

2024 Nautilus TPA Procurement, Contracting & Mgmt. Field Guide

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Disclaimer: The Field Guide is intended to provide general guidance and insights related to TPA Procurement, Contracting, Data Use, & Vendor Management for self funded employer health plans. It does not constitute legal advice. Specifically, Contracting is subject to various legal and regulatory factors that can vary by jurisdiction and individual circumstances.

Readers are advised to consult with qualified legal professionals or experts specializing in healthcare law or contract law when dealing with specific legal or contractual matters. This guide serves as a foundational resource, and its content may need to be tailored to align with the unique needs and objectives of clients and employers.

Version	Version Date	Version Notes
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1. Purpose, Summary, and Introduction

1.1. Introduction

Welcome to the Field Guide for TPA Procurement, Contracting, Data Use, & Vendor Management. This guide is meticulously crafted with a singular purpose: to equip mission-aligned healthcare purchasers with the essential tools, insights, and strategies required to navigate the intricate landscape of the TPA relationship successfully. In this section, we outline the core objectives and intended outcomes that underpin this comprehensive resource.

The information in this field guide is designed to outline activities in a sequential order while also enabling topics to function independently.

Objectives of the Guide

- **Empowerment:** The foremost aim of this guide is to empower readers with the knowledge and expertise needed to excel in the world of TPA management.

Why it Matters: By equipping you with the right information and resources, we empower you to make informed decisions, negotiate favorable terms, and advocate for the best interests of your clients.

- **Comprehensive Knowledge:** Provide in-depth and comprehensive knowledge about every aspect from procurement processes to compliance with regulatory requirements.

Why it Matters: In the complex realm of TPA management, having a thorough understanding of all the intricacies is essential. This guide ensures you have a solid foundation to navigate diverse scenarios and challenges.

- **Foster Compliance:** Promote compliance with relevant laws and regulations, including the Gag Clause Prohibition, to mitigate legal risks.

Why it Matters: Compliance is not just a legal obligation; it's a cornerstone of ethical and transparent business practices. Staying on the right side of the law fosters trust, reduces liabilities, and ensures the well-being of plan participants.

- **Enhance Transparency:** Encourage transparent communication and collaboration among all stakeholders.

Why it Matters: Transparency is the bedrock of successful partnerships. By fostering open dialogue and information sharing, you can build trust, strengthen relationships, and achieve mutually beneficial outcomes.

- **Optimize Outcomes:** Empower brokers/consultants to negotiate favorable terms and achieve optimal results for their clients.

Why it Matters: Clients rely on brokers/consultants to secure the best possible TPA. This guide equips them with negotiation strategies and insights to drive cost-effective, high-quality solutions.

As you use this Field Guide for TPA Procurement, Contracting, Data Use, & Vendor Management, remember that your role with employee benefits and healthcare administration is instrumental in shaping the healthcare landscape. The following sections will delve deeper into each aspect of the TPA relationship, providing you with the knowledge and resources needed to excel in your role. We invite you to actively engage with this guide, ask questions, seek additional resources, and ultimately use this knowledge to make a meaningful impact on the world of employee benefits and healthcare administration.

1.2. Target Audience

This Field Guide is designed to cater to a diverse audience within the realm of employee benefits and healthcare administration. It serves as a valuable resource for broker/consultants, regardless of their expertise levels, offering comprehensive insights for both seasoned professionals and newcomers seeking to enter the field. Brokers/consultants, HR professionals, and insurance experts will find practical recommendations to better serve their clients. Compliance officers can navigate the complex regulatory landscape, including laws like the Gag Clause Prohibition. Healthcare administrators within TPAs gain a deeper understanding of their roles and responsibilities. Legal professionals specializing in healthcare or contract law can stay updated on relevant regulations and negotiation strategies. Employers and plan sponsors can directly benefit from accessible information when selecting medical claim administrators and overseeing employee benefit plans. This guide is versatile, ensuring that individuals at all levels of expertise can leverage its insights as they navigate the intricacies of TPA Procurement and Management.

1.3. Scope of the Guide

What This Guide Covers

This Field Guide offers a comprehensive resource for TPA Management in multiple categories such as navigating the intricacies of contracts and the contracting process, details on the collection and usage of claims data, and guidance of overall evaluation of TPA selection and performance with respect to topics specific to a self-funded Health and Welfare plan. It encompasses a wide range of topics, including procurement processes, contract review, compliance with relevant laws, negotiation strategies, and communication best practices. It is

designed to empower brokers/consultants, compliance officers, healthcare administrators, legal professionals, and employers with valuable insights and tools to make informed decisions and facilitate successful TPA Procurement and ongoing management of claims administration services.

What This Guide Does Not Cover

It is important to note that this guide does not provide personalized legal advice or recommendations tailored to individual situations or employers. Appropriate TPA Procurement can vary significantly based on specific client needs, industry regulations, and regional considerations. Therefore, while this guide offers broad guidance and best practices, it is not a substitute for consulting with qualified legal professionals or experts who can provide customized solutions. Readers are encouraged to adapt the information presented here to the unique circumstances of their clients and seek legal counsel when necessary to ensure compliance with all applicable laws and regulations.

1.4. Guide Roadmap

Roadmap Overview

Selecting the right Third-Party Administrator (TPA) is crucial for your organization's success. This guide takes you through five key phases of the TPA vendor selection and management, along with additional sections on data utilization and essential knowledge.

Phase 1: Prepare for the Vendor Selection Process

This phase guides you in gathering market insights through RFIs, initiating a competitive bidding process with detailed RFPs, and refining your vendor selection using a multi-step approach. You'll also conduct benchmarking and market analysis to ensure you choose the best TPA to meet your organization's needs.

Phase 2: Conduct an Effective Vendor Selection Process

In this phase, you'll execute vendor selection, including identifying potential vendors, crafting RFPs, evaluating responses, and conducting interviews. The focus is on making informed decisions through thorough analysis and due diligence.

Phase 3: Contract With Your Selected Vendor

After selecting a vendor, this phase guides you in formalizing contracts, ensuring fiduciary compliance, navigating regulatory requirements, optimizing costs, and promoting clear communication for a successful, tailored partnership.

Phase 4: Onboard and Implement Your Selected Vendor



This phase covers planning and executing the onboarding process, ensuring a smooth transition. You'll coordinate workflows, integrate systems, and manage change effectively to set the stage for a productive partnership.

Phase 5: Monitor and Evaluate Your Selected Vendor

Ongoing vendor management is critical for sustained success. This phase focuses on monitoring performance, conducting regular reviews, and implementing improvements. You'll learn strategies for maintaining a high-quality partnership that include compliance monitoring, communication strategies, employee education and engagement, and best practices for handling disputes and discrepancies.

Effectively Access & Use Data

This section explores best practices for data management, helping you leverage data for decision-making and optimizing TPA services. It also covers data security and privacy to ensure compliance.

Critical Additional Knowledge

Beyond the phases, this section provides insights into emerging trends, technological advancements, and regulatory changes, offering resources for continuous improvement in TPA procurement. This also gives insight to some common myths and truths surrounding TPA procurement, contracting, and other processes.

Conclusion

By following these phases and leveraging the additional knowledge, you'll be equipped to select and manage a TPA vendor effectively, leading to successful outcomes for your organization.

2.Phase 1: Prepare for the Vendor Selection Process

2.1. Intro to Procurement Strategies

Conducting an effective vendor selection process is crucial for the success and sustainability of any organization, particularly when it comes to managing complex services like health plan administration. When selecting a third-party administrator (TPA), different procurement strategies can be deployed, each with its own set of advantages and disadvantages. This section provides information on common strategies, each more comprehensive than the prior. Which strategy to use is dependent on a number of factors, including time and resources, project goals and plan requirements. Detailed instructions for each strategy are provided in Phase 2.

Strategy: Benchmarking and Market Analysis

Conducting benchmarking and market analysis is a strategic approach to understand the competitive landscape, standard service levels, and market pricing models. By analyzing how similar health plans structure their contracts and comparing the service levels and costs associated with different TPAs, plans can identify best practices and establish realistic expectations for their own contracts. This strategy can also identify opportunities for innovation and differentiation among potential TPAs, enabling plans to leverage unique offerings that can enhance plan performance and participant satisfaction.

Benchmarking compares a TPA's services, costs, performance metrics, and processes against those of other TPAs or industry standards. The goal is to identify best practices, understand performance gaps, and establish standards for improving efficiency and effectiveness in TPA services. Market Analysis involves researching and evaluating the overall market for TPA services, including understanding market trends, pricing structures, key players, regulatory environment, and emerging technologies. This helps employers understand the market landscape and make strategic decisions in selecting or negotiating with a TPA.

Advantages

- **Market Comparison:** Provides valuable insights into both internal performance and external market conditions.
- **Pinpoint Priorities:** Equips decision-makers with the information needed to optimize TPA selection and management.
- **Best Practices:** Helps in identifying best practices and understanding market dynamics, which can lead to cost savings and efficiency improvements.

Disadvantages

- **Incomplete Picture:** Benchmarking and market analysis alone may not account for unique organizational needs, customer requirements, or potential innovations.
- **Reactive Approach:** These processes are typically reactive rather than proactive, focusing on existing conditions rather than future opportunities or threats.
- **Analysis Paralysis:** Without clear direction or objectives, the employer might get stuck in endless analysis without making concrete decisions.

Based on the benchmarking and market analysis, your organization can make an informed decision when selecting a TPA by weighing how it compares to other TPAs.

Strategy: Request for Quote (RFQ)

The Request for Quote (RFQ) process can be used when the employer already knows the exact product or service they need, and all they are looking for is the price. The RFQ typically includes a precise description of the required services, the quantity or scope, the expected timeline, and any specific terms and conditions. The goal is to obtain comparable bids from multiple vendors, enabling the employer to select the most cost-effective and suitable TPA. While the RFQ process is a valuable tool for gathering and comparing vendor quotes, relying on it exclusively might limit an employer's ability to make the most informed and strategic decision.

Advantages

- **Cost-Effective Selection:** Quickly gather competitive quotes, potentially leading to cost savings.
- **Efficiency:** The RFQ process is straightforward and time-bound, allowing for relatively quick decision-making compared to more complex procurement processes.
- **Clear Comparison:** Since RFQs focus on price and specific services, they make it easier to compare vendors based on those factors alone.

Disadvantages

- **Potential for Misalignment:** Vendors may underbid or not fully understand the scope of work, leading to potential issues down the line with service delivery or additional unforeseen costs.
- **Risk of Inadequate Vendor Selection:** Relying solely on the RFQ process may result in choosing a vendor who meets the basic requirements but lacks the capacity or expertise to provide high-quality service or adapt to the employer's evolving needs.
- **Flexibility:** The formal nature of an RFQ might lead to less flexibility in negotiations, as the process is often rigid and focused on comparing like-for-like quotes.

Based on RFQ, your organization can make an informed decision when selecting a TPA by weighing administrative costs.

Strategy: Request for Information (RFI)

Before diving into the detailed Request for Proposal (RFP) process, initiating a Request for Information (RFI) can be an exploratory step. An RFI is used to gather general information about the services, capabilities, and innovations available in the market from potential vendors. This preliminary step can help narrow down the pool of potential TPAs by identifying those that are most aligned with the employer's strategic goals and technological needs. RFIs are particularly useful for understanding emerging trends in health administration, digital health solutions, and data analytics capabilities, allowing plans to refine their RFPs with a better understanding of the current landscape.

Advantages

- **Market Understanding:** Helps the employer gain a broad understanding of available services and the capabilities of different TPAs.
- **Flexibility:** Does not commit the employer to a specific course of action or vendor.
- **Preparation:** Provides valuable input for developing a more focused RFP.

Disadvantages

- **Time-Consuming:** Adds an additional step to the procurement process.
- **No Commitment:** Responses may lack the depth and specificity of an RFP, making it harder to evaluate vendors' true capabilities.
- **Potential for Misalignment:** Vendors may not fully understand the scope of work, leading to potential issues down the line with service delivery or additional unforeseen costs.

Based on RFI, your organization can make an informed decision when selecting a TPA by weighing general information about the services, capabilities, and innovations available from potential vendors.

Strategy: Competitive Bidding

This strategy involves soliciting detailed proposals from multiple TPAs. The aim is to compare the capabilities, services offered, technological infrastructure and cost structures of various TPAs. A comprehensive RFP, outlining the plan's specific needs, including data management, member services, claims processing, and compliance with federal and state regulations should be developed. Evaluating proposals based on a clear set of criteria allows employers to negotiate better terms and select a TPA that offers the best value and alignment with the plan's objectives. The competitive bidding process is designed to ensure transparency, fairness, and the selection of the most suitable TPA. By encouraging multiple vendors to compete, the employer increases the likelihood of obtaining high-quality services at a competitive price.

Advantages

- **Transparency:** Ensures a fair and transparent process, with all vendors evaluated against the same criteria.
- **Competitive Pricing:** Encourages vendors to offer competitive pricing and service packages.
- **Comprehensive Evaluation:** Allows the employer to thoroughly assess the vendors' capabilities, pricing, and alignment with the organization's needs.

