Limitations to Discount Fee Analyses:

Examining Alternate Factors to Consider when Evaluating Health Plans' Cost Savings

Employers continue to face the challenge of rising medical costs at a distressing rate. Given this, as well as other factors such as the disparity in costs amongst providers, the complex dynamics within the health care industry, and some of the paradigm shifts expected in provider contracting due to various payment reform initiatives, it is imperative that employer groups evaluate whether a traditional "Discount from Billed Charges" analysis is the best determinant when choosing a health plan. While this issue is primarily a concern of self insured plan sponsors, it should be considered by fully insured plan sponsors as well, especially where a fully insured plan sponsor is of sufficient size to be significantly impacted by these other factors.

The purpose of this article is to identify other factors beyond discounts from billed charges that impact actual savings and lead employer groups to a more informed decision than what would be achieved solely by a discount analysis. This more comprehensive examination can not only lead to potentially lower costs to the employer and its members, but also to increased employee satisfaction/retention due to the selection of a superior health plan from the employee's perspective.

A traditional discount analysis looks at the average percentage differences between what a provider charges for its services and the amount it is paid for those services by virtue of a negotiated contract with a health insurance plan. This percentage is then compared against those of other plans to determine which health insurance plan provides an employer group with the highest discount option, with the assumption that the highest discount equates to the lowest cost option.

Focusing only on discounts, however, can be a dangerous strategy for several reasons. Below is a list of factors that demonstrate the flaws in a traditional discount analysis and/or are factors that employers should consider beyond a simple discount analysis when making their health plan decisions:

1. Unit Costs and Discounts

Have you ever shopped at a store where you've received a large discount, but in the end you paid the same or even more for that product than at another store where you paid full price? The health care "store" is no different.

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a) Provider charges vary widely. It's not uncommon to see variance in charges for the same procedure, in the same market, in which the charge for the highest cost alternative is two times that of the lowest cost alternative or more.

b) In addition, when contracts are negotiated on a per diem or case rate basis, there isn't a direct correlation between charges and discount as there would be in a discount off of charges structure. Consider this example. If Carrier A negotiates a 20% discount off of a billed charge of $10,000 for a particular service, the net cost of $8,000 is still less than the $16,000 net cost under Carrier B's greater percentage discount off of billed charges (36%), for the same service. This situation can occur frequently on Outpatient services performed at an ambulatory surgery center versus a hospital.

	Billed Charge	Discount	Final Discounted Cost
Carrier A	$10,000	20%	$8,000
Carrier B	$25,000	36%	$16,000

As another example, below are two actual hospitals in the New York City area and their relative costs vs. discounts for the same service.

	Billed Charge	Discount	Final Discounted Cost
Hospital A	$30,764	47.8%	$16,059
Hospital B	$14,638	43.7%	$8,241

As you can see, based solely on discount percents, Hospital A is "better"; but based on total discounted cost, Hospital B is actually the lowest cost. This is not an unusual example and is, in fact, extremely common on a national basis. In order to effectively compare the net impact of discounts across networks, the analysis must also include a comparison of the initial provider charges to which the discounts are applied.

2. Utilization/Cost Management

Different health insurance plans will have different methodologies with which they conduct utilization/cost management. These differences can have a substantial impact on the cost of care delivered. It is very worthwhile for an employer considering its health plan options to take a close look at a plan's utilization/cost management programs to assess the impact those programs

can have on costs as well as on the overall welfare of its employees health. This paper will expand below on different ways in which a health plan may manage total medical costs, which are not included in a traditional discount analysis due to how eligible billed charges are determined (e.g. claims denied or reduced due to medical management are to be excluded from the billed charges):

Traditional Medical Management programs:

Case Management programs can vary among health plans, but are extremely critical in not only lowering overall costs, but also in improving the quality of one's members' experience. They can be effective in reducing or eliminating inpatient days that otherwise would have occurred. In addition, they can also be effective in re-directing care to a more appropriate and often lower cost, setting for the patient and member.

