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State of Wisconsin Employee Trust Funds Medical Self-Insured Financial Impact Overview

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Medical Plan Self-Insured Financial Impact Overview

Wisconsin Employee Trust Funds
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Summary

For the 2013 plan year, approximately 236,000 of the Wisconsin Employee Trust Funds' (ETF) covered members will be enrolled in fully-insured medical plan options. An additional 12,000 members are already in self-insured ETF medical plan options. ETF has expressed interest in understanding the potential financial impacts of using an entirely self-insured environment for its medical plans in lieu of the established managed competition model currently used for the fully-insured HMO plans.

This report considers the financial and risk transfer issues related to self-insurance and stop-loss insurance. Any transition from a fully-insured to a self-insured environment introduces new issues such as those related to claims volatility, risk management, network provider relations, plan design continuity, and provider disruption.

Appendix 1 to this report comments on the financial viability of stop-loss reinsurance arrangements that may be contemplated (though such an arrangement is not recommended). Appendix 2 provides a general overview of self-insurance issues not specific to ETF.

The estimation of potential savings / additional costs related to adopting to an entirely self-insured financial arrangement is dependent on numerous variables and subjective assumptions. Variations in these variables and assumptions produce results that range from savings to ETF to additional costs to ETF. While financial gains can be achieved in some areas by moving to a self-insured arrangement, it is possible that those gains would be more than offset by the loss of the financial advantage of the current managed competition model.

The financial impact from a move to a self-insured environment could range from a net gain to a net loss depending on the actual outcomes of key variables and assumptions.

A more detailed analysis would be needed to further refine the estimated financial impact.

The table below summarizes the key advantages and disadvantages to ETF from moving to an entirely self-insured financial arrangement, many of which may offset each other (those noted by "vs.").

Potential Advantages to ETF In Self-Insuring Entire Population		Potential Disadvantages to ETF In Self-Insuring Entire Population
Elimination of state premium tax (2%) on fully-insured plans.		Loss of current managed competition financial approach that can limit overall cost trends.
Possible single administrator for entire population, providing administrative efficiency of scale.	vs.	Possible reduction in negotiated managed network discount rates due to utilization of "rental networks" (third party administrator cannot access best discount arrangements).
Flexibility to more easily modify plan design. Single self-insured pool reduces potential adverse selection that may occur when a mix of self-insured and fully-insured plan options are available to an employee.	vs.	Potential loss of "HMO" plan design in lieu of PPO Standard Plan design for all members; may equate to possible cost shift to employees.
Elimination of the risk transfer charge by insurers.	vs.	Employer assumes risk of exposure to potential adverse claims variations. Single risk pool mitigates some of this exposure.
Potential reduction in current HMO administrative costs due to less overhead and market competition for no-risk contracts.	vs.	Possible loss of current financially advantageous self-insured administrative services only (ASO) rate with WPS.
Increased ability to manage the timing of cash flows.	vs.	Current fully-insured carriers, upon contract termination, may require payment of a "terminal liability" to continue to process run out claims (may be contractually permitted).
Possible simplification of internal administration (e.g., fewer plans to coordinate with payroll, open enrollment, COBRA) (efficiencies of scale only possible if single administrator selected).	vs.	Embedded dental plans and wellness programs would likely become "orphaned" and would require separate design and administration efforts.

Financial Impact of Adopting Overall Self-insured Arrangement

As many of the above potential advantages and disadvantages to self-insured plans possibly offset each other, and whose financial impacts are dependent upon numerous assumptions and variables, it would be misleading to assign estimated savings or costs to any single factor. Rather, very broad estimates in aggregate across all such factors under a range of assumptions have been developed under upside and downside scenarios.

Estimated 2013 Potential Savings Under Upside Assumptions[1]	Estimated 2013 Potential Cost Under Downside Assumptions[2]
$20 Million Savings (+2%)	$100+ Million Cost (-10% or more)

Note that the above estimates do not include any estimated costs or savings associated with the current embedded dental plans or wellness programs.

The above financial impact estimates are based on possible variations in several key cost drivers:

- **Current managed competition financial approach:** Comparing claims experience (as provided in the Addendum1a submissions from the HMOs) against the medical claims component of the fully-insured premium rates (i.e., premium rates less dental premium component less admin fee), it appears that the managed competition approach is providing absolute savings that, if lost, would possibly contribute to additional costs to ETF.
- **Premium tax:** The elimination of the 2% premium tax would produce an approximate savings to ETF in 2013 of $23 million. This cost driver does not vary across the upside and downside scenarios.
- **Administrative fees and risk charges:** The current admin fees include risk transfer charges that likely would be reduced or eliminated in a move to a self-insured environment. Savings to ETF could potentially range from $0 to $60 million depending on the self-insured administration fee that could be realized. This driver is entirely dependent on what the market would charge, and would need further analysis to refine.