Disadvantages

- **Complexity:** The process can be complex and resource-intensive, requiring significant effort in drafting the RFP, evaluating proposals, and conducting negotiations.
- **Potential for Overemphasis on Price:** There's a risk that the selection process might overly focus on cost at the expense of service quality or fit.

Based on a competitive bid, your organization can make an informed decision when selecting a TPA by weighing the vendor's capabilities for supporting the plan's specific needs.

Strategy: Multi-Step Bidding

A multi-step bidding process combines RFIs, RFPs, and sometimes Request for Quote (RFQs) to progressively refine the selection of a TPA. This approach allows an employer to start with a broad inquiry (RFI) to understand market capabilities, followed by a more detailed proposal request (RFP) to select TPA based on the RFI responses. In some cases, a final step involving RFQs may be used to solicit detailed pricing from the top candidates. This phased approach facilitates a deeper understanding of potential partners and their offerings, leading to a more informed decision.

Advantages

- **Thorough Evaluation:** Provides multiple opportunities to assess vendors, reducing the risk of selecting an unsuitable TPA.
- **Flexibility:** Allows for iterative refinement of proposals, ensuring that the employer's needs are fully met.
- **Risk Mitigation:** Mitigates risk by allowing for detailed assessments and adjustments before finalizing the contract.

Disadvantages

- **Time-Intensive:** The process can be lengthy and resource-intensive, requiring significant time and effort from both the employer and TPAs.
- **Complexity:** Managing a multi-step process requires careful coordination and expertise to ensure that each stage is executed effectively.

Based on a multi-step bid, your organization can make an informed decision when selecting a TPA by weighing how it compares to other TPAs in the market, how it compares to other TPAs evaluated, costs and ability to support the plan’s specific needs.

Refer to the Resources Matrix at the end of this field guide for a host of resources to support the various procurement strategies.

2.2. Procurement Strategies Comparison Chart

Each strategy has its strengths and should be chosen based on specific procurement needs, the amount of available time, the complexity of the plan’s needs and the level of risk the employer is willing to manage.

	Market	RFQ	RFI	Competitive	Multi-Step
Purpose	Compare to market norms	Obtain costs	Gather general information	Obtain detailed proposals	In-depth evaluation
Complexity	Low	Moderate	Low	Moderate to High	High
Time Required	Low to Moderate	Low	Moderate	Moderate to High	High
Evaluation Depth	Surface-level	Surface-level	Surface-level	Comprehensive	Very thorough
Process Flexibility	High	Low	High	Moderate	High
Risk of Overemphasis on Price	Moderate	High	Low	Moderate	Low
Best Use Cases	Less defined project or limited time	Clear, well-defined expectations	Early stages of procurement	Clear, well-defined projects	Complex or high-value projects

2.3 Strategy Selection

The different procurement strategies for selecting a Third-Party Administrator (TPA) in a self-funded employer health plan can both be independent and build upon each other, depending on the complexity and goals of the procurement process. Here's a breakdown of how they interact:

Some procurement strategies can be used independently based on the organization's needs and the complexity of the health plan. For instance:

- Request for Information (RFI): An RFI is often used when the employer is still in the information-gathering phase and needs to learn about the capabilities of various vendors. It may be sufficient when the employer is exploring new services or unsure of the exact requirements, and it doesn't necessarily lead to a Request for Quote (RFQ) or competitive bidding process.
- Request for Quote (RFQ): This can be a standalone process if the employer has clearly defined service needs and is primarily focused on getting competitive pricing from pre-qualified vendors. An RFQ may not require the detailed exploration of vendor capabilities that a Request for Proposal (RFP) or competitive bidding process entails.

In more complex scenarios, procurement strategies often build upon each other as part of a larger, phased process:

1. Benchmarking and Market Analysis: This is often the foundation upon which the entire procurement process is built. By understanding the current health plan's performance and comparing it against industry standards you gain insights into what the plan needs and where improvements can be made. This research is essential for setting the right goals for the rest of the procurement process.
2. RFI (Request for Information): After completing benchmarking, you might use an RFI to gather more detailed information from multiple TPAs about their capabilities and services. The RFI helps you narrow down the pool of vendors to those who are most aligned with your health plan's needs.
3. RFQ (Request for Quote): Once you have gathered information and shortlisted vendors through the RFI process, you may move to an RFQ. Here, you will request detailed pricing and cost breakdowns from the vendors that best meet your plan's requirements.
4. Competitive Bidding: For more complex procurement scenarios, a competitive bidding process may be initiated after an RFP or RFQ phase. This allows the employer to solicit detailed proposals from multiple vendors, compare them side by side, and negotiate the best deal based on pricing, service quality, and vendor capabilities.
5. Multi-Step Bidding: Multi-step bidding is another strategy that builds upon the earlier phases. After prequalifying vendors via an RFI or RFQ, you may conduct several rounds

of bidding where vendors submit increasingly detailed proposals. This process often refines both the vendor's offer and the employer's understanding of their options.

In practice, most procurement processes will involve building upon multiple strategies. For example:

1. Start with Benchmarking and Market Analysis to understand the current plan's strengths and weaknesses and identify key performance metrics.
2. Issue an RFI to gather information from a broad pool of TPAs, learning about their services, technology, and compliance capabilities.
3. Based on the responses, issue an RFQ to request specific pricing and service details from a smaller group of vendors that meet plan requirements.
4. Move to Competitive Bidding or Multi-Step Bidding if the plan requires a detailed proposal evaluation and negotiation, particularly when looking for a long-term, strategic partner.

Independent Use vs. Sequential Use

- **Independent Use:** If the employer has a relatively simple health plan and knows exactly what they need, the process might be as simple as issuing an RFQ to a prequalified list of vendors and selecting the best one based on cost and service.
- **Sequential Use:** If the employer's health plan is more complex or if there's uncertainty about what services or innovations the TPA market can offer, the procurement process will often build upon various strategies, moving from benchmarking, to RFIs, RFQs, competitive bidding, and negotiations.

The procurement strategies are not mutually exclusive. While they can be used independently depending on the organization's specific needs, they often build upon each other in a structured procurement process. By layering these strategies, organizations can ensure they have the information, pricing, and service guarantees needed to make informed decisions and secure the best possible TPA for their self-funded health plan.

3.Phase 2: Conduct an Effective Vendor Selection Process

3.1. Identifying Key Requirements and Objectives

Health plans vary widely in terms of covered lives, benefit designs, cost structures, and administrative needs. Identifying the health plan requirements allows TPAs to propose tailored solutions that align with specific goals, whether it's cost control, enhanced member services, or regulatory compliance. Before engaging with any vendors, It is essential to clearly define the specific needs and objectives of the health plan. This step ensures that the procurement process is aligned with strategic goals. Included is a [resource](#) for collecting the answers to some foundational questions to help clarify the employer's priorities, needs, and long-term objectives.

Typically, a broker/consultant works with the client to clearly outline immediate and long term strategies for the health plan. Those details and the specific objectives and expectations for the TPA should be provided to the TPA during the procurement process so that responses can be tailored to the employer's immediate needs as well as long-term vision and strategic goals. Key information to share with TPAs is:

1. Requirements: Assess the size of your workforce, claims history, coverage needs, compliance requirements, and specific goals (e.g., cost containment, improved member experience, wellness programs).
2. Objectives: Establish clear objectives for what you hope to achieve with the TPA (e.g., reduce administrative costs, improve claims accuracy, or enhance employee satisfaction).
3. Changing needs: Consider any future business changes (e.g., expansion, regulatory changes) that the TPA must accommodate.

This information is most frequently communicated through an RFP or through tailored RFI questions.

Identifying health plan requirements is crucial to ensuring that the selected TPA meets the employer's unique needs. Clear health plan requirements ensure that the selected vendor aligns not only with current operational needs but also with the long-term strategic goals of your plan, such as improving population health management or optimizing member experience.

3.2. Procurement Process Step By Step

The basic steps of the procurement strategies defined previously in this guide share many common steps. Resources are available within the Resources Matrix at the back of this field guide for communicating with TPAs.

Strategy: Benchmarking and Market Analysis Step-by-Step Process

Step 1: Define Key Metrics: Identify the metrics you want to benchmark, such as claims processing speed, accuracy, administrative fees, and member satisfaction.

Step 2: Gather Internal Data: Collect performance data from the current health plan administrator, including service levels, costs, and feedback from members.

Step 3: Research Industry Standards: Obtain industry benchmark data through external sources such as industry reports, professional associations, and surveys. Compare internal metrics against these industry standards.

Step 4: Conduct Market Analysis: Analyze the competitive landscape to understand available TPAs, their service offerings, market presence, and reputation. This includes looking into new technologies, pricing trends, and service models.

Step 5: Identify Gaps: Based on benchmarking results, identify where the current administrator may be underperforming or where improvements can be made. This will establish the plan's procurement goals.

Step 6: Set Goals for TPA Selection: Based on the analysis, set procurement goals related to improving efficiency, lowering costs, or enhancing service levels.

Strategy: Request for Quote (RFQ) Step-by-Step Process

Step 1: Define Detailed Requirements: Clearly outline the scope of services, including all administrative tasks, performance metrics, and compliance needs for your health plan.

Step 2: Create RFQ Document: Prepare an RFQ document that provides an overview of your health plan and includes specific questions for vendors about their pricing models, services, and service-level agreements. A template resource is available within the Resources section of this guide. The resource should be adjusted to meet the needs of the request.

Step 3: Identify Qualified Vendors: Based on benchmarking and market analysis or knowledge of potential TPAs, identify vendors with the capacity to meet the health plan's requirements. Send the RFQ to these vendors.

Step 4: Review Vendor Quotes: Collect and compare the quotes based on cost, service quality, technology platforms, and any other important factors.

Step 5: Clarify and Negotiate: Engage with shortlisted vendors to clarify their quotes, discuss any unclear terms, and negotiate on pricing or services.

Step 6: Select the Best Vendor: Choose the vendor that offers the best combination of price and service quality, ensuring they meet the plan's requirements and are aligned with the long-term strategy.

Strategy: Request for Information (RFI) Step-by-Step Process

Step 1: Define Information Needs: Determine the type of information needed to assess vendors, such as their experience with similar clients, technology offerings, regulatory compliance expertise, and cost structures.

Step 2: Prepare the RFI Document: Draft the RFI, including a detailed explanation of your health plan requirements and questions about the vendor's capabilities, experience, and proposed solutions.

Step 3: Distribute RFI to Vendors: Send the RFI to a pool of TPAs who seem capable of meeting the plan's needs.

Step 4: Analyze TPA Responses: Review the RFI responses to understand which TPAs have the capacity, experience, and technology to support the health plan's requirements.

Step 5: Shortlist Vendors: Based on the responses, create a shortlist of TPAs that are worth further exploration through an RFQ or RFP process.

Step 6: Refine Procurement Strategy: Use the RFI responses to refine your health plan requirements and procurement strategy before moving to the next phase of the vendor selection process.

Strategy: Competitive Bidding Step-by-Step Process

Step 1: Clearly Define Scope: Create a detailed scope of services and a list of mandatory requirements, including compliance with regulations, specific administrative tasks, claims processing standards, and member services.

Step 2: Issue Bid Invitation: Invite a select group of TPAs to submit bids. The bid documents should provide detailed instructions, including how vendors should structure their proposals and what information is required.

Step 3: Collect and Review Bids: Once received, evaluate the bids on multiple criteria, including cost, service quality, customer support, technology, and how well they meet the health plan's specific needs. See Evaluating Bids and Proposal later in this section.

Step 4: Conduct Vendor Interviews: After reviewing bids, conduct interviews or meetings with the top candidates to ask follow-up questions, clarify points, and assess their capacity to deliver services.

Step 5: Negotiate Terms: Negotiate contract terms with the preferred vendor, ensuring clarity on pricing, performance guarantees, penalties for underperformance, and other important contractual details. See Negotiation Techniques later in this section.

Step 6: Select Vendor and Finalize Agreement: Choose the vendor that best aligns with your health plan's goals and finalize the contract.

Strategy: Multi-Step Bidding Step-by-Step Process

Step 1: Prequalification: Begin with an RFI or prequalification process to gather information on a large pool of vendors. This helps filter out vendors who don't meet your basic requirements (e.g., regulatory expertise, claims volume capacity).

Step 2: Preliminary Bids: Request preliminary bids from the vendors that pass the prequalification stage. These bids should provide an overview of pricing, service offerings, and capabilities.

Step 3: Refine Scope and Requirements: Based on the initial bids, refine your service scope and requirements. You may need to add additional specifications based on TPA capabilities or emerging market trends.

Step 4: Request Detailed Proposals: After the initial evaluation, request more detailed proposals from shortlisted vendors. This second round should include comprehensive information about services, pricing breakdowns, technology solutions, implementation plans, and performance guarantees.

Step 5: Evaluate Proposals: Evaluate the detailed proposals based on your pre-defined criteria, such as cost efficiency, service quality, technology capabilities, regulatory compliance, and the ability to scale services.

Step 6: Final Negotiations: Conduct final negotiations with the top TPA(s) to clarify terms, resolve any outstanding issues, and ensure alignment with the health plan's goals.

