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Make the Call

Evaluating Managed Care Networks

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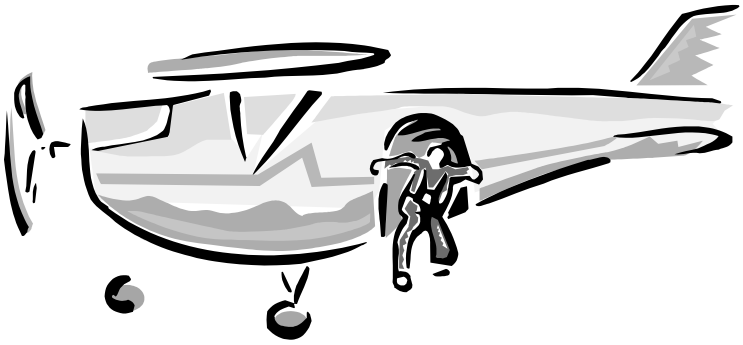

Editor's Note: This article is a recap of Mr. Gaspar's contribution to session 92 "Evaluating Managed Care Networks" presented at the Spring Society of Actuaries meeting in San Francisco in June 2002

Ten years ago I jumped out of an airplane—or more accurately, I parachuted from an airplane. That decision to actually get out of the plane was my moment of truth—I had prepared for the jump all morning and now it was time to make a call. Clearly that call mattered a great deal.

The fact that I was able (some would say stupid enough) to make that decision was a direct result of a process of risk assessment that I had done up to that point. Prior to visiting the parachuting school, I had done some research regarding fatalities and injuries of first-time jumpers. During the half day of training that led up to the jump I was constantly evaluating the risk I was contemplating. Who packed my parachute? How often does a chute fail to open? What are you supposed to do if that happens? Can I trust myself to be able to do what I need to do under the pressure that comes with knowing that I am plummeting toward the earth? And on and on. In the end, when it was my turn to go, I made the call. I chose to jump.

Another call I am asked to make, one that is not nearly so crucial to my continuing heartbeat, involves evaluating managed care networks. I work for a large direct writer of self-funded employer stop-loss coverage. Employers who choose to self-fund the medical benefits for their employees commonly purchase stop loss protection from companies such as mine. Coverage is of two varieties, individual (or specific) risk and aggregate (or group) risk. The presence or absence of a managed care network materially affects my company's risk as the excess loss coverage provider. Given the high prevalence of such networks in self-funded risk arrangements, the more important issue is not *if there is a network present, but which network and in which area?* One of my teams evaluates managed care networks to determine the value of a given network as it relates to the stop-loss coverage. The process my team follows shares some steps with my approach to deciding to jump out of that plane: gather information, assess the risk, and make a call.

I suspect that the instructions given to a firstime parachutist is much more consistent than the information my team gathers from managed care networks day to day. The variance in responses to my network questionnaire is significant. Often this is a result of differences in the backgrounds of the contacts or differences in systems. Getting the data is the hard part. Often this involves repeated phone calls and e-mails.

After the information has been collected, it is refined and dropped into an actuarial model. I review the results of the model and, of course, make a call. This call is in the form of potential rate action for quote opportunities that utilize that particular network.

Assessing the cost basis for a managed care network is at the core of the managed care evaluation issue. Cost data fall into two main buckets: hospital and physician. Hospital arrangements take various forms, but are commonly either straight discounted fee for service, per diem, DRG or case rate based. Outlier provisions are clauses that dictate that a hospital will be reimbursed by the payer at a straight discount off of billed charges for all claims that have a billed amount in excess of

some threshold, e.g., $25,000. Outliers are of particular interest to the stop-loss carrier, as nearly all stop-loss claims will fall into this category (see Hospital Charges Become A Significant Issue Again in the June issue of *Health Section News*).

Most hospital arrangements vary in some fashion by type of service, e.g., a discount for outpatient but a per diem for inpatient, different per diems for med/surg versus ICU/CCU, etc. Some hospitals use combinations of these mechanisms. For example, a hospital contract may indicate a per diem with an outlier except for certain cardiac procedures that revert to case rates.

Issues to consider in evaluating hospital arrangements include: How often can this arrangement change? How does this per diem compare to what I would have paid in this geographic region? Does this network have the right hospitals—can it provide the needed services inside the network?

Physician charges are often expressed in the form of a fee schedule, and are typically provided as a list of fees by CPT code on a spreadsheet. Just about as often, charges are given as a percent of RBRVS. Key issues here are: How soon can this arrangement change? How does this fee schedule compare to what I would have paid in this geographic region? For what areas does this schedule apply?

Once you've collected your data and evaluated the parts, it is time to pull things together into a model. Key assumptions here are: in-and-out-of-network assumption, credibility, physician and hospital weightings, service area, etc.

The in/out of network assumption is a simple concept, but useful statistics often are not available from preferred provider organizations (PPOs). The concept I am labeling as 'credibility' is really a catch-all that encompasses the issue of a lack of timeliness in being informed of contract changes, and mistakes or misreporting of information (it happens).

Decisions need to be made concerning the relative weighting between physician and hospital discounts. Similarly, within the hospital portion the actuary must make an assumption regarding the relative weights of each service type discount—to the extent that reimbursement mechanisms vary by service type.

Service area is another key issue. In the end you will have generated composite discounts for a set of hospitals within a given region, but you still must decide how you will express your discounts. Will they be statewide, by 3-digit zip code, by county, or on some other basis?

Because I am employed by a stop-loss writer, I have a great deal of interest in the leveraging effect of stop-loss deductibles. A $30,000 deductible will leverage medical trend significantly upward, but it will also leverage a PPO discount. Deciding how to account for and express this phenomenon is a significant decision.

And then the door of the airplane opens and your instructor says to get out. . . After gathering all the information, scrubbing the data, and tweaking your model, you have to make a call. What's this network worth? Sit or get out of the airplane. Frequently the actuary will have to make judgment calls on a variety of issues. Having a mechanism for evaluating the accuracy of your calls is important.

One final decision is choosing when to reevaluate a network. Merger and acquisition activity is common in managed care networks, and as a result things change. My preference is to reevaluate networks on an annual basis at a minimum.

Ten years ago, I had to make a call and I did — I jumped. For me, at the time, it was the right call. I glided through the air a couple of thousand feet off of the ground. Minutes later I had a "stand-up" landing (which means I landed on and stayed on my feet). The impact was softer than stepping off of a chair, although I did land off course in a nearby soybean field, but that's another story. . .

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