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State of Wisconsin

State Employee Medical Plans

Self-Insurance Advisability Assessment and Actuarial Cost-Benefit Analysis

Executive Summary

Overview

Recent market and legislative changes to the health insurance industry, particularly the additional fees associated with the Affordable Care Act (ACA) and the current premium taxes paid on fully-insured plans has prompted the State of Wisconsin to consider the advisability of adopting a self-insurance arrangement for its state employee medical plan. Within a self-insured program, these fees and taxes are avoided and represent a potential savings to the State.

The advisability of a self-insured versus fully-insured financial arrangement requires a comparison of the components of cost as well as the overall cost under each approach. This is to determine if there are potential sources of savings that can be realized by self-insuring a covered population. In particular, a fully-insured arrangement has a number of cost components that are not included under a self-insured arrangement, particularly:

- *Affordable Care Act (ACA) Market Share Fees:* The ACA introduces a Market Share Fee that is payable on fully-insured medical plans from 2014 onwards and is expected to escalate each year. This is approximately 2% of health premiums.

- *Premium taxes:* Premium taxes are approximately 2% on health plans in the State of Wisconsin.

- *Profit and Contingency Margins:* A fully-insured plan takes on the risk of adverse claims experience and typically charges an implicit risk transfer fee. The industry norm for profit and contingency margins on commercial lines of business are approximately 2% - 4% of premium income. Based on aggregate 2012 annual statement data reported to the Office of the Commissioner of Insurance, the margins for HMOs operating in Wisconsin were smaller, at approximately 0% - 1% of premium revenue.

Furthermore, additional savings may result from lower administrative and costs unrelated to health care under a self-insured plan versus a fully-insured plan. This is mainly due to efficiencies of scale that can be achieved as well as potentially higher market competition for Administrative Services Only (ASO) contracts.

All else being equal, at a high level a self-insured arrangement represents a potential for approximately 4% - 5% savings resulting from the non-claims related expenses of the current cost of the fully insured arrangement.

However, not all other factors are equal. In particular, the current fully-insured arrangement operates under a unique and complex managed competition and tiering model. This model makes use of multiple HMOs and inherently drives competition between health plans to promote cost efficiency for the State. Without adequate safeguards and controls to maintain competition, the financial benefits to the State of the current model could be lost in changing to a self-insured arrangement.

In addition, any transition from a fully-insured to a self-insured program introduces new dynamics. These dynamics relate to the volatility and uncertainty of claims within a self-insured environment. The primary drivers of uncertainty in claim experience stems from:

- Potentially different provider reimbursement levels and loss of capitation compared to those of the fully-insured HMOs.

- Variability of care management practices on a fully versus self-insured arrangement.

These factors may significantly influence the absolute level of the cost of claims between a fully vs. self-insured program.

Background

Owing to the above considerations, in collaborative consultation with the Group Insurance Board (GIB) Strategic Planning Workgroup, Deloitte Consulting LLP (Deloitte Consulting) was engaged to investigate the advisability of a self-insured arrangement. A particular focus of the assessment was an actuarial cost-benefit analysis to estimate the potential change in claim costs on a self-insured versus fully-insured arrangement taking into consideration the potential savings which are primarily derived from avoiding certain ACA fees and premium taxes.

A formal Request for Information (RFI) was released publicly to any interested third party administrator (TPA)/carriers who are not incumbent plans of ETF's fully-insured program. Concurrently, a Supplemental Information Request was sent to the incumbent health plans. In total, 17 plans responded that they are able to provide self-insurance coverage. Of the total submissions, 15 are incumbent medical plans (out of 18 total incumbent plans), with additional interest from two new TPA/carriers.

There were limitations with regards to the completeness and accuracy of the health care provider reimbursement financial information submitted by the potential TPA/carriers. Incomplete and non-credible submissions were discarded which limited the actuarial cost analysis. However, the RFI information was supplemented with data from the Wisconsin Health Information Organization (WHIO) as well as the 2012/2013 "Addendum 1" data submitted to the Department of Employee Trust Funds by the incumbent HMOs as part of the annual renewal process. The Addendum 1 data includes each plan's membership changes, claims and utilization experience by service category, projected trends, and expected administrative expenses, taxes, fees and contingency margins. Although the precision of the analysis was limited, overall the data provided a credible basis to conduct a high-level actuarial cost analysis and provide meaningful directional results.

The findings of this analysis provide a high level and directional indication of the advisability of a self-insured arrangement. In addition, the analysis identifies areas that require further analysis through a more stringent Request for Proposal (RFP) process to validate the preliminary conclusions gained from the RFI process.

Summarizing the above, the advisability of a self-insured arrangement depends on whether the combined savings arising from the absence of the applicable taxes, fees, contingencies and margins under a fully-insured arrangement outweighs any change in claim costs arising from different provider discounts/reimbursement levels, capitation, and care management practices under a self-insured arrangement, as well as the favorable influences of the current managed competition and tiering model.

Approach

A key consideration of the advisability of self-insurance lies in the number of -- and more specifically which -- TPA/carriers will provide administration and other services. This consideration influences the level of potential provider disruption which may result in the loss of in-network access causing participants to incur higher cost sharing as well impact the level of provider discount/reimbursement levels received.