Step 7: Select and Contract: Select the vendor that offers the best value and finalize the contract, ensuring that all performance expectations, penalties, and timelines are clearly articulated. See Phase 3: Contract With Your Selected Vendor later in this guide.

3.3. Procurement Process Timelines

The timelines for supporting procurement activities can vary based on the complexity of the health plan, the number of vendors involved, and the procurement strategy being used. Below are typical and expected timelines for each procurement strategy:

Strategy: Benchmarking and Market Analysis



Benchmarking and market analysis are foundational steps in the procurement process. They require gathering internal data, researching industry standards, and analyzing potential vendors and solutions.

Typical Timeline: 4 to 8 weeks

Week 1-2: Internal Data Collection: Gather current health plan performance metrics, costs, and employee feedback.

Week 3-4: Industry Research: Research industry benchmarks, pricing, and service trends. Collect data on leading vendors and market leaders.

Week 5-6: Vendor Identification: Analyze the competitive landscape and identify potential TPAs for further exploration.

Week 7-8: Finalize Report and Goals: Summarize findings and develop goals for the next steps in the procurement process.

Strategy: Request for Quote (RFQ)

An RFQ is used when you have well-defined requirements and need detailed pricing information from vendors.

Typical Timeline: 4 to 6 weeks

Week 1: RFQ Preparation: Prepare and finalize the RFQ document with all necessary details, including scope, deliverables, and key requirements.

Week 2-3: Vendor Distribution: Distribute the RFQ to selected TPAs and provide them with enough time to respond (usually 2-3 weeks).

Week 4-5: Vendor Response Period: During this time, vendors prepare their quotes. A designated party should be defined that can field questions or clarify details.

Week 6: Evaluation and Selection: Review vendor quotes, compare pricing and services, and select a shortlist of TPAs for potential negotiation or next steps.

Strategy: Request for Information (RFI)

An RFI is typically used to gather information from vendors when the specific service requirements are not yet fully defined, or when exploring new market solutions.

Typical Timeline: 4 to 8 weeks

Week 1: RFI Preparation: Draft and finalize the RFI document, outlining the health plan's objectives and what information is needed.

Week 2: Vendor Distribution: Distribute the RFI to a wide pool of TPAs.

Week 3-5: Vendor Response Period: Give TPAs 2-3 weeks to respond. A designated party should be defined that can field questions or clarify details.

Week 6-8: Review Responses and Shortlist Vendors: Review the RFI responses, compare TPAs based on their capabilities and solutions, and create a shortlist of TPAs for further engagement (either through an RFQ or RFP).

Strategy: Competitive Bidding



Competitive bidding involves obtaining and comparing detailed proposals from multiple vendors. It requires more time and effort as each vendor is expected to provide comprehensive proposals addressing both services and pricing.

Typical Timeline: 8 to 12 weeks

Week 1-2: Define Scope and Criteria: Clearly define the project scope, requirements, and evaluation criteria for the bid.

Week 3-4: Issue the Bid Invitation: Issue bid invitations to a pre-qualified list of TPAs (typically through a RFI).

Week 5-7: Vendor Response Period: Allow TPAs sufficient time (typically 3-4 weeks) to submit their proposals.

Week 8-10: Evaluation of Proposals: Review TPA proposals based on pricing, service quality, and alignment with your strategic goals.

Week 11-12: Vendor Interviews and Negotiation: Conduct interviews to clarify details and negotiate terms before selecting the final TPA.

Strategy: Multi-Step Bidding

Multi-step bidding is more complex and involves several stages, usually with prequalification of vendors followed by more detailed bids in subsequent rounds. This strategy is typically used when the project is complex or involves higher risk, such as a union plan, municipality or large group employer.

Typical Timeline: 12 to 16 weeks

Step 1: Prequalification (4-6 weeks)

Week 1-2: Define Prequalification Criteria: Establish criteria to filter out TPAs that do not meet the basic requirements.

Week 3-4: Issue Prequalification Documents: Send prequalification forms or RFIs to a broad list of vendors to assess their capabilities.

Week 5-6: Review Prequalification Submissions: Review TPA submissions and create a shortlist for the next bidding stage.

Step 2: Initial Bid (3-4 weeks)

Week 7: Issue Initial Bid Request: Send the first bid request to prequalified TPAs.

Week 8-10: Vendor Response Period: TPAs submit initial bids with basic service offerings and high-level pricing.

Week 11: Evaluate Initial Bids: Review initial bids and identify top TPAs for the next phase.

Step 3: Detailed Proposal Request (4-6 weeks)

Week 12: Issue Final Detailed Bid Request: Request detailed proposals from top TPAs, including specific services, timelines, costs, and implementation plans.

Week 13-14: Vendor Response Period: TPAs prepare and submit detailed bids.

Week 15-16: Final Evaluation and Selection: Conduct a thorough evaluation of the detailed bids, negotiate with finalists, and select the best vendor.

Summary of Expected Timelines	
Benchmarking and Market Analysis	4 to 8 weeks
Request for Quote (RFQ)	4 to 6 weeks
Request for Information (RFI)	4 to 8 weeks
Competitive Bidding	8 to 12 weeks
Multi-Step Bidding	12 to 16 weeks

Each timeline allows time for thorough evaluation, vendor responses, and decision-making. It's important to stay flexible and adapt the timeline based on the complexity of the procurement strategy and the responsiveness of vendors.

3.4. Negotiation Techniques

Negotiating with a Third-Party Administrator (TPA) during the procurement process is a crucial step. The negotiation process ensures that the TPA partnership is aligned with the organization's goals, secures the best possible terms, and sets the foundation for a successful and cost-effective health plan. Here are key reasons why negotiating with a TPA is essential:

Achieving Cost Efficiency

- **Lower Administrative Fees:** TPAs often present initial pricing that may include room for negotiation. By negotiating, brokers can secure lower administrative fees, claims processing costs, or stop-loss premiums, resulting in direct savings for the self-funded health plan.
- **Cost Transparency:** Negotiation helps ensure clarity on cost structures, avoiding hidden fees or upcharges for additional services like reporting or customer support. This transparency allows the employer to budget effectively without surprises.

Customizing Services to Fit the Health Plan

- **Tailored Solutions:** Every employer's self-funded health plan has unique needs based on employee demographics, claims patterns, and plan objectives. Negotiating allows the broker and employer to ensure that the TPA customizes its services (claims processing, customer service, compliance support) to fit the specific requirements of the health plan.
- **Flexibility:** Negotiating can help establish flexible service offerings that adapt to changes in the employer's workforce, plan design, or market conditions. For example, employers

may want the ability to scale services or integrate new technologies as their business evolves.

Ensuring Accountability with Service Level Agreements (SLAs)

- **Setting Performance Metrics:** Through negotiation, the broker can establish clear and enforceable service level agreements (SLAs) that hold the TPA accountable for key performance indicators (KPIs), such as claims accuracy, processing times, and customer service response rates.
- **Penalties for Non-Performance:** Negotiating SLAs with penalties for not meeting agreed-upon service levels ensures that the TPA remains committed to delivering high-quality service. This protects the employer from potential operational disruptions or subpar performance.

Enhancing Employee Experience and Satisfaction

- **Improved Member Services:** By negotiating customer service terms, brokers can ensure that the TPA provides a high level of support to plan members, including fast response times, easy access to claims information, and streamlined customer service processes. This enhances the overall employee experience and increases satisfaction with the health plan.
- **Access to Enhanced Features:** Negotiations can also result in securing additional services, such as wellness programs, telemedicine support, or advanced reporting tools, that improve the health plan offering without significantly increasing costs.

Managing Risk and Compliance

- **Regulatory Compliance:** Negotiating ensures that the TPA's services meet the employer's specific compliance requirements, such as adherence to ACA, HIPAA, and ERISA regulations. It can also clarify the TPA's responsibilities in providing documentation for audits or legal inquiries.
- **Risk Mitigation:** Negotiation can help secure more favorable terms for stop-loss insurance or risk-sharing arrangements, reducing the employer's exposure to high-cost claims or unexpected financial liabilities.

Building a Long-Term Partnership

- **Alignment with Long-Term Goals:** By negotiating, the broker and client can ensure that the TPA understands and aligns with the employer's long-term strategic goals, such as cost containment, member satisfaction, and improved health outcomes. This fosters a stronger, collaborative relationship.
- **Review and Renewal Terms:** Negotiation allows for flexibility in contract terms, including the ability to review and adjust the agreement based on performance. This ensures that the TPA remains responsive to evolving needs over time.

Securing Favorable Contract Terms

- Contract Length and Exit Clauses: Negotiating contract length, renewal options, and exit clauses ensures that the employer has the flexibility to change vendors or renegotiate terms if the TPA underperforms or if the employer's business needs change.
- Rate Caps and Protection Against Increases: Brokers can negotiate caps on fee increases or rate reviews, protecting the employer from unexpected cost hikes during the contract period.

Negotiating with a TPA during the procurement process is essential for securing the best financial terms, customizing services, ensuring accountability, and building a strong, long-term partnership. By thoroughly negotiating, the broker and employer can ensure that the health plan's goals, such as cost efficiency, high-quality service, and regulatory compliance, are met while protecting the organization from unnecessary risks and costs. This approach ultimately results in a well-structured, sustainable health plan that benefits both the employer and the employees.

3.5. Evaluating Bids and Proposal

Scoring and evaluating TPA proposals involves a structured and objective process to ensure that the chosen vendor aligns with the employer's goals, meets service expectations, and offers competitive pricing. This process typically includes defining criteria, assigning weights to those criteria, and scoring vendors based on how well they meet the requirements. Here's a step-by-step guide to scoring and evaluating TPA proposals:

Step 1: Define Evaluation Criteria

Start by identifying the key factors that are critical for the success of the self-funded health plan. These criteria should reflect the goals of the health plan and should be divided into several categories, such as:

1. Administrative Services

- Claims processing capabilities and accuracy.
- Turnaround times for claims and other administrative tasks.
- Member support services (e.g., call center, online portals).
- Customer service availability and quality.

2. Cost and Pricing

- Administrative fees (per employee per month or other fee structures).
- Stop-loss premium rates and terms.

- Total cost estimates based on plan size and expected claims volume.
 - Additional fees for services, such as reporting or member education.
3. Technology and Data Analytics
- Integration capabilities with existing HR and benefits systems.
 - Data reporting and analytics tools (real-time access, dashboards).
 - Member self-service tools (portals, mobile apps).
 - Use of advanced analytics to drive decision-making (e.g., predictive analytics for claims).
4. Compliance and Risk Management
- Regulatory expertise (HIPAA, ACA, ERISA compliance).
 - Data security measures and HIPAA compliance for safeguarding personal health information.
 - Ability to manage high-cost claims and implement stop-loss protections.
 - Audit support and documentation capabilities.
5. Experience and Reputation
- Experience with similar self-funded health plans, particularly within the same industry.
 - Client references and satisfaction scores.
 - Financial stability and reputation in the market.
 - Innovation and ability to adapt to industry trends (e.g., telemedicine, wellness programs).
6. Performance Metrics and SLAs
- Willingness to commit to service level agreements (SLAs).
 - Key performance indicators (KPIs) for claims accuracy, turnaround times, and customer satisfaction.
 - History of meeting SLAs and providing performance guarantees.
7. Implementation and Transition Plan
- Timeline for implementation and onboarding.
 - Training and support for internal staff and plan members.
 - Transition plans from the current TPA (if applicable).

Step 2: Assign Weights to Each Criterion



Next, assign weights to each of the criteria based on its importance to the health plan's goals. For example:

1. Administrative Services: 25%
2. Cost and Pricing: 20%
3. Technology and Data Analytics: 15%
4. Compliance and Risk Management: 15%
5. Experience and Reputation: 10%
6. Performance Metrics and SLAs: 10%
7. Implementation and Transition Plan: 5%

This weighting will guide how much each factor contributes to the final evaluation score. These weights should vary based on the plan's priorities and goals and should be consistently used for all TPAs.

Step 3: Develop a Scoring System

Create a scoring system to rate each proposal against the defined criteria.

This can be a simple point-based system, where each criterion is scored on a scale such as:

Score Key	
1	Does not meet requirements or is inadequate.
2	Partially meets requirements, with some gaps..
3	Meets requirements but lacks differentiation.
4	Meets all requirements with minor strengths
5	Exceeds expectations or requirements.

Step 4: Score Each Proposal



Review each TPA's proposal in detail and score them based on how well they meet the defined criteria. This process should be as objective as possible, using the proposal content, references, and any additional research (such as interviews) to assign scores.

Example:

- Administrative Services: TPA A scores 4, TPA B scores 5, TPA C scores 3.
- Cost and Pricing: TPA A scores 3, TPA B scores 4, TPA C scores 5.
- Technology and Data Analytics: TPA A scores 5, TPA B scores 4, TPA C scores 2.

Step 5: Apply Weights and Calculate Total Scores

Multiply each score by the weight assigned to that criterion and calculate the total score for each vendor.

