



**Overview: Public Entity Risk Pooling  
And  
Health Benefits Trend Management**



Presented to the South Central Assembly Summit, June 13, 2012

# BACKGROUND

## The Problem

- Excessive, rapidly increasing, “runaway” costs for health insurance
- Benefit costs “jump off the page” of a public entity budget and cannot be ignored by decision makers and the taxpayers: a big line item, increasing at a rate several multipliers of inflation
- Contractual obligations that lock the employer into relatively “rich” benefits for several years. Reimbursing employees creates a different set of problems.
- Arbitrators who have missed the economic changes in the last several decades and continue to foster the false conclusion: low public entity salaries must be offset by rich employee benefits
- When seeking solutions from conventional sources (i.e. brokers and commercial carriers), end up circling back to same less-than-acceptable options:
  - Assume greater risk
  - Discontinue expensive, rich plans
  - Shift costs to employees
  - Arrange for limited group purchasing discounts with commercial carriers
  - Change carriers and accept narrower networks

## Initiating Significant Change

- 1980 : Group purchasing of commercial insurance
- 1986: Consortium hires independent consultant to explore options for countering meltdown of Property / Casualty market for municipalities
- 1989: Delaware Valley Insurance Trust – a pool formed by 18 charter municipalities in Bucks and Montgomery Counties
- 1992: Delaware Valley Workers' Compensation Trust
- Several studies on health through brokers falls short – only able to negotiate limited volume discount through cooperative purchasing by five municipalities
- 1997: Hire independent consultant – emphasizes advantages of relying upon a built-in core group with membership of other two Trusts
- 1999: Delaware Valley Health Insurance Trust – 16 charter members

## Initial Goals of DVHIT

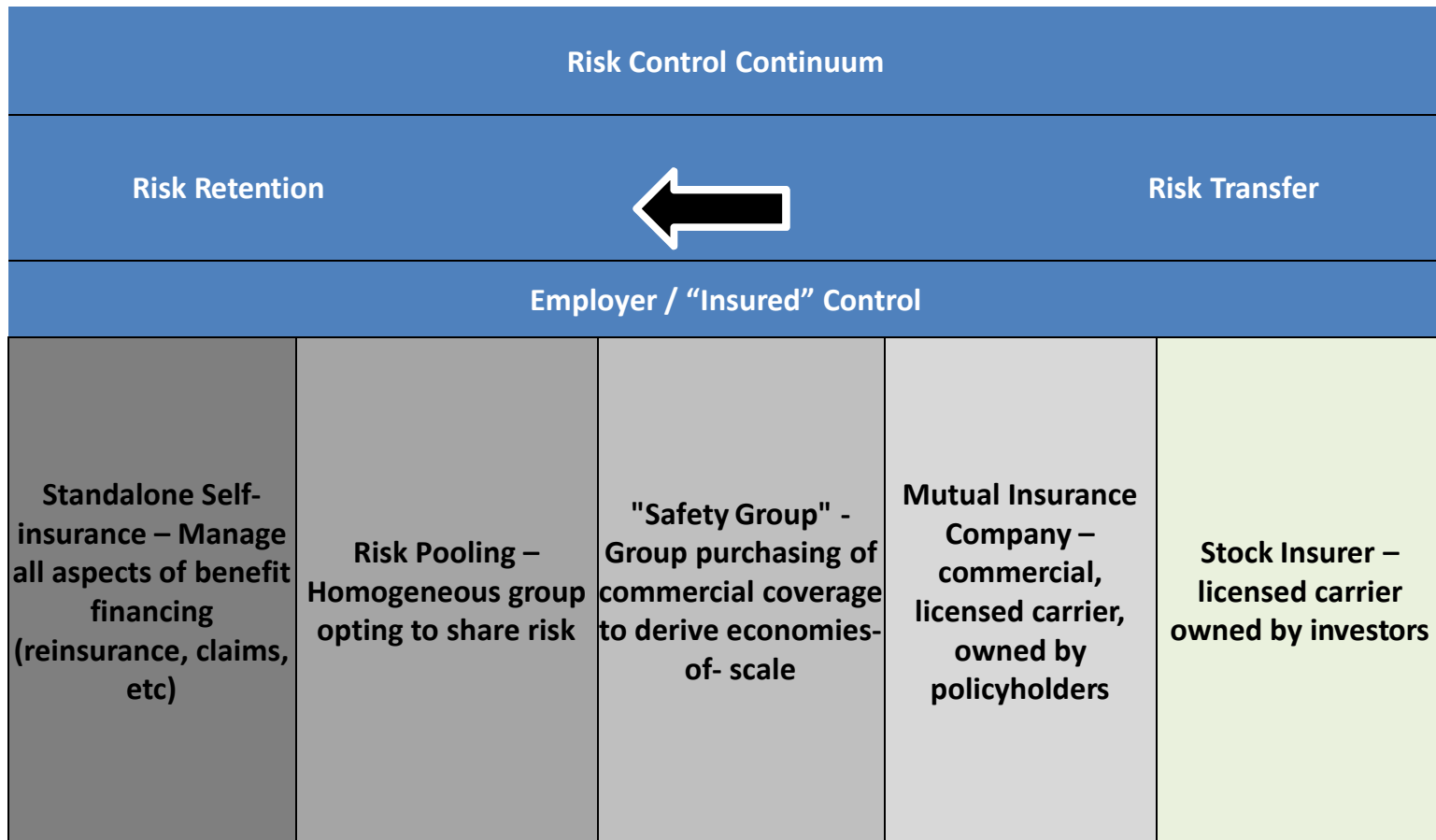
- Commit to an entity controlled by the membership rather than continue to purchase commercial health insurance
- Gain greater control over health care costs and remove the market fluctuations through a commitment to **long-term price stability** and risk sharing
- Create a program **more responsive** to the unique benefit needs of small to mid-sized public entity employers
- Foster a more competitive environment by giving public entities an alternative to the two dominant health insurance companies in the market (Blue Cross and Aetna)
- **Test the theory** that “the municipal workforce is older and heavier utilizers of health care services and therefore benefits from the Commercial Community Rating methodology”