There are also various other programs such as Disease Management, Wellness, and Technology-based patient safety programs that lead to lowered medical costs and improved quality. These programs effectiveness can vary amongst health plans and should be considered in the evaluation of total cost management. All of these programs work to promote and educate employees on beneficial behaviors or direct actions that will result in long term improved health and lower costs.

As discussed, effective medical management programs can have a cost containment impact in ways that are not measured by a discount analysis through the elimination of costs altogether and steerage to lower cost settings. This is another reason why it is essential that the initial provider charges be compared across the health plans prior to running a discount analysis.

As stated above, case management programs often yield a reduction to the average length of inpatient stays. Proactively managing a case, coordinating the timely providing of care, and facilitating the discharge process can drive down the length of stay, which has a direct impact on costs when a provider is contracted on a per diem basis, and this cost savings may not be seen when looking at discounts alone.

A specific example illustrating the affects of lower lengths of stay is as follows:

Plan	Per Diem Provider Charge	Per Diem Contracted Rate	Discount	LOS	Cost Per Case
A	$2,500	$1,500	40%	3.0	$4,500
B	$3,000	$1,400	53%	3.5	$4,900

Although Plan B has a lower per diem rate and a greater discount, when factoring in the lower length of stay for Plan A as afforded them by superior case management, Plan A is the lower cost option for the employer.

Transparency and Provider Steerage

Another way in which a health plan can positively impact costs is by implementing programs that provide members with information on costs, as well as deploying additional programs or techniques in which to steer members to lower cost settings. There is wide variation in innovation and deployment of this type of information among the health plans, and should be considered when evaluating total costs. For example, some health plans have robust transparency tools that provide members with specific cost information, while others are more limited in the information they provide. In addition, some health plans have been successful in leveraging this information as well as other steerage techniques (products, patient management steerage, etc.) to increase the amount of steerage of its members to lower cost settings. This can be particularly meaningful when evaluating Outpatient claim costs, an area that is particularly difficult to review using a discount analysis due to the many locations care can occur.

3. Member/Provider Mix

Member/Provider mix is another issue that cannot be resolved using the traditional discount analysis. Differences in member condition severity, provider mix and other factors can have a profound impact on employer realized discounts, and can impact book of business discounts reported by health plans.

For example, Carrier A and Carrier B may both negotiate a 40% discount off of billed charges with Hospital X and a 50% discount off of billed charges with Hospital Y in a given market. However, if Carrier A's book of business utilization is more predominant at Hospital X and Carrier B's is more predominant at Hospital Y (due to location of customers or other factors), the use of market level discounts may be misleading in estimating the actual discount to be realized for a particular plan sponsor.

Member mix may also influence the discount achieved by a plan sponsor. For example, populations with more women of child bearing ages may see more maternity and NICU claims then what the standard discount analysis would assume.

4. Contracting Differences

Today there are varying contract structures that exist between health plans and providers with varying degrees of complexity, particularly with regard to hospital contracts. The complexity that exists today is only expected to grow as payment reform strengthens, driven by things such as pay for performance, medical homes and Accountable Care Organization (ACO) models. In order to accurately assess the financial picture, it is necessary to understand these differences. Some examples of such differences that can impact a traditional discount analysis are highlighted below:

Percent of Billed Charges: These are the easiest contracts to predict when performing discount calculations, as the discount is simply a percentage off the billed charges submitted by the provider. When comparing one contract to another for a given provider, the higher the discount off billed charges, the more favorable the contract.

Inpatient Per Diems: As stated above, it is important to review length of stay in conjunction with discounts in markets that are primarily contracted using per diems. The length of stay may be a better predictor of overall cost than discount. When looking at length of stay, it is important to exclude catastrophic claims from the analysis as these can skew the results by competitor. It is also important to case mix adjust across competitors to ensure you are comparing the length of stay across a consistent market basket of services.