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[1] No “rental network” loss of discounts, claims trend less than national average, achieve administrative fees consistent with existing WPS levels on current self-insured plans, HMO design dropping in lieu of current PPO Standard Plan design.

[2] “Rental network” loss of discounts, claims trend greater than national average, no decrease in administrative fees, maintain HMO design.

- **Partial loss of discounts:** Under a single self-insured claims administrator, access to some of the existing negotiated HMO provider networks and discounts may be lost. In those cases, access to those provider networks can possibly be continued, though under a slightly less advantageous discount arrangement. The upside and downside scenarios range between an assumed 0% point discount loss to a 10% point discount loss ($0 impact to a $100 million or more cost). A more refined estimate of the impact of this driver would possibly differ HMO to HMO, and would require additional analyses and discussions with the HMOs.
- **Plan design change:** The current uniform plan design of the HMOs is able to be changed under a self-insured arrangement more easily, possibly becoming more in line with/uniform with the current Standard PPO design. Such a change would reduce the actuarial value of the plan, producing savings to ETF. The savings impact for this driver could range between $0 and $50 million in savings, depending on the ultimate plan design that is adopted in lieu of the current uniform HMO design, including out-of-network utilization cost impacts.
- **Tiered and narrow network implementation:** With a state-wide self-insured design, there is opportunity to also develop one or both of:
    - Tiered networks: For those providers with better outcomes, a "network within a network" may be designed, providing better plan coverage for utilization of those providers. A comparison of the increased plan coverage versus the provider savings would be needed to determine net cost or savings potential.
    - Narrow networks: A "tighter" network can be designed to effectively gain better discounts across the smaller network of providers. A comparison of the greater discounts under a tighter network would be needed to determine net cost or savings potential.

  No savings or costs associated with these network change approaches have been estimated in the above range of potential financial outcomes, though it would be expected that, if implemented, such changes would result in additional savings.

The ultimate financial impact will likely not reflect the extremes for all of the above drivers, with an expected financial impact being somewhere within the upside and downside range noted above.

Stop-Loss Coverage

Plan sponsors can mitigate some of the claims volatility risk through the purchase of stop-loss reinsurance, though a risk transfer charge is incurred as an added expense. Given the size of ETF's population, if all members were covered under a self-insured

arrangement, the ability of the ETF plans to absorb claims fluctuations is sufficiently robust that the purchase of stop-loss coverage for ETF would not be recommended.

Appendix 1 to this report provides additional information on stop-loss coverage with respect to ETF.

Appendix 1: Stop-Loss Coverage Overview

The purpose of stop-loss is the same as that of insurance: to spread risk. Catastrophic claims will occur; however, the magnitude of the claim dollars and its impact on ETF's health care expenses will vary year-to-year. Stop-loss can mitigate the risk involved in self-insuring by protecting employers from catastrophic claims over an agreed upon "deductible", whether claims are from a specific individual, several individuals, or both, depending on type of policy purchased.

Stop-loss coverage does not provide insurance benefits for the plan participants but instead is in the nature of excess liability coverage for the employer.

Aggregate Stop-Loss

Aggregate Stop-Loss provides limits on an employer's total liability to a certain dollar amount (creates a ceiling of the maximum amount of dollars an employer would have to pay during a contract period/plan year), otherwise known as the attachment point. Coverage typically reimburses the policy owner when claims exceed 110 percent to 125 percent of the expected annual budget amount.

Specific "Individual" Stop-Loss

Specific stop-loss is coverage that responds after a specific retention or fixed dollar amount per individual or occurrence. This coverage may employ a specific deductible or variations within an aggregating specific deductible.

The terms of stop-loss coverage reimbursement are typically based on one or both of the claims run-in (paid basis) or claims run-out (incurred basis) periods.

A claims run-in arrangement is typically based on a period prior to the plan year for allowable incurred dates (with payment dates being limited to the plan year), or for a claims run-out arrangement with incurred dates to be limited to the plan year, with paid dates extended for a period of months thereafter. The reason for such contractual differences is typically to reduce the cost of the stop-loss coverage (by retaining additional risk).

