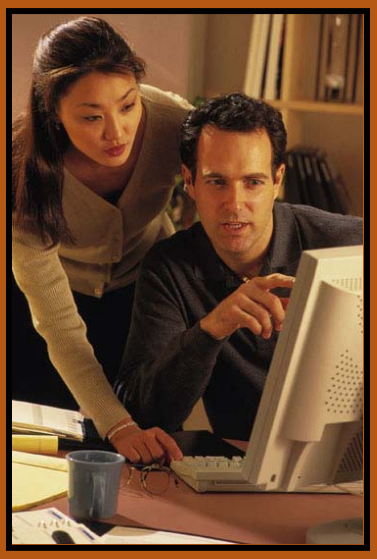
MedCost®

# A Review of Network Evaluation Models



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# Introduction

The cost of providing healthcare benefits to employees continues to soar, with double digit increases projected for the near future. In this climate, health plan decision-making and strategizing are no longer regarded primarily as Human Resources functions. Now CEO/COO/CFO involvement is necessary to ensure cost containment or reduction. Decisions are made based on bottom-line impact. The current environment has intensified the scrutiny of network savings impact to the health plan, with a general market message being delivered to employers that they will save substantially more through a carrier-based network (i.e. BCBS, United, Cigna) compared to an independent or regional network option.

MedCost has participated in network evaluation studies for over 20 years. For the past several years, a growing global market perception has been fostered indicating that an employer cannot get competitive provider rates unless the plan is with one of the large carriers. As described by one employer, "it appears that BCBS and United have become the "Wal-Mart" of healthcare and you have to shop there to get the best rates…." **(This perception is Not True)**. The network gap message presented to employers often conflicts with current MedCost market intelligence. Therefore, MedCost has responded to this growing perception by drilling down on detail components of various network evaluation models in an effort to understand how the "savings gap" is calculated. Over the past two years, we have invested analytical staff and resources in asking questions to consultants and other parties that routinely evaluate network outcomes. The process has been educational and enlightening, confirming that most of the network comparison methodologies are not performed in an "apples-to-apples" manner. Such comparisons, therefore, can produce a distorted view of what an employer will gain by moving to another network.

Since inception, MedCost has operated with the business philosophy of putting the customer's interest foremost. We understand in this economic climate that employers have to make hard decisions to protect the financial health of their businesses. Moving to one of the dominant carrier-based health plan options typically costs an employer more in fixed costs and can result in less flexibility and customer service support. For this reason we feel impassioned about the responsibility to actually deliver to an employer the increased network savings level presented through a network evaluation, since the buying decision is strongly weighted on these promises.

The purpose of this report is to outline the key factors that can render current network evaluation processes flawed and inaccurate. This report will also discuss the various components that should be considered to evaluate true plan bottom-line impact.

# Flaws In Current Network Evaluation Models

The key network evaluation flaws identified by MedCost in our review of methodologies are:

- Based on historical, not current, information
- "Apples-to-oranges" comparisons--inconsistent data and savings definitions are used
- Variations in CPT level analyses
- How data is arrayed into final outcomes report

## Flaw #1: Based on Historical Data

The purpose of a network evaluation should be to present information to an employer that allows a forward-looking buying decision and reveals the financial impact of that decision. This uncovers one of the biggest flaws in the current network evaluation process: network evaluation models are based on historical data (usually 12-36 months). They use a retrospective review of network pricing, factoring those savings levels onto future cost projections for the employer. A network evaluation based on retrospective information, with no adjustments made for significant contract or rate changes, becomes irrelevant and is not a valid indicator of what an employer will actually save by moving to another network. (When consumers prepare to buy a new big screen TV, do they make their buying decision by looking at the price for each TV from 2 years ago? Of course not!)