Example for TPA A:

- Administrative Services: 4 (score) x 0.25 (weight) = 1.00
- Cost and Pricing: 3 (score) x 0.20 (weight) = 0.60
- Technology and Data Analytics: 5 (score) x 0.15 (weight) = 0.75
- Compliance and Risk Management: 4 (score) x 0.15 (weight) = 0.60
- Experience and Reputation: 4 (score) x 0.10 (weight) = 0.40
- Performance Metrics and SLAs: 5 (score) x 0.10 (weight) = 0.50
- Implementation and Transition Plan: 3 (score) x 0.05 (weight) = 0.15

Total Score for TPA A: $1.00 + 0.60 + 0.75 + 0.60 + 0.40 + 0.50 + 0.15 = 4.00$

Repeat this process for each TPA to determine the final scores.

Step 6: Compare Scores and Conduct Final Evaluation

Compare the total scores across all TPAs. The TPA with the highest score is often the best overall choice, but this decision may be refined based on additional factors such as:

1. Vendor Interviews: Conduct follow-up interviews with the top-scoring TPAs to clarify any uncertainties or discuss specific issues that may not have been fully addressed in their proposals.

2. Reference Checks: Speak with other clients of the TPAs to verify their service levels and responsiveness.
3. Best and Final Offer: If necessary, ask the top TPAs to submit a best and final offer to see if better pricing or service terms can be negotiated.

Step 7: Make a Final Decision

Once all proposals are scored, and additional evaluations such as interviews and reference checks are completed, use the final scores to make a decision. The TPA with the highest score should be the most aligned with your health plan's needs and goals, offering the best combination of pricing, service quality, and value.

Step 8: Present Findings to Stakeholders

Summarize the evaluation process and findings in a report to present to decision-makers within the organization. The report should include:

1. The weighted criteria used for evaluation.
2. The final scores for each TPA.
3. A summary of the key strengths and weaknesses of each TPA.
4. Recommendations for the top TPA(s) based on the scoring process.

Scoring and evaluating TPA proposals for self-funded health plans is a critical step in ensuring that the selected vendor meets the organization's specific goals and delivers high-quality services. By using a structured scoring process with clearly defined criteria, weights, and a scoring system, the organization can objectively compare vendors, negotiate favorable terms, and select the best TPA for their needs.

4. Phase 3: Contract With Your Selected Vendor

4.1. Importance of ASO/ASA Contracting

- **Understanding the Crucial Role of ASO/ASA Contracts**

ASO/ASA contracts serve as the foundation upon which the delivery of healthcare services and the management of employee benefit plans are built. The significance of ASO contracting extends beyond the surface, encompassing various ancillary aspects that impact employers, plan sponsors, broker/consultants, and all stakeholders involved.

- **Ensuring Compliance with Fiduciary Obligations**

One of the paramount considerations in ASO/ASA contracting is the fulfillment of fiduciary obligations. Employers and plan sponsors have a fiduciary duty to act in the best interests of their plan participants and beneficiaries. ASO contracts directly influence the administration and accessibility of healthcare services, making it imperative to enter into agreements that align with fiduciary responsibilities. This guide provides comprehensive insights into compliance with fiduciary obligations, offering strategies and best practices to ensure that ASO contracts prioritize the well-being of plan participants.

- **Navigating Regulatory Complexity**

ASO contracting operates within a complex regulatory landscape. Federal, state, and local regulations, coupled with evolving healthcare laws, require careful navigation. This guide equips readers with the knowledge and tools needed to understand and adhere to relevant regulations. It covers crucial topics such as the Gag Clause Prohibition and other legal considerations, ensuring that ASO contracts remain compliant and legally sound.

- **Optimizing Cost-Efficiency**

Effective ASO contracting can lead to cost savings and increased efficiency for employers and plan sponsors. Negotiating favorable terms and optimizing contract structures can result in improved financial outcomes. The guide delves into strategies for cost-effective ASO contracting, empowering readers to make informed decisions that benefit their clients and organizations.

- **Promoting Transparent Communication**

Clear and transparent communication between all parties involved in ASO contracts is vital for success. The guide emphasizes the importance of fostering open dialogue and collaboration between broker/consultants, employers, plan sponsors, TPAs, and other stakeholders. Effective communication ensures that expectations are met, potential issues are addressed promptly, and the overall ASO contracting process runs smoothly.

- **Customizing Solutions**

Each client and employer is unique, and their ASO contracting needs may differ significantly. This guide encourages customization of solutions to align with specific client goals and constraints. It provides a robust framework that readers can adapt to create tailored ASO contracts that best serve the interests of their clients.

- **A Comprehensive Resource for Success**

In summary, ASO contracting is a multifaceted process that goes beyond the formal agreement. It touches upon fiduciary obligations, regulatory compliance, cost-efficiency, transparent communication, and customization. This guide serves as a comprehensive resource, offering valuable insights and tools to navigate the complexities of ASO contracting successfully. It empowers readers to create contracts that not only meet legal requirements but also enhance the quality of healthcare services and employee benefits.

4.2. Understanding ASO/ASA Contracts

What are ASO and ASA Contracts?

ASO (Administrative Services Only) and ASA (Administrative Services Agreement) contracts are instrumental agreements that define the relationship between employers or plan sponsors and third-party administrators (TPAs) or service providers responsible for the administration of employee benefit plans. ASO contracts typically encompass the core administrative functions of a benefits plan, while ASA contracts extend their scope to include specific agreements regarding services rendered. These contracts outline the responsibilities, obligations, and expectations of all parties involved in delivering and managing employee benefits.

Key Elements of ASO/ASA Contracts

ASO and ASA contracts share common key elements that serve as the foundation for a successful partnership. These elements include clear definitions of the services to be provided, the duration of the contract, financial arrangements, performance metrics, data sharing agreements, compliance requirements, dispute resolution procedures, and termination clauses. Within these contracts, precise language and well-defined terms are essential to avoid misunderstandings and potential disputes down the line. Effective contracts provide a framework that allows employers and plan sponsors to maximize the value of their employee benefit programs while ensuring compliance with regulatory standards.

Why ASO Contracts Matter

ASO contracts are not mere administrative formalities; they are the bedrock upon which employee benefits are built. These contracts play a pivotal role in shaping the quality and accessibility of healthcare services for employees and their dependents. A well-structured ASO contract fosters transparency, efficiency, and cost-effectiveness in benefit administration. It empowers employers to fulfill their fiduciary obligations while optimizing their benefit plans to meet the unique needs of their workforce. In essence, ASO contracts are not just legal

documents; they are the cornerstones of a successful, compliant, and cost-efficient benefits program that serves both employers and employees effectively.

4.3. Introduction: Key Elements of an ASO/ASA Checklist

To ensure that ASO/ASA contracts meet the highest standards and serve the best interests of both employers and employees, having a comprehensive checklist is indispensable. This checklist acts as a guiding compass, helping you identify and address the key elements that should be considered when crafting, reviewing, or amending ASO/ASA contracts.

[☰ Nautilus Open Source Beta ASA/ASO Key Issues Checklist](#)

[☰ Nautilus Model ASA/ASO Contract Clauses](#)

4.4. Why It Matters

ASO Contract Term	Consequences of Getting it Wrong
<p>Clear Scope and Services Description Clearly define services to be provided in scope, ensuring alignment between expectations and deliverables.</p>	<p>Consequences of Getting it Wrong If services are ambiguously defined, the third-party administrator (TPA) might not fulfill critical responsibilities, leading to gaps in benefit administration and member dissatisfaction.</p> <p>Benefits of Getting it Right Accurate service descriptions enable efficient service delivery, improving member satisfaction and ensuring that the plan operates as intended.</p>
<p>Duration and Renewal Specifying the contract's duration and renewal options provides clarity on the partnership's longevity and allows for necessary adjustments.</p>	<p>Consequences of Getting it Wrong Ambiguities in contract duration can lead to unexpected contract terminations or difficulties in transitioning to a new TPA.</p> <p>Benefits of Getting it Right Clear terms on contract duration and renewals help maintain stability and allow for strategic planning.</p>
<p>Financial Arrangements Transparent financial terms, including fees and cost-sharing agreements, prevent surprises and budgetary challenges.</p>	<p>Consequences of Getting it Wrong Unclear financial arrangements may result in unexpected costs, budget overruns, or disputes over fees.</p> <p>Benefits of Getting it Right Well-defined financial terms help control costs, ensuring financial predictability and stability.</p>

<p>Performance Metrics Establishing measurable performance metrics allows for objective evaluation of the TPA's effectiveness.</p>	<p>Consequences of Getting it Wrong Without clear performance metrics, it's challenging to assess whether the TPA is meeting expectations, potentially leading to subpar service.</p> <p>Benefits of Getting it Right Defined performance metrics enable ongoing improvement, ensuring the TPA consistently delivers high-quality services.</p>
<p>Data Sharing and Security Protocols for data sharing, privacy, and security are crucial to protect sensitive information and comply with regulations.</p>	<p>Consequences of Getting it Wrong Inadequate data protection measures can result in data breaches, privacy violations, and regulatory penalties.</p> <p>Benefits of Getting it Right Robust data security measures safeguard sensitive information and maintain compliance, enhancing trust in the benefits program</p>
<p>Compliance Requirements Addressing regulatory compliance, including ERISA, HIPAA, and other laws, is essential to avoid legal liabilities.</p>	<p>Consequences of Getting it Wrong Failure to meet compliance requirements can lead to legal risks, penalties, and reputational damage (up to \$10,000 per day for ERISA violation)</p> <p>Benefits of Getting it Right Compliance ensures legal adherence, reducing risks and reinforcing the program's integrity. Further insulation from legal action.</p>
<p>Dispute Resolution A defined dispute resolution process facilitates timely issue resolution and minimizes disruption</p>	<p>Consequences of Getting it Wrong Unclear dispute resolution procedures can escalate conflicts, leading to prolonged disputes and disruptions in service.</p> <p>Benefits of Getting it Right Effective dispute resolution promotes smooth conflict resolution, minimizing operational interruptions.</p>
<p>Termination Clauses Clear termination clauses streamline the contract termination process and facilitate transitions.</p>	<p>Consequences of Getting it Wrong Ambiguities in termination clauses can prolong contract terminations, causing operational challenges and significant cost if early termination penalties are imposed or unnecessary fees incurred.</p> <p>Benefits of Getting it Right Well-defined termination clauses ensure efficient transitions, minimize downtime, and allow clients to ensure flexibility to move on when appropriate.</p>
<p>Audit Rights Guaranteeing unrestricted audit rights is crucial for</p>	<p>Consequences of Getting it Wrong Restrictions on audit rights can limit the ability to detect errors, discrepancies, or improper practices, potentially compromising</p>

<p>thorough examination of financial and operational aspects, safeguarding compliance and payment integrity.</p>	<p>financial accuracy. Unreasonable restrictions could also run afoul ERISA and federal law. Benefits of Getting it Right Unrestricted audit rights empower thorough oversight, helping identify and rectify issues promptly. Full compliance with fiduciary obligations and ERISA requirements under CAA 2021</p>
<p>Medical Rebates Pass-Through Ensuring that medical rebates are passed through to the plan sponsor promotes transparency and cost savings.</p>	<p>Consequences of Getting it Wrong Failure to secure rebate pass-through may result in the loss of potential cost-saving opportunities. Benefits of Getting it Right Guaranteeing rebate pass-through maximizes cost savings and enhances transparency in benefit administration.</p>
<p>Preservation of Vendor Rights Preserving the right to carve out payment integrity vendors and other point solutions ensures flexibility and optimization of the benefits program.</p>	<p>Consequences of Getting it Wrong Inflexible contracts may limit the ability to implement cost-saving point solutions or switch vendors. Particularly problematic is where a TPA requires utilization of a particular payment integrity vendor, which may have misaligned incentives. Benefits of Getting it Right Preserving the right to carve out specific functions and or point solution vendors, including payment integrity solutions, ensures fiduciary obligations can be met and fair/objective standard for evaluation solutions will be in fiduciary sponsors' control</p>
<p>Data Completeness Ensuring the completeness of data is crucial for accurate decision-making, cost analysis, and population health initiatives.</p>	<p>Consequences of Getting it Wrong Incomplete data can hinder effective analysis and compromise the effectiveness of population health initiatives. Benefits of Getting it Right Ensuring comprehensive and complete data provision through contract requirements will empower comprehensive cost analysis and robust population health initiatives</p>
<p>Prohibition of Cross-Plan Offsetting Explicitly prohibiting cross-plan offsetting ensures that the TPA or network provider cannot use funds from one self-funded employer's plan to offset debts or overpayments related to</p>	<p>Consequences of Getting it Wrong Failure to prohibit cross-plan offsetting may result in financial losses and potential legal disputes, including breach of fiduciary duty. Benefits of Getting it Right Prohibiting cross-plan offsetting protects the self-funded employer's financial stability and protects the employer from fiduciary liability and risk.</p>

<p>other plans, safeguarding the employer's financial interests.</p>	
<p>Lesser of Logic Including the "lesser of" logic in the contract ensures that the plan only pays the lower of the billed amount or the negotiated amount for any services, preventing overpayment.</p>	<p>Consequences of Getting it Wrong Without the "lesser of" logic, the self-funded employer may overpay for services, leading to unnecessary expenses.</p> <p>Benefits of Getting it Right Implementing the "lesser of" logic prevents overpayment and optimizes cost control.</p>
<p>Compensation Disclosure Requiring full disclosure of direct and indirect compensation ensures transparency and helps the self-funded employer make informed decisions.</p>	<p>Consequences of Getting it Wrong Inadequate compensation disclosure may result in hidden costs and conflicts of interest. Failing to obtain appropriate compensation disclosure will also result in fiduciary liability.</p> <p>Benefits of Getting it Right Full compensation disclosure promotes transparency and informed decision-making; as well as protection from fiduciary liability as a result of mandated compensation disclosure required by 408(b)(2) of ERISA.</p>
<p>Standard of Care Requiring the TPA or network provider to perform services with the highest degree of care, skill, and professionalism ensures quality service delivery.</p>	<p>Consequences of Getting it Wrong Failing to uphold the standard of care may lead to subpar service quality and potential legal issues; an "industry" standard of care without clearly defining the term will not help clients in a legal dispute.</p> <p>Benefits of Getting it Right Upholding the standard of care guarantees quality service and minimizes legal risks. Clearly defining what is expected within the highest degree of care will ensure protection from errors and omissions that are less than recklessly negligent.</p>
<p>Patient Steering and Network Provider Assistance Ensuring no steering restrictions and network provider cooperation empowers the self-funded employer's decision-making.</p>	<p>Consequences of Getting it Wrong Steering restrictions or lack of cooperation may limit the employer's control and flexibility. Such restrictions may preclude employers from directing patients to higher quality, lower cost providers; potential violation of fiduciary standards.</p> <p>Benefits of Getting it Right No steering restrictions and cooperation facilitate effective decision-making and enable employers to deliver optimal health and financial outcomes for members.</p>



4.5. Transitioning to New Contracts

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

5.Phase 4: Onboard and Implement Your Selected Vendor

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

6. Phase 5: Monitor and Evaluate Your Selected Vendor

The relationship between the Third-Party Administrator (TPA), the employer, and the broker/consultant is a collaborative one, requiring regular communication, reporting, and strategic engagement throughout the plan year.