DVHIT TODAY

## What is DVHIT? A: Everything Listed Below:

- A risk-sharing pool, *exclusively owned, managed and controlled by its 90 public entity members* - (Members opt to leave commercial insurance market and collectively share risk)
- Unlike self-funding, offer a guaranteed rate, with pre-set costs annually
- A non-profit, tax-exempt trust covering 15,500 employees and dependants and generating about \$90 million in annual premium contributions
- Network discounts and claims administration provided by carriers under contract to the Trust
- Will duplicate any commercial plan and save 3 – 6%.
- Delivering tailored, quality health coverage for significantly lower administrative overhead – 8.5%
- Offering responsive, first-party service support
- Returning excess funds to members in rate credits
- Offering a robust, focused, Trust-initiated Wellness Program
- Providing a platform for the formation of parallel pools

# Risk Management Control





## DVHIT Governance Structure

- Each public entity appoints a Trustee to Board of Trustees
- Trustees elect five Officers who serve on an Executive Committee
- Executive Committee meets with staff and advisors once a month to direct program
- Service Providers with very specific functions:
  - Benefit Consultant: Insurance Buyers Council, Cockeysville, MD
  - Medical Claims Administration: Aetna, Blue Bell, PA and Hartford, CT
  - Dental Claims Administration: Delta Dental of PA, Mechanicsburg, PA
  - Reinsurance: Aetna, Blue Bell, PA and Hartford, CT
  - **Medical Network Access: Aetna, Blue Bell, PA and Hartford, CT**
  - Dental Network Access: Delta Dental of PA, Mechanicsburg, PA
  - COBRA Administration: CONEXIS, Irving, TX
  - Employee Assistance Provider (EAP): HMS, West Chester, PA
  - Actuary: Segal and Company, New York, NY
  - General Counsel: Geoffrey L. Beauchamp, Esq., Willow Grove, PA
  - Auditor: Bee Bergvall & Co, Warrington, PA
  - Non-pooled Ancillary Lines (Life, STD and LTD): The Standard Insurance Company

## What Can DVHIT Prospects Expect?

- A complete and total match of your current plan design(s) - All plans are fully customized – duplicating any and all existing health, rx and dental plans (225 unique plan designs to meet or exceed all applicable collective bargaining agreements)
- Premium savings of 3 to 6% at outset of membership, without reducing benefits
- An unblemished record of never unilaterally discontinuing a plan
- *Guaranteed rates* for each calendar year with no retro adjustments
- Superior member service through in-house staff and national account status, now only available due to leveraging and economies of scale
- Comprehensive wellness and fitness reimbursement program

## What Can DVHIT Offer Long Term?

- Rate stability at renewal
  - 7.8% average increase for 2011
  - 5.8% average increase for 2010
  - Single digit average increases for 6 straight years
- Financial strength and stability: \$90 million in premium and significant surplus
- Benefits of ownership: Excess surplus returned to members - Rate Stabilization Fund (\$20 million allocated to members since 2004)
- Satisfaction: 95% group retention rate since inception; 100% the last several years
- Better management: relevant rating driven by access to, and monitoring of, data and performance
  - Claim levels
  - Profit / Loss
  - Vendor management (Reinsurance, Pharmacy Benefit Manager)

## What Can DVHIT Offer Long Term?

- Highly efficient and cost effective risk sharing model
- Sophisticated information technology support
- Leveraging size and economies-of-scale for pricing and programs not available or cost effective as stand-alone entities
- Greater control over benefit program
  - Budgeting – Can offer similar cost control aspects of a Defined Contribution Plan
  - Plan design
  - Collective bargaining
  - Employee education
  - Participation in managing the direction and priorities of Trust
- As part owner, reap the financial benefits of ownership – Excess surplus returned to member / owners through Rate Stabilization Fund (RSF) credits

