RISK strategies CONSULTING

WHITE PAPER

Provider Network Valuation

The Inadequacy and Incompleteness of Uniform Discount & Data Specifications (UDS)

Executive Summary

Selection of an optimal provider network is one of the critical decision points for any plan sponsor when attempting to provide care and benefits to its covered population. Risk Strategies Consulting believes that under the standards of the Inflation Reduction Act[1], the importance of the decision itself, as well as the processes and methodologies undertaken, potentially rise to a level of fiduciary responsibility and liability, given that employee-monies are included through both contributions and cost-share.

Key considerations around network selection are access, quality, and affordability, with patient experience and health equity imbedded within each aspect. Access has ties not just to the size of the provider network, but to the ability to receive the right care at the right time, in the right place. Quality is defined beyond merely the specific providers who are included or excluded from the network, and instead relates to quality-of-care metrics, measurements, and management utilized by the payor to ensure desired clinical outcomes. Affordability is linked to provider reimbursement levels and methodologies. The lower the unit cost and/or the basis for reimbursement, the lower the cost which in turn drives affordability.

At the present time, most network analyses spend a disproportionate amount of resources analyzing affordability while minimizing or ignoring the prioritization of access and quality. The existing methodologies for determining affordability used by major consulting and brokerage firms are the use of the Uniform Discount Data Specifications ("UDS") which is selected data provided by carriers, and/or network repricing exercises, whereby the consultant sends the payors a client's historic claim file and asks the carrier to fill-in the reimbursement levels which would apply to the historic claims, should those claims have been incurred under the bidder's network. In addition, machine-readable files ("MRF") under the Transparency Act are also emerging as a means of measurement.

UDS, network repricing, and MRF each have a number of material flaws in terms of accuracy, completeness, and the ability for payors to manipulate the accuracy of its answers. This white paper focuses on the significant shortfalls of UDS, given its prominence as the primary tool in the market for determining network competitiveness.

Risk Strategies Consulting experts have been examining and publishing on the accuracy and completeness of the UDS process and its results. We have found that UDS is fundamentally and foundationally flawed, to an extent that it needs to be overhauled or stopped. Key issues include, but are not limited to, a focus on discounts rather than cost of care, the two-year lag between the data being submitted and the plan year for which the plan sponsor is selecting a network, vague and incomplete definitions and specifications which enable manipulation of results by submitting entities, inadequate consideration of both provider mix and risk adjustment, lack of alignment with each carrier's penetration of the insured marketplace, and the implicit assumption that each carrier's book-of-business has identical attributes. In fact, it is broadly understood throughout both the consultant and carrier industries that UDS requires a major overhaul and/or cessation.

The multiple underlying UDS flaws, as well as shortfalls in much of the consultants' actual diligence and work, have resulted in inconsistent findings amongst the consulting entities' results in any given market. For instance, the consultants typically fail to run comprehensive retrospective analyses and validation of discounts achieved at years end versus those calculated for UDS. In fact, both repricing and MRF data shows significant inconsistencies and contradictions as compared to results under UDS. In addition, market sales of fully insured business by carriers show significant deviation from UDS results. All of the major insurers attempt to write as much fully insured business as possible as it is their primary driver of reported earnings. The incongruence between fully insured market results and UDS creates significant concerns around UDS accuracy.

UDS Background

UDS began Book of Business ("BoB") compilation in the early 2000s for the purpose of helping self-funded plan sponsors decide across markets where their employees reside, the payors who have the most favorable healthcare pricing for inpatient, outpatient, and professional service types. Each payor's network strengths vary market to market. Payors will have negotiated more favorably in certain markets than others, and negotiation results may vary depending on specific service types. The most prominent determinant of "favorable healthcare pricing" has historically been the degree of unit cost discount from billed charges to allowed amounts achieved by the payors. The composition of the provider network in a geography versus those non-participating provider services also comes into play, which can be especially meaningful in rural areas, where employees may need to travel for specialty care.

UDS data content (note, *not* data *usage*) supplied by the participating payors is decided by the UDS workgroup. Content is compiled and shared twice annually over a rolling 12-month period, Data aggregation and layout per service type are dictated in detail. Below is a high-level listing of what data is *included*.