6.1. Communication

Communication is crucial between a Third-Party Administrator (TPA), broker/consultant, and employer in administering a self-funded employer health plan for several reasons:

Coordination of Responsibilities

Each party has specific roles in managing the health plan. The TPA handles claims processing and administrative tasks, the broker/consultant provides guidance and strategy, and the employer oversees the overall plan. Clear communication ensures that everyone understands their responsibilities and how they interconnect.

Plan Design and Implementation

Effective communication is vital during the design and implementation of the health plan. The broker/consultant needs to understand the employer's objectives and constraints to recommend appropriate plan structures, while the TPA must ensure the plan is administered according to these specifications.

Regulatory Compliance

Self-funded health plans are subject to various regulations (e.g., ERISA, ACA). The TPA often handles compliance matters, but the employer and broker/consultant must be informed and involved to ensure that all legal requirements are met and that the plan remains compliant.

Cost Management

One of the primary reasons employers choose self-funding is cost control. Continuous communication allows the broker/consultant to monitor claims data and advise on cost-saving measures, while the TPA can implement these changes in real-time. The employer needs to be kept in the loop to make informed decisions and adjust the plan as needed.

Claims Processing and Disputes

When issues arise with claims, it is crucial for the TPA to communicate promptly with the broker and employer to resolve them efficiently. Miscommunication or delays can lead to employee dissatisfaction and financial discrepancies.

Employee Education and Support

Employers rely on brokers/consultants and TPAs to help educate employees about their benefits and how to use them effectively. Consistent communication ensures that employees are well-informed, which reduces confusion and increases satisfaction with the health plan.

Renewal and Plan Adjustments

Health plans often require annual review and adjustments. The broker/consultant plays a key role in assessing the plan's performance and recommending changes, while the TPA implements these changes. Clear communication is essential to ensure the plan evolves to meet the employer's needs.

Crisis Management

In situations like high-cost claims, legal challenges, or unexpected changes in the workforce, effective communication allows all parties to respond quickly and cohesively, minimizing potential negative impacts on the plan and its participants.

In essence, effective communication among the TPA, broker/consultant, and employer ensures that the health plan operates smoothly, remains compliant, and meets the needs of both the employer and the employees.

6.2. Reporting

The TPA provides reports to provide brokers/consultants and employers with comprehensive data to track plan performance, identify trends, and make informed decisions. The majority of TPAs have a standard reporting package. Custom reporting needs should be discussed during the procurement process and as need arises.

The broker's role is to interpret these reports and guide the client in strategic decision-making.

Here is a short list of minimal reports and type of information that should be provided and the frequency.

1. Monthly: Claims report, enrollment report, financial performance report.
2. Quarterly: Utilization reports, stop-loss claims updates, pharmacy benefit reports.
3. Quarterly or bi-annually: Benchmarking reports, financial projections, utilization trends
4. Annually: Year-end summary, renewal strategy report, compliance updates.

6.3. Strategic Engagement

Below is an overview of the types of engagement, encounters, and resources that should be expected. It is recommended that all scheduled encounters include the TPA Account team, broker/consultant and/or primary contact(s) and primary employer contact(s).

	Initial Plan Setup and Renewal	Regular Plan Administration	Strategic Planning
Frequency	Annual or as needed during plan renewal or setup	Monthly or bi-monthly	Ongoing, with formal reviews quarterly or bi-annually.
Types of Encounters	Strategy meetings, plan design discussions, contract negotiations.	Regular check-in calls, emails or meetings; Scheduled report reviews, data analysis sessions	Performance review meetings, strategy sessions
Deliverables	Plan documents, TPA service agreements, stop-loss coverage details, enrollment guides.	Monthly claims reports, enrollment updates, stop-loss reports.	Benchmarking reports, financial projections, utilization trends
Engagement Purpose	Ensure the plan is designed to meet the client's needs and budget. Set expectations for the year and finalize agreements with the TPA, PBM, and stop-loss carriers.	Monitor ongoing plan operations, address any issues with claims processing, and discuss participant inquiries or concerns. Ensure compliance with plan documents and regulations	Evaluate whether the plan is performing as expected in terms of costs, participant satisfaction, and health outcomes. Identify areas where the plan may be off course and discuss actionable steps to redirect.

6.4. Compliance Monitoring

The employer sponsoring a self-funded health plan is responsible for ensuring the plan complies with various compliance requirements and legislation, primarily at the federal level, with some

additional state regulations depending on the jurisdiction. Employers often rely on TPAs to help with compliance and the broker/consultant to help with ensuring compliance is managed appropriately. The Regulatory Landscape section of this field guide provides in-depth information of the specific requirements.

The topic of Compliance should be a primary category for discussion and information collection during the procurement process. During on-boarding, Compliance, support, roles and a strategy should be defined. At a minimum, Compliance should be an agenda item for all strategic encounters.

Here's an overview of how TPAs typically monitor and manage these requirements:

1. **Regular Compliance Audits:** Conduct regular compliance audits of the health plan's operations, claims processing, and documentation to ensure adherence to applicable laws and regulations.
2. **Training and Education:** Often provide training and education to their staff and the employer's HR team on the latest compliance requirements, ensuring that everyone involved is aware of their responsibilities.
3. **Plan Document Management:** Ensure that the plan's governing documents, including the Summary Plan Description (SPD), are up-to-date and compliant with ERISA and other federal requirements. They assist in drafting amendments when necessary.
4. **Monitoring Legislative Changes:** Stay informed about changes in federal and state laws that could impact the self-funded health plan. They update the employer on any necessary adjustments to the plan to remain compliant.
5. **Claims Processing and Reporting:** Handle claims in accordance with ERISA's claims procedure regulations and ensure accurate reporting of claims data, which is essential for ACA compliance and other reporting obligations.
6. **HIPAA Compliance:** Implement and maintain HIPAA-compliant processes for the handling of PHI, including secure data storage, transmission, and access controls. They also conduct risk assessments and ensure breach notification procedures are in place.
7. **COBRA Administration:** Manage COBRA notifications, election processes, and premium payments, ensuring compliance with all COBRA requirements.
8. **Reporting:**
9. **Internal Controls and Technology:** Use technology solutions to monitor compliance, track claims, and manage reporting. Automated systems can flag potential compliance issues, ensuring timely intervention.
10. **Consultation and Advice:** Often act as brokers/consultants to the employer, providing guidance on compliance strategies, best practices, and risk management to ensure the health plan remains legally sound.
11. **Fiduciary Oversight:** May assist in managing fiduciary responsibilities under ERISA, ensuring that the plan's operations are in the best interest of participants and beneficiaries.

By proactively managing these compliance aspects, TPAs help employers avoid legal pitfalls, penalties, and costly lawsuits while ensuring that the self-funded health plan operates smoothly and effectively.

6.5. Communication Strategies

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

6.6. Employee Education and Engagement

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

6.7. Handling Disputes and Discrepancies

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

7. Effectively Access & Use Data

Effectively securing access and using data available to your plan is a critical component that should be deeply embedded into your procurement, contracting, and oversight process, but it is important enough to be its own separate section in this field guide to highlight how an effective data strategy comes together.

7.1. Data Strategy and Elements for Successful RFP Process

A data strategy refers to the plan and approach for collecting, managing, analyzing, and using data to make informed decisions. A data strategy ensures that data is leveraged effectively to guide the procurement process, improve vendor selection, and achieve the desired outcomes for the project.

A well structured data strategy focuses on gathering relevant data that will provide insights into the TPA's capabilities, costs and potential for delivering the desired services and solutions. The following are key elements of the data strategy:

- **Data Needs Assessment:** Begin with assessing current data capabilities, needs, and identifying gaps to determine the types of data crucial for the health plan's goals.
- **Data Standardization and Integration Requirements:** Define standardization and integration requirements to ensure seamless data exchange and reduce the risk of data silos.
- **Data Security and Compliance:** Outline strict data security and compliance standards to ensure adherence to regulations such as HIPAA, ensuring member data is protected.
- **Analytics and Reporting Capabilities:** Specify the need for analytics and customizable reporting tools for deriving actionable insights and monitoring plan performance.
- **Member Data Utilization for Personalized Health Management:** Demand capabilities for leveraging member data to support personalized health management and engagement strategies.
- **Performance Metrics and Benchmarking:** Establish clear metrics leveraging data to measure the provider's performance, including administrative efficiency and health outcomes.
- **Scalability and Flexibility:** Ensure the data strategy accounts for future growth and evolving needs, with scalable and adaptable data infrastructure.

The following is a requirement for Comprehensive Data Provision and Third-Party Data Sharing

- The ASO/ASA provider must commit to providing comprehensive claims and financial data in a client-acceptable format and facilitate secure data sharing with designated third-party business associates. This requirement is crucial for

transparency, enabling in-depth analysis, and leveraging external expertise. It includes ensuring compatibility with existing systems, adhering to data protection and privacy regulations, and supporting the client's broader strategy for informed decision-making and continuous improvement.

By including these requirements in your ASO/ASA procurement strategy, you ensure a comprehensive approach that not only meets your current data management and analysis needs but also aligns with your long-term objectives for health plan optimization and member health outcomes. This expanded strategy highlights the importance of data transparency, interoperability, security, and the strategic use of data analytics and third-party collaborations in driving the success of ERISA self-funded health plans.

7.2. Data Use

Introduction

Data is an ever-changing and complex part of the healthcare system. In order to understand how the plan is performing, high quality claims data, eligibility, medical, and pharmacy, is a must. The intent in this guide is to understand the basics of claims data, how to ensure the plan is receiving quality and usable data, what should be expected to be received from the TPA, and when to pushback.

Accessing Your Data

As a fiduciary of your health plan, you have a legal right to access your plan's claims data to ensure you are meeting your fiduciary obligations. With this in mind, if pushback is given from the TPA, be firm in reminding them of their responsibility to provide the data in full. Many times, TPAs who refuse to provide data initially, will attempt to fulfill the request by providing a slimmed down and limited version of the data or access to reports. Remember, reports and full claims data are not the same. Be specific in the request with the list of fields expected and the starting date that the TPA began housing claims (i.e. the start date or run-in period start date).

In the event that the TPA denies your request for data, a demand letter may need to be used. A demand letter is a notice to the TPA of their requirement under ERISA to provide the fiduciary with the claims data within a certain time period. The demand letter will vary for a Fully Insured plan. Templates are available for both a [Self-Funded Plan](#) and a [Fully-Insured Plan](#).

PHI and HIPAA

Claims data includes Personal Health Information (PHI). Under HIPAA, it is of the utmost importance to keep the information safe and protected. It is recommended that several safeguards are in place, including but not limited to: sharing data safely via an SFTP, storing the data in a secure environment, obtaining a Business Associate Agreement (BAA) and/or

Non-Disclosure Agreement (NDA), and limiting the number of individuals who have access to the data.

When sharing data to perform analytics, it's important to remember that only the minimum amount of data required to perform the analysis should be shared. If PHI is not required, safeguards should be taken to remove the PHI and limit the number of fields and quantity of data shared. As always, legal documentation should be reviewed and completed. For internal teams, only the individuals required to have access to the data should have access. Those individuals should undergo annual HIPAA training to ensure the steps to protect the data are done.

