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The Network Discount Shell Game:

How to Compare PPO Network Savings Projections

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You walk into a department store in a shopping mall and find a beautiful outfit that is on sale for 40% off. It is a perfect fit. You decide to buy it and pay $60 for the outfit. On your way out of the mall, you find the exact same outfit on sale for 50% off at a different department store!

Immediately you get mad and feel cheated. But upon closer inspection you notice the original retail price of the outfit at the second store is $140! Suddenly you feel like you got a deal. You saved $10 by purchasing the outfit at the first store, even though the discount percentage was better at the latter store. If only the determination of preferred provider organization (PPO) network plan savings were this easy. Not only is the calculation more challenging, but the dollars in play are vastly larger.

Most people tend to shop around when they buy tangible items because they know retail prices are not always the same. So why do so many employers accept that the expected savings quoted for their PPO medical plan from the available network vendors and/or insurance carriers (hereafter referred to as NetVICs) will be realized? Why do so many employers believe the discount percentage quoted will apply comparably for them? Isn't controlling the dollars that are paid out more important than the percentage of savings realized? There is a difference, but this is not the way the NetVICs market their services. NetVICs tell prospective employers that they will save 5% to 15% or more in reduced claim costs by making a change to them, but at the end of the next year the savings do not materialize. The percentages may have improved but the real dollars paid out are still a higher amount than projected.

The primary problem with the NetVICs analysis is that there is not a standard definition or common methodology utilized for the development of a network savings or network discount percentage. It sounds so simple—the total dollars in discount (realized off billed charges) divided by the billed charges. For example, the doctor bills $100 for a procedure. His contract with the NetVIC says he will be reimbursed $75 (before the application of benefits) for the procedure, so the discount is 25%. This is the "Simple Calculation" (see Table I). To get the total discount or savings percentage for a network, all you have to do is divide the total of all contract reductions from billed charges by the total billed charges for all procedures. Unfortunately, it is not that simple.

Specific NetVICs have their own nuances that they apply to *their* calculation of their network savings percentage. It is not just comparing apples to oranges. It is like trying to compare apples to shoes to hammers. The best way for CFOs, controllers, human re-

(Continued on page 8)

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(Continued on page 22)

source personnel and benefits personnel to navigate this process is to understand the factors that impact the calculation of a network savings percentage.

In addition, it is critically important that decision makers realize the network savings percentage is only one of several factors that need to be analyzed to effectively determine the impact of a NetVIC on the cost of medical benefits. At a minimum, network evaluation must take into consideration the utilization patterns by the members of a company and the NetVIC. This analysis will help decision makers better predict and manage the dollars that will be paid out, which is exponentially more important to an employer's bottom line than percentage savings.

The Network Discount Calculation: Percentage Savings or Dollars Saved?

The major challenge in comparing quoted NetVIC savings percentages is that there are literally hundreds of variables that might be utilized by a NetVIC in the calculation of a network savings percentage. It may be appropriate to include or exclude some of the variables but when there is a lack of consistency, the ability to accurately compare programs is lost. Ideally, the Simple Calculation of the total network savings percentage for a metropolitan service area (MSA) would include *all* covered medical billed charges for *all* medical providers that supply services and/or supplies to members for a defined period of time, except for outpatient retail and mail-order prescription drug expenses. But since there is not a common methodology, each NetVIC decides what variables to include and exclude in their calculation.

MSA Adjustments

The definition of a NetVIC's MSA is the single biggest differentiator in comparing network discounts. No two NetVICs contract with the exact same group of hospitals, physicians or related providers. No two NetVICs have the exact same service area boundaries. This difference in size and demographic composition alone will result in significant variations in the discount calculation.

For example, Network X has 40 hospitals and 4,000 physicians in its defined MSA with a 50% discount while Network Z has 100 hospitals and 8,000 physicians in its defined MSA with a 48% discount. Which discount is better in real dollars? If the defined network service area for Network X is five counties around a major city while the defined network service area for Network Z is 20 counties around the same city, it is difficult to compare. It is likely Network Z has a discount of 50% (at a minimum) for the same five-county service area defined by Network X. Network Z's MSA includes more "rural" providers which historically have lower billed charges and therefore lower discount percentages as compared to "urban" providers (see Table II). Network Z's discount looks less attractive but it might actually be better than Network X's if the same group of "urban" providers are compared. What matters is where the members will go for treatment. This drives how real dollars will be spent.

