantly by state, despite efforts by the National Association of Insurance Commissioners [NAIC] to create model

[3] Figures based on BLS statistics and AIMS estimates of costs/employee.

legislation aimed at minimizing the differences from state to state. Obamacare makes the rules more uniform but unfortunately also mandates coverages that should not properly be included in a true insurance policy[4], thus creating a basis for even steeper price increases as the Act is implemented. No one today can say with any certainty just how much Obamacare will drive up the cost of insurance; only that it is inevitable that the cost will go up faster than it would have without the Act.

Given all these issues, it is no wonder that many small businesses are seriously contemplating simply opting out of providing health insurance and living with whatever the consequences prove to be.

The cost of staying with the traditional approach

Under Obamacare, if a small business elects to continue buying traditional health insurance for its employees it is a virtual certainty that its annual cost will increase 30-40% over what it would have been without Obamacare, even if the underlying cost of healthcare remained the same. In the past, small businesses had few practical options for controlling cost, such as bidding out the plan every year or two, increasing the share of cost paid by employees, increasing deductibles and co-pays, and, if permitted by regulations, eliminating certain coverages. As a practical matter, under Obamacare all options except bidding have been eliminated. While past results yielded less-than-optimum employee satisfaction, large amounts of management frustration, and, despite every effort, ever-increasing costs, it will only get worse under Obamacare.

For a more detailed overview of the mandates in Obamacare that are driving the cost increases, see our accompanying paper "A ℞ For ObamaCare."

While not a perfect solution, the AIMS Smart Health Strategy addresses and mitigates most of the issues raised by ObamaCare.

How does the Strategy work?

It has not been easy, but AIMS has found service and insurance providers willing to buck the historical system. The Strategy breaks plans down into their component parts and allows us to negotiate their terms and conditions separately:

- Plan design and administration
- Claim management
- Predictable claims
- Claims above the predictable level, both on an individual claim basis and on an annual aggregate basis

The largest cost source is predictable claims. Claims up to ~$25,000 each are quite predictable even for small groups and constitute ~45% of total plan costs in most cases. Coverage for claim amounts above

[4] Such as for routine, inexpensive items that could and should be purchased as needed without the added administrative burden and cost of insurance.

$25,000 and an annual aggregate cap on all claims should be in the range of 40% of total. Claim management generally will be in the range of 5%. All other costs make up the other 10%. Controlling the level of predictable claims is, therefore, a primary objective. Claims are a function of plan design and can also be affected through a variety of incentives and disincentives, wellness programs and other measures. The other major cost driver is the cost of excess and aggregate coverage. By controlling predictable claims, the cost of excess and, particularly, aggregate protection will be reduced as well. Some saving can be derived from the remaining 15% of total cost, but it is relatively insignificant. The main advantage of unbundling administrative costs is that they can be held relatively steady regardless of what claims develop. Claim data[5] are the key to making all of this work and allowing the employer to manage plan design to its best advantage while still maintaining an attractive plan.

Taking predictable claims out of the premium also saves the premium tax, usually in the range of 3%. Tweaking the retention level changes the balance between predictable [retained] claims, and premium for excess and aggregate stop loss coverage. This balance can be optimized for the plan and long-term cost stability.

By separating the excess and aggregate insurance from the other elements of the program, it is possible to change, for example, the excess carrier without changing the claim administration or the network, or the plan administration.

With these tools in hand, the employer now has the means to control the individual program elements, tweak the plan, manage the costs, and institute wellness programs aimed directly at the problems highlighted by the claim data.

What are the financial implications of the Strategy?

Because there is an element of self-insurance in each plan, one of the keys to plan design is to make sure that the plan's maximum annual cost cannot exceed a known, pre-established value – which itself should be lower than the cost of a comparable, fully-insured plan. Many small business owners are leery of self-insured plans because they have heard "horror stories" of plan costs getting out of control and surprising an owner with unanticipated costs well after it is too late to do anything about them. An AIMS Smart Health Strategy plan eliminates this problem by setting a known, maximum annual cost prior to plan inception, and fully funding for it during the plan year. In almost all cases, that fully-funded cost is less than the cost of traditional alternatives. When the full impact of ObamaCare is felt in 2014, the cost advantage of an ASHS plan will be significant.

