

Determining discounts



Liz Myers, FSA, MAAA

Healthcare reform has grabbed the headlines with various cost-saving initiatives for employers and individuals alike. However, the potential for significant savings is available without any required change to the current structure.

The carriers who most successfully negotiate with providers can offer some employers significant cost savings with no modifications in their current utilization or provider access. The potential savings, or discounts, will vary based on the group's mix of markets and services, so a medical repricing study can help quantify the differences. Inconsistencies in medical terms and dollar definitions along with limited understanding of the nuances of network discounts can lead to inaccurate reimbursement comparisons. In this paper, we cover the most frequently asked questions by the market around the calculation and evaluation of medical discounts. We highlight various methods for estimating discount differences. We conclude with how these discount differences impact the overall medical cost to the employer.

FREQUENTLY ASKED QUESTIONS ABOUT DISCOUNTS AND MEDICAL CLAIMS REPRICINGS

Why are network discounts important?

A key cost factor in self-funded health benefit plans is the negotiated rates paid to the providers. Discounts are a common measure of overall network reimbursement levels. The discount measures the reduction from billed charges achieved through provider contracting efforts and provides a way to compare the competitiveness of the carrier contracts.

What should be included in the discount?

The effective discount should represent only the true negotiated savings from billed charges under the contractual provisions. If non-covered, ineligible, or voided amounts are included in the savings, then the discount will be overstated. The difference between the eligible billed charge (i.e., submitted charge less non-covered, ineligible amounts) and the negotiated reimbursement rate (i.e., allowed amount) represents the discount. It can be expressed as a percentage as follows:

$$\text{Discount \%} = 1 - (\text{Allowed Amount} / \text{Eligible Billed Amount})$$

Or as a dollar amount:

$$\text{Discount \$} = \text{Eligible Billed Amount} - \text{Allowed Amount}$$

Are dollar fields consistently defined throughout the industry?

Dollar fields differ by carrier. A data layout or dictionary may provide some additional insight but can still be open to interpretation. Final confirmation by the incumbent carrier is an important step when working with healthcare data. Field names often sound self-explanatory (e.g., "discount," "allowed," or "eligible") but can represent something else entirely. Incorrect interpretation of the data fields will affect the validity of the analysis.

Is there a market standard for defining discounts?

Many carriers and networks participate in a current industry initiative to set standards for compiling and measuring network discounts. Their efforts resulted in the development of the Uniform Discount Standard (UDS), which are guidelines that serve as an industry standard approach for compiling "book-of-business" data and reporting discounts. The group meets periodically to discuss and refine the measures as needed.

Should discount profiles be based on member ZIP code or provider ZIP code?

Member ZIP is the market standard for compiling and reporting carrier discounts. The lowest level of reporting available in the market is at the member three-digit ZIP code level. The advantage of member ZIP code discount profiles is threefold:

1. Discount profiles are used for employer requests for proposals (RFPs) and repricings. Employers want to know what to expect based on where their employees are located.
2. Provider ZIP may be the billing location rather than physical location of the provider.
3. Discount profiles in rural areas would lack the more intensive-type services if based on provider ZIP. Members in rural areas still incur these services; however, they may travel to the next major metropolitan area for care. If so, the discount profiles will reflect where they travel for care.

Do discounts really vary?

Discount levels can fluctuate significantly. The following examples illustrate differences by location and claim type.

FIGURE 1: DISCOUNT DIFFERENTIAL BY STATE

STATE	DISCOUNT RANGE
CALIFORNIA	55% - 65%
NEW JERSEY	50% - 60%
TENNESSEE	40% - 50%
UTAH	30% - 40%

Discounts vary by area. An employer group located in multiple markets must be compared at a market level and then weighted by billed volume to determine the best overall effective discount across all areas. No one carrier will have the deepest discounts in all markets. Results are largely dependent on the group's geographic mix.

Discounts also fluctuate by type of service. As shown in Figure 2, inpatient hospital discounts are lower than outpatient hospital and professional categories in the Southeast market; yet, in the Midwest market, facility discounts are substantially higher than professional discounts. Similar to carrier competitiveness by market, carrier ranking varies by type of service. Some carriers focus their efforts on negotiating better facility contracts, while others concentrate on the professional side.

FIGURE 2: DISCOUNT DIFFERENTIAL BY TYPE OF SERVICE

CATEGORY	SOUTHEAST MARKET	MIDWEST MARKET
INPATIENT HOSPITAL	29%	57%
OUTPATIENT HOSPITAL	38%	57%
PROFESSIONAL	37%	41%
AGGREGATE	36%	52%

What can be done to reflect an employer's mix of areas and services when comparing network discounts?