## DVHIT Advantages Compared to Being Fully Insured

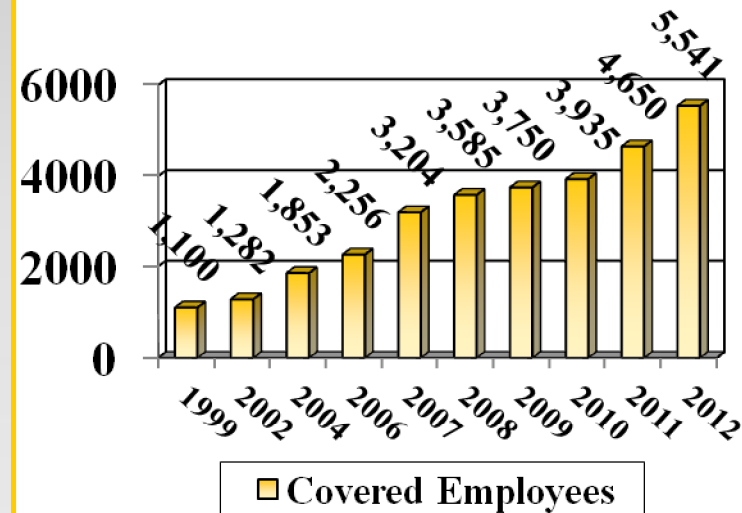
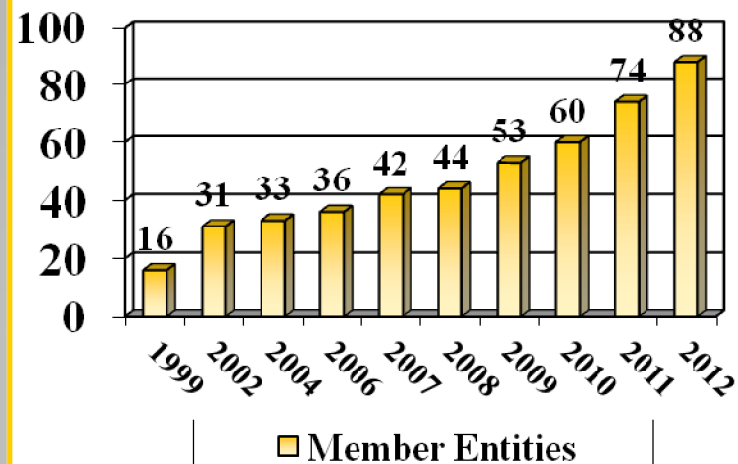
- Administration costs of less than 9 cents – i.e. everything that is NOT treatment
- Coverage and pricing stability
- Because of greatly reduced administrative expenses, more of each premium dollar is going to care and treatment
- Insulation from market vagaries – market may drive trends contrary what your own experience may justify
- “Carrier” stability because you are part owner of the “carrier”
- Employer directs benefit plan structure, not carrier
- Outsourced support for many of the benefits administration functions for small to midsized municipalities
- A proven model which has worked for over 13 years in controlling health care costs without compromising benefit levels and quality of care

## DVHIT Advantages Compared to Self-Funding

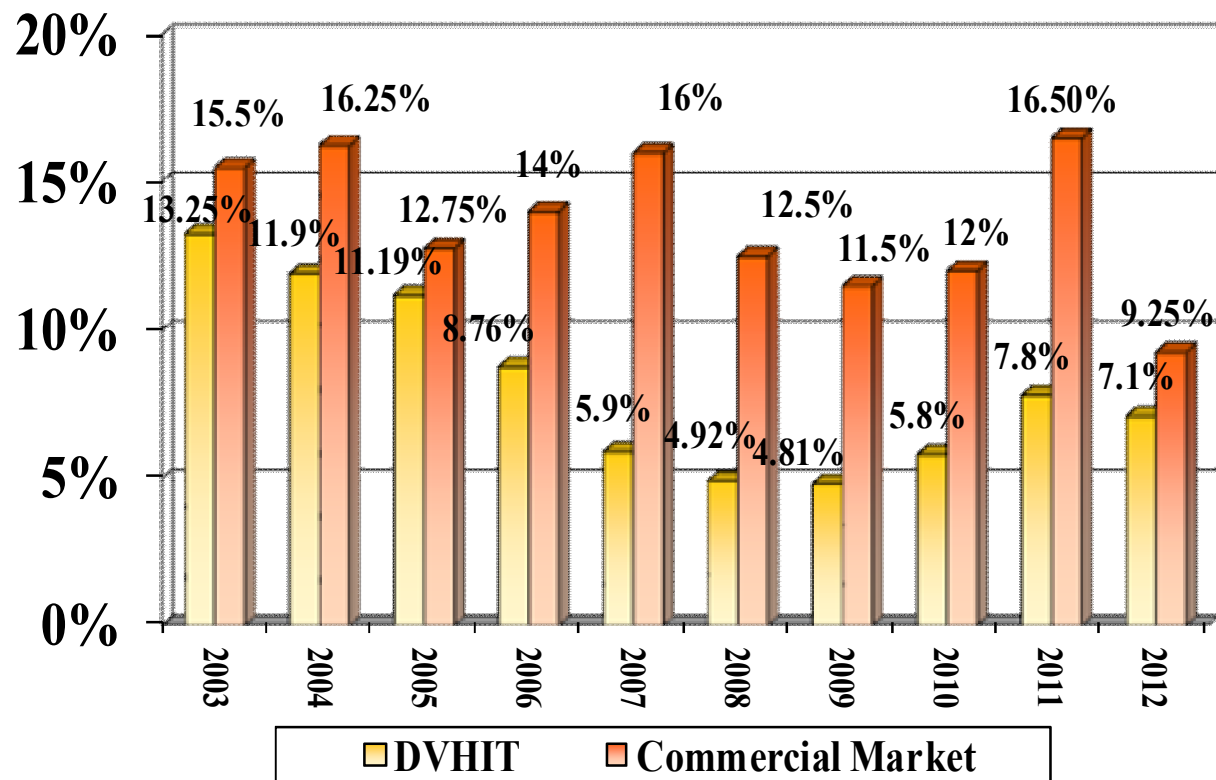
- Lower administration costs in most cases
- Members billed a conventional equivalent rate (guaranteed for 12 months) specific to their plan design. (DVHIT does not use “Common Rates”)
- Trust, not the public entity, assumes risk on shock claims (\$600,000)
- Most stable health insurance platform in the region with average annual increases of 6.33% since 2006
- No complex risk sharing formulas
- No specific or aggregate reinsurance to purchase
- No aggregate risk corridor to fund
- Excess surplus returned through Rate Stabilization Fund credits
- A proven model which has worked for over 13 years in controlling health care costs without compromising benefit levels and quality of care