- Group claims only
- Private exchange business
- Claims from all providers (except for those noted to be specifically excluded)
- Claims from in- and out-of-network providers
- High-cost claims
- All claims covered under medical benefits
- Claims paid through product rental networks
- Other specified provider payments and those applicable to medical coverage not included in administrative fees for fully insured and self-funded business (for example, withholds, pay for performance, risk settlements, bonuses, pre-payments, provider incentives, care collaboration payments, provider fees to fund administrative functions)
- Claims adjudication adjustments

Conversely, below is a high-level listing of what data is *excluded*.

- Claims for members aged 65 or older
- Medicare claims
- Medicaid claims
- Claims as secondary payor
- Mail order and retail prescription drug claims
- Dental claims not covered under medical benefits
- Vision hardware claims not covered under medical benefits
- Interest expenses
- Regulatory fees
- Prompt pay penalties
- Custom network claims
- Claim lines with ineligible charges
- Capitation payments
- Covered life assessments
- Network access fees
- Prisoner claims
- Railroad employee claims
- Denied and pended claim lines
- Claims for certain medical provider customers, who have a standard industrial classification of 8061 or 8062
- Provider identification
- Member identification

Strengths of Using UDS Data

The highly detailed UDS data specification, if followed, creates a basic degree of consistency in data reporting across payors. Having a standardized, complete, and uniform method for viewing network discounts across payors is critical in evaluating the basic financial values of provider network options.

Evaluators of the discount data typically allow for a margin of error, commonly about two percent in discount points, or four to five percent difference in unit cost. Evaluation of service types (i.e., inpatient, outpatient, professional) is relevant with respect to comparison of employee utilization patterns, which are typically aligned to member demographics, medical condition mix, and accessibility.

Limitations of Using UDS Data

Discount evaluation of a network using rolled up data submissions is oversimplified, vague, and allows for manipulation, as well as conjecture, of the true value of the data, as demonstrated by inconsistent results and rankings submitted by the various consultants. The UDS process *overly* relies on discounts as a proxy for (only) unit cost. Risk Strategies Consulting believes other methodologies that incorporate true cost and the values of payment integrity, medical management, use of appropriate site of care, efficient utilization, and well-being and risk management should also be incorporated as they offer significant value. Risk Strategies Consulting has also found that dollar fields are submitted variably, and the data studied does not adequately accommodate for several key factors, including but not limited to:

- Utilization patterns
- The overall size and mix of the network
- The actual charges billed
- The population demographics other than to examine a three-digit level zip code for employee residence
- Clearly delineated out-of-network (OON) utilization
- Other costs that are charged to the plan sponsor via bank accounts/ claim wire.
- Limited line of sight into what data any carrier has excluded
- Inconsistency between reported membership on for profit data submitters in their 10Q and number of members submitted for UDS files. There is no reconciliation or cross walk on membership differences for UDS and for-profit company reported membership in the 10Q.
- Provider mix and accumulations by member to assess impacts of large claims by carrier
- Standardization of each carrier's unique BoB which included industry mix
- Out-of-network (OON) claims and impact on cost not discount achieved

