Healthcare Cost Trends and Drivers. Should you self-insure?

GFOA and CONNPERLA

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What Employers are Saying…

- Many employers are gravely concerned that mandated essential benefits will require more generous levels of benefits while doing nothing to change the underlying cost drivers - only further contributing to higher rates of medical utilization and trend inflation.

- Employers believe “strategy should drive structure.” If we are looking to achieve “affordable care”, we must structure essential benefits that are more likely to achieve improved health status and better manage chronic illness. Starting with the notion of a rich basic package of mandated benefits commits the cardinal sin of letting “structure drive strategy”.

- Most employers believe that a “basic” level of benefits should be created to deliver low, single digit medical trends. Today’s open access PPO/EPO designs continue to drive double digit growth and there is increasing openness to “medical home” as a concept to transition from “treating chronic illness” to “rewarding its prevention.” Employers are uncertain if essential benefits would enable the transition to medical home or preclude it.
Determining Essential Benefits – Employees believe that unobstructed access to self directed healthcare resources and rich reimbursement equals “a good health plan”

What employees want...

- To be left on “$10-$20 Copay Island”
- Reduced cost shifting through contributions and lower out of pocket costs (take-home pay is flat)
- Choices, but not too many!
- Technology to learn about benefits, research on conditions, personal cost modeling
- Financial incentives and a roadmap to better health

Source: Cigna Healthcare

Our challenge is balancing infinite demand against finite resources. Any plan must strive to socialize consumers to the notion that access does not equal quality. In many cases, low co-pay, open access benefit designs lead to overconsumption of services, waste and low value outcomes.
Determining Essential Benefits – Employers want plan designs that drive healthy behaviors, disease management and consumer engagement – leading to low single digit trends....

- Insured employers have consistently received annual double digit healthcare increases over the last five years. These increases are normally mitigated by reducing plan design and cost shifting through higher contribution requirements, higher co-pays, co-insurance and high deductible arrangements.

- Medical trend is driven by four fundamental supply side components:
  - Hospital (inpatient/facility): 40%-50%
  - Specialty: 15%-25%
  - Prescription Drug: 10%-20%
  - Primary Care: 15%-25%

- Current employer plan designs are driven by access, not affordability. An employer would rather increase cost sharing than reduce access to a smaller panel of providers and centers of excellence. The result of open access PPOs and limited PCP care coordination has led to an unsustainable medical utilization and an unrealistic expectation from employees that “access means quality.”
Employers understand that lifestyle and age drive cost but most employer, pooled risk financing arrangements do not offer “good driver discounts.” Typically good risks subsidize bad risks.

Source: Dee Edington, PhD, University of Michigan (risk factors include tobacco usage, sedentary lifestyle, Extremely high/low body weight, high blood pressure, high blood glucose, high stress, depression)
Health Care Reform – What it Means for You…

- Health Care Reform changes for 2011 attribute to approximately 1.5% of your medical insurance increase.
- Children to Age 26
  - Plans currently providing coverage for dependents must extend coverage to children up to age 26.
- Individuals Under Age 19 and Pre-Existing Conditions
  - Pre-existing condition exclusions on individuals (children or employees) under age 19 enrolled in the group health plan are prohibited.
- Medical Loss Ratio
  - Insured plans are required to satisfy certain thresholds with respect to premium dollars spent on claims and activities to improve health care quality – 85% large market – 80% small market. Rebates MAY BE available to the plan and participants if these thresholds are not satisfied.
- Preventive Care Services
  - A group health plan must cover in-network preventive services without cost sharing (e.g. deductibles, copays).
- Lifetime and Annual Maximums
  - A group health plan may not impose lifetime limitations on essential benefits.
    - Ambulatory patient services
    - Emergency services
    - Hospitalization
    - Maternity and newborn care
    - Mental Health and Substance Abuse
    - Prescription Drugs
    - Rehabilitation services
    - Preventive and wellness services and chronic disease management
    - Pediatric services, including oral and vision care
The market is moving slowly from cost shifting to consumer control. This can only be achieved through ACOs/Medical Home Models anchored by health risk assessments, biometric testing, compliance based designs and the elimination of barriers to preventive and chronic care benefits.

Can an effective essential benefit plan design drive lower trend?

Benefits Focused
- High deductible plans
- Catastrophic plans
- HRA/HSA based plans
- Revised formularies
- Revised co-pay structures
- Buy downs

Cost Shifting
- Benefit design choices
- Provider performance information for treatment choices
- Provider network and informed consent choices
- Patient liability information for budget choices

Increased awareness

Consumer Decision Making
- Wellness plans
- Chronic care management
- Health risk, biometric and predictive modeling
- Preventive plans focusing on key chronic disease drivers

Early stage health engagement

Enhanced Health Mgmt
- Consumer incentives that “reward” engagement
- Value-based benefits
- Personal health record and HIT enabled medical homes
- ACOs/PCP based care

True consumer engagement

Integrated Health Mgmt

Consumer Control
- Guidance at enrollment
- Personal health and wealth management
- Transitional life stage support

Total health and wealth convergence

Source: 2008 Chapter House, LLC
Individual employees are our best hope for improving quality and cost efficiency

Factors that affect health are principally behavioral.