# Member Entities and Employees

Growth has been measured and consistent



## DVHIT Renewals - Consistently Below Commercial Market Averages and Gap is Widening

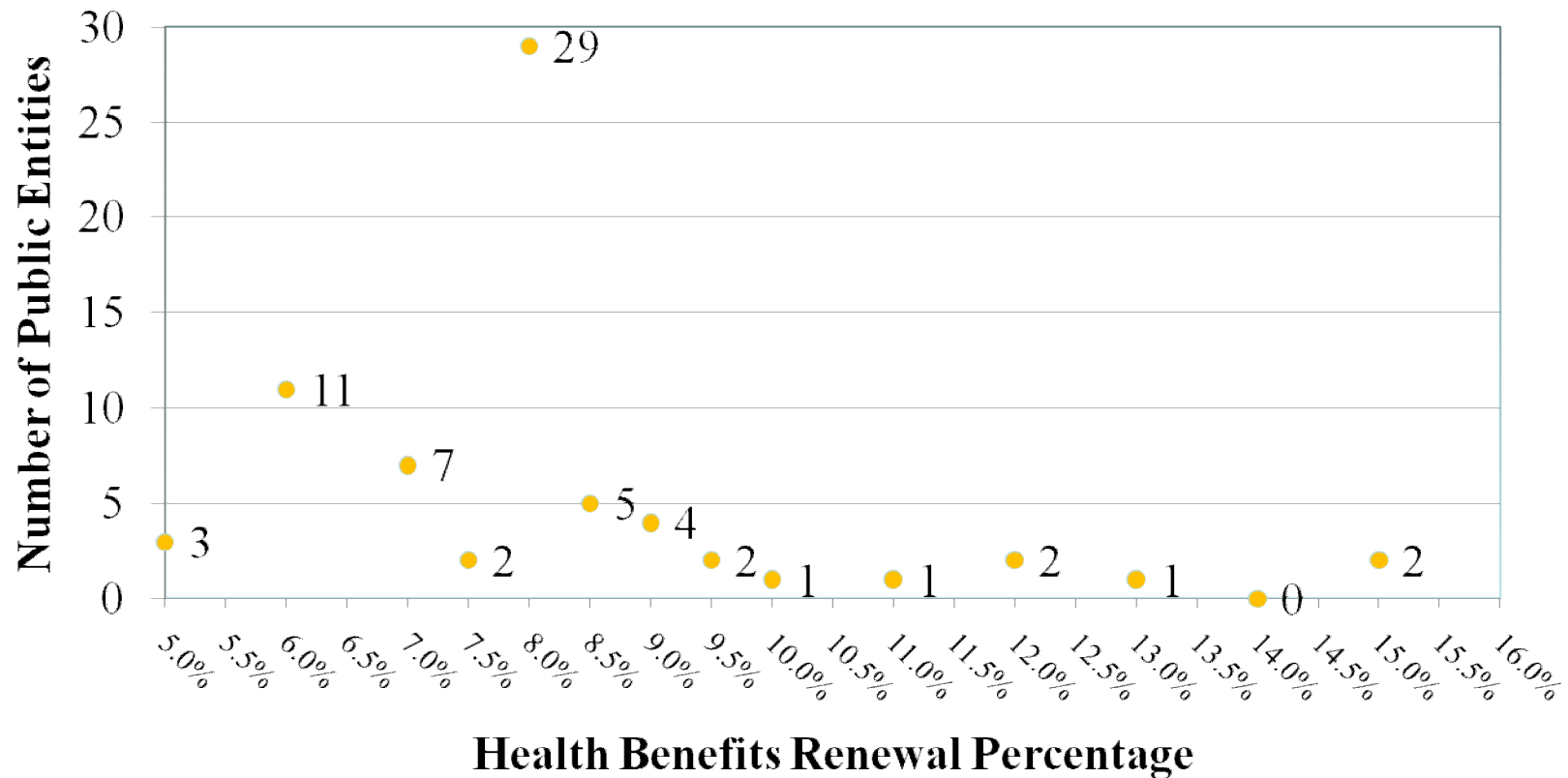


- Composite rate increases include Medical, Rx and Dental premiums.
- DVHIT averages do not include Rate Stabilization Fund Credits and/or Multi-Trust Discounts.
- Average commercial market increase based on a credible sample of fully insured renewals in the marketplace for comparable plan designs



## Distribution of Renewal Increases

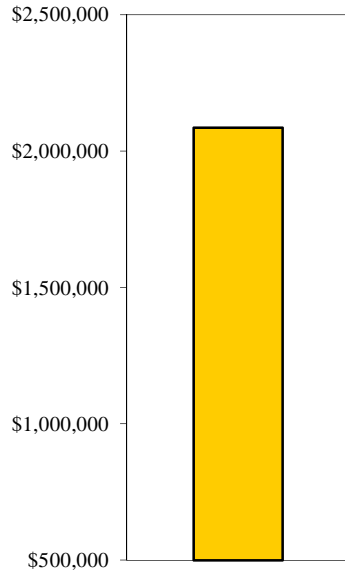
### Frequency of Renewal Increases by Count and % Increase