Case Rates: Another common method for Inpatient contracting is case rate or Diagnostic Related Group (DRG) contracting. In this type of contracting scenario, discounts will vary by hospital depending on the mix of services utilized, and the severity of the case. This makes these contracts difficult to project forward (e.g. will the case mix in the following year be consistent with the case mix in the current year?), and it also makes them difficult to compare under a discount analysis without case mix adjusting and risk adjusting.

Per diem/Case rate hybrid: Most hospital contracts are structured for inpatient services as either a per diem type of reimbursement or one of several forms of case rate reimbursement. However, some contracts are structured as a hybrid between per diems and case rates, in which case the discount calculation is more complex. The hybrid-structured contracts usually have per diem rates that are applicable to the majority of cases and case rates that are "carved out" of the arrangement and apply to various high cost, high complexity cases. This type of contracting will also make it difficult to predict future discounts at a given facility.

Stop Loss Differences: Beyond the per diems and case rates discussed above, some hospital contracts have an additional feature called a "stop loss provision". Generally this provision will change the standard reimbursement for a given case to provide higher reimbursement once a certain threshold of charges for that case is surpassed. The variables with regard to stop-loss are that there are several types of stop loss structures (first dollar stop loss where the reimbursement fee for the entire case is adjusted once the charge threshold is surpassed, or second dollar stop loss where additional reimbursement applies only to charges above the threshold), the charge thresholds can vary significantly between arrangements, and the reimbursement once the stop loss is triggered can vary substantially.

Most discount analyses include large claims in their calculations of discounts. It is more appropriate to look at discounts prior to large claims to ensure those are not skewing the analysis across health plans. It is necessary to compare large claim discounts, but given the nature of the claims, the discounts could vary widely depending on the reason for the large claim and where that large claim took place. This means that less credibility can be assigned to the large claim discount.

As you can see, there are a variety of ways to contract with a given provider. This makes the calculation of a discount as a way to compare costs more volatile, and in some instances such as per diem markets it may be more beneficial to review length of stay as another measure to aid in determining total cost.

5. Claims Management

Different plans have different clinical and claim editing policies and software that provide additional, critical utilization management. These can vary widely from carrier to carrier.

Note a study that was published by the AMA in 2010 (AMA National Health Insurer Card, 2008-2010 Data) that identifies the number of payer-specific claim edits that are used by several major health plans*.

Effective Claims Management Savings – Payer specific claim edits by carrier

Carrier	Claim Edits
Aetna	210,272
Anthem	64,557
CIGNA	442
Coventry	0
HCSC	194,108
Humana	5,033
UHG	247,961

* Note that these are not unique claim edits and thus the numbers may be higher for those carriers processing claims on more than one claims processing platform

These claim edits can achieve savings by minimizing payments for unnecessary services, either through the identification of billing errors ahead of payment resulting in pre-payment reductions or denials, or by identifying overpayments after the fact and initiating recoveries of such amounts. There are also departments within the plans specializing in the detection and investigation of billing fraud. These mechanisms within certain plans allow them to realize savings that would not be factored into a discount analysis. Health plans could agree to limit some of the claim policies in favor of deeper discounts with providers. If they have implemented these methods, their overall starting point for provider eligible charges should be higher than those with these claim edits. This is yet another reason it is important to review provider submitted charges to ensure consistency across health plans.

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6. Other Data and Savings to Consider When Evaluating Costs

In addition, there are other data or metrics that could be used to evaluate the relative comparisons as to how different health plans are managing costs. Those might include:

- Inpatient readmission rates
- Average length of stay
- Members per 1,000 who receive emergency room services within 30 days of initial admission
- Admissions per 1,000 whose initial length of stay was extended due to complications
- Number of one night lengths of stay per 1,000 members

In summary, a discount from billed charges analysis is one way of evaluating the cost differences between plans, but in light of the factors discussed in this paper there are a number of other important considerations that should be factored in to the decision of which plan an employer should choose. A thorough evaluation of all these issues will lead to a more informed and better decision by the employer than that produced by a simple discount analysis, from the standpoint not only of cost, but also of better employee satisfaction and better health outcomes for its employees.