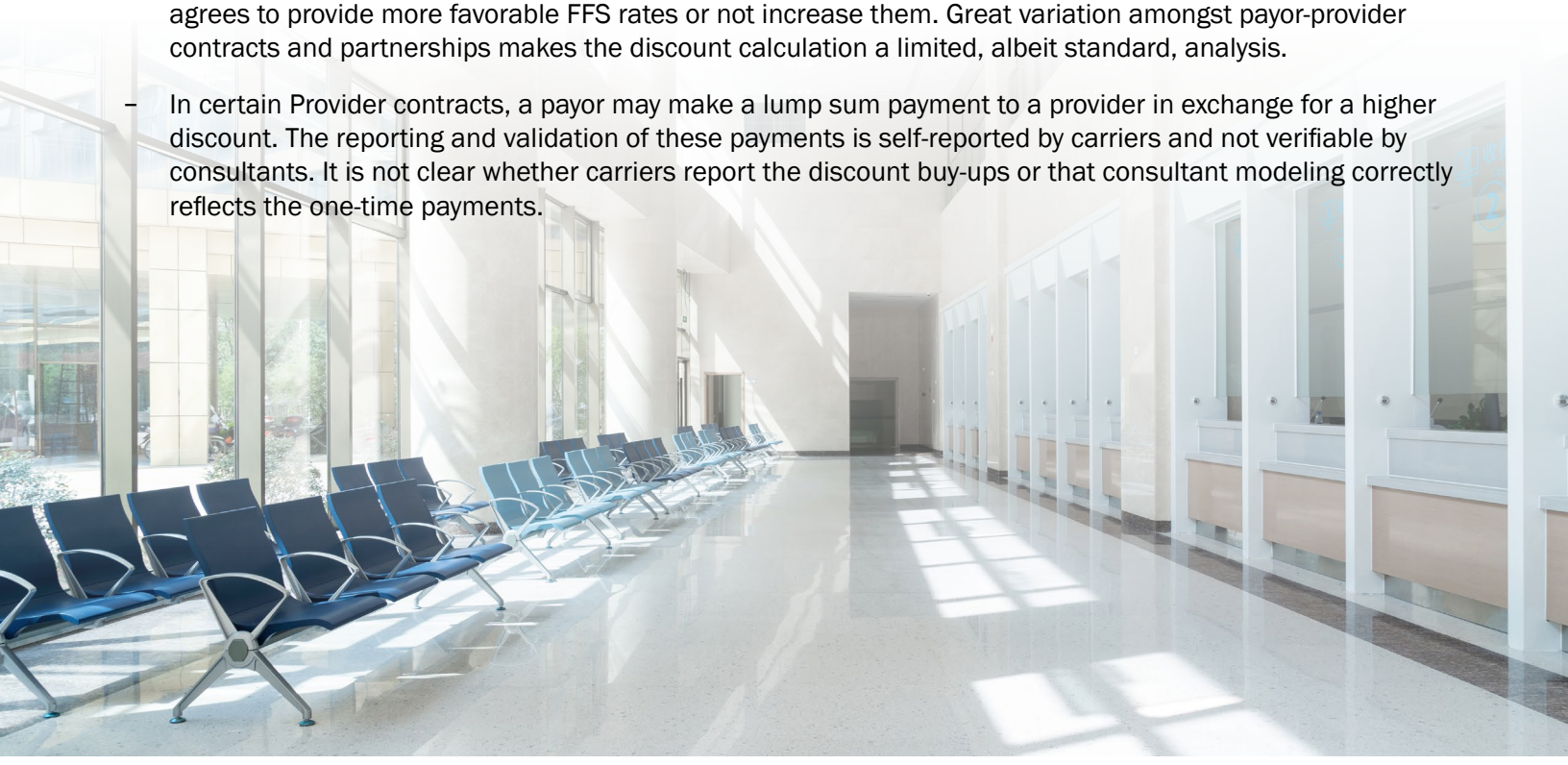
Although UDS data is collected and passed through actuarial modeling, both the inconsistencies in the data, as well as the missing key aspects mentioned, result in inadequate and unreliable output. Data manipulation is an additional area of concern. Payors submit UDS data to optimize their market positions, and any such data manipulation is not fully disclosed or understood by the various consulting firms. One indication of such manipulation includes a carrier's submission that improves by 300 or more basis points in any market in any single submission. This is particularly alarming, as on average only one-third of the providers are negotiated in any given year, and such a data point would mean a 9% or more improvement in discount position at a time when providers are seeking greater reimbursement. In addition, the current UDS file lacks certain key data that significantly impacts accuracy in certain Metropolitan Statistical Areas (MSAs) – provider ID (mix), claimant ID (high-cost claims), Standard Industrial Classification (SIC) (industry impacts underlying clinical and financial risks, as well as utilization patterns). Consultants generally do not highlight these limitations to their clients and oversell the accuracy of UDS.

There is also significant consultant variation on treatment of out-of-network claims (OON). Typically, an OON claim is more costly than an in-network claim. Most consultant models give discount credit for OON claims reduction programs which can generally cause misstatement of claims cost as OON claims are not managed, and a discount for an OON claim can still be more expensive than an in-network claim.