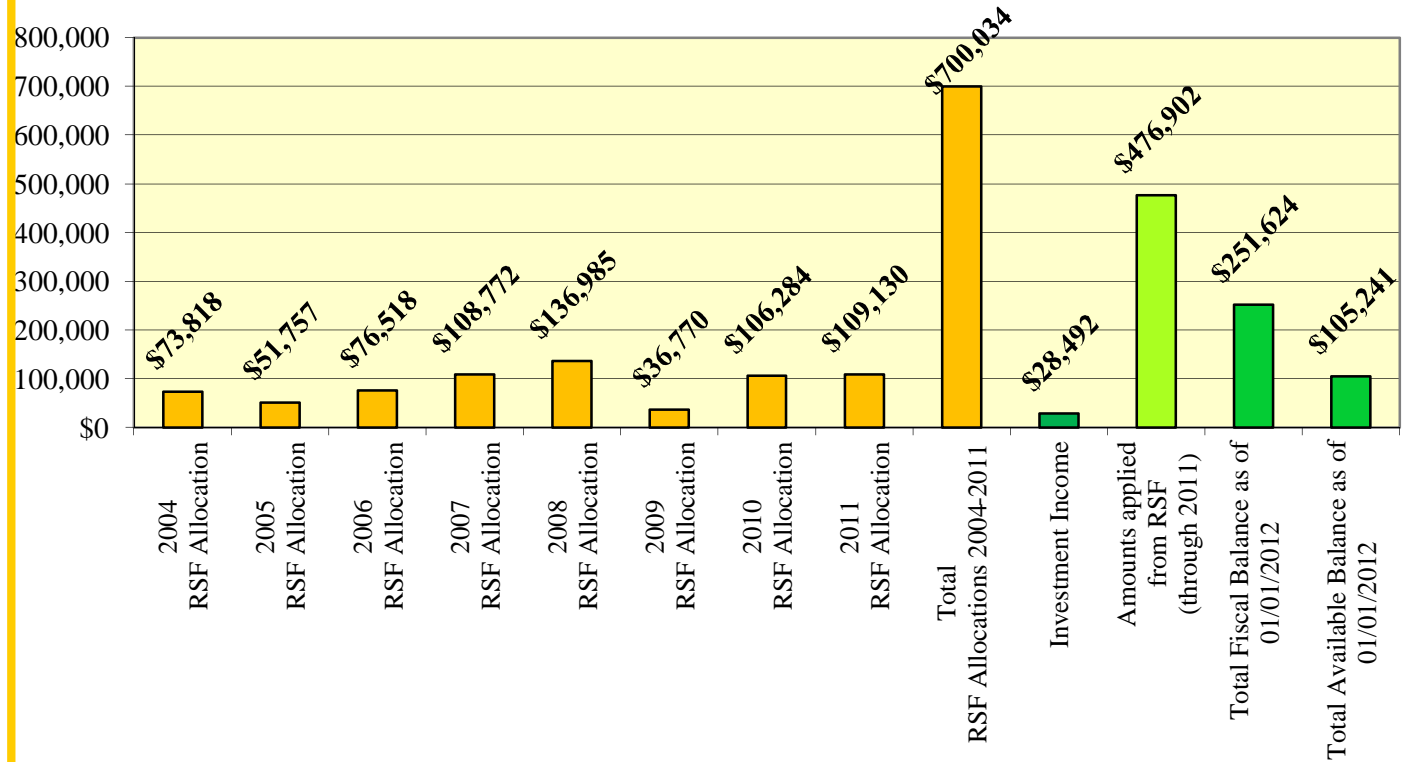
- Percentages are rounded for graphing purposes
- Based on 2012 renewals assuming no plan design changes and before application of RSF

