Seeking Transparency

How network discounts can impact stop loss pricing

When third-party administrators (TPAs) solicit quotes for stop loss insurance for their client companies that self-insure, they may not be getting the maximum discounts available from stop loss carriers if the carriers don't receive transparent data from the provider network.

That's why it's so important to make sure the network is sharing data at every level, says Brian Fallon, director, payor relations and new business development and data analytics at HealthLink.

"TPAs are now asking the carriers about the network ratings and the frequency of their evaluation," says Fallon.

How is a managed care network evaluated by a stop loss carrier?

A key component to the evaluation of a managed care network is its claimed discounts relative to stop loss pricing. Several factors are involved in determining the effectiveness of a discount. Some include the location of the member, the location of the employer (they are not necessarily identical) and the composition of the provider contracts.

The clinical referral patterns of the providers are also taken into consideration and are important, as a member located in a rural market may incur initial care at a rural facility. However, specialty or tertiary care will typically migrate to a metropolitan market, where the available scope of services is enhanced and the managed contracts are structured on a per diem or DRG basis. Those contracts also contain fixed pricing for inpatient and outpatient services, reducing the exposure to billed charges.

All factors contribute to a stop loss carrier evaluation of the network. Additionally, carriers review the structure of the network, the volume of claims flowing through the network on an aggregate basis and the credibility factor assigned to the network. A network with credible claims data will have less reliance on manual pricing.

Why is transparency of data so important?

The greatest challenge that a reinsurance carrier has is the lack of transparency provided by the networks being evaluated. Networks may provide average savings or net effect discounts that are not regionally based but are reflective of larger geographic regions, thus distorting the accuracy of the discounts. Carriers need to be able to consider the contractual allowed amounts at a specific facility, as well as paid amounts. In addition, networks need to disclose actual facility rates inclusive of actual stop loss provisions at the facility.

Network discounts at high dollar amounts are not reflected accurately via the averages that are commonly cited. When brokers or consultants market self-funded employer groups with stop loss, typically they only provide the overall average discount for the group. Networks and ASO carriers market their overall average discounts and, again, the focus is on the total claims.

How do network discounts impact stop loss pricing?

The discount information is important for complete understanding of the aggregate attachment point calculations, but not really relevant or helpful for specific or large claim evaluation.

PPO discounts for high-dollar claims after the specific deductible will differ from the averages that are typically provided. The actual discounts are typically lower on shock claims, but the reduction in stop loss liability is higher. Networks should be able to engage in the discussion with the carrier as to the net effect discount as it relates to various stop loss price points.

Other factors impacting stop loss pricing are the availability of vendors or arrangements that impact trigger diagnosis such as dialysis or an effective pharmacy benefit management program. Pricing offsets can be as impactful as a 5 to 10 percent of the specific deductible premium.

We are also seeing the emergence of small groups entering the self-funded market. Mandated benefits, premium taxes and the unknown liabilities contained in Patient Protection and Affordable Care Act (PPACA) legislation are now providing small employers enough motivation to explore self-funding.

The conclusion for the TPA is to know how a stop loss carrier rates the network being promoted to the client —— and how often the networks provide the data. Networks used to be sold by the merits of the participation of providers.

TPAs and their clients alike are looking for new ways to address cost. We see the emergence of conversations of narrow networks — that is, steering through benefit plan design — to the most cost-effective providers. Reported discounts are also being evaluated on an adjusted cost basis through case mix indexing. Members are also becoming prudent consumers as they share more of the burden of cost.

Now, networks will be challenged to provide these methods of transparency to the reinsurance carrier to ensure accurate valuation of the network in order to obtain price points to compete in the self-funded market. It's also incumbent on the TPA to have the dialogue with the reinsurance carrier regarding network valuations and for the network to demonstrate their effectiveness to both the TPA and reinsurance carrier.