

A photograph of a person skydiving over a canyon. The skydiver is in the center, falling towards the bottom right. Below them is a large rock peak with the word "GO" painted on it. The background shows a vast canyon with layered rock formations and a blue sky.

LOOK BEFORE YOU LEAP

15

REASONS WHY
ALL NETWORK
DISCOUNTS ARE NOT
CREATED EQUAL

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All Network Discounts and Payers Are Not Created Equal. Take A Closer Look And Examine The Facts.

After several years of double-digit rate hikes, the promise of large provider savings can sound very attractive. But before you change to another plan on the promise of big carrier-based network discounts, it's good to pause and ask a few important questions.

- 1. How are the proposed provider discounts being calculated and what is included in the projected discount?**

What counts is not the percentage of discount promised, but how the discount is being calculated. For example, if duplicate claims are denied before being paid, but included in the calculations, the savings may appear to be greater than actual. Remember that in any cost projection, an apples to apples comparison is critical.
- 2. Are projected discounts based on actual claims or the overage expected provider discount?**

Valued agents and advisors recommend that a consistent basis of comparison be used to determine a savings calculation. Rather than a DRG or other variable, consider comparing plans based on the average payment per day for local in-hospital care or cost per local hospital admission. This type of analysis will help you make better decisions over the long run.
- 3. What about member, employer and provider locations?**

Insurers often boast about a discount that may only apply in a major metropolitan area. If many covered members work at another facility in a rural setting, the same discount may not be in effect. It's important to ask if the projections are based on the location of the corporate office, a satellite facility, members or providers?
- 4. How will out-of-network claims be addressed?**

Out of network claims are typically paid at a lower percentage than in-network claims. In other words, the employee copay is higher when out of network providers are utilized. Some payers will also charge higher administration fees on out of network claims or retain a percentage of the savings realized because the plan paid less. Make sure you ask how these claims will be handled and how the savings will be reported.
- 5. Will you receive reports on out of network claims and the savings on these claims?**

TPAs have the technology to identify out of network claims and they consistently take the time to document these. It's the only way to know when members are going out of network for medical treatment and to identify the savings that will accrue to the plan as a result.
- 6. If there are multiple fee schedules within a geographic area, how have these schedules been presented?**

When the primary objective is to win your business, provider fee schedules and percentage discounts can be presented in a number of ways. With provider fee schedules varying significantly from market to market and area to area, there could be a very distorted presentation of the projected savings.
- 7. What data and decision support tools will be used in the claims administration process?**

TPAs use clinical logic and cutting-edge claims analysis software to assure that plans are being charged only for benefits which are authorized. Lack of unbundling, up-coding errors, billing errors and other inaccuracies are corrected throughout the claims adjudication process, which is critical to cost control. Asking about these capabilities will help you compare plans and payers accurately.
- 8. Are your plan administration fees fixed or variable?**

Some larger plans provide for variable administration fees which fluctuate according to the provider discount obtained or the percentage of savings realized. Administrative bonuses or percentage overrides may even be applied to each claim processed within a specific network. It's important to know how administration fees are being calculated so that alternative plans can be compared on an equal playing field.
- 9. If you have favorable claims experience, will your organization receive a return of excess premium?**

With a self-funded plan, costs are lower if claims experience is better than projected. The opposite is true, of course, when claims exceed expected levels and specific or aggregate reinsurance (stop loss) coverage is used. In a fully insured plan, premiums are charged in full regardless of claims experience, and premium reductions seem to have disappeared from the marketplace.
- 10. Will you receive full disclosure of all compensation paid to brokers - even "Non-5500" compensation?**

There is so much competition these days that some large carriers are offering bonus and incentive payments to brokers - huge non-5500 reported compensation, over and above their earned 5500-reported commissions. Do you know if your insurer is paying non-5500 reported compensation?
- Other Important Considerations...**

While these points may seem insignificant, they will make a big difference in the overall cost of health benefits and the well-being of your employees.
- 11. Will you receive detailed plan information on a regular basis?**

What type of health benefit plan information will be given to you on a regular basis? Will you receive provider reports with a clear description of costs and savings or will the vendor simply talk about the percentage discount without providing specific backup?
- 12. Be sure to ask about retroactive termination administration?**

In cases where an employee has been terminated, and the employer does not provide prompt notification, some insurance administrators will use the notification date rather than going back to the actual date of termination. Most TPAs will go back to the actual termination date so that benefits can be administered in accordance with the plan document.
- 13. Determine how a new plan will handle pre-existing conditions.**

Commercial insurance carriers seldom go back and ask for medical history when a claim appears to be linked to a pre-existing condition. This means the claim may be paid like any other claim, and the plan may incur greater costs than actually authorized. When we identify the possibility of a pre-existing condition, a letter asking for medical history is immediately sent. This step can help control costs for the plan and all covered employees.
- 14. Will you receive detailed monthly claim reports?**

We provide self-funded clients with far more data than the typical insurer will furnish. Claim reports are made available on a monthly basis to keep management informed on where plan dollars are going. Timely and meaningful information on claims contributes to better decisions on benefits, cost management strategies and wellness issues going forward.
- 15. What will your overage turnaround time be on claims?**

While claims preprocessing time may not be a determining factor in the overall cost of employee health care, it's often an indication of overall operating efficiency and the quality of administrative services being provided. Most TPAs strive to adjudicate claims in ten days or less and many consistently surpass this goal.

As a full service benefits administration firm, we're accustomed to helping our clients analyze and evaluate projected network savings. If you need to re-evaluate your health benefit program or a provider network arrangement, or if you have questions about any of the strategies described in this pamphlet, give us a call today.

TPAs. Discover the Benefits.™