The managed care contracting environment has undergone tremendous change over the past 2-3 years. Providers, responding to their own financial pressures, have leveraged their clout in contract renewals demanding more reasonable reimbursement levels, especially from large carriers. Many deep discount levels attached to multi-year contracts or exclusive arrangements have been reduced, yet carriers may report those deep discounts in their historical data used for network evaluations for up to another 2 or 3 years. As providers have adjusted discount levels in contracts and continue to make changes to "level the playing field," the reporting of these outdated savings levels can be reasonably considered a form of "false advertising." Some hospitals are beginning to question whether carriers are using unfair trade practices to grow their market share and influence the perception of their contracting leverage.

The use and analysis of historical data has many meaningful purposes in the healthcare industry. However, for the purpose of a network evaluation to determine health plan financial impact, it is necessary to make best efforts to present network comparison outcomes in a manner that is as valid an indicator as possible on the level of savings that will be actually delivered by the network. MedCost stresses two components that we believe are critical to achieving this objective:

1. Data used for the network evaluation should be based on the past six months of network savings data for all networks being evaluated;

2. Each network should have to provide a summary of any significant changes in aggregate level savings for any key provider/geographic area used by the employer during the past year or for the defined timeframe the dataset is based on. Networks should also be willing to sign an attestation statement that they are presenting to the best of their knowledge the level of savings based on current and in-force contracts.

## Flaw #2: "Apples-to-Oranges"

If all the networks providing information for a network evaluation are not using the same baseline data components and savings definitions, then the network evaluation outcomes are not comparable. Varying terminology (billed, covered, eligible, allowed) and calculation definitions can make interpreting reported savings confusing, if not impossible. There are several key factors that can produce "apples-to-oranges" results when comparing networks:

- Data from a claims repricing system versus data from a claims adjudication system. Regional or independent networks produce data reflective only of the network contracted terms, so data submitted will be the actual amount billed by the provider and the actual network contract reimbursement allowed amount. Thus, network savings is purely the difference between the billed and allowed amounts. Data from carrier claim adjudication systems may include other disallowed amounts (COB savings, non-covered expenses, ineligible expenses, patient liability, duplicate claims) into the network savings category. Also, payers use various definitions of "eligible expense," "allowed," and "savings." The result is that carrier-based reported outcomes that include other disallowed expenses can show inflated savings levels compared to an independent network that is reporting pure network information.
- Carrier savings levels can be based on blended savings from all product lines to include special HMO or governmental program pricing results. If a PPO network evaluation is being performed, only PPO product data and savings levels should be included in the data or reported savings levels.
- Some networks will report savings levels based on provider-specific level outcomes while others are reporting savings levels based on market service area averages which may not be reflective of the level of savings in the geographic location where an employer is located. Further, some will provide savings for a geographic area defined at the 3-digit zip code level while others look at the actual 5-digit level.
- Except for the incumbent network that may be providing actual network savings results, networks are submitting self-reported savings information for a network evaluation. Some may submit aggregate savings levels; some may submit the "targeted" fee schedule; and some may submit the lowest allowed amount they have contracted in a specific geographic area.

The impact of this "apples-to-oranges" issue can be significant. Below are examples of the reported savings level impact:

### Impact Example 1

*Cigna's published standard discount definition: "The allowed amount, also known as the covered amount, is the total amount billed by the provider less any non-covered expenses less savings from coding or UM savings. The eligible amount is defined as the allowed amount less the negotiated provider discount."*

| Assumptions | Carrier Definition | MedCost |
|---|---|---|
| Total Claim Billed Amount | $10,000 | $10,000 |
| Network Contracted Rate | $9,000 | $9,000 |
| Non-covered Expenses | $1,000 | (not factored in—payer information) |
| Network Savings Reported | $2,000 (20%) | $1,000 (10%) |

