ORACLE
Insurance

EXECUTIVE
INSIGHT

Opportunity Ahead for Agile and Efficient Medicare Advantage Plans

Medicare Advantage (MA), first launched in 1997, provides a managed care alternative for Medicare beneficiaries, designed to reduce costs and improve outcomes. Participation has risen steadily, and as of August 2018, MA plans cover more than 21 million members, who account for 35% of all Medicare enrollment. This number is expected to reach 50% by 2025, according to the The Henry J. Kaiser Family Foundation.

As the U.S. senior population surges to 71 million in the coming decade, millions more will enroll in MA plans. The healthy growth in the market presents a unique and powerful opportunity for healthcare payers offering MA plans. Annual revenues for MA plans will rise from $215 billion in 2017 to more than $500 billion by 2025, according to PwC—with upwards of $250 billion in play.

These plans, due to the sheer number of potential enrollees, represent tremendous opportunity for payers. In addition, MA plan participants are a very loyal population, with only approximately 10% of enrollees changing plans annually, regardless of price, added benefits, and Centers for Medicare & Medicaid Services (CMS) Star Ratings. This is a level of stickiness that few other enterprises enjoy, but it should not be considered a permanent condition. Markets and customer preferences can change rapidly, as we've seen all too often in these times of digital disruption.

While the opportunity is great, MA plans are not automatically a wise or profitable business decision for all health insurers. There is growing competition as new players enter the market, and cost and margin pressures continue unabated. To make the most of this opportunity, MA plans must look to accelerate innovation while optimizing costs across their enterprises—from marketing and enrollment to plan configuration, claims processing, compliance, and renewal.

Developments to Consider Now

1

Time to flex strength with expanded flex benefits.

In 2019, MA plans were cleared to offer new flex benefits, designed to move plans toward expanded population health capabilities. The authorized benefits fall into two categories:

- Reduced cost sharing for services "medically related" to the treatment of certain health conditions, encouraging members to receive predictive care
- Supplemental non-medical benefits (such as respite services, non-emergency transportation, and non-skilled in-home care) that can assist in managing care

Analysis of CMS data shows that there are 824 condition-benefit category flex benefits being offered in MA plans this year; but these benefits are "clustered in just 153 plans, meaning most MA plans have no flex benefit offerings yet. Of the 824 flex benefits, 458 are reduced cost sharing and 366 are additional supplemental flex benefits."

In April 2019, CMS announced plans to allow additional flex benefits in 2020. MA plans will have the opportunity to offer chronically ill patients access to "a broader range of supplemental benefits that are not necessarily health-related but have a reasonable expectation of improving or maintaining the health or overall function of the enrollees." This might include meal delivery in more circumstances and transportation for non-medical needs like grocery shopping, and home environment services to improve health or overall function as it relates to a chronic illness." For example, an MA plan could cover home air cleaners or carpet cleaning to reduce irritants for asthma patients. The updates also include actions designed to help combat the nation's opioid crisis by giving MA plans flexibility to offer targeted supplemental benefits, cost sharing reductions, and other benefits for patients with chronic pain or who are in addiction treatment.

These new rules offer plans tremendous opportunity to differentiate themselves in the market. Many, however, do not have the agility needed to quickly configure, price, and deliver new benefits due to hard-coded legacy systems. They also may lack analytical capabilities needed to determine which additional benefits could offer the greatest incentive to current members and pools of prospective members. And, of course, benefit expansion must be balanced against cost and margin considerations.

Oracle Health Insurance's product definition component provides easy-to-configure-and-maintain benefit-configuration capabilities by breaking these into three hierarchical levels of service definitions. Further, the cost-share elements are separated from the service definitions and are automatically applied based on business rules. This allows health plans to introduce flex benefits quicker into the market giving a significant competitive advantage.

2

Choices ahead: MA plans look to differentiate on other fronts and deliver high levels of service—without placing profitability and stability in peril.