A historical extract that contains a recent 12 months of incurred and/or paid claims will represent the distribution of markets, providers, and services utilized by the group. Alternative carriers can repricing this data specific to their networks to estimate the reimbursement with their contracts during comparable time periods. The repricing process provides a method to measure potential cost or savings under alternative networks specific to the employer's healthcare consumption.

What are the current methodologies in the market for repricing claims?

Several carriers have established their own internal best practice approaches for repricing claims. These methodologies may be reasonable approximations, but ultimately they are estimates. Understanding the differences in carriers' repricing methodologies is important when comparing medical repricing results in order to identify any assumptions used and limitations with the analysis. The table in Figure 3 outlines possible approaches to repricing claims with the advantages and disadvantages of each.

FIGURE 3: ADVANTAGES AND DISADVANTAGES OF REPRICING METHODS

REPRICING METHOD	ADVANTAGE(S)	DISADVANTAGE(S)
A: PROVIDER AND DETAILED SERVICE*	(1) REFLECTS SAME MIX OF PROVIDERS IN EMPLOYER'S DATA (2) MOST DETAILED LEVEL OF REPRICING	(1) POTENTIAL FOR LOW CREDIBILITY OF BOOK-OF-BUSINESS DATA AT THIS LEVEL (2) ISSUES WITH PROVIDER TAX IDS AND VARIANCES IN PROVIDER NAMES MAKE LINKING TO EMPLOYER DATA CHALLENGING
B: PROVIDER AND MAJOR SERVICE CATEGORY**	(1) REFLECTS SAME MIX OF PROVIDERS IN EMPLOYER'S DATA (2) MORE CREDIBLE THAN METHOD A	(1) NO ADJUSTMENT FOR CASE MIX AT FACILITY (2) ISSUES WITH PROVIDER TAX IDS AND VARIANCES IN PROVIDER NAMES MAKE LINKING TO EMPLOYER DATA CHALLENGING
C: ZIP CODE AND DETAILED SERVICE*	(1) NO ISSUES WITH MATCHING ON PROVIDER TAX ID AND PROVIDER NAME (2) BOOK-OF-BUSINESS DATA MORE CREDIBLE THAN AT A PROVIDER-SPECIFIC LEVEL	(1) ASSUMES THE MIX OF PROVIDERS FOR THE GROUP IS COMPARABLE TO BOOK-OF-BUSINESS BY SERVICE CATEGORY
D: ZIP CODE AND MAJOR SERVICE CATEGORY**	(1) NO ISSUES WITH MATCHING ON PROVIDER TAX ID AND PROVIDER NAME	(1) ASSUMES THE MIX OF PROVIDERS FOR THE GROUP IS COMPARABLE TO BOOK-OF-BUSINESS (2) ASSUMES THE MIX OF SERVICES WITHIN THE CATEGORY** IS CONSISTENT WITH BOOK-OF-BUSINESS
E: METROPOLITAN STATISTICAL AREA (MSA) AND MAJOR SERVICE CATEGORY**	(1) NO ISSUES WITH MATCHING ON PROVIDER TAX ID AND PROVIDER NAME	(1) ASSUMES THE MIX OF PROVIDERS FOR THE GROUP IS COMPARABLE WITH BOOK-OF-BUSINESS (2) ASSUMES THE MIX OF SERVICES WITHIN THE CATEGORY** IS CONSISTENT WITH BOOK-OF-BUSINESS (3) ASSUMES THE MIX OF ZIPS WITHIN THE MSA IS EQUIVALENT TO BOOK-OF-BUSINESS

*Detailed service is defined as a more detailed level than major service category (e.g., maternity, emergency room, outpatient surgical facility).

**Major service category is defined as inpatient hospital, outpatient hospital, or professional.

What repricing methods are used most frequently in the market?

Repricing Methods B, C, and D shown in Figure 3 are used most frequently by carriers to reprice claims. Method B reflects a mix of providers specific to the employer’s data but it does not adjust for case mix at the facility. Method C is specific to the service incurred but not the provider utilized. As outlined, all the methods have advantages and disadvantages, so a clear understanding of the methodology employed is important when comparing results for the alternative carriers.

What is the preferred repricing approach?

Method B and Method C provide reasonable repricing results for most national account groups. In certain cases, Method B (specific to provider and major service category) may be the preferred approach, where a regional/local group is directed to a particular facility with a significantly different billed chargemaster. The example in Figure 4 highlights this situation.

FIGURE 4: BILLED CHARGE RATIOS

FACILITY	BILLED CHARGE RATIO
HOSPITAL ABC	1.40
HOSPITAL XYZ	1.00

Hospital ABC and Hospital XYZ are located in the same geographic area. An alternative carrier negotiates with both hospitals for the same reimbursement level because both facilities are full-service hospitals in the same area. Hospital ABC’s starting billed chargemaster is 40% higher than Hospital XYZ’s, so Hospital ABC’s discount will be significantly deeper than Hospital XYZ’s to get to the same level of reimbursement.