Other important factors in defining the savings for a metropolitan service area are:

- Location of providers/hospital affiliations
- Selection of facilities and physicians
- Weighting of provider mix (primary care physicians vs. specialists vs. ancillary)
- Required service groups (medical providers a NetVIC must include in network to treat its population)
- Hospital stop-loss contracts (point at which discount converts to different reimbursement rate for a large claim in terms of dollars or days)
- Date service area is defined
- Application of provider contract changes.

All Covered Expense or *Ineligible Expense* Adjustments

The most common adjustment to the Simple Calculation is to reduce the total billed charges by the amount of *ineligible expenses,* which usually consist of billed charges for claims incurred that are not covered by the benefit plan, or duplicate charges.

The exclusion of ineligible expense allows a NetVIC to base its discount on covered expenses only. In the calculation of a savings percentage, it is reasonable to utilize covered expenses

Table I—The Simple Calculation

	Quoted Discount Savings Percentage	Gross Billed Charges With Ancillary	Network Discount Savings Percentage With Ancillary	Gross Billed Charges Without Ancillary	Network Discount Savings Percentage Without Ancillary
Facility Inpatient	50%	$4,000,000	$2,000,000	$4,000,000	$2,000,000
Facility Outpatient	30	$1,800,000	$ 540,000	$1,800,000	$ 540,000
Physician	35	$3,600,000	$1,260,000	$3,600,000	$1,260,000
Ancillary	25	$ 600,000	$ 150,000	N/A	N/A
Gross Billed Charges	N/A	$10,000,000	$3,950,000	$9,400,000	$3,800,000
Gross Network Discount (Simple Calculation)			39.50%		40.43%

Table II—MSA "Rural/Urban" Mix

	Billed Charges for Facility	Amount Allowed	Discount Percentage
Hospital Charge for Heart Surgery—Rural Facility	$30,000	$20,000	33.33%
Hospital Charge for Heart Surgery—Urban Facility	$40,000	$25,000	37.50%

Table III—"Covered Expense" Adjustments to Simple Calculation

	Quoted Discount Savings Percentage	Gross Billed Charges With Ancillary	Network Discount Savings Percentage With Ancillary	Gross Billed Charges Without Ancillary	Network Discount Savings Percentage Without Ancillary
Facility Inpatient	50%	$ 4,000,000	$2,000,000	$4,000,000	$2,000,000
Facility Outpatient	30	$ 1,800,000	$ 540,000	$1,800,000	$ 540,000
Physician	35	$ 3,600,000	$1,260,000	$3,600,000	$1,260,000
Ancillary	25	$ 600,000	$ 150,000	N/A	N/A
Gross Billed Charges	N/A	$10,000,000	$3,950,000	$9,400,000	$3,800,000
Gross Network Discount (Simple Calculation)			39.50%		40.43%
Adjustments to Simple Calculation (Savings dollars remain constant)					
Gross Billed Charges		$10,000,000	39.50%	$9,400,000	40.43%
Less Out-of-Network Charges (5% of gross billed)	$ (500,000)	$9,500,000	41.58%	$8,930,000	42.55%
Less Ineligible Expense (15% of gross billed)	$ (1,425,0000)	$8,075,000	48.92%	$7,590,500	50.06%
Less Employee Deductible, Copays, Out-of-Pocket Expense (10% of remaining gross billed)	$ (807,500)	$7,267,500	54.35%	$6,831,450	55.63%

only, but not every NetVIC has the same capability. If ineligible expenses are included in the total of billed charges, then the discount percentage shown will not reflect the true savings realized (see Table III). Knowledge of a NetVIC's definition of all covered expense or ineligible expense will dramatically help a decision maker's analysis process.

Ineligible expenses are not the only items that might be excluded from the Simple Calculation. Other services might be excluded because they historically have a small contracted savings amount or because they are not big service fields. Or they are excluded because of the contractual nature of the individual benefit program. Some of the other types of services that may not be part of the discount calculation include:

- Services for allied and/or ancillary providers
- Mental health and substance abuse services
- Preventive care services
- Outpatient lab and/or x-ray services
- Hospital-based physicians
- Emergency room treatments
- Unique or exceptional coverage (e.g., in-vitro fertilization)
- Maternity and/or newborn services
- Injectable drugs and other specialty pharmacy
- Claims incurred on retirees (both under age 65 and over)
- Coordination of benefits claims
- Claims for COBRA individuals
- Claim amounts in excess of a designated dollar amount (e.g., $75,000)

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- Claim amounts in excess of the individual specific stop-loss threshold
- Claim amounts in excess of a hospital's stop-loss contractual amount
- Claim treatments under a disease management or disease-specific program
- Transplant claims.