In a Fully-Insured environment, accessing PHI information can create one more layer of challenges. Oftentimes, Fully-Insured carriers have more legal documents to review and sign. It's common to see some form of client acknowledgment or sharing document that requests permission directly from the employer group to share data in addition to the NDA and BAA.

What Type of Standard Reporting Should You Expect?

In addition to raw claims data, TPAs should also provide a comprehensive reporting package. These reports can be used to review how the plan is performing as well as to validate the raw data for one-off or custom analyses.

<p>Aggregate Spend Report</p>	<ul style="list-style-type: none"> a. Description: A high-level month over month summary of spend, member lives, Aggregate contract terms and usage, and specific contract terms and usage. b. Expected Frequency: Monthly c. Why It's Important and How to Use It: An Aggregate report is a one stop shop to see how the plan is performing. This report shows how close to or over the spec deductible medical and pharmacy claims are on a monthly basis and allows the fiduciary to plan accordingly.
<p>Monthly Spend Report</p>	<ul style="list-style-type: none"> a. Description: A month over month report showing plan spend, member spend, and overall total spend. b. Expected Frequency: Monthly c. Why It's Important and How to Use It: This report comes in handy to see the breakdown of plan spend and member spend overtime to ensure the plan is performing as intended. If the plan offers no cost to member services, the member spend will give insight into if members are following the plan design or if alternative approaches need to be taken.

<p>Stop Loss Specific Detail Report</p>	<ul style="list-style-type: none"> a. Description: A Specific Stop Loss report indicates all claimants that have hit the 50% threshold of the specific limit. This report will include the names, diagnosis codes, dates of service and paid amounts, the specific limit, the percentage of that limit per member listed, and any amount over the specific limit. b. Expected Frequency: Monthly c. Why It's Important and How to Use It: Knowing where members are in relation to the specific limit can help the fiduciary allocate funds and seek alternative steerage approaches to help the member receive high quality care for a better cost.
<p>Utilization Report</p>	<ul style="list-style-type: none"> a. Description: This report shows claims utilization month over month. This can be shown at a high level such as claims volume, or broken down by category. b. Expected Frequency: Monthly c. Why It's Important and How to Use It: This report helps point to areas where steerage may need to come into play or a direct contract or implementing a vendor may be beneficial. Understanding utilization shows where the plan can expect to consistently be spending time and money, meaning, it's an area that matters to the population that's being served. By crossing utilization with spend, it removes outlier or one-off cases like emergencies and shows disease states or procedures that the population may consistently experience.
<p>Top Spend Reports</p>	<ul style="list-style-type: none"> a. Description: This report shows the highest areas of spend across multiple categories. It is recommended that the top providers/facilities, claimants, place of service, procedure category, and diagnosis category are included. b. Expected Frequency: Monthly c. Why It's Important and How to Use It: Looking at the highest areas of spend by the plan is an additional report to see where intervention may be necessary or helpful to the plan. By looking at where the plan is consistently spending funds over time, the fiduciary can plan for vendors, direct contracts, member education, or steerage efforts. In addition, top reports are great for executive reporting and strategy conversations.
<p>Census/Enrollment Report</p>	<ul style="list-style-type: none"> a. Description: A report showing the volume of members enrolled or disenrolled in the plan month over month and

	<p>their breakdown by member category (employee, dependent, etc.)</p> <ul style="list-style-type: none"> b. Expected Frequency: Monthly c. Why It's Important and How to Use It: Understanding the population of a plan is key in identifying potential risks, predicting future needs, and maintaining financial stability. Knowing the population's average age, for example, gives you insight into common health concerns they may be susceptible to and where additional benefits may need to be allocated towards.
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While healthcare data is complex, obtaining the raw data, having a TPA that acts as a partner, and consistently receiving and reviewing basic reports help the fiduciary create a high performing plan for the members it serves. There are many levels and lanes that can be taken in the area of data which makes it important to understand the goals of the employer, its members, and how the population will behave when changes and adjustments are made. Pushback becomes an art in ensuring the quality of data and the amount of data being sent. As the owner of the data, making sure to receive the most comprehensive and accurate data set enables the plan to make the best decisions for the members it serves.

7.3. Model Data Agreement

This portion of the field guide has not been created yet. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

Data Safeguarding Agreement: [DATA SAFEGUARDING AGREEMENT](#)

8. Critical Additional Knowledge

8.1. Key Considerations, Avoiding Pitfalls, and Pushback Themes

8.1.1: Key Considerations when assessing a TPA

Choosing the right TPA involves balancing financial considerations with service quality, technology, and compliance. By thoroughly vetting a TPA against these criteria, you can ensure they are a reliable partner who will meet organizational needs and support overall benefits strategy.

Financial Stability and Experience

- **Financial Stability:** Investigate the financial health of the TPA. Ensure they have the resources to manage claims and other financial obligations, even in adverse conditions.
- **Experience:** Assess their experience in the industry. A TPA with a long history in the business is likely to have a more robust operational framework and a better understanding of market trends.

Service Offerings and Expertise

- **Service Scope:** Evaluate the services they offer. Do they provide the full range of services needed (e.g., claims processing, risk management, compliance services)?
- **Industry Expertise:** Confirm their expertise in the specific industry or the types of benefits offered. A TPA with specialized knowledge will better understand unique needs.

Technology and Data Security

- **Technology Platform:** Review the technology they use for claims management, reporting, and communication. It should be modern, user-friendly, and integrate well with other systems.
- **Data Security:** Data protection is crucial. Ensure the TPA has strong cybersecurity measures, including encryption, secure data storage, and compliance with relevant data protection regulations (e.g., HIPAA).

Cost and Fee Structure

- **Transparency:** The fee structure should be transparent, with no hidden costs. Understand how they charge—whether it's a flat fee, per member, or a percentage of claims—and how this aligns with the budget.
- **Value for Money:** Balance cost with the value they provide. Sometimes paying a higher fee can be justified by superior service and better outcomes.

Client References and Reputation

- **References:** Ask for and check references from current clients, particularly those in similar industries or with similar needs.
- **Reputation:** Research their reputation in the market. Look for reviews, testimonials, and any industry awards or recognitions they have received.

Compliance and Regulatory Awareness

- **Regulatory Compliance:** Ensure the TPA is up-to-date with all relevant regulations and compliance requirements, such as ERISA, ACA, or other industry-specific mandates.
- **Proactive Updates:** They should actively keep you informed about regulatory changes that could impact your benefits plans.

Member Services Support and Educational Resources

- **Member Support:** Evaluate the quality of their member services, including accessibility (24/7 support), responsiveness, and the ability to resolve issues quickly.
- **Educational Resources:** Check if they offer educational resources for members, such as webinars, newsletters, and personalized support, to help them understand their benefits.

Employee Communications

- **Communication Tools:** Assess the tools they use for communicating with employees, such as online portals, mobile apps, or direct mail. These should be user-friendly and accessible.
- **Clarity and Frequency:** The TPA should communicate clearly and frequently with both the employer and employees, providing updates on plan changes, claims status, and other critical information.

8.1.2: Pitfalls and Pushback themes

When selecting a new TPA, organizations often encounter specific pitfalls and common pushback themes.

Pitfalls

Selecting the wrong TPA as well as setting inadequate expectations within the TPA relationship can have adverse financial and legal implications. Below are some common themes.

Inadequate Due Diligence

- **Lack of Thorough Evaluation:** Failing to thoroughly vet the potential administrator's track record, financial stability, and service capabilities.
- **Overlooking Compliance and Regulatory Issues:** Not ensuring that the administrator complies with all relevant regulations and standards, which could lead to legal issues.
- **Ignoring Scalability:** Choosing an administrator that can't scale with the organization's growth or adapt to future needs.

Poor Fit with Organizational Needs

- **Mismatch with Company Culture:** Selecting an administrator whose service philosophy or approach doesn't align with the company's values and expectations.
- **Inflexibility in Plan Design:** Choosing an administrator that is not flexible in accommodating specific plan designs or unique needs of the organization.

Underestimating Implementation Challenges

- **Transition Difficulties:** Underestimating the time, resources, and complexity involved in transitioning to a new administrator.
- **Insufficient Training and Support:** Not accounting for the training required for HR staff and employees to effectively use a new system.

Cost Mismanagement

- **Hidden Costs:** Overlooking potential hidden costs, such as additional fees for certain services, which can inflate the overall expense.
- **Short-Term Focus:** Prioritizing upfront cost savings over long-term value and service quality, leading to higher costs down the line.

Technology Integration Issues

- **Incompatible Systems:** Selecting an administrator whose technology doesn't integrate well with existing HR and benefits platforms.

- **Outdated Technology:** Choosing an administrator with outdated or less user-friendly technology that could frustrate users and slow down processes.

Common Pushback Themes

Resistance to Change

- **Employee Concerns:** Employees may fear disruptions to their healthcare benefits or worry about changes in service quality.
- **HR Department Hesitation:** HR teams may resist changing administrators due to the workload associated with transition and fear of the unknown.

Cost Concerns

- **Upfront Costs:** Concerns about the initial expenses involved in transitioning to a new administrator, including implementation fees and training.
- **Long-Term Financial Impact:** Skepticism about whether the change will result in genuine long-term savings or just shift costs elsewhere.

Quality and Service Level Doubts

- **Uncertainty about Service Quality:** Concerns that the new administrator might not deliver the promised level of service, leading to potential dissatisfaction among employees.
- **Fear of Disruption:** Worries that the transition could lead to service disruptions, affecting claim processing times and employee satisfaction.

Technology and Integration Worries

- **System Compatibility:** Concerns about whether the new administrator's systems will integrate smoothly with existing HR and payroll systems.
- **Training and Usability:** Doubts about the ease of use of the new system and whether sufficient training will be provided.

Compliance and Regulatory Concerns

- **Regulatory Adherence:** Pushback based on the fear that the new administrator might not fully comply with all relevant healthcare regulations, potentially leading to legal issues.
- **Data Security:** Concerns about the security of sensitive employee health data during and after the transition.

Strategies to Mitigate These Challenges

These steps can help address the common pitfalls and pushback themes, leading to a more successful transition to a new medical claims administrator.

- **Comprehensive Evaluation:** Conduct a thorough evaluation of potential administrators, including reference checks, to ensure a good fit.
- **Stakeholder Engagement:** Involve key stakeholders early in the decision-making process to address concerns and build buy-in.
- **Transparent Communication:** Clearly communicate the reasons for the change, the expected benefits, and how challenges will be managed.
- **Focus on Training and Support:** Provide ample training for HR staff and employees to ease the transition and ensure everyone is comfortable with the new system.
- **Plan for a Smooth Transition:** Develop a detailed implementation plan that minimizes disruption and includes contingency measures.

8.2. Common Myths and Truths

Myths	Truths
Procurement for ASO/ASA Services Is a Quick Process	The procurement process for ASO/ASA services can be time-consuming. It involves evaluating potential vendors, negotiating contracts, and ensuring compliance with legal and regulatory requirements.
Procurement for TPAs Is Only About Cost	While cost is a significant factor in TPA procurement, it's not the only consideration. Evaluating the TPA's track record, service quality, experience, and alignment with your organization's goals is equally important.
The Lowest Bidder Is Always the Best Choice	Selecting the lowest bidder may not guarantee the best value. It's crucial to consider the overall value proposition, including quality, reliability, and the ability to meet your organization's specific needs.
Procurement Can Be Handled Solely by the Purchasing Department	The procurement process for ASO/ASA services should involve cross-functional teams, including HR, finance, and legal departments. Collaborative input ensures the contract meets various departmental needs.
Procurement Can Be Handled Solely by the HR Department	The procurement process for ASO/ASA services should involve cross-functional teams, including HR, finance, and

	legal departments. Collaborative input ensures the contract meets various departmental needs.
Relying on RFP Templates Is Sufficient	While RFP templates provide structure, a one-size-fits-all approach may miss critical requirements. Customize RFPs to address your organization's unique needs to receive accurate and relevant responses.
Procurement Is a One-Time Event	Procurement is an ongoing process. Continuously evaluating and monitoring ASO/ASA contractors or TPAs ensures they continue to meet your organization's evolving requirements and compliance standards.
Procurement Is Solely About Cost Reduction	While cost efficiency is essential, procurement should also focus on achieving strategic objectives. It's an opportunity to enhance service quality, reduce risks, and improve the overall performance of your benefits program.
All TPAs Are Interchangeable	TPAs vary in terms of expertise, service offerings, and industry knowledge. Assessing their specific capabilities and aligning them with your needs is crucial for successful procurement.
Contracts with TPAs Are Always Beneficial	While TPAs offer advantages, they can also pose risks, such as conflicts of interest. Not all TPAs will act in your plan's best interest. It's essential to thoroughly assess potential TPAs and their contracts.
Negotiating ASO/ASA Contracts Is Unnecessary	Failing to negotiate ASO/ASA contracts can lead to unfavorable terms. Negotiation allows you to secure more favorable terms, protecting your organization and ensuring the contract aligns with your objectives.
ASO/ASA Contracts Are Set in Stone	ASO/ASA contracts can be negotiated and amended. If circumstances change, it's possible to revisit and modify the contract to better suit your organization's evolving needs.
TPAs Must Have the Best Interests of Your Plan	While TPAs should act in your plan's best interests, conflicts of interest may arise when they also serve as stop-loss carriers. It's essential to scrutinize their actions and ensure they prioritize your plan's well-being.
ASO/ASA Contracts Are Only for Large Organizations	ASO/ASA contracts can benefit organizations of various sizes. Small and mid-sized businesses can also leverage these

	contracts to improve plan management, reduce costs, and enhance services.
You Can't Amend TPA Contracts	TPA contracts are negotiable and amendable. If there are clauses or terms that you find unfavorable, you can work with the TPA to make necessary changes to protect your interests.