## Accumulation of Rate Stabilization Fund Credits

2012 Projected Premium



Township 1-100 employees

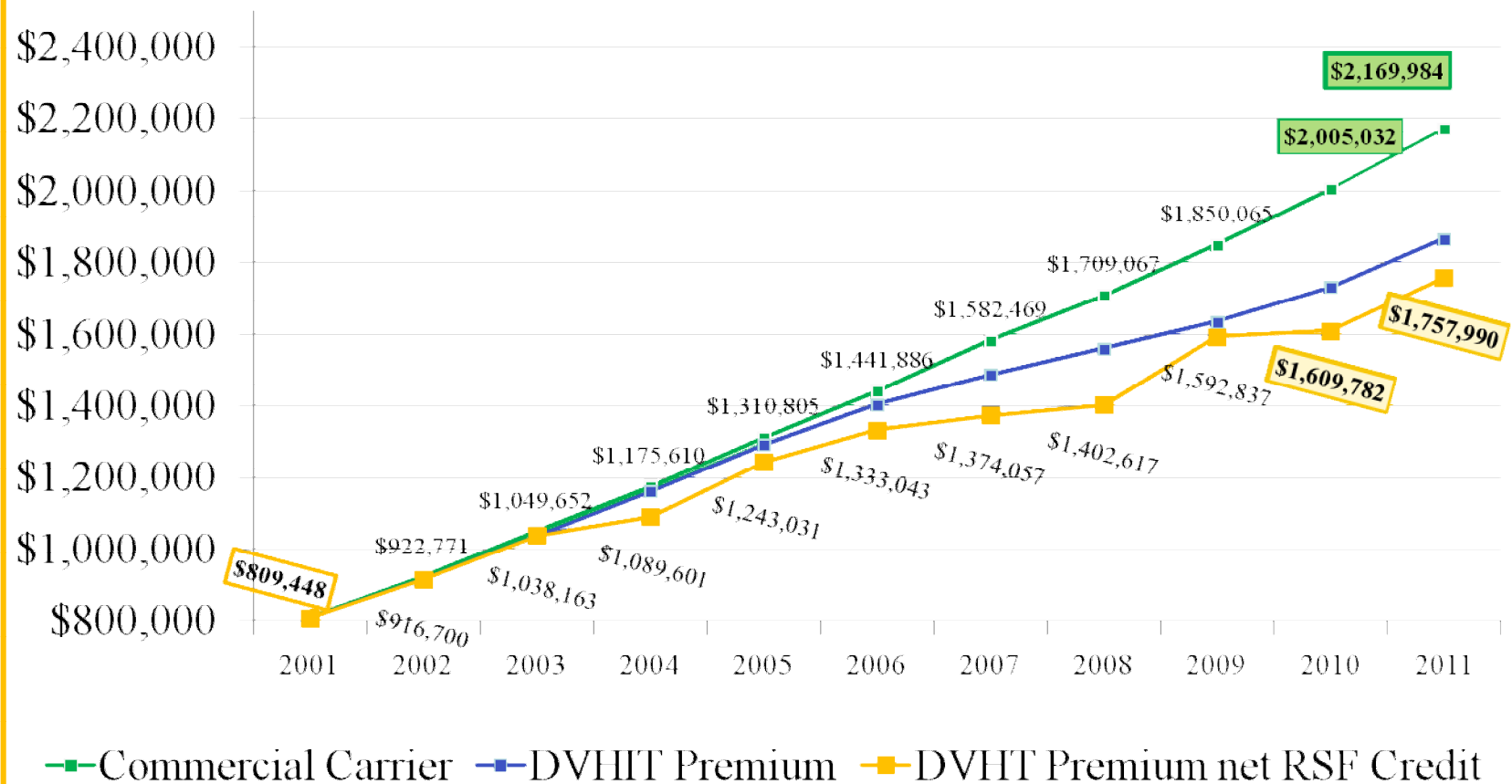


Township Projected 2012 Premium	2004 RSF Allocation	2005 RSF Allocation	2006 RSF Allocation	2007 RSF Allocation	2008 RSF Allocation	2009 RSF Allocation	2010 RSF Allocation	2011 RSF Allocation	Total RSF Allocations 2004-2011	Investment Income	Amounts applied from RSF (through 2011)	Total Fiscal Balance as of 01/01/2012	Total Available Balance as of 01/01/2012	RSF Fiscal Balance (if all of AVAIL. Balance Applied in 2012)
\$2,086,982	\$73,818	\$51,757	\$76,518	\$108,772	\$136,985	\$36,770	\$106,284	\$109,130	\$700,034	\$28,492	\$476,902	\$251,624	\$105,241	\$146,383

# Cumulative Premium Comparison

## DVHIT vs. Commercial Carrier

(based on Actual 100+life group)



### Notes:

"2010 and 2011 premium from broker renewal exhibit.

"RSF credit based on an equal blend of 3 similar sized HMO members.

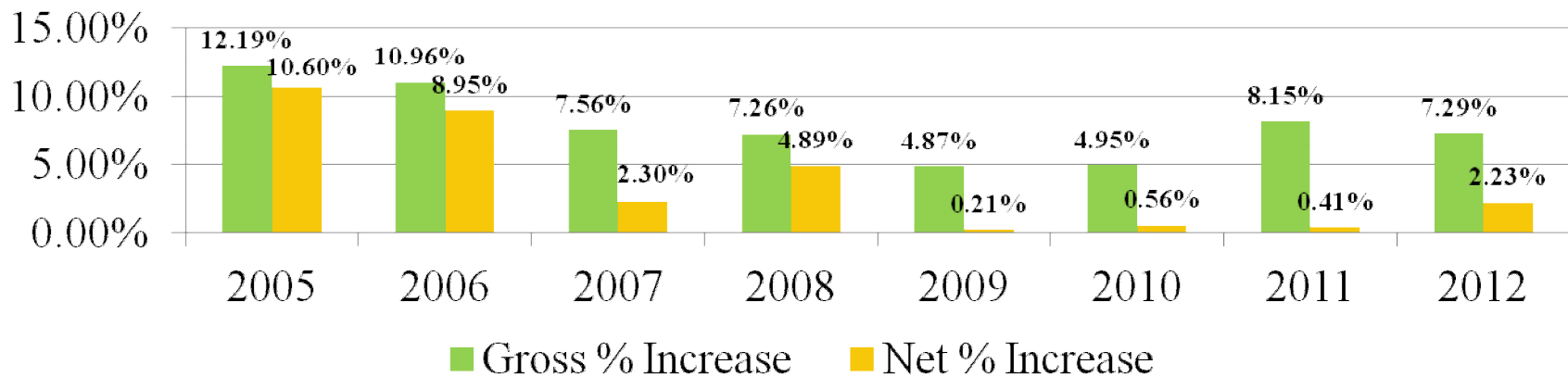
## Impact of Overpayment of Premium

	Entire Group	“Overpayment” of Premium Per Employee
<b>2010 and 2011 Premium Differential</b>	\$578,197	\$5,305
<b>2010 and 2011 Premium Differential net RSF</b>	\$807,244	\$7,406
<b>2001 through 2011 Cumulative Premium Differential</b>	\$1,122,718	\$10,300
<b>2001 through 2011 Cumulative Premium Differential net RSF</b>	\$1,859,520	\$17,060

**Notes:**

“ Based on 109 covered employees

## Impact of RSF Credits on Renewal History (100 employee group with mix of HMO & PPO enrollment)



Year	Gross Premium		Gross \$ Increase	Gross % Increase	Applied RSF Credits	Net \$ Increase	Net % Increase
	Year Begin	Year End					
<b>2005</b>	\$1,162,708	\$1,304,435	\$141,728	12.19%	(\$18,454)	\$123,274	10.60%
<b>2006</b>	\$1,330,500	\$1,476,332	\$145,831	10.96%	(\$26,736)	\$119,095	8.95%
<b>2007</b>	\$1,478,177	\$1,589,962	\$111,785	7.56%	(\$77,844)	\$33,941	2.30%
<b>2008</b>	\$1,652,820	\$1,772,774	\$119,954	7.26%	(\$39,144)	\$80,810	4.89%
<b>2009</b>	\$1,824,603	\$1,913,509	\$88,907	4.87%	(\$85,000)	\$3,907	0.21%
<b>2010</b>	\$1,820,186	\$1,910,340	\$90,154	4.95%	(\$80,000)	\$10,154	0.56%
<b>2011</b>	\$1,933,767	\$2,091,448	\$157,681	8.15%	(\$149,724)	\$7,957	0.41%
<b>2012</b>	\$2,080,635	\$2,232,343	\$151,708	7.29%	(\$105,241)	\$46,467	2.23%
<b>Totals/Averages</b>	<b>\$13,283,396</b>	<b>\$14,291,143</b>	<b>\$1,007,748</b>	<b>7.59%</b>	<b>(\$582,143)</b>	<b>\$425,605</b>	<b>3.20%</b>