With continued prospects for growth, we can expect to see additional MA plans enter the market. In 2018, there were more than 3,100 MA plans in the United States, up from 2,700 in 2017, according to CMS. And today, most Medicare beneficiaries have the option to choose from 10 or more MA plans. This growing field fuels competition for new members and has historically elevated costs associated with member acquisition as plans double down on marketing initiatives.

In addition to offering expanded flex benefits, MA plans are eager to differentiate themselves and the member experience in other ways. For example, as new members become increasingly comfortable with technology, MA plans may look to expanded remote care options.

"Health plans must think like the customer, consider what they want next and offer it before they ask. The findings in this study (Customer Friction Factor) highlight why health plans must transform the digital experience to eliminate confusion in the enrollment process and serve customers best," said Shashi Yadiki, president, Health Plans, NTT Data Services. The study indicates that many MA plans fall short in creating a holistic and frictionless customer experience. Eighty-eight percent of health plans did not provide the same experience (format or design) across transactions, creating a disjointed journey and potentially forcing the customer to call the health plan, increasing customer friction (frustration) and plan costs.

Oracle Health Insurance solutions provide ease of access to the data required to create a frictionless customer experience, independent of the channel through which members reach the health plan. Oracle's next-generation RESTful APIs provide the ability to create rich mobile and web experience for member management.

3

Payers are eager to bring new urgency and focus to improving claims accuracy and delivering innovative provider payment models.

More than 7% of claims are not paid correctly the first time, second time, or third time, according to the American Medical Association National Health Insurer Report Card. And, the cost of remediation exceeds

$43 billion annually. That figure represents simply the direct financial costs and does not take into account accompanying compliance and reputational risk.

"Not only does this (remediation) waste time and money, but it also impedes providers' ability to manage their revenue cycle effectively, erodes their confidence in payers, and creates a barrier to closer strategic alignment. Consumers, like providers, expect claims to be paid accurately and quickly, and the system to be focused on delivering good health care—not rectifying payments," writes Amy Larsson, vice president, clinical claims management at Change Healthcare, in Reinventing Claims Payment for a Value-Based World.

In tandem with and complementing their focus on improving the accuracy of claims payments, payers seek to expand their ability to offer and administer flexible provider payment options, such as bonuses for performance and outcomes.

In addition, MA plans are looking for greater flexibility to leverage full-risk or global risk models in which they pay provider groups a set amount for the plan population, transferring greater control over patient care and responsibility for outcomes to providers. This model is leveraged extensively in regions such as South Florida and Southern California, and continues to build momentum, with significant opportunity for growth.

Full-risk models shift risk and reduce administrative costs, benefits that can be passed along to members in the form of lower premiums. However, to create models that are fiscally viable and drive improved outcomes, MA plans require modern and flexible core systems, as well as deep insight into performance and claims—capabilities that continue to elude many payers today.

Working with customers, Oracle Insurance has created a one-of-a-kind standalone, value-based payments module that provides MA plans the ability to innovate on provider payment models without having to do a major overhaul of the core claims processing systems. Oracle Health Insurance Value-based Payments components can administer a wide variety of advanced capitated arrangements. Additionally, Oracle Health Insurance Claims component provides the capability to administer prospective bundled payments with ease.

A New Reality: Elevating Service and Experience While Optimizing Costs

For many years, the goal of elevating service and member experience while optimizing (and ideally reducing) costs has remained aspirational. A new era can begin today with strategic application of established and emerging technologies.

