



Considerations for Comparing Provider Networks

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I. Executive Summary

As healthcare costs continue to rise, the need to save on medical claims also escalates.

Employers today are looking more closely than ever at their health plan options in order to find ways to manage those costs.

The natural inclination, when comparing plan options, is to focus on the discounts offered. Some employers have even gone so far as to create narrow networks that take higher-cost providers out of the equation. But this limited focus is flawed for a number of reasons.

- For one, it's fairly easy for a network to shape a discount story in a way that makes a comparison questionable. It's not unlike comparing brand-name mattresses between two neighboring discounters. The variation of model numbers, mattress colors and other features renders an "apples-to-apples" comparison virtually impossible.
- For another, even if you understand the numbers the discount alone doesn't tell the whole story. In order to maximize savings on medical claims, you need more than just the steepest discounts. You also need a network broad enough to maximize the opportunity to use those discounts. That is, a provider's discounts are only as good as the members' propensity to seek care from that provider. Consider the following example: Network A's discounts are lower by five points, but the number and mix of providers results in a higher "hit rate." The result is a higher savings despite the less competitive discounts offered.

- For another reason, it has long been established that members demand choice. Healthcare is simply too personal a decision. Particularly when it comes to major treatments many members will take the financial hit of going out-of-network – and therefore, so will you – in order to see their provider of choice. Therefore, a cost management strategy that limits provider choice, and/or puts all of its eggs in a single network basket (particularly a narrow one), will always be at risk of costs that aren't covered by that network.
- Finally, medical costs are just too high to focus on cost management alone. Networks also need to focus on cost *avoidance*. Such medical management has historically been attempted through gatekeeper models, as with HMOs, that limit costs by placing restrictions on care delivery. With evidence-based technology a more effective and patient-friendly approach is now possible. Networks have the data at their disposal to help providers catch potential treatment errors or opportunities that can help save medical costs by avoiding them in the first place.

It's not an easy comparison to make, but making the right choice in networks can mean everything for employers as you work to maintain member choice while battling steadily rising healthcare costs. The guidelines in this discussion paper should help you make the best decision based on a fair and complete comparison.

Table 1: Average Discount vs. Hit Rate

| | Network A | Network B |
|-----------------------|------------------|------------------|
| Billed Charges | \$100,000 | \$100,000 |
| In Network (Hit Rate) | \$65,000 | \$50,000 |
| Average Discount | 40% | 45% |
| Network Savings | \$26,000 | \$22,500 |

II. Why Providers Join Networks

In evaluating the potential effectiveness of a network, it's important to understand why providers participate in them to begin with. There are three chief benefits they expect to receive:

- A steady stream of patients directed to them through network listings, directories and telephone referrals. This lowers their marketing costs, therefore justifying the discounts given. This benefit also explains the appeal of narrow networks to the provider. The fewer competitors in the network, the stronger the patient flow and therefore, the greater the discount offered.
- Fast reimbursement for services rendered, made by a financially stable party (e.g., an insurance company instead of an individual). This facilitates cash flow, lowers their risk and also reduces their billing and collection costs.
- Control over the discounts taken. PPO networks offer an open and collaborative means of lowering claims costs but arbitrary methods such as repricing based on "reasonable and customary" charges are also used. Participation in a network guards against these less predictable – and from a provider's perspective, less fair – cost management methods.

III. Determining Network Scope

A network with the deepest discounts and fewer provider relationships may yield lower savings than a broader network with less competitive discounts if members in the former plan are often compelled to seek care outside the network. Said another way, discounts are only as strong as the opportunity a network provides to make use of them. That's why a network comparison must include a close look at the make-up, or scope, of the network.

Scope is determined by size (number of providers and locations), mix (types of providers and availability of sought-after providers), and stability (provider loyalty).