\*RSF credit based on an equal blend of 3 similar sized HMO members.

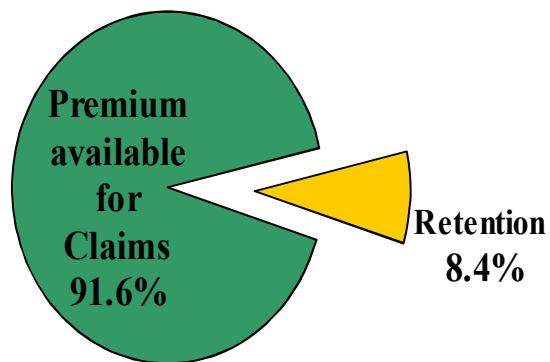
## Value-Added Programs and Member Services

- Ancillary Lines Program - Leveraged discounts and extended rate guarantees for group life and disability coverage
- Own Member Wellness Initiative (MWI)
- Compliance and collective bargaining / plan design consulting
  - Prepare cost-saving options for negotiations
  - Present seminars, workshops and training on timely benefit topics such as Healthcare Reform
- Enhanced member service - DVHIT staff serve as benefit liaisons
- Health Advocate™ - Personalized advocacy and health care delivery resource for member and families
- COBRA Administration
- On behalf of Members, Trust files Medicare D Retiree Drug Subsidy, Early Retiree Reinsurance Program (ERRP)
- Employee Assistance Program (EAP)

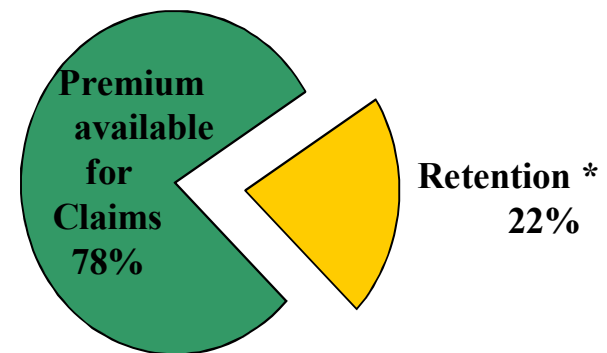
# DVHIT vs. COMMERCIAL MARKET

# DVHIT-Unparalleled Administrative Efficiency

*DVHIT*



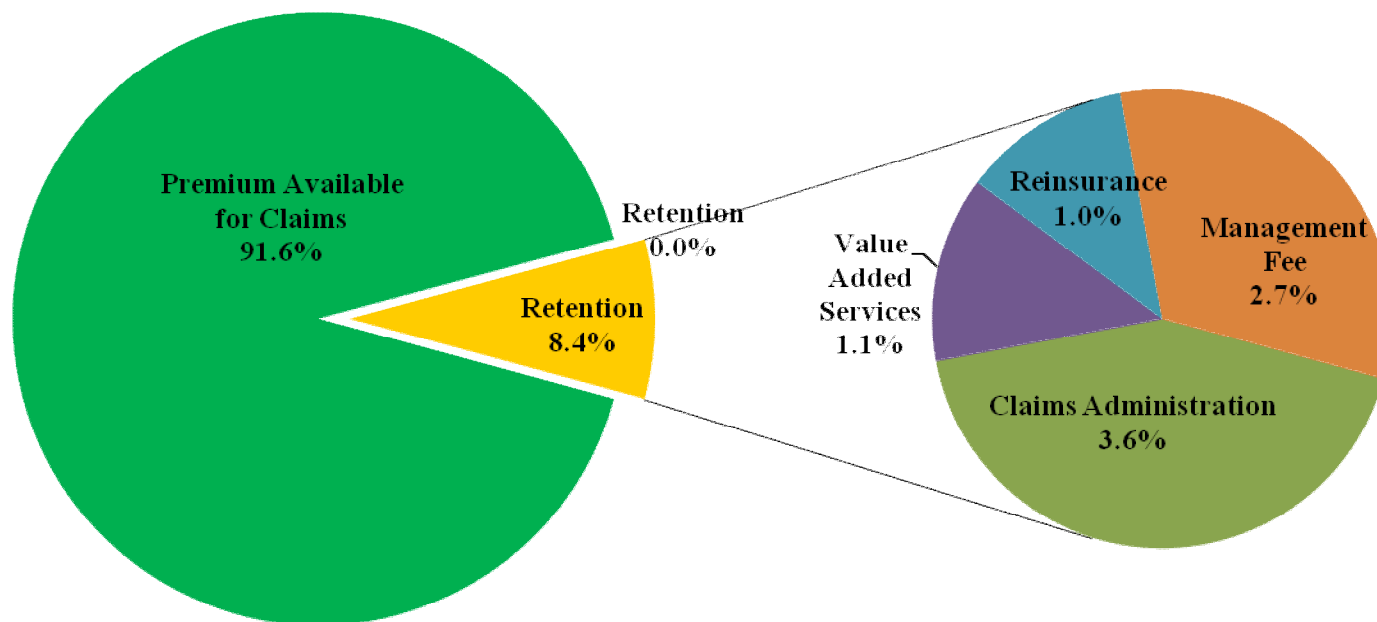
*Commercial Market*



\* Commercial market retention ranges from 19-25% and can include the following: administration, risk margin, stop loss/pooling charges, commissions, premium tax, and profit.