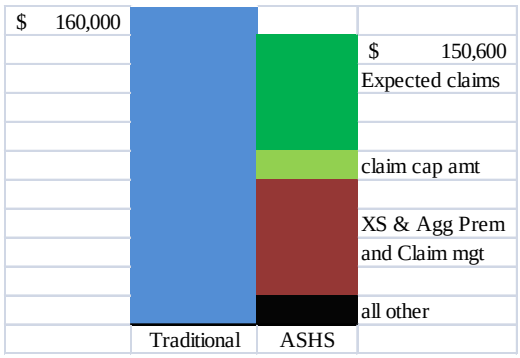
Here's how the claim funding plan works. Let's assume that the traditional plan has 20 enrolled participants [including families], and that the best available annual premium is $8000 per enrollee, or $160,000. The comparable ASHS plan cost might be:

expected self-funded claims	$ 54,000

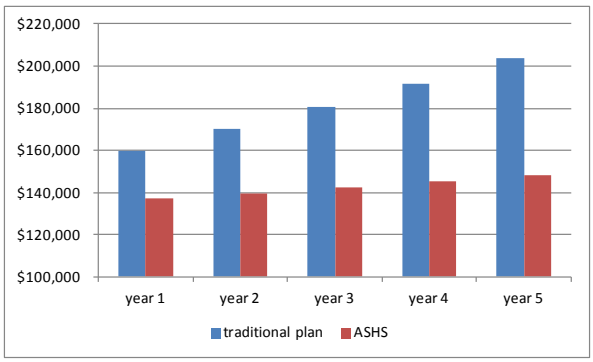
[5] Always HIPPA compliant

excess/agg premium	$	60,000
claim management	$	8,100
all other	$	15,000
Total Expected cost	$	137,100
additional claims to cap	$	13,500
maximum annual cost	$	150,600

In this case, the ASHS maximum annual cost of $150,600 would be funded during the year, so that the employer would realize an immediate saving of $9,400 [6%] v. the traditional plan. Six months after the close of the plan year, total incurred claims within the self-funded layer would be calculated[6]. They could be anywhere from something close to $0 – very unlikely – to a maximum of $67,500 [expected plus cap]. If the self-funded claims come in at the maximum, the employer gets nothing back from the plan. If the claims come in below the maximum, the employer gets back the difference between the maximum [which the employer funded during the year] and whatever the claims actually were. If at expected, then the employer would get a return of $13,500, making the total saving $22,900, or 14%.



Whatever the saving is, it is immediate and real. With an effective claim control plan in effect, let's assume that over five years the ASHS plan's cost increases 2% per year, for a total 5-year cost of $713,500, but the traditional plan increases at the historical 6.22% rate for a total cost of $906,000. Total realized saving from the ASHS over the five year period would be $192,500, or 21% of the total standard cost and 27% of the standard cost in the fifth year. This saving would just continue to grow in succeeding years.



Is it realistic to think that employers can realize savings in this order of magnitude? Yes, it is, but achieving the goal requires that the employer work closely with the plan designer and administrator, and with his employees, to take full advantage of the cost saving opportunities that materialize along the way. There is some cost attached to doing that. On the other hand, employees will be healthier and happier, and thus more productive and missing fewer days to illness, other management expenses will go down [cost of annual rebid process, for example], and the plan will become increasingly efficient.

[6] Including plan-year claims reported after the close of the year.

Underwriting

Not every employer will qualify for the Strategy. Careful underwriting at the outset is a key element in making the plan work for those that qualify. Employee populations with better-than-average health profiles will benefit more from the Strategy than those with worse-than-average profiles, but even those should see significant benefits in both the short and long term. However, groups having a high percentage of employees with significant health issues may find that they are better off in the traditional market where premiums will be capped by community rating rules or other rating restrictions imposed by the state or HHS.

Summary

The ASHS combines a plan of action with an ART approach to insurance that lowers cost immediately and keeps cost below traditional plans over many years. It works by unbundling plan elements, including separating claims into predictable and unpredictable layers and assuming the predictable cost. Total annual costs are capped at a level that in most cases will be less than the cost of a traditional plan. The Strategy should enable employers to continue to provide effective and efficient health insurance to employees while keeping costs significantly below the cost of traditional insurance.

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Other Frequently Asked Questions

How are claims handled?

All claims are submitted to the plan Administrator, which is responsible for all claim payments and record keeping.

Will employees have access to their preferred medical service providers?

CIGNA/GreatWest and Aetna are the primary network providers, but 140 other networks are available. It would be rare that the Strategy could not provide an appropriate network.

Are there plan design options?

There are many plan designs available, and deductibles, co-pays and the like are almost infinitely variable depending on each employer's preferred plan design and cost containment appetite.

Is pharmacy included in the plans? Where do employees fill prescriptions?

Each plan option contains a prescription drug benefit. Employees can fill their prescriptions at almost all local pharmacies or from mail-order houses. Some plans will contain incentives to use the mail order houses.

In order for a group to qualify for the Strategy, do employees have to fill out medical questionnaires?

In most cases, yes. Larger groups, over 50 enrolled employees, may not have to complete individual questionnaires. Generally, it is to the group's advantage to complete the questionnaires, and it is particularly so for groups that exhibit better-than-average health characteristics.

Will all employers benefit from the Strategy?

Probably not. The Strategy is particularly helpful to employer groups that have relatively healthy populations, and to employers who are willing to invest time and energy into developing and maintaining effective employee wellness programs.