Financial Services

The Largest Health Plans are Eating up the ASO and Stop Loss Market

WHITE PAPER / MAY 14, 2018

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Table of Contents

INTRODUCTION

No longer is Self-Funded (ASO) Group coverage relegated to the largest Employers and National Accounts. ASO arrangements are now being sold to smaller sized employers, who at one time would never have considered self-funding as an option. As the ASO market continues to expand to include smaller groups, Health Plans need to provide innovative administrative pricing and risk mitigation, tailored to each Group's individual needs.

Self-Funded (ASO) medical plans, now cover 63% of all employees enrolled in health plans, a new all-time high. This represents over 100 million Americans that are covered by these self-funded plans, more than any other form of coverage[1]

Many Health Plans, some quite large, are all too reliant on systems that are decades old or manual processes that are too labor intensive to scale.

Many Plans find their overall revenue growth is being limited by their ability to manage and support ASO arrangements. In fact, some Plans are also finding that their contracts with the Groups support fees that their systems and processes can't support, they are simply leaving money 'on the table'.

Carriers are also finding Stop Loss coverage is important for these smaller groups. But they may not offer Stop Loss Coverage, or they realize Stop Loss is complex and relies too heavily on their manual processing to be scalable.

While facing these issues Health Plans are realizing that the very largest Plans have solved these issues and are offering innovative and flexible arrangements. They did this by being creative in their approaches but also by moving away from their antiquated systems and converting to a Commercial Off The Shelf (COTS) software solution. These very large Plans have migrated their in-house legacy systems and manual processes and as a result are reaping the benefits and rapidly grabbing market share.

COMPETITIVE BUSINESS CASE

Groups are being offered Flexible Administrative Fee pricing, not just the traditional Employee (PMPM) or Family (PSPM) fees at the group level. Leading Plans can set up global pricing that can be overridden at any level of the Group's hierarchy. Fees can easily be varied from active employees to retirees or any other mix that the Group needs. Enrollment based pricing can quickly be set as a composite rate across all tiers or customized rates at the tier level (single, family, two-person etc). Admin fees can also be based on the claims either a fixed fee per claim or as a percentage of the claim.

Even more importantly, leading Plans can recover claims and claim based fees by defining an unlimited number of claim add on fees, with the ability to mark up or down these fees. Each of these fees can be either rolled into the claim amount when billing, and reported as a part of the claim amount or as a separate line item on the bill under each claim. These fees can include the Blue's Inter-Plan Tele-Processing Services (ITS) fees, National Care Network (NCN) Carrier Fees, paper vs. electronic claim submission fees, etc. Many plans can contractually pass on these fees to their customers, but simply don't have the billing system and processes in place to do so, and therefore they are missing revenue opportunities.

Leading Plans are also able to model 'customized reports' that support the invoice to the individual receiving the report, not through brute force, but through automation. Reports can be modeled and customized down to a specific user at the Group. Summary and detail reports, whereby optional fields can easily be added or removed, are available. The sort order of the reports can also be quickly customized. Safeguards in place to ensure that a PHI agreement is in force before a report is sent out. If there is not a PHI agreement on record, reports automatically eliminate or mask the PHI data from each report. This is until the PHI contracts are recorded as in place and the PHI data is included or unmasked. The 'report' format can also vary from a PDF to a spreadsheet, or in a text format. Leading Plans can also model how reports are delivered to each user, by common carrier, fax, email, or via the Plan's Employer Portal. These reports are not manually produced, but come out of each bill run and are automatically distributed to the Group.

To help move down market Plans are offering Level Funding options, which provide the group with a consistent monthly cost, much like a Fully Insured arrangement, with a final settlement at the end of the contract period.

DISCOUNT SHARING VS ADMIN FEES

Innovative Provider Network Discount Sharing arrangements are being offered to groups as an option to Admin Fees. Some full provider discount plan options allow the Group to take complete advantage of the carrier's significant network discounts. Groups have the option for the entire or a portion of the discount passed along to them. These Discount Sharing arrangements are being offered to control up-front administrative services fees and help the Groups manage their overall health care expenses.

The typical options being offered are:

- **Full Discount Share**: The carrier passes the full discount, giving employers the greatest potential to save. Employers continue to pay full administrative service fees under these arrangements.