Members of an employer group are driven to Hospital ABC because Hospital XYZ is not in the current carrier’s network. In this case, repricing with Method C (i.e., specific to ZIP and detailed service) will understate the repriced discounts if both facilities are in the alternative carrier’s book-of-business data. Method B (i.e., specific to provider and major service category) would provide a more appropriate repriced discount—a deeper discount at the higher billed charge facility. However, the billed chargemaster differences need to occur at a significant volume of facilities and claims in the employer’s data before the benefits of a provider-specific approach clearly outweigh the limitations.

Do carriers fully re-adjudicate claims when repricing an employer’s data?

Repricing at this level of detail is impracticable for several reasons—(a) number of files necessary to adjudicate claims correctly, (b) manpower and time needed to re-adjudicate claims in an alternative carrier’s data system, (c) difficulty with automating complex facility contractual terms, and (d) availability of repricing estimation methodologies, as described, to serve as a proxy. Therefore, most medical repricings are performed using the methods outlined in Figure 3.

What is the variance in the discount for various repricing methodologies?

The entity repricing the claims should be able to answer this question, because it would have likely performed testing to quantify potential variance. Generally, a variance of plus or minus two discount points is an acceptable range based on current market standards. The variance reflects the estimation characteristic of a repricing because claims are not fully re-adjudicated.

Should the incumbent carrier reprice its own data?

The most objective measure of discounts is the actual historical data because it reflects the carrier’s contracts and the service and provider mix specific to the group. Historical discounts do not include any estimate or variance inherent with a repricing exercise. The employer’s actual experience with the incumbent should establish the baseline for a discount comparison. If the current carrier wants the opportunity to reprice, it is important to understand its intent.

This type of request is typically made when the incumbent wants the opportunity to incorporate contract changes under a prospective method. Reconciliation between the incumbent’s historical and repriced discounts allows for an understanding of the carrier’s estimated change in contracts between the time periods. While it is reasonable to expect a small discount change (in either direction), significant differences require additional validation.

Is there a central data repository for discount comparisons?

Several large healthcare benefit consulting firms and brokerage houses collect the carrier UDS data, as described previously, to estimate the discount differential by carrier for their employer group clients. For those who do not participate in the data collection, they must rely on ad hoc approaches for estimating differences in carrier networks, or facilitate employer repricing exercises.

What kinds of claims should be included in a medical repricing analysis?

All valid medical claims paid as primary should be included. Exclusions that are due to the non-contracting status of the provider, difficulty with evaluating unit counts, ancillary services (e.g., ambulance, durable medical equipment, or home health), or carved-out benefits lead to a limited analysis because these claims represent valid medical costs to the employer.

What kinds of claims should be excluded in a medical repricing analysis?

Claims extracts typically contain a substantial amount of “noise,” which may understate or overstate the historical discount if not excluded. Frequent examples of these types of claims include:

- Pending, denied, duplicate, or voided claims
- Claims with an allowed amount equal to zero
- Incurred dates well outside of the repricing period
- Secondary or Medicare primary claims (carriers employ various methods to adjudicate these claims so they may not be representative of an achievable discount)

- Claims with an unusual dollar relationship (i.e., billed is greater than \$0 and allowed is less than \$0, or vice versa; or billed = \$0 and allowed is greater or less than \$0)
- Management/access fees or taxes
- Retail prescription drugs
- Dental claims not covered under the medical plan

Do missing fields in the historical extract affect repricing results?

Yes, the fewer the fields in the historical data the more assumptions are needed, which can affect the validity of the repricing. Each organization will require different fields when repricing claims; but, at a minimum, a data extract should include the following:

- Claim number
- Incurred date
- Provider tax ID
- Provider name
- Provider ZIP code
- Primary diagnosis code
- CPT-4/HCPCS code
- Revenue code
- Place of service
- Provider type
- Eligible billed charge
- Coordination of benefits (COB)/Medicare indicator (for identification and exclusion prior to repricing)

What is the difference between a retrospective and prospective discount analysis?

Retrospective discounts are based on actual paid claims for a carriers' commercial book-of-business data. Medical repricings are based on an employer's data for a recent incurred period, so the retrospective approach will align the time periods of the employer's and carrier's data.

Prospective discounts can refer to the current and/or a future time period. The purpose of prospective discounts is to reflect changes in provider contracting to model the newest information available.

What considerations should be made in a prospective discount analysis?

The benefit of a prospective repricing is that it provides an estimate of what the carrier is currently achieving or will achieve in the near future; however, the following should be considered:

- It adds an additional layer of estimation to the repricing. Changes in physician fee schedules are relatively easy to evaluate; conversely, facility contracts are much more complex and renegotiation may only apply to a small number of services at the facility.