**Impact Example 2**

*ClaimsQuest is a network analysis model performed by Milliman USA on behalf of a Blue Cross Blue Shield Association. The purpose of the ClaimsQuest analysis is to take an employer's claims data and run it through a "claims repricing model" to show the employer what they would gain by using the Blue Cross network vs. the employer's current network. MedCost entered into discussions with Milliman to understand how the model worked and confirmed that actual BCBS network provider contracts are not used in the study. Instead, an average aggregate discount by type of service is applied to detail line items at the 3 digit zip code level, resulting in a high level aggregate savings estimate compared to actual provider level contract rates for the incumbent network. Milliman also confirmed that no adjustments are made to the historical data used in the analysis to reflect changes that may have occurred in significant hospital reimbursement terms. The net impact is that you have overall network outcomes assumptions presented using estimated discounts on a broad data set for BCBS compared to a very limited data set that consists of one employer's provider utilization and savings results. It is clear that the ClaimsQuest analysis is not a true repricing analysis.* ***MedCost took actual employer claims data and applied the Milliman estimated savings methodology to calculate the reported savings level and found up to a 15% variance in reported outcomes.*** *MedCost requested to apply the Milliman methodology to our data before submitting it for a requested ClaimsQuest study and were told they would not allow that -* ***only actual claims data could be submitted and compared against aggregate data.*** *The final Milliman report provided to an employer ends with a long section called* ***"Report Limitations"*** *in which there are multiple disclaimers about the analysis, and specifically states that the repricing results are not a forecast of projected costs for the employer.*

## Flaw # 3: Variations in CPT Level Analyses

A common network evaluation method to assess network physician savings is to ask networks to complete a CPT code questionnaire for specified markets. The questionnaire can ask for the contracted rate for as few as 10 CPT codes and as many as several hundred CPT codes, with the most common questionnaire requesting information for 50 codes. MedCost has reviewed those surveys asking for 10-50 codes and validated that the codes represented on these limited surveys typically represent between 25% and 45% of the total physician dollars for an employer—yet the survey results are used to communicate an overall across-the-board network savings rating or score. Some of the surveys do not ask for information regarding the high dollar surgical type services that are performed frequently and focus only on office services, labs, and radiology services. This narrow view of a network's physician reimbursement terms cannot come close to adequately predicting which network will produce the overall best savings outcomes.

The problems associated with inconsistent data definitions and varying savings levels calculations, as discussed in the previous section, have a tremendous impact on whether a CPT analysis is an effective gauge of physician network performance. A critical consistency issue that has significant impact in the numbers reported for each CPT is the definition of whether the contracted rate is reported at a "blended" or "unblended" level. When a "blended" contracted rate is reported, the network averages all of the allowable amounts for the CPT code regardless of whether a modifier is attached to the code. Reporting of "unblended" contracted rates reports the network allowable using the specific CPT code billed information. Those networks using the "blended" approach will show a lower contracted rate that will imply a higher level of savings—but when compared to a "non-blended" number this would be an inaccurate assumption.

**Impact Example**

| CPT Code 20550 | Blended Approach | Non-Blended Approach |
|---|---|---|
| Billed Charge | $3000 | $3000 |
| Network Contract Rate w/o Modifier | $2000 | $2000 |
| Network Contract Rate w/ Modifier –50 | $1,000 | $1,000 |
| **Contract Rate Reported on CPT Survey** | $1,500 | $2,000 |
| **Savings Level Assumption** | **50%** | **33%** |

Historically, MedCost has reported at a "non-blended" level to show information at the most detailed and accurate level. However, recently a large, reputable actuarial firm advised us that *all the carriers* report at a blended level***. On MedCost aggregate network 2003 data, the savings variance between blended and non-blended reporting is 7%.***

## Flaw # 4: How Data is Arrayed When Reported by the Network

When reporting aggregate level savings, data can be arrayed many ways. Some networks report in a manner that makes the savings level look most attractive versus reporting at the level that is most accurate for predicting costs. Many networks roll their county-level aggregate savings into a metropolitan statistical area (MSA) for reporting purposes, however, not every network may define the MSA the same way. The following table demonstrates three different ways savings could be reported in a network evaluation process:

**Example 1**

| County | Network Aggregate Hospital Savings | Employer Hospital Dollars Billed in the County | Projected Employer Savings Based on Aggregate Savings Level |
|---|---|---|---|
| County A | 40% | $100,000 | $40,000 |
| County B | 5% | $500,000 | $25,000 |
| County C | 10% | $200,000 | $20,000 |
| County D | 20% | $300,000 | $60,000 |
| **Totals** | **(Avg = 18.75%)** | **$1,100,000** | **$145,000 (Avg Savings = 13%)** |

***Different Ways Networks Can Array Hospital Savings When Reporting Network Outcomes:***

**Outcome 1:** A network could define counties A, B, C, D as a market service area and report the average aggregate savings level for each of the counties requested by the questionnaire without factoring in the utilization patterns of the employer. In this case the savings level reported for each county would show as 18.75%.

**Outcome 2:** A network using counties A, B, C, D as a market service area could factor in the employer utilization patterns and show an aggregate savings level of 13% for each of the counties requested.

**Outcome 3:** A network could just report their actual county level aggregate savings to be factored into the financial model, which in this example range from 5% to 40%.

**Example 2:**

To further illustrate the potential impact of different arrays of data in a network evaluation process, MedCost has taken actual data for one year for an existing customer and applied various methodologies and array options. If each of these were presented as different network options, which would you choose for as delivering the best savings outcomes? ***All of the options are MedCost---using the same set of data! Note a 13-point spread in reported network savings! MedCost has seen all of these evaluation methods used over the last year.***

| **Array Options** | A | B | C | D | E | F | G |
|---|---|---|---|---|---|---|---|
| **Aggregate Savings Level** | 28% | 26% | 30% | 29% | 39% | 34% | 32% |

A = Standard blended calculation to include modifiers

B = Standard non-blended calculation that excludes modifiers 50, 51, 80, 81, 82

C = MSA blended calculation; uses average allowed amounts for a defined market and includes modifiers

D = MSA non-blended calculation; uses average allowed amounts excluding modifiers 50, 51, 80, 81, 82

E = Best Rate calculated savings using the best rate available on an ideal fee schedule

F = Applies average market discounts to each procedure code billed; blended to include modifiers

G = Applies average market discounts to each procedure code billed; non-blended excludes modifiers

## Actual Evaluation Case Studies

Summarized below are a few of the real world MedCost examples that demonstrate the distorted or misleading information that can be produced through network evaluations.

- An employer very satisfied with their current plan configuration and the high level of service delivered by their claims administrator determines they will have to move to a carrier option presented to them that shows considerable dollars to be saved through improved network savings. With MedCost's assistance, they drill down on the estimated savings presented to the hospital level. The carrier is showing almost three times the MedCost discount at the hospital where the plan has the most facility expenditures. MedCost, through recent contract renewal discussions, has been told by the hospital that there is not a savings gap. The employer calls the hospital and confirms that they will get the same savings through MedCost as through the carrier. The carrier responds to the inaccurate information by saying they had calculated a regional average savings and reported that for all hospitals that fell in that region.

- MedCost participates in a request for proposal process for a prospective employer that is a health care provider. The physician savings levels for various networks presented to the employer show significant variance, with one carrier reporting savings levels that the provider knows to be inaccurate. When challenged, the carrier says they were reporting "targeted savings" not actual savings.

- Several employers in a specific geographic area are presented ClaimsQuest reports that show that hospital discounts will more than double if the employer moves to the carrier. The dominant, high volume facilities in the geographic area are contacted and all of them dispute the level of savings that have been reported and indicate that the contracts are not anywhere close to that level.

## MedCost Recommendations For a Meaningful Network/Plan Evaluation

- **Ask questions about the data content and definitions:**
  - What is the timeframe of the data to be used (should be no greater than 12 months old)?
  - What type of claims data will be included—PPO only, HMO, government program data?
  - Are there any types of claims that will be excluded by carriers (i.e. outlier claims, behavioral health providers or other network "carve-outs")?
  - What are the data definitions for (every party should be working from a standard set of definitions):
    - Covered charge
    - Eligible charge
    - Disallowed amount
    - Non-covered
    - Billed
    - Allowed
    - Savings
  - Specifically, ask if any other type of data is included in the savings level reported (non-covered services, ineligible amounts, patient portion such as deductibles/co-pay/co-insurance)
  - How will savings levels be presented—at the provider level, county level, 3-digit zip, 5-digit zip, metropolitan statistical area (what defines the MSA)?