At one end of the spectrum, a single TPA/carrier may potentially maximize administrative gains from economies of scale, but it involves the replacement of up to 18 current HMO plans. In addition, based on a high level analysis, no single TPA/carrier offering statewide coverage can provide reimbursement levels as favorable as the combination of the current incumbent plans. This is particularly true for areas of the State with the largest concentration of State employees and the most competition among current health plans. It appears that a single TPA/carrier across the state would most likely result in an increase in the cost of claims compared to the fully-insured arrangement.

Thus, balancing the desire to lower administration expenses, the ability of a number of incumbent plans to expand into regions they currently do not service, and interest from new TPA/carriers, the most optimal approach to assessing a potential self-insured arrangement occurs at the regional level. Based on this approach, the potential TPA/carriers in each region are:

- The incumbent plans noting an interest to continue in a self-insured environment
- The incumbent plans noting an interest to expand into regions they do not currently service
- Interest from new TPA/carriers

Identifying Potential Self-Insurance TPA/Carriers

The next step in assessing the advisability of a self-insured arrangement is to identify the possible TPA/carriers at a regional level. The potential TPA/carriers must satisfy a number of stringent requirements including:

- Sufficient Network Access (i.e., qualified to operate in that region)
- Adequate ASO experience
- Adequate ASO capability
- Minimal provider disruption to members
- Willingness to participate in a self-insured arrangement
- Credible and complete provider discounts/reimbursement levels provided in response to the RFI

These requirements were assessed at a high level. Owing to the limitations in the data received, a more comprehensive RFP process is required to further refine and assess these requirements.

Impact of Provider Discounts

Following the identification of the possible TPA/carriers per region, the next step is to identify which TPA/carrier in each region, if any, is able to offer more advantageous provider discounts/reimbursement levels compared to the current fully-insured arrangement. This is necessary to determine if the adoption of a self-insured arrangement will result in a net savings for the State.

However, negotiated provider discounts are highly competitive information and are generally not disclosed in the public domain. As such, in order to analyze how claim costs could potentially change within a self-insurance environment, a Relative Cost Factor (RCF) was defined to assess the cost structures between potential TPA/carriers as well as compare the cost structure under the fully-insured program in each region.

Based on the RCF analysis, a self-insured arrangement, with further study and other controls, may be advisable in some regions of the state. Directionally, it appears that TPAs are available that may potentially result in a lower claim cost compared to the current fully-insured arrangement. This will need to be further investigated and validated through an RFP process prior to any form of a self-insured arrangement being implemented.

Other Considerations

The consideration of a self-insured arrangement is dependent upon a number of other factors, including the aforementioned potential loss of gains currently being realized under the fully-insured managed competition and tiering model.

As noted earlier, the avoidance of the ACA fees, premium taxes, contingencies and margins represents an estimated potential savings under a self-insured arrangement of approximately 4-5%. In addition to assessing the potential impact of different provider discounts/reimbursement levels, the advisability of a self-insured arrangement also depends on whether any net savings are also outweighed by the favorable influences of the current managed competition and tiering model.

The current tiering model has been in place since 2004 and has been effective in producing rate stability and single digit to low single digit premium increases. Based on an analysis of actual claims experience compared to premiums charged, final insured premium trend rates compared to benchmark trend expectations, and a comparison of final insured premium bids across the existing health plans compared to preliminary bid levels, it is estimated that the current managed competition and tiering program saves the State a minimum of 4-5% of premium.

As a result, for any change to self-insurance to be advisable, the expected provider discount/ reimbursement levels would need to be more favorable than realized by the current fully insured health plans, as the expected savings from avoiding fees and taxes under self-insurance is likely offset by the loss of savings currently being realized under the managed competition and tiering model. Additionally, the State absorbs significant risk under a self-insured arrangement if projected claims experience is understated where the current fully insured arrangement has no risk to the State.

Although this study is focused on the State programs it is important to understand how a self-insured arrangement might impact the Wisconsin Public Employers Group Health Insurance Program for local government employers. This analysis did not attempt to quantify whether or not such arrangements would provide a gain or a loss for the Local program. Again, a formal RFP would be needed to determine the potential savings/loss under a self-insured arrangement for the Local plan.

Conclusion

At a state level, the gains from the absence of ACA fees, premium taxes, profit and contingencies is offset by the potential increase in claim costs arising from the absence of the tiering model. However, as noted the impacts vary by region.

A comprehensive RFP process is strongly recommended to further refine the analysis and validate the provider discount/reimbursement rates and potential cost savings. In particular, the impact of potential health provider disruption and any potential cost-shifting to employees due to provider disruption needs to be further investigated.

Based on the need to complete a comprehensive RFP process before implementation of a self-insurance arrangement, a 2014 effective date is not feasible for a pilot program. If the State decides to pursue a formal comprehensive RFP to select potential self-insured TPA/carriers for a pilot program anticipated to be effective January 1, 2015, the timing will need to be carefully managed. Such an RFP would require significant lead time and would likely need to be released in early 2014.

Finally, it should be noted that the short term “quick-wins” of a self-insured arrangement need to be balanced against the potential long term risks of a self-insured arrangement. The risks range from uncontrolled utilization and trend increases to catastrophic claim events which could possibly be managed through reinsurance at a cost.

Thus, any move to a self-insured arrangement needs to proceed with caution, and particular attention paid to the drivers of claims experience as the State becomes liable for unexpected variances in costs. Consideration of the impact on the Local program also needs to be evaluated as part of the process.

It is important to note that this analysis provides a high level analysis of the advisability of a self-insurance arrangement and offers directional guidance into the areas that need to be further investigated through an RFP process to definitively conclude on the advisability of any form of self-insurance.