All of these items may have an impact on the network savings percentage based upon the policies, procedures and/or benefit design. But the plan is still paying real dollars for these types of claims. It is important to know how these types of claims impact the savings realized. It is also important to be aware of any NetVIC that includes benefit adjustments as part of the definition. Savings or discount definitions should never reflect reductions for a deductible, copay, coinsurance, reasonable and customary reduction, or any other dollar amount an individual is out of pocket.

Decision makers also have to watch out for additions to the savings component in the Simple Calculation. Savings percentages might be inflated with the inclusion of items that are not directly due to the primary NetVIC contract discounts. Examples of these types of additional savings components that might be included are:

- Secondary or passive network discounts
- Hospital bill audit results
- Subrogation collections
- "Bundling software" adjustments
- Fraud and abuse
- Utilization review savings
- Utilization management negotiations
- Special claim negotiations
- Prompt pay discount.

These services are all very valuable in helping control the cost of medical coverage and are an important part of the analysis process. Despite these favorable impacts, these services are not savings components that should be included in any network savings percentage calculation.

Other Adjustments

I have already demonstrated that the provider mix and what is considered covered can vary dramatically. The development of a network savings percentage is usually based upon the average savings for all covered network services performed in the network service area for some designated recent period of time. Unfortunately, the NetVICs do not offer what time period is utilized in their calculation. They could be projecting their savings percentage based upon data that is for a short period of time, like the last six months. Or they could be using older information from a prior calendar year. And how have recent NetVIC contracting efforts impacted the factors? These are all important considerations that impact the network savings percentage.

In addition, because historical data is the basis for future projections, another critical issue is the balance of inpatient facility claims, outpatient facility claims, physician claims and all other claims. Historical data is heavily weighted for each NetVIC based upon the types and size of companies they have historically contracted. A new employer will be using the NetVIC's historical demographics and applying it for their company. How does a decision maker know that their employees will have comparable utilization to that of other employers in the same service area? They don't, thus the need to understand the utilization patterns of the claimants, both for the NetVIC and for a company.

Each NetVIC develops a "total discount" for an MSA based upon the utilization from all providers. Some discount calculations are more heavily weighted toward inpatient expenses, some toward primary care physician services, etc. If the propensity of utilization for the company's employees is known, the decision makers will be better positioned to know which NetVIC will be more beneficial for their company. After all, someone that tells a decision maker that "you will save 42% with our network" may have based the discount on 75% of the claims being inpatient utilization at a 45% discount while all other services only had a 25% to 35% discount. But if an employer's actual in-

Table IV—Provider Weighting

	Quoted Discount Savings Percentage	Gross Billed Charges for Network X	Gross Billed Charges for Network Z
Facility Inpatient	50%	$ 7,500,000	$ 4,000,000
Facility Outpatient	30	$ 400,000	$ 1,800,000
Physician	35	$ 1,900,000	$ 3,600,000
Ancillary	25	$ 200,000	$ 600,000
Gross Billed Charges	N/A	$10,000,000	$10,000,000
Total Savings as a Percentage of Gross Billed Charges		$ 4,585,000	$ 3,950,000
Gross Network Discount		45.85%	39.50%

Table V—Marketing Discount Trap

	Quoted Discount Savings Percentage	Current Gross Billed Charges	Amount Reimbursed by Contract	Current Gross Dollars of Savings
Facility Inpatient	50%	$ 4,000,000	$2,000,000	$2,000,000
Facility Outpatient	30	$ 1,800,000	$1,260,000	$ 540,000
Physician	35	$ 3,600,000	$2,340,000	$1,260,000
Ancillary	25	$ 600,000	$ 450,000	$ 150,000
Gross Billed Charges	N/A	$10,000,000	$6,050,000	$3,950,000
Gross Network Discount				39.50%

	Quoted Discount Savings Percentage	Trended Gross Billed Charges	Amount Reimbursed by Contract	Trended Gross Dollars of Savings
Facility Inpatient	55.36%	$ 4,480,000	$2,000,000	$2,480,000
Facility Outpatient	37.50	$ 2,016,000	$1,260,000	$ 756,000
Physician	41.96	$ 4,032,000	$2,340,000	$1,692,000
Ancillary	33.04	$ 672,000	$ 450,000	$ 222,000
Gross Billed Charges	N/A	$11,200,000	$6,050,000	$5,150,000
Gross Network Discount				45.98%

patient utilization is 40%, then the network savings percentage could drop to 37% or lower (see Table IV). And the response from the NetVIC will likely be that they cannot predict utilization. Yet predicting utilization is exactly what they try to do every time they quote discounts.

