Vālenz® HEALTH

SME SERIES

Hear from Vālenz® Health and
Certus Management Group
Subject Matter Experts in this deep dive
series on transparency in healthcare.

Meet our final group of SMEs from Certus Management Group, a Valenz affinity company:

Steve Butz,
Senior Vice President,
Business Development

Steve has spent almost 35 years leading the development of stop loss solutions for self-funded groups of all sizes to bring certainty of coverage to their benefit plans.

Beth Madden, CEBS,
Senior Vice President,
Operations

Beth draws from her deep expertise in stop loss underwriting oversight, actuarial and program management, as well as her work in the domestic fully insured space.

Welcome to the final round of our Vālenz® Health SME Series!

Today's series offers insights on how data transparency contributes to more efficient delivery of medical underwriting and risk mitigation services to self-insured health plans. Then, at 11:30 a.m. ET Wednesday, July 12, we'll wrap up the series as we join a conversation with CEO Rob Gelb on transparency in healthcare: how to access, share and leverage those data-driven insights to drive greater value for the future. Mark your calendars for a lively discussion and a Q&A with the audience! You'll join here: bit.ly/ValenzSME-Live

How does transparency benefit the customer for stop loss underwriting and quoting?

Steve Butz: Transparency of information within a self-funded plan impacts everything we do in stop loss. When we're talking about transparency, we're talking about how the increased data from recent federal requirements in healthcare allows us to properly identify risk and develop strategies to manage that risk from the beginning. Those data-driven insights provide a clear picture of what has taken place historically within a plan, and further, they allow the underwriter to recommend the best solutions for impacting plan cost and the member's positive experience going forward.

Increased transparency for healthcare data allows our stop loss underwriter to have access to and effectively use all that data upfront. Our underwriters are the experts at accurately evaluating the risk inherent within a group and predicting the group's total plan cost in any given year. When we have more information upfront about a group and the unique elements of risk inherent to each group, we can predict the plan's costs through our underwriting more accurately. Our commitment to data transparency gives health plans greater insight into opportunities to reduce costs and optimize member experience, improving overall self-funded plan management.

Beth Madden: Additionally, we leverage data to evaluate the current network solution and cost containment options. This allows the underwriting process to identify the cost drivers and recommend new solutions. Data transparency allows us – and our clients - to be very proactive. Without transparency, assumptions are made and there is a limited view into the results that can be achieved by implementing a new point solution. A "status quo" approach forces underwriters to be reactive at renewal and situations that otherwise can be avoided, such as potentially adding lasers or rating the risk higher because the data was unavailable. That's why we are so committed to transparency, from precertification through specialty drug review, and into the billed/allowable medical data segmented even by provider and service level. We can offer data-driven solutions, which, when coupled with our experience, lowers the cost curve for the plan and its members.

"Our underwriters are the experts at accurately evaluating the risk inherent within a group and predicting the group's total plan cost in any given year."

- Steve

The approach to stop loss underwriting is more than just quoting groups, so what is happening in support of transparency right now? What is the best way to leverage that data to support customers' decision making and other key processes?

Beth Madden: We often talk about how we get better underwriting results year over year, *not* just one year at a time. What's not talked about as often is the advantage at claim time, which makes the year-over-year benefit possible. The underwriting process is often validated at claim time, meaning the auditors need to know what plan design was quoted, what cost-containment solutions were quoted, and what network discount was applied during the underwriting process. We do have the experience and validate all these items when a claim comes in the door, allowing the underwriting team to better analyze the outcomes of their assumptions, but when the plan is not properly implemented, those outcomes are reactive in nature. Without the data needed to properly adjudicate the claim, the plan, and sometimes the member, may experience delays and unnecessary demands, often due to situations out of their control.

Transparency in claim data would come in the form of an itemization, possibly a network or PBM contract clause or calculation, eligibility information, and sometimes medical records. When we integrate with Valenz and the plan implements the full Healthcare Ecosystem Optimization Platform, we have access to this data from the beginning of the healthcare journey. We know payment integrity has already been achieved, which takes out the step of waiting for itemized bills or making sure we have complete, accurate information before we pay a claim. We're so familiar with the Valenz process and the increased access to data that when a claim hits our door, it's going to be ready to go and ready to be paid. We are involved the whole way through, not just at quote time. That trickles all the way down to the member experience, resulting in reduced anxiety about their bill. There's no need for providers to follow up and track down payments, because their claims have been paid accurately and in a timely way. Transparency isn't just having the tools to get a cheaper service done – it's all these other factors working together to deliver better results at every step.

"Access to data from the beginning of the healthcare journey...delivers better results."

- Beth

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Steve Butz: We have a lot of expertise from a claims standpoint at Certus Management Group, derived from reviewing thousands of stop loss claims during our 24-plus years in business. Our excess claim auditors have the experience to review each stop loss claim to ensure it has been properly adjudicated prior to payment to the provider. The transparency of information required by law today has brought more attention to the plan sponsor's fiduciary responsibility to pay the right amount for every covered service. With increased access to data at claim time, our stop loss claim auditors are better able to identify mistakes, as well as waste, fraud and abuse, in any provider bill. And, as the stop loss insurer, our interests are aligned with the plan sponsor in making sure the claim is properly adjudicated before a provider is paid. Again, engaging early and often with the stop loss carrier in the management of a large claim as it develops will help ensure the plan has met its fiduciary responsibility.

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Join us for the first SME Series live conversation
with CEO Rob Gelb on July 12, 2023 at 11:30 a.m. ET.
bit.ly/ValenzSME-Live