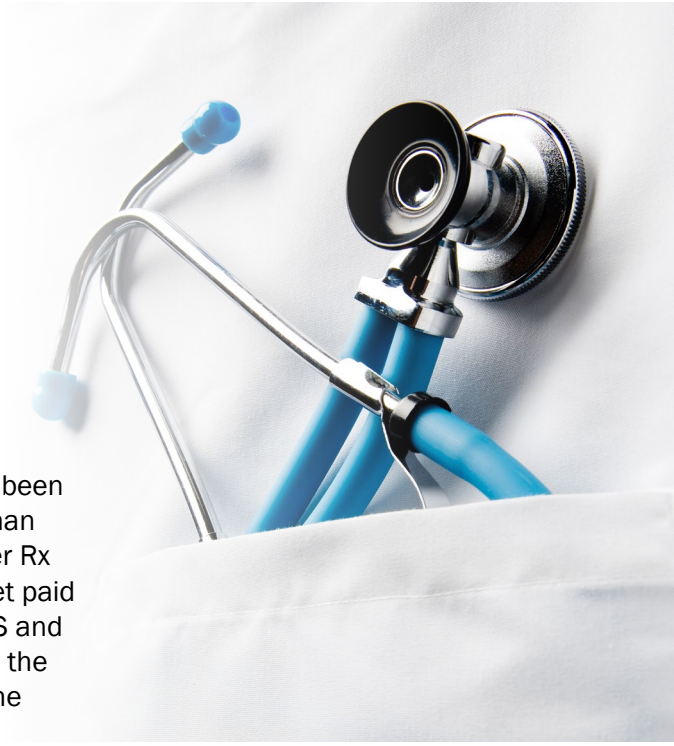
Key Limitations

Risk Strategies Consulting recognizes the significant role UDS plays in plan sponsor decision making. However, Risk Strategies Consulting believes that in addition to addressing the aforementioned limitations, consultants and the industry itself need to address, audit, and investigate the following **key limitations** within UDS submissions.

- **Adjustments specifications:** Adjustments specifications should be more prescriptive. *Adjustments are overutilized by carriers and too many consulting firms blindly accept them.*
- **Administrative costs:** Administrative costs to support cost and quality programs that impact the value of the network are not captured such as out of network negotiations and oversight, among others. These costs must be accounted for to understand the *total impact* to the plan sponsor.
- **Appendices:** Many believe, even with specification standards, too much flexibility exists including using the data specification form appendices, where participants share additional information.
- **Billed charge variation:** Stating a discount percentage from billed charges and knowing they and chargemasters can meaningfully vary (i.e., run higher/ lower amongst different provider organizations) in the same geography is aiming for a moving target in a snapshot of time. Not to mention those providers who are outside the member's zip code that are included in the analysis due to the need for medical travel, especially in rural areas or for those seeking centers of excellence offered by payors in alternative geographies.
  - Furthermore, fee-for-service (FFS) contracts may also contain outlier provisions that basically cause a default to billed charges when the tallied charges meet a pre-defined threshold, and those charges may or may not be first dollar. Another occasional practice with payor-network partnerships is for the payor to "buy down" the network such that in exchange for providing an upfront payment, the provider, typically a large health system, agrees to provide more favorable FFS rates or not increase them. Great variation amongst payor-provider contracts and partnerships makes the discount calculation a limited, albeit standard, analysis.
  - In certain Provider contracts, a payor may make a lump sum payment to a provider in exchange for a higher discount. The reporting and validation of these payments is self-reported by carriers and not verifiable by consultants. It is not clear whether carriers report the discount buy-ups or that consultant modeling correctly reflects the one-time payments.



- **Book of business attributes:** Payor BoB attributes, such as these below, vary considerably, impacting cost and utilization; however, sufficient modeling to neutralize these differences does not exist.
  - Average case size
  - Illness burden
  - Industry
  - Medical management programs
  - Participation levels
  - Plan designs
  - Provider usage
  - Wellness programs
  - Provider steerage
  - Out-of-network claims costs and associated expenses
  - Whether or not pharmacy is carved in or carved out. It has long been asserted by carriers that carved-in Rx produces better results than carved-out Rx. Note that the exclusion of retail Rx and mail order Rx causes measurement problems in UDS given that rebates do get paid on Rx in the medical plan but are nowhere accounted for in UDS and that when Rx is carved in, some Rx claims that were paid under the medical program under a carved-out scenario, may move into the Pharmacy Benefit Manager (PBM).