Getting individuals engaged in their personal health is the best way to effect change!

Source: IFTF, Center for Disease Control and Prevention
Is Self-Insurance the Answer?

- Employer assumes all or a portion of the risk for health benefits
- Administrative options available to employers choosing self-funding:
  - Administrative Services Only (ASO)
  - Third Party Administration (TPA)
  - Self-Administrator
  - Fixed Costs
  - Variable/Claims Costs
Self-Insurance Terms…

Administrative Fee:
- Fee charged for claims adjudication, billing, eligibility, customer service, plan document maintenance, access fees, Managed Care Fees

Setup Fee:
- One-time charge for the input of eligibility and benefits in order for the plan to be administered

Expected Claim:
- Total claims underwriter expects you to have in one policy year, actuarially determined from your past claims experience
Protection Against Unexpected Claims…

- What can the self-funding employer do to protect assets against such losses?
  - Stop Loss Insurance is designed to offer effective protection against excessive claims by limiting the amount of risk on any individual insured.
  - 100% of covered losses you pay for any individual in excess of the individual policy year deductible will be reimbursed for the remainder of the policy year.

- Aggregate Stop Loss: The Ultimate Protection!
  - The expected claims of any given group can usually be predicted with a fair amount of accuracy and thus become budgetable.
    - But, when these expected claims are incurred by a surprisingly high number of insureds, an unforeseeable fluctuation occurs.
  - The impact of any unpredictable fluctuation could jeopardize the financial stability of a company.
    - Aggregate Stop Loss Insurance is a precautionary measure designed to protect you from the unknown, guarding your assets and preserving cash flow.
Stop-Loss Insurance

Specific/Individual Stop Loss:

– A shock loss may be defined as an abnormally large and unexpected claim.
  
  ▶ Could be the result of severe accident or serious illness

– Insurance companies are prepared for such occurrences – build margin into premium to help offset the financial impact shock losses can cause
Individual Stop-Loss

Example of how a $157,000 claim would be handled ($100,000 ISL):

Employer pays the claims up to the stop-loss amount: $100,000

If the individual Stop Loss Deductible is $100,000...

...the Insurance Company pays the excess over the deductible amount: $57,000

The amount funded but not reimbursed ($100,000 in this example) will apply toward the Annual Aggregate Deductible.
Aggregate Stop-Loss – 120%

Example of how a $3,500,000 claim year would be handled (120% ASL):

Expected Claims: $2,500,000

At 120% Aggregate Stop Loss, the client would have to pay $3,000,000 maximum

...the Insurance Company pays the excess over the Aggregate Stop-Loss Amount: $500,000

Maximum claim projections (Aggregate Claims) are rarely realized by the client.
Self-Insurance Advantages

- **Flexibility in Plan Design**
  - Self-funded plan not bound by state mandates

- **Risk Management effectiveness through Stop Loss Insurance**
  - Employer may choose the amount of risk to retain and the amount to be covered under stop loss protection. Under an insured arrangement, insurance company sets the pooling level.
  - Protection from monthly swings can be controlled through a Monthly Aggregate.

- **Tax Savings**
  - No premium tax for the self-funded claim fund; thus, an immediate savings equal to the amount of premium tax is realized. (Average state tax is 2%)
    - Assuming annual premium of $626,000 x 2% = $12,520 in potential savings to you!

- **Retention**
  - Administration of the plan less expensive under a self-funded arrangement without sacrificing a reduction in services
    - Also the option of choosing services à la carte

- **Additional Cash Flow**
  - Employer holds onto reserves
    - Assuming annual premium of $626,000:
      - Projected reserves = $130,416 ($626,000/12 x 2.5).
      - Self-funding implies that employer must fund for incurred but unreported reserves. Assuming “reserve” is maintained in an interest-bearing account, employer can regard it as a source of income. Therefore, additional income is generated.

- **Margin**
  - Insurance companies typically charge 3-10% for margin (for fluctuations in claims)
    - Under self-funded arrangement, this component is eliminated
Self-Insurance Disadvantages

- **Risk Assumption**
  - Employer assumes risk between the normally anticipated claim level and Stop Loss Coverage level

- **Asset Exposure**
  - Employer’s assets are exposed to any liability created by legal action against self-funded plan

- **Fiduciary Responsibility**
  - Employer is responsible
Some final thoughts….  

- Employers must be “engaged” before their employees become engaged. Incentives to provide employee testing, compliance designs and expanded wellness should be under consideration.

- Additionally, steps should be made to make basic claim experience available to all employers over 100 employees to facilitate actionable population risk management plans.

- It is imperative to review the current and past claims experience to see if moving to a self-insured platform makes sense for your organization.
Thanks for your attention!