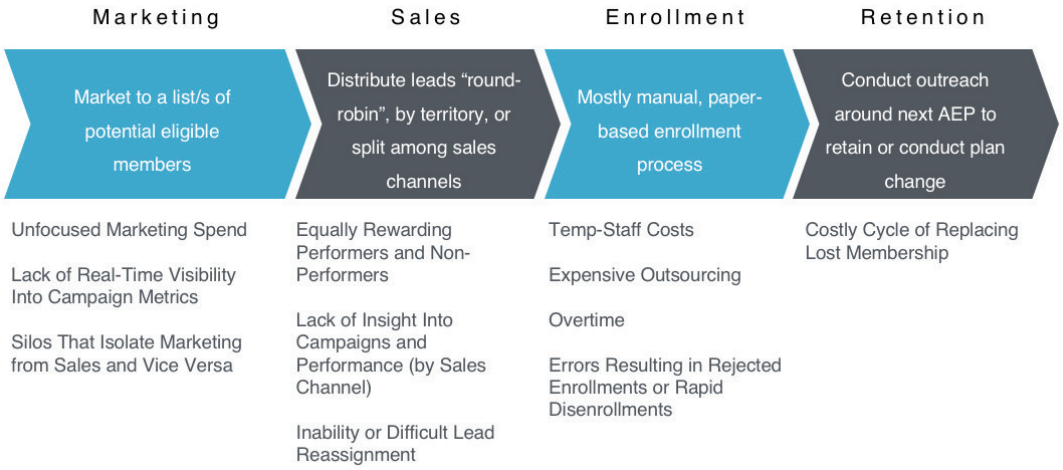
We offer a three-part strategy for success:

- Improve conversion while reducing member acquisition costs through seamless, compliant, digital, and data-driven sales through enrollment processes.
- Gain greater flexibility from defining plan features through payments while reducing administrative costs with a flexible, highly-automated, transparent core processing environment.
- Leverage disruptive technologies such as blockchain, internet of things (IoT), artificial intelligence (AI) and machine learning (ML) to further infuse value across front- and back-office processes.

Take Aim at Member Acquisition Complexity with Seamless, Compliant, Digital Sales through Enrollment

Inefficiencies and missed opportunities continue to proliferate across the member acquisition lifecycle—driving up costs and impairing the customer experience.

Member Acquisition Process: Administration Cost Drivers



Source: CAVULUS

Unfocused marketing outreach to lists of potential eligible members is all too common, and most organizations lack real-time visibility into campaign metrics. In addition, information silos isolate marketing from sales functions and vice versa.

Sales processes continue to focus on distribution of leads by round-robin models or split among sales channels. This approach serves to equally reward performers and non-performers; does not ensure efficient and timely follow up; precludes the insight needed into campaigns and performance by channel; and makes it difficult to reassign leads in real time to optimize conversion potential. In addition, potential members, who typically contact a plan in at least two different ways during the sales process, often receive conflicting messages as they progress across channels, complicating the process and creating friction where it is most dangerous.

The enrollment stage remains largely manual and paper-based, which drives up administrative costs, including overtime and outsourcing, and contributes to errors that result in rejected enrollments or rapid disenrollments as well as compliance challenges.

The retention portion of the lifecycle also largely lacks the data-driven insight needed to precisely target initiatives and interventions throughout the year, as opposed to widespread outreach around each annual enrollment period.

Analytics, Integration, and Automation at Every Step of the Way

In modernizing the acquisition lifecycle to prepare for new opportunities, MA plans should look to incorporate analytics, integration, and automation at every step of the way.

In the lead gen process, plans can increase propensity to respond through predictive regression models that continuously learn and improve. These techniques can be instrumental in driving higher gross response and enabling payers to focus on beneficiaries who are most likely to become members. Similarly, for lead capture, the analytics, integration, automation approach enables plans to cover all capture sources—from phones to Web portals, and then quickly tailor messaging based on plan benefits, geography, language, and more. As important, it helps to ensure consistent messaging and experience across

all channels. For lead conversion, payers should look to utilize behavior-driven and customizable lead assignment algorithms that reward top producers, ensure more timely lead follow up, and are proven to increase conversion rates.

For the enrollment phase, integration and automation considerations point the way forward. It is important to accommodate a 24-hour cycle—with the ability to take an enrollment application and submit it to CMS within 24 hours—as speed translates to growth. New member confidence is boosted with quick confirmation of enrollment and receipt of acceptance letters. MA plans should seek to incorporate built-in CMS and business logic, such as presenting election types, to reduce manual work and obtain a higher rate of member acceptance.