8.3. Roles and Responsibilities

Identifying and defining the roles and responsibilities of the TPA, broker/consultant, and employer/union ensures accountability, promotes efficiency, reduces risk, ensures compliance, enhances communication, improves plan performance, and facilitates strategic planning. In this section, we'll review the general roles of each party in managing the health plan, specific roles within the procurement process and how parties and collaborating for success.

8.3.1. General Roles and Responsibilities

In a self-funded employer health plan, several key parties have distinct roles and responsibilities to ensure the plan operates effectively and meets legal and regulatory requirements. Below is an overview of the roles and responsibilities for the employer/union, broker/consultant and the Third-Party Administrator (TPA).

The employer/union, as the plan sponsor, has the ultimate responsibility for the health plan. Their responsibilities include:

- **Plan Design and Funding:** Designs the health plan to meet the needs of their workforce. They decide on the coverage options, benefits, and any cost-sharing arrangements (like deductibles and copays). The employer is also responsible for funding the plan, which involves setting aside the necessary financial resources to pay for claims and administrative costs.
- **Plan Compliance:** Must ensure that the plan complies with federal and state regulations, including ERISA, HIPAA (Health Insurance Portability and Accountability Act), and the ACA. This involves working closely with the TPA and legal brokers/consultants.
- **Selection and Oversight of TPA:** Selects the TPA and is responsible for overseeing their performance. This includes reviewing the TPA's work, ensuring they meet service level agreements, and making adjustments as needed.

- Employee Communication and Education: Is responsible for communicating the plan's details to employees, including benefits, enrollment procedures, and how to use the plan. They may also provide educational resources to help employees make informed healthcare decisions.
- Funding and Reserve Management: Must manage the funds allocated for the health plan, ensuring there are sufficient reserves to cover unexpected large claims.

The broker/consultant acts as an advisor to the employer, providing expertise and guidance in the selection and management of the health plan. Their responsibilities typically include:

- Plan Design and Strategy: Assists the employer in designing a plan that meets the needs of the workforce while being cost-effective. This includes analyzing healthcare trends, advising on benefit levels, and recommending plan structures.
- Vendor Selection: Helps the employer choose the right TPA, insurance carriers (for stop-loss coverage, if applicable), and other vendors. They may conduct RFP (Request for Proposal) processes and negotiate contracts on behalf of the employer.
- Compliance Assistance: Provide guidance on regulatory compliance, helping the employer navigate complex legal requirements and avoid penalties.
- Market Analysis and Benchmarking: Conducts market research to help the employer understand industry trends, competitive benefit offerings, and how their plan compares to others in the market.
- Cost Management: Work with the employer to manage plan costs, including analyzing claims data, advising on plan changes to control expenses, and recommending wellness programs or other cost-saving measures.
- Employee Communication Support: Often helps the employer with communication strategies, including creating materials for open enrollment, plan summaries, and other educational resources.

The TPA is a crucial partner in the administration of a self-funded health plan, providing various services to ensure the plan operates smoothly. Their responsibilities typically include:

- Claims Processing: Responsible for processing and paying claims for healthcare services rendered to plan participants. This includes adjudicating claims according to the plan's terms, determining payment amounts, and issuing payments to healthcare providers or reimbursing employees.
- Compliance and Reporting: Ensures that the plan complies with all applicable federal and state regulations, such as ERISA (Employee Retirement Income

- Security Act) and the Affordable Care Act (ACA). They handle required reporting, such as providing Form 5500 and generating summary plan descriptions (SPDs).
- Plan Design and Administration Support: Assists the employer in designing and managing the health plan. This can include setting up plan structures, determining benefits, and updating plan documents as needed.
 - Customer Service: Often provides customer service support to plan participants, answering questions about benefits, coverage, and claims status.
 - Network Management: If the TPA manages a network of healthcare providers, they ensure that participants have access to a broad range of in-network services and negotiate pricing with providers. Otherwise, the TPA facilitates provider access through network contracts.

In summary, the TPA manages day-to-day administration and compliance, the employer designs and funds the plan while ensuring overall compliance, and the broker/consultant provides strategic guidance and support to optimize the plan's effectiveness and cost efficiency. Together, these roles collaborate to provide a well-functioning health plan for employees.

8.3.2. Roles and Responsibilities within the Procurement Process

In the procurement process of selecting a Third-Party Administrator (TPA), the roles of the employer/union, the broker/consultant and the TPA are distinct but interconnected. Each party has specific responsibilities that contribute to the successful selection of the most suitable TPA for the employer's or union's health plan needs. Below is an overview of these roles during the procurement process

The employer or union, as the plan sponsor of the self-funded health plan, plays a central role in the procurement process. The plan sponsor's responsibilities include:

- Defining Objectives: Defined the goals and objectives for the health plan, including cost containment, employee satisfaction, and compliance with regulatory requirements. This step sets the criteria for selecting a TPA.
- Budgeting: Establishes a budget for the plan, including administrative costs, expected claims expenses, and any stop-loss insurance premiums. This financial framework will guide the selection process.
- Request for Proposal (RFP) Development: Often with the help of a broker/consultant, develops a Request for Proposal (RFP) that outlines the requirements for the TPA. The RFP includes details about plan design, network needs, reporting requirements, customer service expectations, and compliance obligations.
- Evaluation and Decision-Making: After receiving proposals from potential TPAs, the plan sponsor participates in evaluating these proposals based on the

established criteria. This involves reviewing the services offered, costs, experience, and reputation of each TPA.

- **Final Selection:** Makes the final decision on which TPA to select, taking into consideration the recommendations from the broker/consultant and the results of the evaluation process.
- **Contract Negotiation:** Once a TPA is selected, involved in negotiating the contract terms, ensuring that the agreement aligns with the company's objectives and budget.

A broker/consultant serves as an expert advisor to the plan sponsor throughout the procurement process. Their roles and responsibilities include:

- **Needs Assessment:** Works with the plan sponsor to assess the specific needs of the health plan, considering factors such as the size of the employee population, geographic location, and desired plan features.
- **RFP Development and Management:** Assists the plan sponsor in drafting the RFP, ensuring that it clearly communicates the plan sponsor's requirements and expectations. They also manage the distribution of the RFP to qualified TPAs.
- **Market Analysis and TPA Identification:** Conducts a market analysis to identify TPAs that are best suited to meet the plan sponsor's needs. This includes researching TPA capabilities, experience, and reputation in the industry.
- **Proposal Review and Analysis:** Once proposals are received, reviews and compares them, providing the plan sponsor with a detailed analysis of each TPA's strengths, weaknesses, and alignment with the employer's objectives.
- **Facilitating Interviews and Presentations:** Arranges and facilitates meetings or presentations with shortlisted TPAs, allowing the plan sponsor to ask questions and gain a better understanding of each TPA's offerings.
- **Recommendation:** Based on their analysis and expertise, provides a recommendation to the plan sponsor, advising on which TPA(s) would be the best fit for the plan sponsor's needs.
- **Support in Contract Negotiation:** The broker/consultant often assists in the negotiation of contract terms between the plan sponsor and the selected TPA, ensuring that the terms are favorable and protect the plan sponsor's interests.

The TPA's role is primarily to present their services and demonstrate how they can meet the plan sponsor's needs. Their responsibilities include:

- **Responding to the RFP:** Prepares a comprehensive response to the RFP, detailing their service offerings, capabilities, and how they plan to meet the specific requirements outlined by the plan sponsor. This includes providing information on pricing, network access, customer service, reporting, and compliance.

- Showcasing Expertise: Must effectively communicate their experience and expertise in managing self-funded plans, particularly in areas that are important to the plan sponsor, such as cost containment, claims processing, and regulatory compliance.
- Providing References and Case Studies: To build credibility, may provide references from other clients or case studies that demonstrate their success in managing similar plans.
- Conducting Presentations: If shortlisted, may be invited to present their proposal to the plan sponsor and the broker/consultant. This presentation is an opportunity to clarify any points from the RFP response, answer questions, and showcase their customer service approach.
- Negotiating Terms: Once selected, the TPA participates in contract negotiations, ensuring that the terms are mutually agreeable and clearly define the scope of services, fees, and performance expectations.
- Implementation Planning: After the contract is signed, the TPA may begin collaborating with the sponsor and broker/consultant on the implementation plan, ensuring a smooth transition and setup of the health plan.

8.4. Regulatory Landscape

8.4.1. ERISA and Fiduciary Responsibilities

Implementing a group health plan is a significant decision for employers, offering benefits to both the employees who join the plan and their dependents, as well as to the employer itself. However, the administration of such a plan and the management of its assets necessitate adherence to specific obligations and the performance of certain duties.

Employers are obligated to be acquainted with certain fundamental regulations, particularly the Employee Retirement Income Security Act (ERISA), which outlines the standards of behavior for those who oversee employee benefit plans and their assets, known as fiduciaries. An ERISA-regulated group health plan is one that provides coverage for medical care, including services such as hospital stays, sickness, prescription medications, vision, and dental care. This coverage can be offered through a trust fund, by purchasing insurance, or by directly funding benefits from the employer's general assets. A guide titled *Understanding Your Fiduciary Responsibilities Under A Group Health Plan* provides a concise overview of the fundamental fiduciary duties applicable to group health plans under the law (see Resources).

The guidance is aimed at private-sector group health plans, as ERISA does not apply to public sector or church-sponsored plans. It offers a simplified breakdown of the law and its regulations, without serving as a legal interpretation of ERISA or a substitute for professional health benefits advice. It also excludes discussion on Federal tax or state insurance laws that might impact group health plans.

Key components of a plan include:

- A written document that outlines the benefits and operational procedures;
- A trust for holding the plan's assets;
- A system for keeping records of contributions, benefits, and participant information, and for preparing required reports;
- Necessary documentation to inform employees participating in the plan and the government.

It's common for employers to engage external experts or utilize internal resources, such as an HR department or a committee, to manage the day-to-day operations of a plan. Those with discretionary authority over the plan are considered fiduciaries.

Fiduciary status is determined by the functions performed for the plan, not merely by one's job title. This includes discretion in plan administration and management, or control over the plan's assets. Plan fiduciaries may include administrators, trustees, investment managers, and any individual or committee members making administrative decisions.

Decisions such as establishing, amending, or terminating a plan are considered business decisions of the employer, not fiduciary actions governed by ERISA. However, implementing these decisions on behalf of the plan may confer fiduciary status.

Being a fiduciary carries significant responsibilities and standards of conduct, as fiduciaries act on behalf of participants and their beneficiaries. These duties include acting solely in the interest of participants and beneficiaries, executing duties prudently, adhering to the plan documents (as long as they are consistent with ERISA), ensuring assets are held in trust, and ensuring reasonable plan expenses.

Fiduciaries must demonstrate prudence in their decisions, which might involve hiring professionals for expertise in certain areas. Regular documentation of decisions and their bases is crucial for demonstrating due diligence and prudence.

Liability is a concern for fiduciaries, who may be held personally accountable for any losses to the plan or improper gains from the plan's assets due to their actions. However, fiduciaries can mitigate their liability through documented procedures and by ensuring they engage service providers wisely, transferring certain liabilities to them while retaining responsibility for their selection and oversight.

Monitoring service providers is essential to ensure they fulfill their obligations, including reviewing performance, understanding fee structures, and ensuring they carry out the agreed-upon services effectively. Regularly revisiting and assessing the service providers' performance is necessary for maintaining the integrity and efficiency of the plan.

In summary, the role of an employer as a fiduciary under a group health plan is multifaceted, involving the careful selection and monitoring of service providers, adherence to ERISA standards, and the prudent management of plan operations and assets. This underscores the importance of understanding and fulfilling fiduciary responsibilities to ensure the well-being of plan participants and their beneficiaries.

8.4.2. Gag Clause Prohibition and CAA

Compliance Guide: Gag Clause Prohibition Compliance Attestation (GCPCA)

The Consolidated Appropriations Act, 2021 (CAA 2021), in its Section 201, introduced new transparency mandates aimed at eliminating gag clauses in contracts between health plans, issuers, and various healthcare entities. These clauses historically restricted the disclosure of critical cost and quality of care information, preventing . Effective from December 20, 2020, this section not only prohibits such restrictive clauses but also mandates that health plans and issuers annually attest to their compliance with this prohibition through the Gag Clause Prohibition Compliance Attestation (GCPCA) to the Secretaries of the Departments of Treasury, Labor, and Health and Human Services.