- **Clinical management:** Clinical care management is rightfully becoming a more important and visible consideration that impacts medical costs as more payors compete on the quality, cost, and experience value of their member engagement, chronic disease management, concierge and advocacy programs, high-cost claims focus, site of care redirection, medical policy development, use of evidence-based medicine protocols, utilization management expertise, focus on high-cost medical conditions, level of care advisement, and incorporation of value-based models of care ("VBC"). Any impacts to costs resulting from these programs need to be *reconciled and verified*, which is not well-considered today. In fact, the difference in UDS carrier data sets can influence observed results — a higher percentage of national accounts in a carrier's book-of-business that contains steerage elements impacts achieved discounts. These differences are not standardized in UDS.

- **Disclosure:** Carriers are failing to disclose a series of key practices that artificially inflate the value of their discounts. These include, but are not limited to, such strategies as prepaying providers significant amounts of money in order to achieve a higher discount, increase provider attribution and other fees that are utilized to negotiate deeper discounts, and/or the use of "new business" discount rates while depicting them as the payors overall market standard.

- **Exclusions:** UDS submitted data may not be relevant to the payor's total or actual book-of-business enrollment due to exclusions of datasets or timing incongruencies related to quarterly enrollment and provider rate structure. Consultants sometimes reinforce these inclusion/ exclusion criteria by applying different submission standards and data selection to different payors — especially for the aggregated Blue ("Blue Cross Blue Shield Association") plans. Examples of exclusions that can result in material impacts to which payor appears as lead in a market may include the following:

  - Claims associated with providers under examination for fraud, waste, and/or abuse
  - Client populations: Labor, government, fully insured
  - Custom provider networks or certain hospital or group providers (e.g., children's hospitals)
  - Edited claims activity (e.g., prospective versus retrospective editing that can falsely promote or erode the discount)
  - Ineligible billed charges captured inconsistently
  - Outlier claims
  - Pharmacy claims
  - Zero discount claims
  - Claims paid outside the UDS data submission parameters — some large claims are submitted late by providers and claims adjustments that increase amounts previously paid may also fall outside the UDS data timeframes.

- **Field definition:** Regardless of the data layout "specifications" being named as such, dollar fields such as "allowed" or "eligible" can be, perhaps surprisingly, open to interpretation, affecting validity of the analysis.[2] A need for better definition of claim types, which causes questions about claims classification accuracy and consistency amongst participants, is also vital.

- **Forecast to actuals validation:** Consultants and/or Brokers do not standardly validate the actual client results to verify forecasts made, which may be grossly overstated, and hence, a mechanism for any sort of performance guarantee is typically absent as well. When performance guarantees are offered, they tend to be for less than $100k, which is not a meaningful impact for a plan sponsor.

- **Large claims:** Large claims standardization is absent, which inherently encompasses a large percentage of the total dollars spent and may fall into outlier payments and carved out services that are not contemplated. In addition, since claimant ID is not a UDS field, current UDS analyses assume equal impacts of large claims by carrier and equal cost, which is not appropriate.

- **Machine Readable Files ("MRF"):** MRF are fairly new and there are some questions as to the comprehensiveness and sometimes accuracy of MRF files. However, MRF files are showing that in certain areas the published MRF data fails to align with UDS results indicative that UDS may be inaccurate. Note that some carriers are now leveraging MRF in their provider negotiations and also that providers too are using MRF to negotiate with carriers.

- **Margin of error:** The UDS plus/ minus two percent confidence interval/ margin of error is too large, allowing consultants to offer opinions that may not be fact-based. Sharing more data points would be more effective at communicating margin of error than just a statement or footnote about the definition of margin of error itself.

- **Market position spikes:** Purported changes in excess of three percent in market position have been submitted; however, contracting status suggests this is impossible to achieve given that a payor is negotiating approximately one-third of its contracts in any given year.

- **Metropolitan geography:** Major metropolitan areas are riddled with unconcise data representation due to the characteristic provider-payor contract complexities of large geographies that also contain a high variability in provider/service/and case mixes.