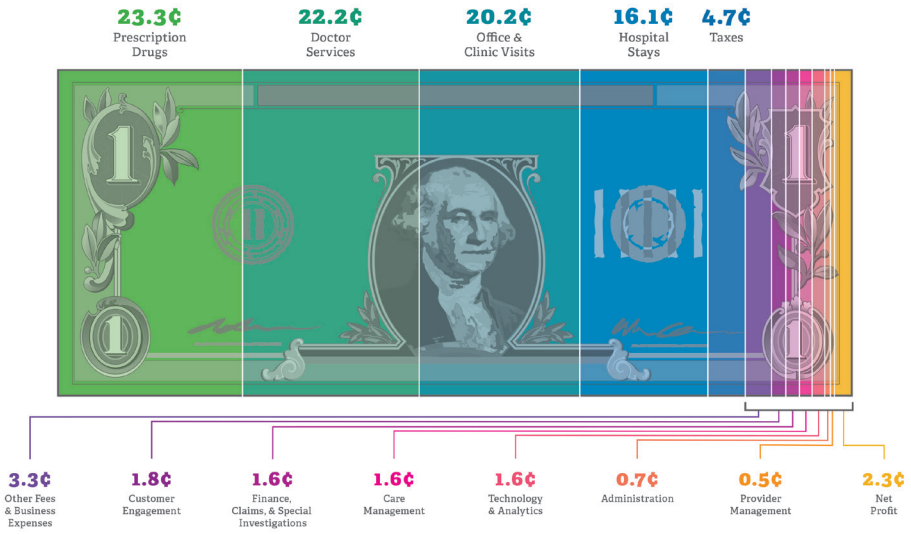
In turn, increased member acceptance can lead to a reduction in avoidable rejections, less regulatory scrutiny, higher member satisfaction, and an increase in a plan's CMS Star Rating. For sales channel adoption, faster enrollment feedback mechanisms greatly improve the member experience and stickiness, and external agents gravitate to plans that provide confidence that enrollments have been accepted. The reputation factor weighs heavily.

Finally, one cannot ignore compliance responsibilities in front-office processes. Automation is king.

Solutions should support key requirements such as:

- Tracking of CMS approval codes on marketing materials
- Creation of a complete audit trail based on recording ID, call notes, and consent level
- Capture of all required eligibility information
- Ability to store, measure, and report Scope of Appointment and Permission to Contact metrics
- Tracking of broker/agent credentialing status
- Prompting of corrective actions based on complaints and grievances
- CMS-approved web-based retail enrollment
- Dynamic CMS-approved call scripting for telephonic enrollment
- Enforcement of CMS required timeframes for hardcopy applications submission

Optimize Back-office Administrative Costs and Reduce Complexity with Flexible, Highly-automated, Transparent Core Processing



Expenditure estimates above produced by AHIP. Distribution of spending among administrative categories and taxes, based on analysis by Milliman, Inc. Milliman's analysis is available upon request.

Source: AHIP, 2018

MA plans operate on razor-thin margins—approximately $.027 for every premium dollar, according to AHIP. High medical costs and IT operations costs contribute to these low margins. Other obstacles that preclude MA plans from making the most of market opportunities include the ability to:

- Increase program flexibility and modularity to deliver value-added services
- Transform reimbursements
- Assure program integrity and health outcomes
- Gain traction on reducing fraud, waste, and abuse
- Support all CMS requirements and standards and manage regulatory complexity

MA plans can change this equation on all of these fronts, and technology plays a vital role. In general, the path to success calls for eliminating bottlenecks, duplication, and process silos, including:

- Manual and batch (delayed) processes
- Paper payments
- Multiple claims adjudication engines
- Multiple enrollment and billing solutions
- Suppliers who aren't modernizing

At the same time, payers should look to invest in:

- Real-time processing
- Payment transparency
- Adaptable and rules-driven core systems
- Digital platform technologies
- Data and predictive analytics
- Business process outsourcing (BPO) for non-differentiating services

Focus on the Core

The core administrative processing system (CAPS) is the nerve center of the modern insurance enterprise. Many organizations, however, continue to append, adapt, and nervously rely on legacy systems that are simply not designed to deliver the agility and insight that today's MA plans require. To drive down IT and administrative overhead, while gaining the flexibility to meet the needs of a new breed of Medicare consumer, MA plans should consider the following in assessing their CAPS capabilities and requirements.

