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THE PERILS OF SELF-FUNDING

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Self-funding conversions do not necessarily save money. The potential savings that plan sponsors could realize from administrative costs, premium taxes and plan design flexibility can quickly be erased if the coordination of care is weakened or if there is a new network arrangement with inferior provider discounts. In general, the potential savings are greatest if the fully insured plan being replaced has high administrative costs and/or margins and if the network design remains unchanged (i.e., there is no change to the existing network or a preferred provider network is replaced by another preferred provider network).

Understanding the many variables that come into play during a self-funding conversion is important. Some are known (reduction in administrative costs), some are somewhat known (changes in provider discounts and utilization patterns), and some are unknown (the ability to manage risk). The variability can have a significant impact on the conversion's success. In its analysis for the Wisconsin Employee Trust Funds, Deloitte concluded that converting the state's health care program from its current "managed competition" arrangement to a self-funded plan could either save the state up to $20 million per year or cost the state more than $100 million per year. That means the conversion would either trim the state's health care bill by 2 percent or add another 10 percent or more to its costs.[1]

POTENTIAL SAVINGS

There are two types of tangible, immediate savings that can be realized in the conversion to a self-funded plan:

1) The elimination of taxes assessed on fully insured plan premiums; and

2) Increased flexibility in plan benefits

The Affordable Care Act imposes an approximate 2-percent tax on the premiums of fully insured plans. Because self-funded plans are exempt from this tax, a Wisconsin employer paying $50 million in premiums could save $1 million per year by converting to self-funding. The savings, however, are not concrete. The ACA premium tax, for example, has been suspended for 2017 and, based on bipartisan

[1] State of Wisconsin Employee Trust Funds Medical Self-Insured Financial Impact Overview (Deloitte, October 26,2012)

discussions, could be repealed or further delayed similar to what occurred with the "Cadillac tax" on high-cost health plans.[2]

Most states mandate that fully insured plans sold in their state pay for special medical services. In Wisconsin, there are currently more than 30 mandated medical services, including autism spectrum disorder, breast reconstruction, chiropractic care, cochlear implants, contraceptive coverage and home health care. Because they are governed under federal, not state, law, self-insured plans do not have to provide state-mandated benefits, which can provide cost savings. A plan sponsor's ability to realize these savings, however, depends on other considerations. Government plans are typically required to include state-mandated benefits even if they are self-funded. Private-sector employers with labor contracts may also have a difficult time excluding many of these medical services.

Self-funded employers can achieve additional savings through a reduction in administrative costs and by recouping the portion of the premium that represents the insurer's margin or profit. The higher the fully insured plan's administrative costs and profit, the greater the potential savings.

POTENTIAL COSTS

Offsetting any savings are the increased expenses plan sponsors can incur in a self-funded arrangement. The primary concerns are the impact of changes on provider discounts, network design and care coordination. Moving from a fully insured to a self-funded plan often entails changes to the provider network and the discounts negotiated with providers can vary considerably between networks. In a self-funding conversion, even a small change in negotiated discounts can mean the difference between saving money and spending more money. For an employer with $50 million in billed medical claims, a 5-percentage-point shift in provider discounts could increase their medical costs by $2 million to $3 million.[3]

Savings will also be affected by any changes in the design of the network. Care coordination and health system integration can have a significant impact on the utilization of medical services. Generally speaking, provider-coordinated care in an integrated health care system will result in more efficient utilization of medical services. An HCTrends analysis of claims data from the Wisconsin Health Information Organization found that the state's larger, more integrated health systems utilized 4 percent fewer resources to treat the same types of episodes as non-integrated providers.[4]

Experience has shown that moving from a fully insured HMO-style plan to preferred provider network will increase the consumption of medical services. Many employers experienced this 15 years ago when many insurers replaced HMO-style plans with less-restrictive PPO networks. Premiums increased by 15 to 20 percent per year. The annual increases dropped into single-digit increases by 2006, but PPO-style plans remained more expensive. This change can be illustrated by the claims experience of Wisconsin's state employee health plan. In 2001, the plan's PPO network was approximately 21 percent more expensive than the HMO plans offered by the state. By 2014, the gap had widened to 92 percent.[5] This

[2] In December 2015, legislation was passed to delay the implementation of the Cadillac tax from Jan. 1, 2018 to Jan. 1, 2020.