- **Modeling inconsistency:** Different consultants produce materially varying results for the *same data* due to lack of modeling consistency, raising credibility concerns over their payor placements.
- **Out-of-Network ("OON"):** OON activity is mishandled by UDS modeling. Overall, OON is more costly and is bereft of clinical programs, but in many instances, consultant modeling favorably assumes or depicts OON discount levels without assessing the overall detriment and cost of such OON utilization. Inclusion of claims where third-party vendor negotiations take place makes verification particularly difficult, for example through MultiPlan, who is oft cited for low case rate negotiations. Notably, payors *may actually benefit* financially from a total paid amount, while members face high OON payments. Conversely, some suspect a practice of including projected discounts for providers that will soon be in-network without consistent auditing validation of actuals achieved.

  It is also significant to note that one payor claims, and is given credit for, achieving 80% discounts on out-of-network claims. These results would seem to call into question the need for contracting in-network providers, given the that achieved in-network discounts usually top-out in the 60% range.
- **Provider mix:** Provider mix, not considered in UDS, may be materially different by payor in certain geographies, which can significantly increase the likelihood for misrepresentation of market standing, especially where dominant providers, who are aligned with specific payors, are present.

- **Real world incongruency:** UDS results often do not correlate to real-world insurance outcomes. As an example, UDS may name a certain payor as the lead in a particular MSA but the payor may have limited membership in that MSA. This is likely the result of statistically invalid levels of data. A second set of examples is tied to the fully insured line of business for each carrier by MSA. Often times, carriers listed as having the most favorable discounts have limited, if any, insured business in a given MSA. This reflects that carrier's internal actuaries as being unwilling to assume insured-based risk. Insured premium typically results in higher profit levels than the self-funded block of business. If a carrier has a reimbursement advantage, it should result in a pricing advantage, and a readiness to underwrite insured membership. In fact, a review of carrier filings with the various state insurance departments has shown a level of conservatism, and inconsistency, around actuarial assumptions and underwriting factors, as compared to supposed discounts realized under UDS.

  A last data point ties to the underwriting practices of the stand-alone stop loss carriers. When assuming risk, these carriers consider the payor/network by MSA. A survey of these carriers finds significant inconsistencies in their valuation of networks, as compared to UDS results. It is important to keep in mind that these insurers receive and analyze actual reimbursement levels when paying claims incurred under the stop loss.

- **Rural geography:** Rural populations, where credible data may be nonexistent among carriers, are frequently and incorrectly rated via UDS modeling algorithms that incorporate them into the larger MSA data. This is particularly concerning because membership geography is the starting framework for UDS analysis. Payors should agree ahead of time on the number of claims that are credible for discount calculations. Consultants need much stronger disclosure with respect to the potential "inaccuracies" of UDS on rural populations.

- **Sales strategies:** Payors may tout various "sales" strategies such as new business discounts to their clients and/ or lump sum payments to providers that enrich UDS discount position; however, disclosure and verification of these practices are absent.