Network Size

When comparing networks based on number of providers it's important to know what you're counting. Sometimes the number of providers may refer to the number of actual providers, and other times it could be the number of provider locations. For instance, if Dr. Smith is a pediatrician with two practice locations, she could be counted once--as Dr. Smith--or twice, as Dr. Smith at her downtown location and Dr. Smith at her suburban office.

The practice of counting by location instead of provider is not intended to mislead. In fact, because a network's value is tied to how many choices members have to utilize in-network providers, the number of locations is usually more indicative of the network's ability to lower medical costs.

The combination of location and specialty can also lead to potential double-counting of providers. If Dr. Smith is a pediatrician and a primary care provider she could very well be tallied four times: at two locations in the primary care provider category, and at two locations in the specialist category. Again, the practice of counting Dr. Smith four times gives a more accurate representation of the choices available to plan members.

Bottom line: networks you are comparing can give you information by either location or headcount. Make sure you use the same method for each network you compare on the basis of size.

Network Mix

Medical networks typically group providers into four types:

- Hospitals
- Ancillary care facilities (e.g., labs, surgery centers, home health agencies)
- Primary Care Providers
- Specialists

In order to offer sufficient choice to keep members within the network, it's important that there be a high number of providers in each category. Here again, comparisons can be hampered by the definitions used. For example, one network may count a rehabilitation hospital or a mental health facility as a hospital and another may limit this category to acute-care facilities only. The specialist category may include physicians as well as "mid-level" – or non-physician – providers such as licensed social workers, registered nurses and counselors.

Provider mix should also factor in the specific "marquee" facilities in the region(s) to be covered.

Network Stability

A final consideration regarding network scope is the stability of the network. PPO networks are created through contractual relationships between the healthcare providers and the owner of the network. When these contracts are directly held, the network owner has more control over the relationship and can therefore take a more active role in ensuring the provider receives the value expected—and remains a loyal participant.

Sometimes a network needs to lease access from another network in order to fill gaps in its coverage. These arrangements should be completely transparent to you and your members; however, your network can't fully control the way in which those providers are reimbursed or serviced so it's a good idea to understand the extent to which the network's providers are available through direct versus leased arrangements.

IV. Understanding Discounts

It's very important, when comparing networks based on their discounts, to fully understand the information provided. Networks express financial savings in terms of averages. If a client's claims totaled \$1,000,000 but were discounted to \$550,000, the average discount would be 45%:

$$\$450,000 \text{ saved} \div \$1,000,000 \text{ originally billed}$$

This average savings analysis is fine, when it is made in retrospect against actual claims. But networks can apply a number of different definitions and assumptions in estimating financial savings, so when evaluating a network in advance it's important to understand what numbers make up the numerator and denominator in the equation.

The Numerator: Amount Saved

The amount saved is, simply, the original billed charges multiplied by an average discount. However, discounts often vary based on factors such as type of network and geographic location, so in evaluating stated average discounts make sure they reflect your specific membership. Ask yourself the following questions:

1. **Do the quoted discounts apply to the network you will access?** Sometimes a network will post its most favorable discounts (e.g., from its HMO product) when these aren't available to you unless the HMO level of benefit is taken.
2. **Do the quoted discounts apply for a like area?** Typically, providers in rural areas with lower patient traffic tend to discount less than those in major metropolitan areas. If a network publishes averages based only on the largest cities in your region, the savings you realize could be considerably lower than expected unless members go to those "big city" providers.

3. **Do the quoted discounts apply for the services indicated?** Discounts will vary by type of provider. At a minimum, you should request discount averages for hospital inpatient services, hospital outpatient services, ancillary facility services, and practitioners (physicians and other specialists).

4. **Are the discounts quoted on a net or gross basis?** Some networks retain part of the discount, so make sure the discounts quoted are those that are being made available to you.

5. **What frequency is reflected in the discounts?** If a network states its most favorable discounts without regard to frequency, potential savings can be overstated. For example, if procedure “A” has a discount of 60% and procedure “B” has a discount of 20%, you may be quoted a discount of 40% as an average of the two rates. But if procedure “A” is performed once in every 1,000 patients and procedure “B” occurs for every one in two, the actual savings realized would be closer to 20%. Similarly, if a network’s most favorable fixed fee schedule is cited but that schedule is only in place at a fraction of the network’s locations, potential savings can be overstated.