[3] A company with $50 million in a network offering a 40-percent discount would pay $30 million in allowed charges. If the same company self-funded and moved to a network with a 35-percent discount, it would pay $32.5 million, or 8 percent more.

[4] HCTrends analysis based on WHIO DMV14, commercial payers only

[5] HCTrends analysis of state employee health plan premiums 2001 through 2014

gap can be attributed to two factors: the weaker care coordination inherent in a preferred provider network and inferior provider discounts.

UNDERSTANDING THE DIFFERENCE BETWEEN PROJECTED SAVINGS AND ACTUAL SAVINGS

Plan sponsors are often willing to consider self-funding based on the success stories of others. Unfortunately, these success stories are often based on projected savings that are never achieved. For example, when Milwaukee County converted from fully insured to self-funding in 2006, it projected it would save $31.5 million over the course of three years (2006, 2007 and 2008) due to its conversion to a self-funding arrangement.[6] An HCTrends analysis of Milwaukee County budget documents indicates that the savings attributed to the self-funding conversion were likely considerably less than initially estimated and may have been non-existent.

The projected cumulative savings from 2006 through 2008 were based on an assumption that Milwaukee County's health care costs would grow by 15.8 percent per year if no changes were made.[7] In reality, the trend likely would have been lower because the growth in health care costs nationally and locally slowed around this time. According to Segal, which benchmarks PPO premiums nationally, annual increases decreased steadily during this period – from 10.4 percent in 2005 to 9.7 percent in 2008.[8] The HCTrends' Annual Employer Health Care Benefits Survey, which measures health care costs in southeastern Wisconsin, showed that the trend for public-sector employers ranged between 5 and 9 percent during this same time period. If the county increases mirrored the average of these trends, the savings attributed to Milwaukee County's self-funding conversion would have been closer to $20 million, more than a third less than the initial projection.

Because Milwaukee County significantly reduced its workforce between 2001 and 2008, HCTrends also compared changes in employee health plan costs on a per-active-FTE[9] basis. That analysis, which used Milwaukee County budget documents, indicated that by the end of 2008, FTE costs were approximately the same as they would have been had Milwaukee County not made any changes and its health plan costs increased at the Segal national PPO average.

DISRUPTION

The final concern in a self-funding conversion is disruption. This generally occurs in three areas:

1. Patient-Provider Relationships
2. Payer-Provider Relationships
3. Plan Sponsor Budgets

Disruption to the patient-provider relationship can impact both care coordination and employee satisfaction. It can also increase plan costs if accessibility issues motivate employees to use higher-cost, out-of-network providers.

Disruption to the payer-provider relationship impacts negotiated discounts, care coordination and provider satisfaction.

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[6] Milwaukee County Inter-Office Communication from Jerome J. Heer, Director of Audits, to Richard D. Nyklewicz Jr., Chairman, Finance and Audit Committee, March 12, 2008

[7] This was the maximum allowed increase allowed under the insurer's contract with Milwaukee County

[8] 2016 Segal Health Plan Cost Trend Survey National Medical Trend for PPOs

[9] Full-time-equivalent employees currently working for the county

Budget disruptions are also common in self-funding conversions. Claim costs often drop in the first year of a new network or plan design. This is because employees, unsure of how the change will impact their finances, tend to use more medical services immediately prior to the change. As a result, claims are often lower in the first year of a new plan. Typically, there is a significant year-to-year increase in claims and claim costs during the plan's second year as things return to normal.[10]

Milwaukee County's experience demonstrates the volatility that can occur when funding mechanisms (fully insured vs. self-insured) or provider networks are changed. The county converted from fully insured to self-funding in 2006. In 2007, it experienced a small increase in its medical plan costs per FTE (3.8 percent), but that was followed by a 26.5-percent increase in 2008. In 2009, Milwaukee County switched health plan administrators – from WPS to UnitedHealthcare. In its first year with UnitedHealthcare, plan costs dropped 1.3 percent on an FTE basis, but then increased 9.4 percent in 2010, the contract's second year.[11]

CONCLUSION

Self-funding can help employers save money, but the savings are not guaranteed. Health care costs are determined by the dynamic interplay of multiple forces. Focusing on the specific tangible savings of a self-funding conversion while ignoring the potential impact of the change on other cost drivers can mean the difference between a conversion that saves money and a conversion that costs money.

[10] For more information, see "Timing's Everything: The Impact of Benefit Rush" (Society of Actuaries Health Watch, May 2008)

[11] HCTrends analysis of Milwaukee County budget documents