- **Does your current system enable you to simplify and accelerate plan set up?** This would include capabilities to separate enrollment and claims components with varying levels of information content and separate services covered and other plan attributes. Health insurers should also seek a reusable, multi-tier hierarchy for service categorization; the ability to automatically generate detailed service definitions for a product that can be loaded into the claims adjudication system; and the ability to store division of financial responsibility (DOFR) data at multiple layers.
- **Can you easily provide flexible reimbursement options?** Increasingly, MA plans need the ability to pre-define contract options and templates as well as separate static configuration from contract-specific configurations. They also look for extensive features that can reduce contract setup time and eliminate errors to curb future recoveries.
- **Does your CAPS help you to improve authorization and limit management processes?** The ability to conduct multi-dimensional authorization matching to reduce claims-pending volume is increasingly important. Today, CAPS must be able to support review processes that determine reimbursement for a medical service prior to the actual rendering of the service; administer an unlimited number of counters/accumulators at multiple levels (member or provider); and integrate readily to a claims system for denied authorization.

- **How far can your current platform take you on your journey to automate claims adjudication?** To achieve this increasingly vital requirement, an MA plan must have the ability to fully and accurately capture provider contract and benefit adjudication rules into the system, integrate readily with third-party systems with pre-built APIs, and support continuous improvement of automation.
- **Can you quickly introduce new payment models and transformation while continuing to ensure compliance?** Key capabilities might include the ability to:
    - Set the minimum number of attributes for a provider to receive payment per period
    - Make adjustments on top of the fee, such as administration charges or provider withholds
    - Tailor the way a calculation is done for a contract by adding unique logic on primary care provider grade, age, and gender
    - Split the amount for different payment receivers
    - Define the time windows over which a calculation applies, e.g., calendar months, weeks, years
    - Identify which members are relevant to the contract, e.g., only members over 18-years old

Keep Looking Ahead

The pace of technology innovation continues to accelerate, which is welcome news to the payer community. MA plans are wise to look ahead and begin to embrace (or at least explore) emerging technologies. Blockchain is an example of a technology that can advance efforts to ensure both security and accelerate plan delivery innovation. For example, as soon as services are rendered and trust is verified by the blockchain (which would take time, but less than today), a smart provider contract and the patient's updated medical record can be uploaded, and the plan can initiate payment to the provider.

Additional advantages include:

- Blockchain is a permanent record and, hence, auditability becomes inherent
- Transparency makes reporting easier, including regulatory and quality reporting, and reduces fraud, waste, and abuse
- Integrated AI/ML can make blockchain processing more efficient and provide processing efficiencies
- Personal data does not need to be stored on the blockchain—only the medical transaction needs to stored

Prepare Today for a Bright Future

MA plans find themselves in exciting times, as opportunity continues to grow. While success is not a given, proactive planning and investment can create a powerful advantage, including driving down costs across the lifecycle. Reducing costs sets off a chain reaction toward profitability. When payers are able to reduce costs, they can offer members additional benefits or lower premiums. In doing so, payers are more likely to earn high star ratings. Those high marks lead to greater payments and rebates from Medicare, which enable payers to continue offering more value.

Replacing legacy systems with modern healthcare technology needs to be a top priority for all health insurers, especially those involved in MA. The sooner payers can begin leveraging data-driven insight, enabling ubiquitous integration, and automating processes—across the entire enterprise, the sooner they can free up resources to strengthen quality of care, enhance customer service, and improve their plan's performance.

