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Administrative Services Only + Managed Care = Success

By Mark Troutman and Jon Anderson

Introduction –

The formula looks simple enough. However, successful execution of the items in the formula is a bit more complicated and time-consuming.

Employers are continually searching for ways to control the escalating costs of an employer-sponsored healthcare benefits programs. Many have turned to managed care organizations such as HMOs and PPOs to control healthcare expenses while others have used the flexibility and cost control aspects of self-funding their healthcare benefits program. Managed care organizations such as HMOs which can offer administrative services only (ASO) products and services bring the employer the best of both worlds. This article provides information on why HMOs should become involved in this self-funded business segment and key factors for success for HMOs desiring to participate in this important market segment.

There are many reasons for a managed care plan to consider entering the ASO business:

1. It's a large and growing market. There are over 50 million members in the commercial market, which belong to self-funded employee benefits programs. Over 50% of employees and dependents enrolled in commercial plans work for companies that self-fund their employee benefits. There are over 400 Third Party Administrators (TPAs), which provide administration for these types of employee benefits programs. If a managed care plan won't provide this option to an employer group, TPAs will. Membership in self-funded plans grew 7% from 2005-2006 for most of the industry's leading health insurance carriers such as Blue Cross / Blue Shield, United Healthcare, CIGNA, Aetna, Humana, Wellpoint, Health Net and Coventry (Source: Mark Farrah Associates / Health Insurer Insights).

2. ASO business will drive additional membership to a provider network.

3. Rating agencies appreciate ASO business product diversification.

4. ASO fees help cover infrastructure costs, which will increase profitability among all lines of business.

5. Plans offering ASO products can earn commissions through vendor arrangements on other ancillary (i.e. non-medical) products such as employer stop loss, life, dental and disability.

More and more local and regional HMOs are addressing self-funding for these reasons. It's particularly important to address this large and growing market since there is declining enrollment in traditional HMO programs.

HMOs have been slow to embrace self-funding historically for several reasons:

1. As a traditional provider of "fully insured" HMO products, they focus on premium paying coverage rather than self-funding with employer dollars. They have the mentality of a fixed payment approach (involving capitation) for a fixed program of government-mandated benefits. The HMO focused on managing care and premiums for an employer, not managing care as vendor without financial responsibility.

2. There was no push to grow in other product lines as long as there was growth in the traditional HMO segment.

3. HMOs have not been adept at "unbundling" their programs and services into medical management, provider network contracting and administration. Similarly, they are not typically adept at reporting experience for specific employer groups and specific functions.

Why is self-funding so advantageous for employers? Reasons employers choose to self-fund their healthcare benefits program include:

1. Full plan design flexibility for ERISA plans vs. state mandated benefit requirements for insurance policies and limited benefit options from insurance carriers. The employer can design the medical plan to meet its own specific needs.

2. Control over reserves and cash flows. Claims are paid as they occur rather than prepaid monthly as premiums.

3. Premium taxes are only applicable to a small percentage of the employer's overall healthcare expenditures, again due to ERISA (The Employee Retirement Income Security Act).

4. Self-funded employers believe their group claim experience is better than average. They want to receive the benefit of their own favorable claim experience, but take on additional risk in doing so.

Key Factors for Success –

What does it take to be successful in the self-funding marketplace? Key factors for success in this market include:

1. **Change –** A cultural adaptation by the managed care plan to the self-funded marketplace is required. An HMO cannot continue to act like an HMO. First and foremost, this is because the employer is now assuming the risk for claim severity and frequency up to any specific and aggregate stop loss coverage purchased from an insurance carrier. It is their benefit plan and their money, so they need to make the decisions. The TPA handles day-to-day administration with this need for employer flexibility in mind. Secondarily, a managed care plan needs to be ready, willing and able to unbundle its products and services to meet a wide variety of employer needs. One size doesn't fit all, particularly in self-funding. A plan needs to do this while maintaining its core competencies of medical management and provider network contracting.

2. **Add Value –** Develop a unique value proposition centered around the plan's ability to provide medical management and a strong provider network, just as it does with its HMO coverage. Most HMOs believe they have the best local provider arrangements and medical management through their sponsoring hospital system and participating providers. They must demonstrate their quality and cost advantages with concrete savings data. Self-funded employers pay more attention to minimum, expected and maximum claim liabilities since they are directly responsible for them. An HMO must be able to compare its provider network arrangements (be they DRGs, per diems or fee-for-service discounts) to the competition to clearly demonstrate how provider network arrangements benefit the employer group.

Plans typically prefer to offer their net-

work, medical management and administrative capabilities in a single integrated offering. However, they must be willing to unbundle those services in an ASO environment. Plans need to be able to offer flexible, unbundled and customized solutions better than the competition. Tell employers they can "have it their way". Some self-funded employers may wish to utilize independent vendors for medical management, so the plan must be prepared to make its case regarding the need to integrate the network, medical management and claim paying functions to be successful.