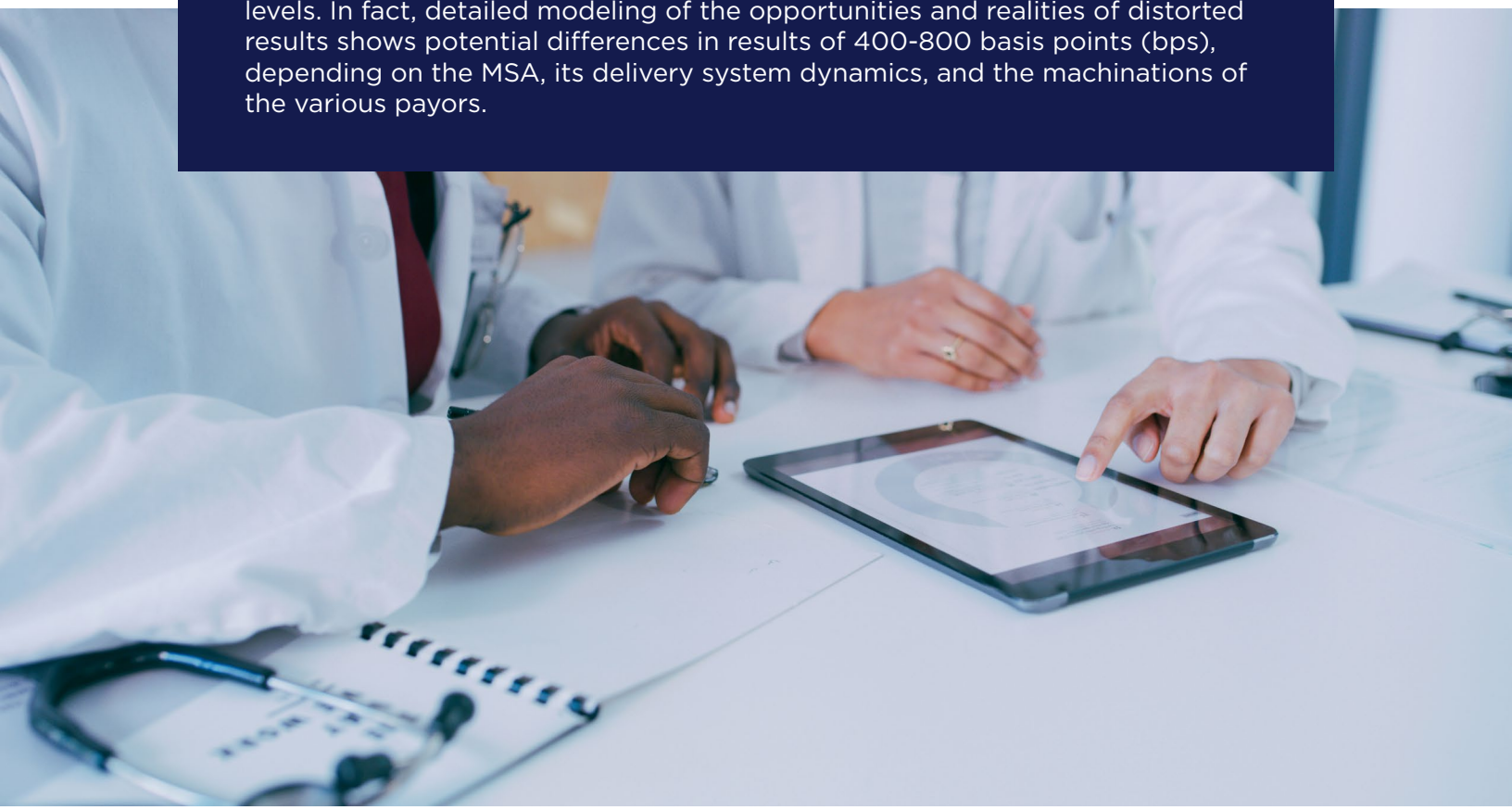
- **Timing:** UDS data is significantly delayed, by two to three years; too late to be utilized in the current sales cycle. Historical data may well not be reflective of the contracts in place in the renewal year, as these are frequently renewed tri-annually. While UDS does allow for discount projections, such elements are not verifiable by anyone and as such could be subject to material manipulation by any carrier.

- **Value-based arrangements:** With more respect to value-based arrangements in place with providers, whether they sit within large or narrow networks, great variety in construct of these programs exists for providers in the commercial segment, making the granting of UDS "credit" to these programs less straightforward and misrepresentative of the value they may/ not offer to the overall network. Additionally, the glide path to risk can be slow, which means year-over-year, surplus or risk-sharing percentages may change. As a result, the value model may or mostly cover the total cost of care (TCOC) or may only apply to specific condition or procedurally based episodes of care. The timing of these payments is also highly variable. To illustrate, care coordination fees that are designed to incentivize quality or provider investments — in addition to FFS payment — or that offer a vehicle for interim payments may occur monthly, quarterly, or vary with actual performance and outcomes. Sometimes, performance payments "simply" drive the FFS payment higher or lower based on specific outcomes.

  With TCOC models, a reconciliation of quality and cost within the year under examination may occur several months after the end of the performance year, which may not be captured within the timeline assessed for the discount analysis. It is of value to note that with providers new to these programs, surplus and risk payment amounts are difficult to predict, and the amounts can vary depending on the parameters within the negotiated contract. Furthermore, contract measurement is highly negotiable with commercial value-based care (VBC) contracts (unlike Medicare VBC, which dictates measurements and performance standardly).