A New Advantage: Oracle and Cavulus

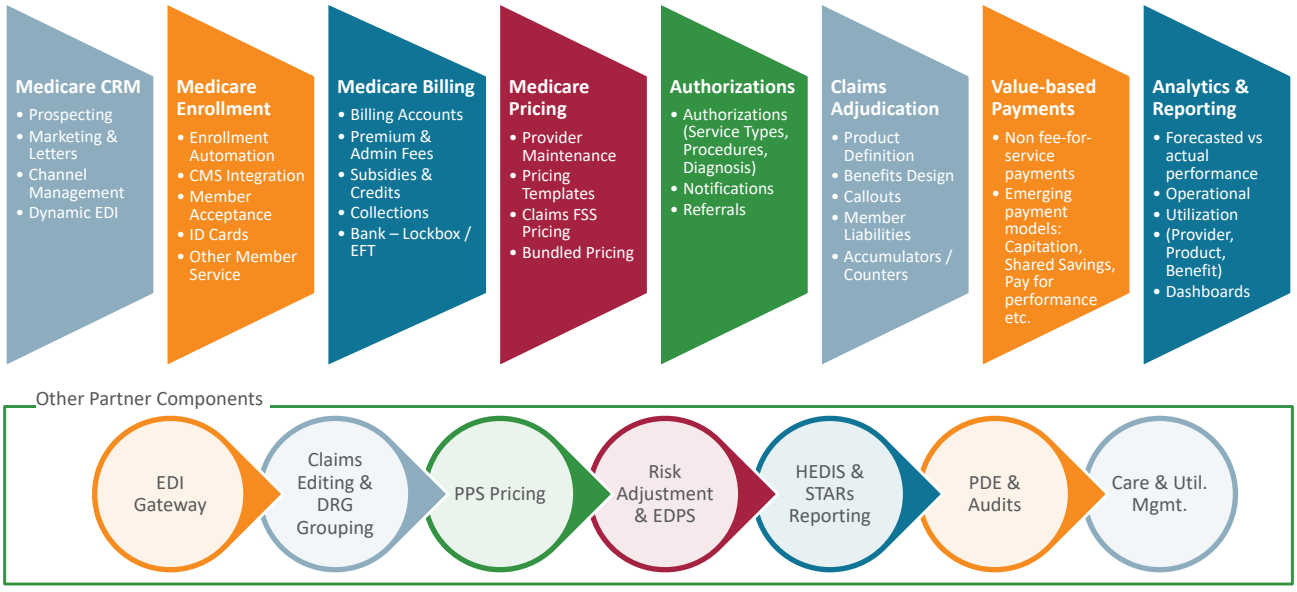
The market continues to pursue digital transformation while creating a more member-centric MA administrative model, so payers are seeking simplified enrollment, claims processing, and benefit administration to promote convenience, mobility, and improved member experience. To that end, Oracle has partnered with Cavulus, an established leader in Medicare Advantage member engagement and enrollment, to create an end-to-end solution encompassing all aspects of MA plan administration—from enrollment to claims processing. The solution combines enhanced MA auto-enrollment functionality and a full suite of

Oracle Health Insurance components working together to reduce errors and increase claims automation. The partnership supports start-up, mid-size, and national payers in targeting, capturing, and retaining MA membership.

The joint Cavulus & Oracle Health Insurance solution offers end-to-end capabilities for MA plans. The solution is componentized by major functional areas to enable a progressive consumption model. Further the solution is available as Software-as-a-Service (SaaS) Cloud-based delivery model to further reduce the technology costs and simplify consumption.

Oracle Cavulus Solution Capabilities

Best of Breed Components to Provide End-to end Solution Support



About Oracle Insurance

Oracle provides modern, innovative technology that enables insurers to drive their digital transformation strategy forward. With Oracle's flexible, rules-based solutions, insurers can simplify IT by consolidating individual and group business on a single platform, quickly deploy differentiated products, and empower their ecosystem to improve engagement with customers and partners. Learn more at oracle.com/healthinsurance.

CONNECT WITH US

Call +1.800.735.6620 or visit oracle.com/insurance.
Outside North America, find your local office at oracle.com/contact.

blogs.oracle.com/insurance facebook.com/oraclefs twitter.com/oraclefs

Integrated Cloud Applications & Platform Services

Oracle is committed to developing practices and products that help protect the environment

ORACLE