- All carriers renegotiate contracts but not all carriers perform prospective repricings. How will carriers who do not submit a prospective repricing be compared with those who do?
- Discounts do not always improve when a contract is renegotiated. A frequent misconception is that discounts are always improving. If the trend on the negotiated rate (i.e., allowed amount) is higher than the chargemaster increase, then the discount declines.

Should provider disruption be included in a repricing analysis?

Provider disruption identifies the providers' statuses with an alternative network based on the providers currently utilized by the employer group. It is frequently requested as an independent comparison or may be included as part of a repricing. Provider tax ID, name, and ZIP code are needed in the historical data to complete a disruption. The benefit of a disruption in a repricing is twofold: (a) it reflects network size; and (b) it incorporates total discount into the repricing, where total discount represents both in-network and out-of-network services.

Employers are concerned about the impact of disruption for the members of the health plans they offer if a carrier switch is made. Disruption measures the impact and can be calculated based on eligible billed dollars, count of claims, count of providers, or count of members. A provider disruption is typically based on the providers currently utilized with the incumbent's network without any adjustments for provider steerage. It is reasonable to expect some improvement in the alternative network penetration rate if the group makes a switch depending on the benefit design and the alternative carrier's network offering.

What is the advantage of a total discount analysis?

In-network charges usually account for more than 85% of an employer's total billed so the primary focus is on the in-network cost. However, out-of-network charges still represent a cost to the employer and are typically paid at a significantly lower discount level than in-network charges. The example in Figure 5 illustrates the importance of a total discount comparison.

FIGURE 5: COMPARING TOTAL DISCOUNT

	CARRIER A	CARRIER B
IN-NETWORK DISCOUNT	50.0%	51.0%
IN-NETWORK PENETRATION RATE*	96.0%	90.0%
OUT-OF-NETWORK DISCOUNT	15.0%	15.0%
TOTAL DISCOUNT	48.6%	47.4%

*Based on eligible billed charges.

An analysis limited to in-network discounts would indicate in this example that Carrier B is better on a discount basis, but it ignores the 10% of charges out-of-network with Carrier B. Based on a total discount approach, Carrier A achieves the higher discount because 6% more of the group's charges receive an in-network discount resulting in an overall discount advantage of 1.2%, or 2.3% on an allowed basis.

What happens if a carrier misses the reported discount shown in the repricing?

Nothing happens to the carrier if there is no discount guarantee with the employer. If a guarantee is in place, then the downside for the carrier is usually minimal while the penalty for the employer can be substantial. A percentage of the administrative fees is frequently put at risk in a discount guarantee, which will only apply after the risk-free corridor. This typically amounts to very little in the overall cost, as shown in Figure 6.

A miss of three discount points (two discount points outside of the risk-free corridor plus one discount point below that) on a group with a discount guarantee of 50% is worth 6% of the allowed. The carrier will reimburse the employer 1% of the 6% but the employer must cover the difference. A competitive discount without a strong guarantee offers little consolation to the employer if the promised discount is not realized.

What are standard exclusions for discount guarantees?

Discount guarantee language can vary substantially by carrier. The more frequent types of exclusions in a guarantee include:

- Out-of-network claims
- Catastrophic claims
- COB and/or Medicare claims
- Ancillary services
- Significant demographic changes
- Paid-as-billed providers
- Provider network status changes

FIGURE 6: DISCOUNT GUARANTEE EXAMPLE

DISCOUNT GUARANTEE	50%
RISK-FREE CORRIDOR	48% (LOW END) 52% (HIGH END)
FEEES AT RISK	20% OF ADMINISTRATIVE FEES
ADMINISTRATIVE FEES AS A % OF ALLOWED	5%
EFFECTIVE DISCOUNT	47%
DISCOUNT DIFFERENTIAL	50% - 47%=3%
COST TO GROUP FOR DISCOUNT MISS	$(1 - 0.47) / (1 - 0.50) = 6\%$ OF ALLOWED
COST TO CARRIER FOR DISCOUNT MISS	20% OF ADMIN = $0.20 \times 0.05 = 1\%$ OF ALLOWED
NET COST TO GROUP	6% OF ALLOWED - 1% OF ALLOWED = 5% OF ALLOWED

A guarantee based on an aggregate discount with no other exclusions places the greatest burden on the carrier to manage all costs and services, to the extent they are controllable. As shown in Figure 6, discount guarantees are frequently based on a percentage of the administrative fees, which may represent negligible compensation to the employer if the target is missed. A guarantee that reimburses an employer on a dollar-for-dollar basis or on a percentage of the missed discount helps mitigate the downside risk for the group.

Liz Myers is a consulting actuary in Milliman's Atlanta office. Contact her at liz.myers@milliman.com.

The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.