6. **Do the quoted discounts apply to the entire claim?** Sometimes a discount changes after a certain cost threshold, length of hospital stay, or other cost factor. Usually when such “stop loss” levels are reached the lower discount is taken on the entire claim, and not just the amount exceeding the threshold. Therefore, the actual savings can be dramatically lower than the quoted discount would imply, as shown in Table 2.

Table 2: Average Discount vs. Stop Loss

| | Network A | Network B |
|---------------------|-----------|-----------|
| Charges Submitted | \$100,000 | \$100,000 |
| Stop Loss Threshold | \$50,000 | \$0 |
| Average Discount | 50%/20% | 30% |
| Quoted Savings | \$50,000 | \$30,000 |
| Actual Savings | \$20,000 | \$30,000 |

The Denominator: Billed Charges

It would seem that this figure is not in question. The charges billed are, simply, the charges billed. But if ineligible charges, employee deductibles or other costs are removed before calculating the discount, the denominator is reduced and the resulting savings is higher than if those charges were not factored into the analysis. As Table 3 shows, even with the same original charges and net amounts paid, the calculated savings can be different based on how original billed charges are manipulated.

Table 3: Average Discount vs. Billed Charges

| | Network A | Network B |
|------------------------------------|-------------|-------------|
| Original Billed Charges | \$1,000,000 | \$1,000,000 |
| Ineligible Charges | \$200,000 | \$0 |
| Billed Charges Basis (Denominator) | \$800,000 | \$1,000,000 |
| Net Amount Paid | \$400,000 | \$400,000 |
| Calculated Avg Savings | 50% | 40% |

Bottom line: in addition to clarifying the numerator by asking the questions above, understand the definition of billed charges that are used to calculate savings averages.

Discount Stability Over Time

The discount arrangements that networks make with providers can take a number of forms. One particularly common structure is percentage off charges (e.g., a 25% discount off the provider’s “retail” rates. Of course, retail rates can change at any time. A 25% discount on procedure “A” may have been established when that procedure’s cost was \$100, lowering the claim to \$75 and establishing an expectation of \$75 for that treatment.

When the cost of that procedure increases to, say, \$150 the discounted amount also rises by the same percentage. At a minimum, predictability of future costs is impeded.

Even though they are a type of “percentage off” discount, networks that use fee schedules that link percentages to specific procedures are less vulnerable to the changes that can occur in retail rates. Typically, these schedules are pegged to geographically-adjusted rates that the Federal government establishes for Medicare reimbursement and therefore have a built-in mechanism to allow for market factors and inflation.

Other fee schedule arrangements include per-diems and case rates. These are generally limited to hospital inpatient charges, and afford a greater degree of predictability because there is more control over the basis on which the charges are made. With per-diems, the charge will be, for example, \$500 per day regardless of services rendered. With case rates, the charge will be, for example, \$150,000 per treatment regardless of the specific services rendered.

Regardless of the discount mechanism in place, contract language should include contractual language that limits a provider’s charge master “creep” to the Consumer Price Index or other inflationary measure.

Bottom line: make sure you understand the mix of financial arrangements the network has with its providers, and the mechanisms in place to guard against cost increases.

V. Going Beyond the Network

If you subscribe to the concept of a narrow network with deeper discounts, you and your members are particularly vulnerable to out-of-network costs. But even the broadest primary PPOs generate these types of charges. In addition, PPO networks generate health care

savings retrospectively; that is, on claims that have already been incurred. But there are dramatic additional savings to be had if the network also helps to avoid medical costs from being incurred in the first place.