## Components of Retention



\* Value-Added Services:

- ✓ COBRA Administration
- ✓ Health Advocate (Member Health Advocacy Service)
- ✓ Member Wellness Initiative
- ✓ Employee Assistance Plan

\*\*DVHIT Reinsurance is net of commissions.

# DVHIT MEMBER WELLNESS INITIATIVE

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## DVHIT Member Wellness Initiative

### MWI GOALS

- Facilitate healthier lifestyles and member health awareness
- Decrease health care costs through active management of at-risk members
  - Identify current at-risk population
  - Determine “ticking time bombs”
  - Prevent or minimize healthy members from migrating to at-risk members
- Avoid health care costs through a comprehensive prevention and disease management program
- Increase productivity and reduce absenteeism
- Improve member satisfaction and self-worth
- Provide access to proven wellness education programs
- Provide a value-added member service and improved DVHIT “branding”

# DVHIT Member Wellness Initiative

## A Microcosm of the Advantages of Pooling

- A comprehensive approach to reducing health care costs through proactive identification and active management of high-claim related diagnoses
- Funded through administrative savings
- Leveraging membership to provide a benefit unavailable or not cost effective for small and mid-sized employers on a stand-alone basis
- Launched July 2005 with Targeted Diagnoses and Conditions:
  - Obesity
  - Diabetes
  - Smoking
  - Hypertension
  - High Cholesterol

These 5 conditions are either directly or indirectly related to 12 of DVHIT's top 15 diseases/conditions.

## How Member Wellness Initiative Works

- Voluntary Participation
- Cash Incentives:
  - Health Club Membership Fee Reimbursement - \$250 for employee and spouse – 100 visits in 12 months
  - Colonoscopy - \$150
  - Comprehensive Physical (Blood, Urinalysis, EKG)– Submit results to nurse - \$100
  - Women's Health - \$50 for Mammogram / \$50 for Cervical Screening
  - Biometric Screening – Nurse visit - \$50
  - Weight Watchers™ at Work and Incentives for Losing Weight – reimburse \$135 fee if attend 9 of 10 sessions.
- Employees diagnosed with one or more of the targeted conditions, receive cash incentives for participation in each stage:
  - Stage 1: Comprehensive Health Screening
  - Stage 2: Treatment and Education
  - Stage 3: Management of Conditions

***Investing in Member Wellness and  
Healthier Lifestyles is the Ultimate Win-Win!***

WHAT HAVE WE LEARNED?

## Risk Pooling Works When Managed Properly

- You can simultaneously:
  - offer a competitive and stable rate structure
  - provide access to full spectrum of products (HMO/POS/PPO)
  - provide reliable and responsive claims administration
  - offer broad networks, with competitive discounts
  - build surplus and return excess to members
  - improve and “personalize” individual’s access to the healthcare delivery system
  - strike an effective balance between the technology and data driven large Managed Care Organizations and the accessibility of a small niche insurance company
  - provide resources for the refinement of Disease Management and Wellness to actually positively impact on the bottom line
  - “control your own destiny” through leadership and strong member-based governance

## Folklore is Not Fact

- “Community rates” are not a 50/50 balance between “good risk” and “bad risk” groups. For the overwhelming majority of small to mid-sized groups, community rates are inflated.
- Despite an older average age employee base (DVHIT average age is 45) and rich benefit levels, there is nothing “risk specific” to municipalities and public entities making pooling prohibitive
- Union objections tend to be negotiating leverage or fear of change rather than “fact” based. Independence Blue Cross was specified in labor agreements when we first began operating in 1999. Now, DVHIT plans are specified in labor agreements.
- Even in the toughest collective bargaining environments changes can be negotiated to achieve cost savings in employee benefits
  - Prioritization
  - Education
  - Communication



# Pooling Expands Horizons

- Pooling offers small to mid-sized public employers an option that is NOT:
  - As expensive and restrictive as purchasing insurance
  - As risk adverse and internally disrupting as self-insuring
- **Requires a discipline to re-commit to a shared purpose, and not compromising the model:**
  - Trust is not a commodity or just another “market”
  - Since not selling insurance, limited broker involvement – will not pay commissions
  - Primary goal of *long-term* cost containment
  - Answer only to membership : customized plan designs for each member
  - Problem? Don’t threaten to leave – work to help fix it
- Expanded membership creates a new level of critical mass that did not exist, allowing:
  - The driving of economies-of-scale, administrative efficiencies and leveraging carriers
  - May lead to new frontier of improving treatment and care delivery, at lower cost

## The Future

- Managed growth, to drive down administrative costs even further
- Diversification, by adding other public entities such school districts as members
- Geographic expansion to other areas of the Commonwealth
- Establishing and effectively managing spin-off pools, as demanded by membership and associated groups
- Rounding off some of the sharp edges in treatment and treatment costs
  - Started with MWI
  - Applying a rationale to coverage disputes and listening to medical providers – rediscovering a moral compass
  - Negotiating additional discounts for selected services directly with providers
  - Operating clinics / pharmacies – simultaneously lower cost and improve care and treatment

## Questions?

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