businessolver

Service, repair or overhaul?

5 tips for tuning up your pooled group health plan

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Is your pooled group health plan running like a well-oiled machine? Or is it pulling a little to the left? Is the AC low on refrigerant? How's that air filter look?

Just like our vehicles, health plans require regular maintenance. This is especially important for pooled insurance groups. Whether you're an association, trust, cooperative, multiple employer welfare arrangement, (MEWA), or association health plan (AHP), your health plan must fire on all cylinders for both your members and their employers.

To keep your plan running smoothly, it helps to have an owner's manual. More importantly, you need to know what to look for throughout the plan year, not just during annual enrollment or as you're preparing to issue an RFP.

These five questions can jump start your engine as you consider scheduling service, repairs, or a complete overhaul of your pooled group health plan.

1. Who are my stakeholders?

As the benefits administrator for your pooled insurance group health plan, you're the Connector-in-Chief. The first step in reviewing your plan is to own that role. List all the people and companies you work with (and for), including your board of directors, broker, claims administrator, stop-loss provider, independent vendors, and other partners. **Ask yourself how their involvement impacts your success, for better or worse.** Look at the bottom line and beyond the bottom line. Consider how each stakeholder impacts your ability to stay competitive over the long-term

Specific questions you should ask include:

- Have I fully conveyed my needs and goals to my broker or consultant?
- What kind of technology do my stakeholders use or recommend that helps ensure my success?
- When is the last time I went to market?
- What kind of RFP resources are available to me?
- Are my vendors able to grow with my pooled insurance group?

Consider how each stakeholder impacts your ability to stay competitive over the long-term.

Don’t forget your member stakeholders.

Without them, you wouldn’t have much of a mission. Their satisfaction with their benefits has a direct impact on how they feel about their employer, which in turn could impact your relationship with them. Worse, unhappy members may leave their current position for better benefits from one of your competitors. **Invest resources to determine whether your members are delighted or dissatisfied with the benefits you offer.** Separate the feedback in terms of the benefits themselves, the delivery of those benefits and your role in administering them.

Specific questions you should ask include:

- Does my benefits administration solution instill confidence or cause confusion?
- Am I offering the benefits my members truly value?
- How much do my members really know about their benefits?
- Am I doing enough to support benefits literacy?
- What does the data tell me about my members’ engagement with their benefits?

A special note for publicly funded plans: Your list of stakeholders is longer and full of more complexities than those of your counterparts in the corporate world. **Add these to your list: taxpayers, governing bodies, individual legislators, administrative offices, unions, and advisory groups.** Gathering the right data, as we discuss in the next section, will help you make your case in a way that resonates with the interests and motivations of your various stakeholders.

Specific questions you should ask include:

- What political forces are at work?
- How long will it take to implement any improvements?
- How early should I prepare my stakeholders for possible changes?
- How much transparency do I owe the media and taxpayers?
- What’s the attention span of my decision makers? Are they in it for the long-haul?

2. What's the data tell me?

Data is everywhere these days, and it can overwhelm even the most analytical minds. **Choosing the right data sets to analyze can help.** Historical aggregate claims data, for example, can provide some insight into the health of your member population. But health claims data is kind of like looking in your rear-view mirror. You need to consider the data that will keep you looking through the windshield. Pharmacy data is a good example. According to the Centers for Disease Control and Prevention, 71% of the total health care spending goes to treat patients with more than one chronic condition. Looking at what your pharmacy data says about your Rx spend for chronic conditions can help you predict costs for next year and many, many years to come.

Specific questions you should ask include:

- What is the best source of data for insight on how my members engage with their benefits?
- What trends am I seeing year over year?
- Are any outliers skewing the numbers, such as a long hospitalization or specialty drugs?
- How can I measure the impact of "feel-good" benefits, such as wellness programs.
- Are there data sets I'm missing simply because I don't have access?

Also look at the data from your benefits administration software.