Managing Non-Contracted Claims Costs

It’s unavoidable. Members may need care while traveling, living outside the covered area, or may simply prefer to see a provider not in the primary network. Often these costs are substantial, involving the need for emergent care that simply can’t be put off until the member is back in the local coverage area.

Cost management strategies should include mechanisms to reduce these costs that fall outside the primary network. Of course, arbitrary “reasonable and customary” repricing can help. The problem with this approach is that it offers no protection for the member, who often ends up paying the difference between what the provider charged and the amount the payer covered. Providers feel such “balance billing” is justified since they had no say in the final amount paid.

There are two other options that lower claim costs while giving the provider more control over reimbursement. One of these is a **secondary or “wrap around” network**. As the name implies this is another network – usually national in scope -- that is used when claims fall outside the primary coverage area. It effectively expands discount arrangements beyond a geographic location or specific set of providers.

Wrap networks can be used to cover employees that reside outside the core service area, or to protect against costs incurred while those members travel. In these cases, the wrap networks are extensions of the primary PPO. The member pays in-network co-pays and/or co-insurance and the provider is reimbursed accordingly.

Wrap networks can also be used to give members choices outside the primary network

that still offer some level of savings. When used in this way, the member may pay out-of-network benefits but their out-of-pocket costs – and yours -- are reduced by the contracted discount. Providers still receive the benefits of patient flow, reimbursement facilitation and control over discounts taken.

The second option is **fee negotiation**. When a claim can't be reduced through network discounting specific outreach to negotiate savings can result in significant savings. Providers will often agree to reduce the charges in exchange for guaranteed fast reimbursement by the insurer or other payer on a specific claim because it eliminates the cost and risk of collecting from the individual. Such negotiated settlements also typically protect the patient from being billed the difference between the original and negotiated amounts, so result in less member dissatisfaction than the “reasonable and customary” alternative.

Primary PPO access and discounts being equal, the difference between a plan that addresses non-contracted costs and one that doesn't can be substantial, as shown in Table 4:

Table 4: Avg Discounts vs. Non-Contracted Costs

| | Network A | Network B |
|-------------------------------------|------------------|------------------|
| Billed Charges Submitted | \$1,000,000 | \$1,000,000 |
| Claims In Primary PPO | \$700,000 | \$700,000 |
| Primary PPO Savings (45% discount) | \$315,000 | \$315,000 |
| Claims in Wrap Network | \$200,000 | \$0 |
| Wrap Network Savings (40% discount) | \$80,000 | \$0 |
| Claims Eligible to Negotiate | \$75,000 | \$0 |
| Negotiated Savings (20% average) | \$15,000 | \$0 |
| Total Saved | \$410,000 | \$315,000 |
| Total Overall Discount | 41% | 31.5% |

Bottom line: understand your exposure to claims costs not covered by the primary PPO, and put strategies in place to cover all bases.