- **Discount Sharing with a Guarantee**: This option allows Groups to reduce up-front administrative service fees in exchange for committing to a set network discount share with the carrier, offering predictable discounts to help Groups budget their health care spending.
- **Split Discount Sharing**: This option allows Groups to reduce the up-front administrative service fees in exchange for sharing the network discount with the carrier, offering a closer balance between administrative service fees and savings. The share percentage offered is customized for each Group.

STOP LOSS IS KEY

Additionally, and importantly, Groups are being offered Stop Loss coverage with a wide range of options customized to their situation and needs. Customized Stop Loss coverage is key to carriers selling ASO arrangements to small and smaller groups. Stop Loss calculations can be complicated and unfortunately today many, if not most Plans, rely heavily on mostly manual processes to calculate Stop Loss coverage and credits.

Larger leading Plan's Systems have fully automated their Stop Loss policy administration and billing while also offering a wide range of options. These include:

- Run In options, offering limits that can be set by Health Coverage Class (Health, Dental,Rx etc.)
- Flexible Stop Loss Admin Fees, matching the flexibility they offer with their ASO Admin Fee options.
- Individual (often called Specific) Stop Loss coverage with immediate Settlement, allowing any Stop Loss Credits to be credited on the Group's very next invoice. No reimbursement scenarios are necessary with immediate settlements.
- Aggregate Stop Loss coverage with a cumulative monthly cap, is also available with Immediate Settlement.
- Stop loss coverage can vary from ASO billing, meaning that fees included in ASO need not accumulate toward Stop Loss and vice versa.
- Aggregate Stop Loss can cover more Health Coverage Classes than Individual Stop Loss. For Example, Individual Stop Loss may only cover Health and Dental, while Aggregate can also cover Rx claims in addition to Health and Dental claims.
- Leading plans are also offering a number of exclusion options (lasering) for even more flexibility. These include exclusion by provider, by specific claim, and at a member or subscriber level with either full or partial lasering.
- COTS also offer the largest leading Plans the ability to add Stop Loss months after an ASO Arrangement has been in full force or to change the Stop Loss contract parameters and pricing even months into a contract. This process of 'Reseeding Stop Loss' results in an immediate adjustment on the Group's next invoice. It also provides a longer sales window for plans to provide the Plan more time to sell the Group on Stop Loss coverage. Something too manually intensive for most Plans to consider.

INNOVATIVE MODELS

Putting it all together the largest Plans can administer ASO and Stop Loss arrangements efficiently via automation and they have enhanced their revenue. They offer flexible products and pricing, while minimizing their overhead by taking advantage of full automation. All these capabilities combine to make these Plans formidable in the marketplace.

Customized Admin Fees, Claims and Claims related fees, Customized Reporting options, down to the user at the Group, Level Funding, Provider Network Sharing to offset Amin Fees, Individual and Aggregate Stop Loss coverage with Run In, Immediate Settlements, exclusions and Reseeding capabilities and all their options, adds a lot of complexity but is also becoming the necessary options to compete in the marketplace.

Leading plans are also able to offer non-ASO related charges to flow on to the Group's invoices, including Capitation, third-party vendor fees, with mark-up, even Fully Insured premium charges for Groups with some of their employees covered under an ASO agreement, while others are under a fully insured arrangement.

Adding new products and pricing no longer becomes an Information Technology (IT) department request or a major project, many updates on COTS can quickly be made by Business users via simple point-and-click options and user's configuration and do not need coding changes. Some Plans are nimble organizations that can respond to the demands of the marketplace quickly.

To realistically continue to compete many Plans today will find it very difficult. In fact, they simply cannot compete and leading plans are taking advantage of all their capabilities, and are gaining market share. Plans lacking modern automation simply can't scale while keeping their overhead in check. The innovative ASO and Stop Loss models in the market today offer an almost unlimited number of combinations of options customized to each Group. Plans relying on COTS are offering all these options, while also reducing their own administrative overhead.

CHANGES CAN HAPPEN QUICKLY

Successful plans will offer significant flexibility and benefits to their Group customers, while also enhancing their administrative overhead and Revenue Management capabilities.

One of the true advantages COTS offer is to quickly turn things around and migrate to a new modern system that is fully automated. The average conversion project from a legacy system with manual processes typically takes less than a year. Plans can now move more quickly than they often realize and greatly enhance their market capabilities and reduce their overhead.

SOURCES

[1] Kaiser/HRET, 2015

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May 2018