And don't get caught in the marketing discount trap. Some NetVICs will have a different discount for marketing purposes. This discount is usually calculated as the normal method for their NetVIC with one significant difference. A marketing discount is for prospects who will incur claims in the future so the discount is "adjusted" for the impact of trend. The billed charges utilized for the determination of the simple discount will be increased by the projected trend. And there may be a further adjustment of the discount (either up or down) based upon the NetVIC's current projection of cost with provider contracts. So a NetVIC might show a current network discount of 40% but because trend will increase billed charges by 12% for next year, the marketing network discount will increase to 45% (see Table V).

"But I Received a Network Discount Guarantee!"

These guarantees will certainly provide some additional peace of mind but little security. Most guarantees quoted by NetVICs are based upon their block of business data and then the guarantees are adjusted based upon an employer's enrollment, or even utilization. These adjustments are usually based upon data that is not predefined. And the data the NetVICs report is designed to reflect their calculation of network savings so it is not clear what is included or excluded from the final factor. But more importantly, most of the guarantees put very little at risk (usually a percentage of the NetVIC fee) compared to the potential claim liability. A five-percentage point overestimate in the network savings rate may mean a refund of a few thousand dollars while a five-percentage point loss of discount could be hundreds of thousands of dollars. These agreements are needed and can be a useful tool, but they are certainly not a guarantee.

"What Can I Do to Make Sure I am Maximizing Dollar Savings?"

To achieve the most favorable result in the network discount shell game requires some hard work. First, a decision maker must completely understand all of the components in a NetVIC's definition of savings. Second, a decision maker must make the necessary adjustments in order to equate the savings percentages on an "apples to apples" basis. Then comes the most critical play in the game—utilization analysis. This is where percentages become real dollars. This is where decision makers will compare the utilization statistics of the NetVIC's underevaluation and then determine how these statistics apply for their company. With these facts, a decision maker will now have the necessary tools to calculate the probable financial impact of a change in network for their company.

The best way to effectively ascertain the impact of a NetVIC change in terms of dollars is to understand how the utilization patterns for a company's employees will be impacted by the change. There are several critical utilization indicators:

(Continued on next page)

The Network Discount Shell Game
(Continued from previous page)

- Average length of stay (med/surg, ob/gyn, mh/sa, etc.)
- Admissions per 1,000
- Average cost per day
- Average cost per admission
- Readmission rate
- Bed days per 1,000
- ER visits per 1,000
- Primary care physician visits per 1,000
- Specialists visits per 1,000
- Outpatient facility utilization per 1,000
- Payment per incidence
- Ratio of claims filed to payments
- Severity adjustments.

Why is it important to know these critical utilization indicators? Because the real determination of dollar savings is based on a NetVIC's ability to control utilization, and these statistics help define how well a NetVIC manages activity. If a NetVIC shows great savings on paper, but it does not manage the utilization effectively, an employer will be spending more dollars than projected even though the NetVIC reports great savings.

For example, Network X indicates a savings of 50% for inpatient services in an MSA while Network Z indicates a savings of 45% for inpatient services in the same MSA. But if Network X has an average length of stay of 4.5 days per 1,000 members and Network Z has an average length of stay of 3.75 days per 1,000 for the same MSA, then in terms of real dollars, less money would be spent for Network Z because it does a better job of getting members out of hospital more quickly (see Table VI). There are other factors to consider, but the focus is now on total potential dollars vs. the savings percentage.

Table VI demonstrates the reality of the difference in percentage savings and dollars saved. The decision to select a Network X with the highest savings percentage may actually cost a company real dollars because utilization is not incorporated into the equation. But when utilization is factored into the analysis, Network Z is the better choice because the company will pay out fewer dollars, even though the percentage of savings is reduced.

And this is what it is all about: spending less real dollars. A company's expenses must be paid in dollars, not percentages, so the analysis needs to focus on how to manage the dollar expense. And that is accomplished by looking beyond percentages. Doing this will help a decision maker accurately and effectively translate network savings discounts into hard dollar savings. Effective network analysis will help a decision maker positively impact the bottom line. ■

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Table VI—Discount Calculation With Utilization Analysis

	Inpatient Facility for Network X	Inpatient Facility for Network Z
Quoted Discount Savings Percentage	50%	45%
Gross Billed Charge per Day	$ 5,000	$ 5,000
Average Length of Stay (Days)	4.50	3.75
Amount Billed for Average Admission	$22,500	$18,750
Total Dollars Paid for Average Admission	$11,250	$10,313
Total Dollar Savings for Average Admission	$11,250	$ 8,438