Managing Costs by Avoiding Them

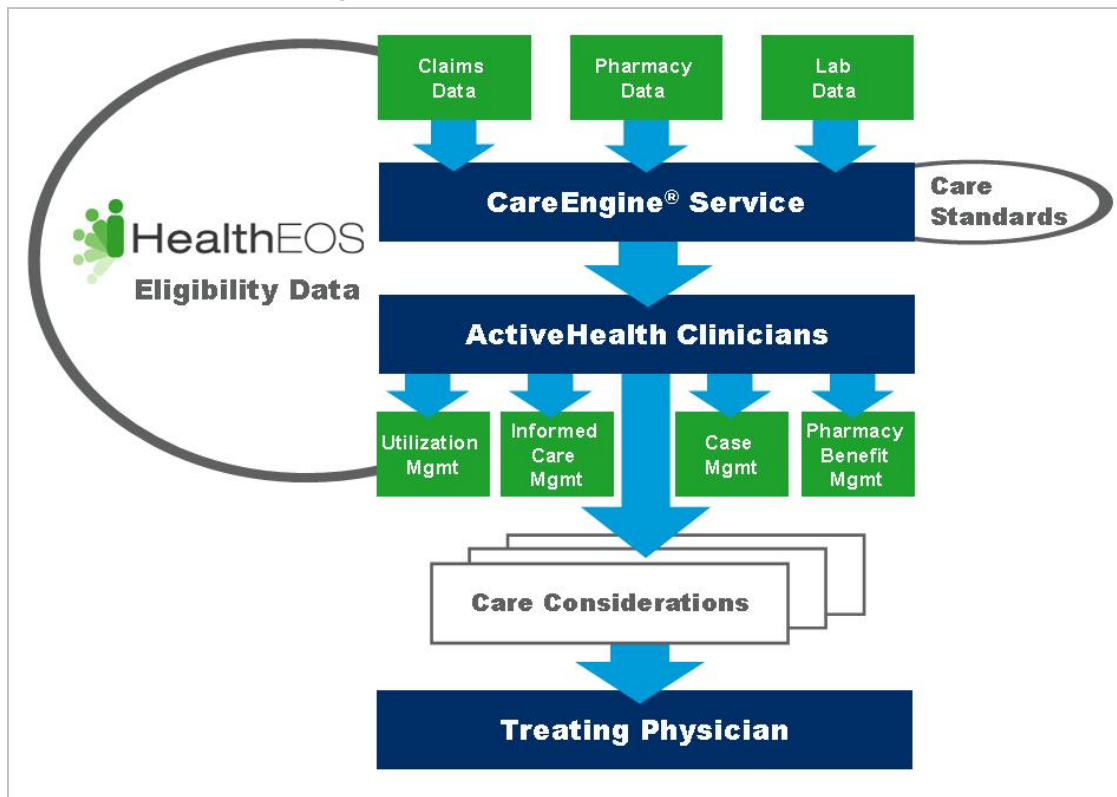
Medical management programs such as HMO gatekeeper models, utilization review, pre-authorization and case management services that have been used for many years have largely fallen out of favor because of their unpopular restrictions, burdensome administration and inability to show empirical evidence of savings.

With evidence-based technology a more effective and patient-friendly approach is now possible. Networks have the data at their disposal to help providers catch potential treatment errors or opportunities that can save medical costs by avoiding them in the first place, not because policies require them to refuse services but because the services have been deemed unnecessary or even inappropriate.

For example, through their participation in the HealthEOS by MultiPlan® network, providers receive access to the CareEngine® Service, an evidence-based technology that collects and analyzes claim and clinical data to detect and warn against errors and omissions in care.

As shown in Figure 1, HealthEOS by MultiPlan feeds the data to CareEngine daily, which are then compared to thousands of care considerations. When potential errors or opportunities to improve care are uncovered, treating physicians are contacted by clinicians, given evidence and considerations for treatment, and then have the option to proceed as planned or alter the protocol.

Figure 1: Evidence-Based CareEngine® Service



The potential savings through the use of such cost avoidance programs are significant. A Case Western Reserve Study, peer-reviewed by the University of Michigan in 2005, has shown the potential for savings on medical claim costs alone, before factoring in the indirect costs of productivity loss, disability, etc., to be over \$10.00 per employee per month.

VI. Conclusion

Health plans use networks in order to lower the cost of medical claims. These cost reductions are achieved through discounts that providers agree to give in exchange for participation in the network. It seems reasonable, then, to make a network decision based on the level of discounts offered.

But a discount-based comparison isn't enough. Employers also need to consider:

- How many of what types of providers are in the network. After all, an 80% discount from a provider that never gets seen by a patient yields a savings of \$0.
- How stable and controllable the provider relationships are. If a member's provider leaves the network, chances are the member – and therefore the plan -- will incur out-of-network costs in order to maintain that patient-provider relationship.
- How achievable the quoted discounts are given the plan member population, plan type and other factors.
- How stable the discounts remain over time, or how vulnerable they are to healthcare cost inflation.
- What options are provided to help avoid medical costs, and to control costs that aren't covered by the network.