The Departments have stated that, at this time, no specific regulations will be formulated to enforce this prohibition and they expect plans and issuers to interpret and comply with the statute in good faith. Additional resources, including FAQs, a User Manual, and templates, have been provided to facilitate the submission of GPCAs, accessible through the CMS website, all of which are accessible in the

Compliance Guide: Gag Clause Prohibition Compliance Attestation (GCPCA)

The GCPCA requirements are applicable to health insurance issuers providing individual and group coverage, as well as fully insured and self-insured group health plans, encompassing ERISA plans, non-federal governmental plans, and church plans. Exemptions are made for plans offering only excepted benefits, short-term insurances, Medicare and Medicaid plans, CHIP, TRICARE, the Indian Health Service program, and Basic Health Program plans.

The prohibition targets any contractual terms that restrict the sharing of provider-specific cost or quality of care information, electronic access to de-identified claims, and encounter data in compliance with HIPAA, GINA, and the ADA, as well as the sharing of such information with HIPAA business associates.

For the attestation, detailed information regarding the attester and the reporting entity must be provided, alongside an affirmation of the authority to attest, compliance with the gag clause prohibition, and the accuracy of the information submitted. This process culminates in an electronic signature and submission via a designated online interface, ensuring that plans and issuers formally acknowledge their adherence to these new transparency and compliance standards.

8.4.3. Federal and State Regulations

The contracts ASO/ASA Contracting process must be informed by the multifaceted regulatory environment that includes both federal mandates and state-specific laws. Understanding these regulations is crucial for compliance and for providing effective administration of health plans. This section of the TPA Field Guide outlines the essential considerations regarding state and federal regulations that TPAs must adhere to.

Federal Regulations

At the federal level, TPAs are primarily governed by the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act (ACA), and the Consolidated Appropriations Act (CAA), among others. These laws set forth the standards for health plan administration, including benefits management, privacy protections, transparency requirements, and fiduciary responsibilities.

- ERISA: Sets standards for private health and pension plans to protect individuals in these plans.
- HIPAA: Protects the privacy and security of certain health information.
- ACA: Establishes requirements for health insurance providers and plans, including TPAs, in areas such as coverage standards and reporting.
- CAA: Introduces transparency in coverage rules and prohibits gag clauses in contracts between health plans or issuers and TPAs.

State Regulations

State regulations can vary significantly and may impose additional requirements on TPAs beyond those mandated federally. State insurance departments often regulate TPAs to ensure they comply with state-specific insurance laws, consumer protection standards, and licensure requirements.

- Licensure: Most states require TPAs to obtain a license to operate. The licensing process typically involves submitting an application, paying fees, and demonstrating compliance with state-specific requirements.
- Consumer Protection: States may have laws aimed at protecting consumers from unfair practices, requiring TPAs to adhere to specific standards in claims processing, appeals, and communications.
- Financial Standards: Some states impose financial solvency requirements on TPAs to ensure they have the resources necessary to fulfill their obligations.

Navigating the regulatory environment for TPAs requires a thorough understanding of both federal and state laws. By staying informed about these regulations and developing a proactive compliance strategy, group health plans that contract with TPAs can mitigate risks and ensure that their vendor partners are able to provide high-quality, compliant services to the plan.













9. Conclusion


An effective procurement strategy for a self-funded employer health plan hinges on a clear understanding of the health plan's goals and the systematic execution of procurement activities. By integrating thorough benchmarking and market analysis, leveraging RFIs and RFQs, and utilizing competitive and multi-step bidding processes, employers and brokers can navigate the complex vendor landscape and select the most suitable partners. Strong negotiation techniques further ensure that TPAs provide the best possible combination of cost-effectiveness, service quality, and compliance support, aligning with the employer's long-term health plan objectives. An established data strategy ensures that data is leveraged effectively to guide the procurement process, improve vendor selection, and achieve the desired outcomes for the project. A well-structured ASO contract fosters transparency, efficiency, and cost-effectiveness in benefit administration.

Ultimately, the procurement process should be viewed as a collaborative effort between the employer, broker, and TPA, aimed at achieving sustained cost savings, improved member experiences, and robust regulatory compliance. By clearly defining expectations, establishing performance benchmarks, and fostering transparency, the procurement process becomes a powerful tool for optimizing self-funded health plans and driving value for both employers and their employees.

10. Supporting Resources

11. Resources Matrix

Name	Type	Description
 Nautilus Model ASO/AS...	Template Contract	Sample ASO/ASA contract
 Nautilus Open Source B...	Template Resource	ASA Key Issues Review Checklist to simplify reviewing administrative services agreements
 Nautilus Model ASA/AS...	Template Resource	Model contract clauses for key issues to include when redlining contracts from other organizations.
 Template Request for Q...	Template Resource	Resource to define and communicate RFQ request
 Request for Proposal (R...	Template Resource	Resource to define and communicate RFP request
 Nautilus TPA RFP Quest...	Template Resource	RFP questions list
 Compliance Guide: Ga...	Guide	Resource about the Gag Clause
 CAA White Paper Qualit...	Resource	Resource that provides a concise overview of the fundamental fiduciary duties applicable to group health plans under the law
 Funded Plan Sponsor C... and  Plan Sponsor Carrier Da...	Template Resource	Data Demand Letters for fully-insured groups and self-funded groups
 DATA SAFEGUARDING...	Template	Model Data Agreement
 Template Procurement ...	Template	Template notices for kicking off the Procurement process

 Key Requirements and ...	Template	Resource for collecting the answers to some foundational questions to help clarify the employer’s priorities, needs, and long-term objectives
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11.1. Glossary of Terms

This portion of the field guide is a work in progress. If you are interested in contributing to this or any other section, please contact the Nautilus team at contact@nautilushealth.org.

This glossary provides a foundational understanding of common terms related to self-funded employer health plans, which can help employers, TPAs, brokers, and employees navigate plan management and administration.

- **Administrative Services Agreement (ASA):** An Administrative Services Agreement (ASA) with a third-party administrator (TPA) is a professional services contract in which an organization, association or union pays a third party to perform administrative services.
- **Administrative Services Only (ASO):** A service arrangement where a third-party administrator (TPA) or insurance carrier provides administrative services (such as claims processing and record keeping) for a self-funded health plan, without assuming any of the financial risks of paying claims.
- **Aggregate Stop-Loss Insurance:** A type of stop-loss insurance that protects the employer from total claims costs exceeding a certain threshold for the entire employee group. It caps the employer's financial liability by covering claims that surpass the predetermined aggregate limit.
- **Attachment Point:** The predetermined dollar amount at which stop-loss insurance coverage begins. For specific stop-loss, this refers to the dollar amount of claims incurred by an individual, and for aggregate stop-loss, it refers to the total claims amount for the group.
- **Benefits Design:** The structure and components of the health plan, including what services are covered, cost-sharing arrangements (deductibles, co-pays, coinsurance), and limits on benefits (e.g., coverage maximums or exclusions).
- **Capitation:** A payment arrangement in which a provider is paid a fixed amount per member per month, regardless of the actual services provided. This is typically seen in fully insured models rather than self-funded plans but may influence vendor contracts.
- **Claims Adjudication:** The process of reviewing and processing a medical claim by a TPA or insurer to determine payment based on the terms of the plan, coverage limits, and any applicable deductibles or cost-sharing provisions.
- **Claims Runout (Run-Out Claims):** Claims that are incurred during the coverage period but submitted for payment after the plan year has ended. In self-funded plans, run-out

claims are covered depending on the stop-loss contract terms (e.g., 12/15 or 12/18 contract types).

- **Coinsurance:** The percentage of healthcare costs that an employee must pay after the deductible has been met. For example, a plan may have an 80/20 coinsurance split, where the employer pays 80% of the covered expenses, and the employee pays 20%.
- **Cost Containment:** Strategies or measures taken to control or reduce the costs associated with a self-funded health plan. Examples include utilization reviews, provider network agreements, formulary management for prescription drugs, and wellness programs.
- **Deductible:** The amount an employee must pay out-of-pocket for covered healthcare services before the health plan begins to pay. Deductibles apply annually and vary by plan design.
- **Dependent Eligibility Audit:** An audit conducted to ensure that only eligible dependents (spouses, children) are covered under the health plan, which helps reduce unnecessary claims costs by removing ineligible participants.
- **Discounted Fee-for-Service:** A provider reimbursement arrangement in which providers agree to accept discounted payment rates for services rendered to plan members, negotiated by the health plan or TPA to control costs.
- **Employee:** for ease of reference this field guide refers to employees although they may actually be members or have other classifications within the health plan. This is often referred to as “EEs”.
- **Employee Assistance Program (EAP):** A voluntary program that offers free and confidential services to help employees resolve personal or work-related problems, which may include counseling, mental health support, or substance abuse services. While not directly part of the medical plan, EAPs are often included in benefits offerings.
- **Employer Contribution:** The amount the employer pays toward the total cost of the health plan, which often includes contributions to premium equivalents, administrative fees, and stop-loss premiums.
- **Formulary:** A list of prescription drugs that are covered by the health plan, usually organized into tiers based on cost and effectiveness. A formulary helps manage prescription drug costs by promoting the use of generics and preferred brand-name drugs.
- **Health Reimbursement Arrangement (HRA):** An employer-funded account that reimburses employees for qualified medical expenses. HRAs are often paired with high-deductible health plans (HDHPs) to help employees cover out-of-pocket costs.
- **Health Savings Account (HSA):** A tax-advantaged savings account that employees can use to pay for qualified medical expenses. HSAs are paired with HDHPs and are funded by the employee, employer, or both.
- **High-Deductible Health Plan (HDHP):** A health insurance plan with a higher deductible and lower premium costs. HDHPs are often paired with HSAs, incentivizing employees to make more cost-conscious healthcare decisions.
- **Incurred But Not Reported (IBNR) Claims:** Claims for healthcare services that have been provided but not yet submitted to the health plan for reimbursement. IBNR claims are factored into financial reserves in self-funded plans.
- **Maximum Out-of-Pocket (MOOP):** The maximum amount an employee must pay for covered healthcare services in a plan year. After the MOOP is reached, the plan covers 100% of additional covered expenses.

- **Pharmacy Benefit Manager (PBM):** A third-party administrator that manages prescription drug benefits on behalf of the health plan. PBMs negotiate prices with drug manufacturers, manage formularies, and process pharmacy claims.
- **Preferred Provider Organization (PPO):** A type of health plan where members pay lower costs when they use providers in the plan's network. Members can also use out-of-network providers but will incur higher costs. PPOs are commonly used in self-funded plans for flexibility and cost control.
- **Premium Equivalent:** The amount an employer budgets per employee for self-funded health plan costs, including claims, administrative expenses, and stop-loss premiums. It functions similarly to a premium in fully insured plans but reflects actual costs.
- **Referenced Based Pricing (RBP):** RBP is based on the idea that a plan's pricing should be based on an objective value for medical services, rather than the average charge of providers in a geographic area. The plan uses a metric, such as Medicare rates, to determine the allowable amount for medical claims.
- **Request for Proposal (RFP):** a document that solicits proposals, often made through a bidding process, by an agency or company interested in procurement of a commodity, service, or valuable asset, to potential suppliers to submit business proposals.
- **Request for Information (RFI):** a standard business process whose purpose is to collect written information about the capabilities of various suppliers. Normally it follows a format that can be used for comparative purposes.
- **Request for Quote (RFQ):** sometimes also known as an invitation for bid (IFB), is a document that asks suppliers to provide price quotes for the chance to fulfill a task or project. Some companies send RFQs as standalone requests, or as part of the request for proposal (RFP) process.
- **Self-Funded (Self-Insured) Plan:** A health plan in which the employer assumes the financial risk of providing healthcare benefits to employees. The employer pays claims directly, often using a TPA to handle day-to-day administration. The employer typically purchases stop-loss insurance to limit liability.
- **Sponsor:** The sponsor of a self-funded employer health plan is the organization that establishes and maintains the plan, and is typically responsible for paying claims. For the purposes of this field guide, for ease of reference, the sponsor will be identified as the 'employer' although it can mean employer, association, union or other organization.
- **Stop-Loss Insurance:** Insurance purchased by self-funded employers to protect against catastrophic claims. Specific stop-loss covers claims that exceed a certain threshold for individual members, while aggregate stop-loss covers total group claims that exceed a certain limit.
- **Summary Plan Description (SPD):** A document that outlines the health plan's benefits, eligibility rules, cost-sharing structures, and other essential details. The SPD is a legal requirement under ERISA (Employee Retirement Income Security Act) for most employer-sponsored plans.
- **Third-Party Administrator (TPA):** An external organization that handles the administrative functions of a self-funded health plan. TPAs are responsible for processing claims, managing provider networks, and ensuring compliance with federal and state regulations.
- **Utilization Review:** The process of evaluating the appropriateness, necessity, and efficiency of healthcare services provided to members. Utilization review can help control

costs by ensuring that only medically necessary services are approved and covered by the plan.

- **Wellness Program:** A health promotion program offered by employers to improve employee health and reduce healthcare costs. Wellness programs may include fitness incentives, smoking cessation, stress management, and chronic disease prevention.
- **Variable Costs:** Costs in a self-funded health plan that fluctuate based on the actual claims incurred, unlike fixed costs such as administrative fees. Variable costs include medical, pharmacy, and stop-loss claims.