The table below illustrates common claims run-in and run-out provisions that are available, though not all of these would be applicable to ETF's situation.

Contract Terms	Basis	2012 Plan Year				2013 Plan Year				2014 Plan Year			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
12/12 (Paid)	Paid					Claims Incurred Dates / Claims Payment Dates							
15/12	Paid				Claims Incurred Dates	Claims Payment Dates							
18/12	Paid			Claims Incurred Dates		Claims Payment Dates							
24/12	Paid	Claims Incurred Dates				Claims Payment Dates							
12/14	Incurred					Claims Incurred Dates							
						Claims Payment Dates							
12/15	Incurred					Claims Incurred Dates							
						Claims Payment Dates							
12/18	Incurred					Claims Incurred Dates							
						Claims Payment Dates							
12/21	Incurred					Claims Incurred Dates							
						Claims Payment Dates							
12/24	Incurred					Claims Incurred Dates							
						Claims Payment Dates							

For ETF as a potentially newly-insured population, several of the above contractual arrangements would not be applicable (highlighted in gray), namely the 15/12, 18/12, and 24/12 run-in provisions, which only apply to existing self-insured arrangements.

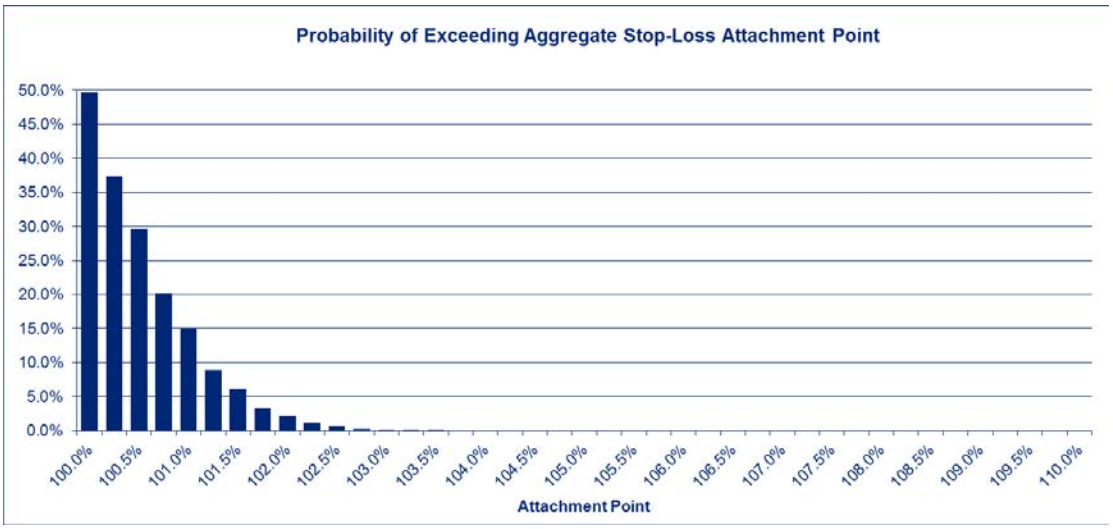
With respect to aggregate stop-loss coverage, for 2013, ETF's average medical claims per member per year are estimated to be approximately $5,800 ($969 million in total) for the current fully-insured population.

When an aggregate stop-loss attachment point of 125% is applied, stop-loss coverage would provide reimbursement for all claims in excess of $969 million x 125% = $1,211 million.

For a group the size of ETF's current fully-insured population, it is expected that the probability of exceeding even a 103% claims attachment point is effectively zero[3].

[3] Based on a Monte Carlo simulation of claims experience for such a scenario, the 125% aggregate stop-loss attachment point was not reached even once in over 14,000 trials. The highest attachment point reached was only 103.7%. It is not impossible to have aggregate claims in excess of 125% of expected claims, but the statistic likelihood is virtually zero.

The chart that follows illustrates the actuarially expected probability of incurring sufficient claims to receive reimbursement under an aggregate stop-loss arrangement, based on ETF's plan designs, and the 2013 tier breakpoint rates for the fully-insured plans.



As aggregate stop-loss coverage is rarely available at an attachment point less 115%, aggregate stop-loss coverage would be inappropriate for ETF.

With respect to specific stop-loss coverage, there are general stop-loss industry rules of thumb with respect to the establishment of an "appropriate" specific stop-loss deductible level:

- For mid-sized and small groups, establish the specific stop-loss deductible at a level that would produce 2 claims per year.
- For a large-sized group, establish the specific stop-loss deductible at a level that would produce a count of claims equal to 0.1% or less than the size of the covered population (this is a less established rule of thumb).