Take the case of a pooled insurance group who, working with Businessolver, identified premium shortages of nearly $1.3 million annually. They also discovered data discrepancies that were costing them more than $540,000 per year. The data from their system also showed a return on investment in the software itself; compared to their previous benefits administration solution, the Benefitsolver platform resulted in a savings of more than $124,000 per year — not a bad talking point if you must discuss the return on investment with your board of directors.

Specific questions you should ask include:

- What story does my annual enrollment data tell?
- Does data from other systems support the story, or add other dimensions?
- Am I capturing the right data to determine ROI on investments like tech or training?

Take the case of a pooled group whose data identified premium shortages of nearly $1.3 million annually.

Above all, ensure your data is accurate.

Your stakeholders will question the validity of the data you present, and well they should. **Before using your data to support a new policy or a strategic direction forward, use third parties to validate it.** Chances are, you'll learn more, not less. Let accurate data guide your strategy. If it doesn't support it, you'll need a new strategy. When you speak to your stakeholders, remember that numbers don't lie. Whether you're recommending a campaign to increase enrollment in high deductible health plans (HDHPs) or making the case for requiring your members to choose and use a primary care physician, ensure your data is accurate before you create that PowerPoint.

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Specific questions you should ask include:

- Is my data prone to the common pitfalls of inconsistency, inaccessibility and incompleteness?
- Who is responsible for ensuring our data is accurate?
- What are their qualifications?
- Are all analysts in agreement?
- How does my data compare to similar organizations and the analysis methods they used?

3. Do I have the right network and plan designs?

Location, location, location. It's a phrase used to talk about gaining the advantage in business. And indeed, if your members don't have access to your network, it's the same as not offering them any benefits at all. **But location isn't the only thing**. Think beyond the geographical footprint of the network you use. You also need to consider your negotiated rates and the providers' ability to provide the kind of care that keeps your members as healthy as possible for as long as possible.

Specific questions you should ask include:

- How transparent is the monthly billing process?
- What methodology do providers use to establish their rates and how often do they change?
- How do rates compare to those established by Medicare Plus?
- Are any differences among providers justifiable in terms of geographic location or other factors?
- How does balance billing work and what's the impact on my members?

Think beyond the geographical footprint of the network you use.

Consider whether your members have access to value-based care.

These payment models differ from a fee-for-service approach in which providers are paid based on the volume of services they deliver. The "value" in value-based health care comes from measuring health outcomes against the cost of delivering the outcomes. **Examples include accountable care organizations, medical homes and hospital value-based purchasing programs.** These payment arrangements between the network, provider and, in some cases, the employer, encourage primary care physicians (PCPs) to provide the kind of quality care that results in lower long-term costs. Then make sure your plans are designed to take full advantage of this value-based care. For example, plans that require your members to work closely with their PCP can prevent disorders such as opioid addiction, as outlined in Dave Chase's The Opioid Crisis Wake-up Call.

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Specific questions you should ask include:

- What are the quality ratings of my network compared to available options?
- Have I been offered a financial stake in quality outcomes?
- What happens when a value-based care organization fails to meet quality requirements?
- How active has my network been in addressing emerging disease/disorder trends?
- Is my network at risk for acquisitions, mergers or other changes that could impact my negotiated outcomes?

4. How is my PBM performing?

As the pharmacy industry continues to become more and more sophisticated at maximizing profits, selecting the right pharmacy benefits manager (PBM) is becoming more important than ever. A good place to start is by asking yourself whether to bundle or carve out. A health/Rx package through one carrier may work for some plans, while others will find more value in working with the carriers separately.

Ask yourself whether to bundle or carve out your PBM.

Here are the pros and cons to each:

PBM bundled with carrier

Pros: Easy to administer because you're only working with one carrier. You only have one contact and one place to go for customer service. Generally, bundled plans provide consolidated reporting, as well.

Cons: Lack of flexibility. Someone else is controlling the terms of the agreement with the vendor ultimately delivering services to your members. Also, you lose control of things such as formularies, preferred drug lists, and other details that can impact your overall Rx spend. Should your carrier change the PBM they use, you won't have much say and that could cause disruption and confusion for your members.