3. **ERISA –** Understand ERISA plan design flexibility and take maximum advantage of it. Employers will often eliminate state mandated insurance benefits if they're able to do so in a self-funded program. Understanding ERISA requires substantial expertise and training. This can be developed through in-house resources or through external vendors, but be sure to hire or access dedicated resources. It's critical to establish a clear product focus and product champion at the highest levels of the organization. Otherwise, little will change and the HMO will continue acting like an HMO.

4. **Sales and Marketing –** Managed care HMO sales representatives need to be fully trained on the differences of an ASO product portfolio and operations so they can communicate these to employers and retail brokers. This requires additional understanding of products, competitors, and market opportunities presented by self- funding. Once a managed care plan has developed its unique selling proposition, it must sell it! Managed care plans often have no specific ASO branding or separate sales material. This must be developed since ASO business requires a more consultative sales approach, and TPAs will be marketing superior service with low service fees. In addition to sales force training, specific compensation strategies for external brokers or consultants and the internal sales force may be appropriate.

5. **Administration –** It is also critical to have a dedicated resource to oversee the development and ongoing operations of the ASO product line. There are numerous strategies for HMOs to consider in developing administration capabilities for ASO business:

   1. Contract with one or more existing TPA.
   2. Buy an existing TPA.
   3. Establish a separate TPA subsidiary operation.
   4. Incorporate self-funded products into HMO operations via product hybrids, if permissible by state insurance regulation.

   Some HMOs rent their network to several TPAs and leave the TPA administration to these vendors. Others desire to contract with one TPA and develop a proprietary product. Others may buy a TPA or set up a TPA subsidiary operation for more control and branding. It depends on the plan's level of commitment to self-funding and its view of the opportunities and risks associated with this marketplace.

   The network provider agreements need to be available to the TPA program. Will the provider still offer the same HMO contracts in a self-funded environment if there is a different benefit program, less management of care and more options to use non-participating providers?

   Can a self-funded employer add or subtract providers from the standard network? Employers may also use different or multiple wrap networks for out-of-area coverage (a "wrap" network provides access to preferred provider agreements outside of the plan service area). There are a variety of wrap networks available and these need to be integrated into the managed care operation.

6. **Employer Stop Loss –** Many self-funded employers will purchase specific and aggregate stop loss insurance to mitigate severity and frequency risk they have assumed. A managed care plan needs to establish a strong relationship with an employer stop loss carrier to offer this coverage. Develop one key partner in this area and work together to develop a book of business.

   It is critical that the employer stop loss arrangements produce pricing that reflects the value of the network provider agreements and medical management capabilities of the managed care plan. Work with a managing underwriter who understands managed care network provider agreements and can develop specific base rates for the provider network and medical management programs being offered in the self-funded environment.

7. **Reporting –** The managed care must demonstrate that it continues to add value in a self-funded environment. Some managed care plans may be deficient in employer level reporting capabilities. Be able to demonstrate the value of provider network agreements and medical management capabilities to the employer. This also provides a clear understanding of a plan's own fixed and variable cost structure and the value of each of its programs and services. Sample employer reports may include the following:

Sample ASO Reports

Financial Measures

- Claim expenses grouped by size and frequency
- Claim lag analysis
- Large claims
- Payments by benefit type
- Premium to claims loss ratios

Medical management

- In-network utilization and out-of-network costs
- Costs and utilization frequency by procedure code

- Inpatient and outpatient utilization by diagnosis
- Discounts to billed charges
- Ineligible charges, coordination of benefits, subrogation
- Utilization and costs by provider type
- Disease management program returns on investment
- Overall medical cost management summary

Membership / census reports

Ad-hoc reporting as desired by client

8. **Pricing –** The unbundled service model ala Carte items must be priced appropriately. The employer must also be offered options for claim run-in and claim run-out. There should be a price for everything, and everything should have a price. Managed care plans, which don't have a sophisticated service-by-service pricing model, need to roll up their sleeves and develop one.

Conclusion

Remember the old joke, "How many psychiatrists does it take to change a light bulb? One, but the light bulb has to want to change." HMOs which successfully adapt their managed care infrastructure to a self-funded environment are still the exception rather than the rule. Nothing is as easy as it seems. They have to want to change and do the legwork behind the formula for success. Given the transition away from HMOs in a managed care backlash, this transitional effort to address employer healthcare needs via self-funding is critical to an HMO's survival and success. In doing so, a managed care plan positions itself to increase market share and drive volume to its affiliated provider organizations while maintaining its financial viability through successful diversification.

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