ETF would fall under the second rule of thumb. The following table provides estimated 2013 specific stop-loss deductible levels at a variety of rule of thumb benchmarks.

Rule of Thumb	Number of Expected Specific Stop-Loss Claims Per Year	Specific Stop-Loss Deductible
0.10%	173	$275,000
0.05%	85	$400,000
0.02%	35	$600,000
0.01%	17	$800,000

Given the size of ETF's potential covered self-insured population, it would appear that the expected prevalence of large claims is (1) not relatively volatile, and (2) such that ETF's aggregate funding levels would be sufficient to absorb any claims volatility without the need for specific stop-loss coverage, especially since stop-loss coverage generally is provided at a loss ratio of 40% - 60% (i.e., for every dollar paid in premium, actuarially expected claims payments are about 50¢.

Appendix 2: Self-Insurance Overview

A self-insured, or self-funded plan, is one in which the employer assumes financial risk for providing health care benefits to its employees. Rather than obtaining medical coverage from an insurance carrier, the employer elects to fund the risk. A Reinsurance or Stop Loss policy can be purchased to mitigate some of the risk the employer assumes. An insurance carrier or third party administrator (TPA) administers the plan. Their responsibility includes maintaining eligibility, customer service, adjudicating and paying claims, preparing claim reports, plus arranging for managed care services such as network access and case management. The TPA retains no claims liability risk under this arrangement.

Advantages:

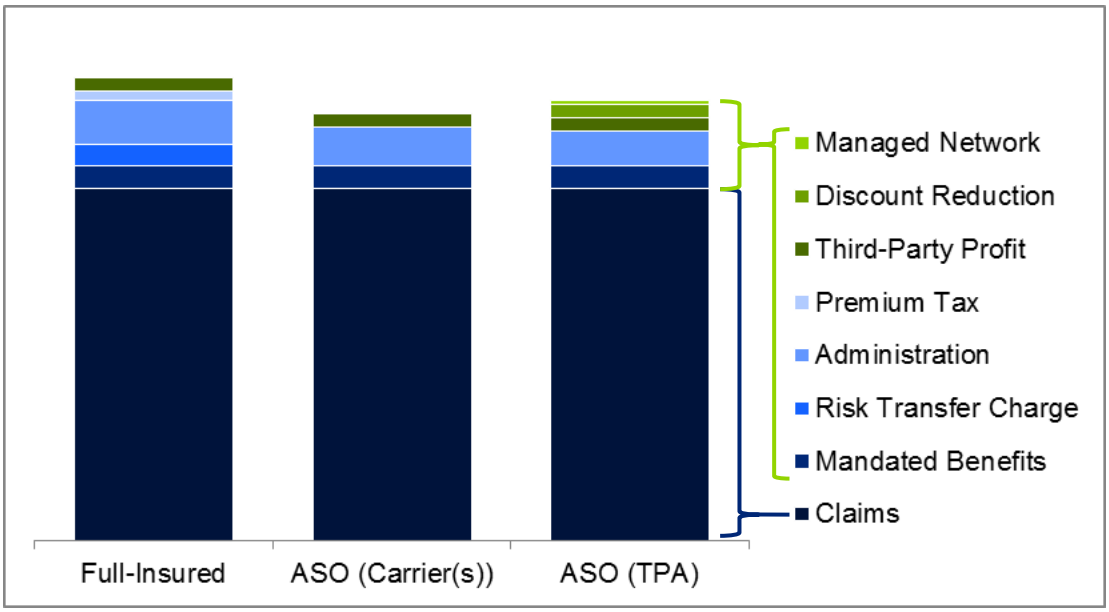
- Plan provisions do not have to meet state mandated benefits because the contract is not recognized as an insurance product. *(Not applicable in ETF's case.)*
- No state premium tax is payable.
- There are no risk charges because the employer assumes all financial risk under the plan.
- Administrative costs are possibly reduced because there is less overhead and extreme market competition for no-risk contracts.
- Short-term cash flow savings may be realized because funds are not drawn until claims are submitted for payment.
- Claim reserves are held by the employer, allowing for additional cash flow control and possible investment income.

Disadvantages:

- Employer assumes all risk under the plan (unless partially mitigated by use of stop-loss reinsurance)
- Adverse claims fluctuations can cause the employer to experience cash flow variations.