Third party carve-out

Pros: Standalone PBMs provide the employer with more plan design flexibility. You get more control over the terms of the contract and the formulary and there's usually more transparency. The idea of "cutting out the middleman" may also be appealing.

Cons: The total cost of ownership is generally higher. Your organization has to deal with yet another vendor. Depending on the size of your organization, this could result in a greater administrative burden, including more FTEs you haven't budgeted for. Also know that some health carriers may charge you for not using their PBMs, applying line item expenses such as reporting fees, connection fees or increased administration fees, etc.

Focus most of your attention on the per member per month (PMPM) cost.

This considers every dollar spent, including the manufacturer rebates, discounts, administrative fees and the prescriptions that were filled unnecessarily. **Be sure to look at cost-containment programs such as prior-authorization and step therapy.** Not all PBMs enforce these programs at the same level.

Specific questions you should ask include:

- How effective are the cost containment strategies the PBM recommends?
- Would they commit to a maximum PMPM as part of the contract?
- Is the candidate willing to share denial rates on step therapy and prior authorization programs?
- How is my PBM addressing the rising costs of specialty pharmacy?
- Is member education part of their cost-containment and/or customer satisfaction strategy?

5. How efficient is my benefits administration technology?

What seems efficient or cost-effective today may not be the best solution tomorrow, especially when it comes to multi-year contracts. In the end, it's all about the total cost of ownership. This section offers some tips shared in a recent Businessolver webinar featuring a large self-funded plan for public employees.

Data Access: Check to see whether your benefits administration software allows you to schedule customized reports and inquiries. Depending on the size of your plan, you may find yourself having to ask others for the information you need to fully understand your population of covered individuals and what was happening during annual enrollment.

Automation: Manual processes should not be a given in our industry. People have mid-year changes. They retire. They require arrears adjustments, and so on. Ask whether your solution has automated processes in place so that nothing is ever "unforeseen."

Compliance: In an industry as regulated as ours, you need a partner to help you navigate all the intricacies of benefits administration.

In the end, it's all about the total cost of ownership.

As the war for talent heats up, the organizations you serve are doing everything they can to attract and retain talent.

This includes offering unique benefits and fine-tuning those benefits each year to help your clients stay current and competitive.

Configurability: Find out whether your benefits administration platform is rules-based. If it isn't, you may find yourself spending valuable resources "customizing" (rather than "configuring") your software to meet your needs. In our case study, our webinar guest told us it took 30 months for her ERP to design a workaround to remove the employer contribution from the payroll stub. Had her benefits administration solution been configurable, this change could have been processed within a pay period or two.

User Experience: The employers you serve are also taking a closer look at the overall employee experience, especially among the younger generations. Like it or not, they're comparing your benefits portal to Amazon, Netflix and even their local grocery store that recently started offering same-day online delivery orders. Consider your populations demographics. Some may be entirely mobile dependent while others need decision support tools to help them save money on health care expenditures. As for your own user experience, consider whether your benefits administration platform has the tools necessary for impactful, year-round benefits communication and other features that make life a little less stressful.

The employers you serve are taking a closer look at the overall employee experience.

Learn more:

Whether your pooled group health plan is self-funded or fully insured, scheduling periodic maintenance will help you evolve alongside health care trends and the changing needs of your member population. Unlike car mechanics, however, the individuals who would help you fix your plan and turn it into the well-oiled machine you need can't simply "look under the hood." To understand what's working and what isn't, they need a lot of input from you. And, chances are, you're going to need more than one technician.

We hope this guide helps prepare you for your next tune-up. Please share this resource with your colleagues and remind them to consider the five core questions we offer here. If you're writing an RFP, you'll probably get feedback right away.If not, keep a record of comments and observations that come your way throughout the year. When the time comes, looking back on your notes will almost certainly help you plot a course forward.