- **Ask questions about the financial modeling:**
  - If provider-specific savings levels are not provided, how will the financial modeling be performed?
    - Aggregate savings by type of provider or geographic area (or both)?
    - Utilization patterns factored in (company specific or aggregate utilization patterns)?
    - Will physician savings be evaluated at a CPT level? (Aggregate savings, fee schedule?)
    - Will hospital savings be evaluated at aggregate IP and OP levels, or for specific service types?

- **Ask questions about savings outcome accountability:**
  - What process is used to update the savings levels to reflect significant contract or rate changes to assure savings levels reported are current and useful for actual savings projections?
  - If a major variance in savings levels by network is identified, what steps are taken to validate that the savings gap is accurate and that some error or distortion does not exist?
  - If it sounds too good to be true it is probably not true!
  - Do any discussions occur with high volume providers to validate savings levels reported?

- **What is the total cost of network access? Are there additional percent of savings to be paid on top of a fixed network access fee? This can eliminate true savings impact to the employer.**

- **If a significant savings gap is reported, is it reflected in the stop-loss rates? A savings gap of 10+% should show up in lower quotes from reinsurance carriers as well.**

- **Is a big picture view of financial impact to the plan being considered? It is not all about network discounts:**
  - Fixed administrative fees for claims administration
  - Fixed administrative fees for managed care services
  - Variable administrative fees based on percent of savings or other type arrangements
  - Network savings (best efforts at apples-to-apples)
  - Medical management savings —days of care/1,000; effective case management. (If you switch for 5% additional network savings, but days of care/1,000 are less effective, what is the overall financial impact to the plan?)
  - Reinsurance rates (If the carrier is reporting significantly better network savings, this should be clearly reflected in lower reinsurance rates for the employer.)
  - Reinsurance interface fee?
  - Commissions?
  - Any other cost to the employer?

- **Service impact?**
  - While difficult to factor into a financial model, there is cost associated with the level of service and support an employer receives.
  - How easy is it to reach a customer service representative?
  - How easy is it to get a claims adjustment made or error corrected?
  - Are employees satisfied or frustrated by plan administration?

# Conclusion

MedCost acknowledges that evaluating networks is a complicated exercise and that there is no financial model that allows access to real-time provider level information to produce pure network outcomes for a blend of independent and carrier networks. Our challenge to the industry is to implement some basic components of accountability to the existing network evaluation processes to allow an employer to make health plan decisions based on comparable and current network outcomes.

### MedCost Position on Release of Claims Data for Network Evaluations

To assure that MedCost is represented as fairly and accurately as possible in third party network evaluation analyses, MedCost will release network claims data and authorize affiliated payers to release network claims data under these conditions:

- *MedCost will talk to the third party entity performing the analysis to understand drill down details regarding methodology to be used.*
- *MedCost will participate only with agreement to these contractual conditions:*
  - *Confidentiality terms*
  - *Clearly defined data parameters*
  - *MedCost will adjust data provided to be consistent with methodology of carrier submitted data*
  - *All networks agree to provide current pricing information or a summary of any significant changes to hospital/market pricing to reflect current level of savings delivered.*
  - *MedCost gets a copy of the final comparative report showing how the network compares.*
  - *Third party entity agrees to acknowledge and respond to any disputed savings gap information questioned by MedCost.*

### MedCost Assistance is Available

MedCost's Health Information Unit is available to assist in drilling down on network evaluation methodology and outcomes. Please contact Laura or Alicia to get us involved.

Laura Patterson – 336-774-4373
Alicia Stewart – 336-774-4280

MedCost is also committed to pursuing all credible information that shows a significant savings gap to attempt best efforts to improve contracted rates.

Please send questions about information in this report to lpatterson@medcost.com.