Components of Cost

A comparison of a typical self-insured financial arrangement against a typical fully-insured financial arrangement provides an overview of potential sources of savings that can be realized by self-insuring a covered population. Each employer's specific circumstances will come into play in determining the extent to which, if at all, each cost component is a factor.



Components:

- **Claims:** The underlying current fully-insured incurred and paid claims for the covered population. Not expected to change under a self-insured arrangement, other than due to differences in discounts and network access (see below).
- **Mandated Benefits:** Fully-insured plans are required to provide any benefits mandated by the state. Self-insured plans are not required to provide state-mandated benefits.
- **Risk Transfer Charge:** A fully-insured plan takes on the risk of adverse claims experience and, as a result, typically charges an implicit risk transfer fee. Under a self-insured plan arrangement, no risk is transferred. Thus, this fee would be eliminated.
- **Administration & Bundled Services:** Administrative and other bundled services (e.g., network access, fiduciary responsibility) typically are provided at less cost under a self-insured plan administered by insurance carriers, and at an even greater cost reduction under a self-insured plan administered by a TPA. Efficiencies of scale can be achieved when reducing the number of carriers.
- **Premium Tax:** Fully-insured plans are typically subject to premium taxes. In Wisconsin the premium tax rate is 2% on health plans.

- **Third-Party Profit:** The profit charge assessed by the insurer or claims administrator. This fee typically does not change when moving from a fully-insured plan to a self-insured plan.
- **Discount Reduction:** Preferred provider networks are negotiated to include contractual discounts off of standard charges. For self-insured plans administered by one or more carriers, these discounts typically are the same as for a fully-insured plan. However, for self-insured plans administered by a TPA, there can be a loss in some of the discounts if existing networks need to be "rented" by the TPA (since the TPA would not have its own negotiated provided arrangements).
- **Managed Network:** A self-insured plan administered by a TPA may also not have as "managed" a provider network as would be the case for a fully-insured or a carrier administered self-insured plan, and could possibly, though not necessarily, experience a slight increase in costs due to a lesser level of treatment management.

Internal HR and Finance Issues

The following table identifies the departments that are responsible for processes related to a medical plan and identifies action items that will be necessary in order to properly manage the self-insured medical plan.

Department	Process	Actionable Item
Finance/HR	• "Premium Payments"	• Represents administration expenses and possible stop-loss costs.

Finance	• Funding of claims	• Selected plan administrator(s) will provide substantial guidance to ETF.
		  • Establish banking arrangement (e.g. sub-account, zero balance)
		  • Funding claims – typically wire transfers
		  • Frequency of transfers – daily, semi-weekly, weekly, or bi-weekly
		  • Documentation/ reconciliation requirements
		  • ETF internal contact person identified

Department	Process	Actionable Item

Finance/HR	• Annual review of plan	• Process currently is in place at ETF.
		  • Review budget challenges for acceptable levels of increase in State costs
		  • Determine whether plan design changes, new programs, stronger steerage to a “sponsored” medical plan are warranted
		  • Input on plan design changes, new programs, steerage goals and
		  • Renewal negotiations (may have multiple year rate guarantees for administrative services. Stop-loss rates are re-negotiated each year)

Finance/HR	• Establish medical plan budget and COBRA rates each year	• Budget process includes input from HR, Finance and consulting actuary • Projections of total plan costs • EE/ER cost-share formulas explored and resulting funding of the budget • COBRA and W-2 rate calculations produced from budget process

Department	Process	Actionable Item

Finance	• Monitor Budget Accrual versus Actual Costs
	• Establishing the IBNR claim liability
		<u>Overview:</u>
		• Budget projections (prospective) establish the projected total funding requirements of the plan. Costs include:
		  • Fixed fee premiums – known costs
		  • Claim expenses – variable costs
		• Any deviation between actual costs and projected budget will be State's financial responsibility
		<u>Actionable Items:</u>
		• Determine budget methodology
		• Establish a tracking mechanism to capture "revenues" (State accrual plus EE contributions) against liabilities (fixed plus variable). The balance each month will be a "surplus" or "deficit" from budget.
		• Report should be released to Finance/ HR monthly to demonstrate plan performance (monthly, plan year to date)
		• Establish IBNR
		  • Cash accounting versus incurred
		  • Auditors must approve reasonableness of IBNR accrual

HR	• Performance guarantees	Work with selected vendor(s) to understand how reporting of results will be documented and frequency
Finance/HR	• Analysis of claims cost drivers and utilization	An annual review is performed to compare utilization statistics against benchmark targets. This process helps HR to evaluate new or improved benefit management strategies.