The methods by which the payments are made to providers differ such as via plan sponsor claim wire, special fees with self-funded plan sponsors, or additional payments made directly by payors for fully insured client membership, or payors may decide to secure certain guarantees with respect to these models with their clients. The bottom line is that surplus and risk payment amounts are difficult to predict, the amounts can vary depending on the parameters within the negotiated contract, and they may be paid up to 18 months after the start of a measured "performance period," meaning these will not equate to fee-for-service claims payment timelines, which obviously necessitates more consideration than an appendix summarization. Finally, when a payor declares a certain number of members/ employees are aligned with value-based providers, the sophistication of the arrangement greatly impacts the true value to which this translates for the member and plan sponsor. For a more comprehensive view, then, taking the presence of these models into account and seeking validation of their impacts on total costs, quality, and member and provider experience are prudent practices — all of which culminate in an evaluation of the network.

The various limitations of the UDS data and the accompanying manipulation of that data by some of the payors has created a situation where UDS findings cannot be trusted as a valid datapoint in determining network discount levels. In fact, detailed modeling of the opportunities and realities of distorted results shows potential differences in results of 400-800 basis points (bps), depending on the MSA, its delivery system dynamics, and the machinations of the various payors.



Financial Accountability: Discounts and Transparency

A common provider contracting methodology is based on discounts for services delivered. This financial methodology does not adequately support insurance companies and plan sponsors who need to establish accurate accruals and liabilities on a Per Member Per Month (PMPM) cost basis. A compounding accountability issue is the lack of transparency around agreed-to reimbursement levels between payors and providers. Both parties claim confidentiality around reimbursement levels including protecting themselves with such language in their contracts. While Risk Strategies Consulting understands the proprietary and market competitive nature of the issue at hand, we are also concerned that plan sponsors are expected to make a purchasing decision based on highly limited financial data for network options that also fail to adequately distinguish themselves with distinctive quality of care metrics and measures.

Recent fiduciary lawsuits are a reflection of an amplified frustration over lack of transparency, clarity, and understanding of how healthcare services and access are selected, managed, financed, and made available to employees/ members. These sentiments are evidenced through growing consumer transparency legislation over recent years including the Transparency in Coverage Rule.[3] While headed in the right direction, a side-by-side evaluation of how a hospital and payor "transparently" reflect their reimbursements and patient costs is a challenged exercise. Some transparency information is represented at an "episode" level, member coinsurance/ benefit plan information status impacts the amount, and other care continuum activity have an impact on the actual total cost to the member and the plan sponsor.

Recent suits focus on fiduciary responsibility associated with regulations stemming from the Employee Retirement Income Security Act of 1974 ("ERISA") and the Consolidated Appropriations Act of 2021 ("CAA"). Ensuring transparency and clarity of the content and impact of all direct and non-direct carrier revenue that impacts plan sponsors is highly important for them to responsibly understand, manage, and make strategic decisions regarding healthcare benefit administration on behalf of their employees. Revenue types should be contemplated within the following high-level categories:

- Administrative fees
- Affiliated organizations
- Clinical fees
- Pass-through savings
- PBM-specific
- Performance payments

Recommended Improvements to the Measurement of Network Value Results

These findings are a *call to action* for everyone in the healthcare industry to expect more, not just more data, but *more transparency in data* that is meaningful for true network valuation and discerning how this translates into consequences for member care and affordability. An important way to accomplish this is to assess evidence of medical and pharmacy reimbursement structures that incentivize clinical outcomes and care coordination, and the data represented needs to reflect these efforts, programs with providers, and payment mechanisms from all sources (i.e., claim wire banking, upfront payments in exchange for FFS discounts, value-based incentives, percent of charge defaults, and other outlier payments). Broad sweeping statements or adjustments cannot be taken at face value; those simply result in inconsistent assumptions and generalizations with "credit" given. Instead, value drivers within in the network must be plainly, yet comprehensively, shared — and within the context of the market where members reside.

Most relevantly, the healthcare industry needs to hold itself *accountable for more consistency* in UDS submission, evaluation, auditability, and verification of statements made. We are not striving for perfection, rather, progressive improvement. Expecting consensus upon each topic within the UDS committee is unreasonable when making said improvements. Risk Strategies Consulting believes both payors and consultants can take the following steps to ensure this consistency.

Payors

Need to be accountable, through sign off from their chief actuary, for the accuracy of their UDS submissions and to require consultants to use certified valuation methods. Practices such as excluding high-cost claims and certain plan sponsor accounts should be revisited. Payors need to clearly disclose any changes made to actual data, including use of data filters, to ensure an accurate historical experience. Finally, payors should execute data use agreements with their consultants. This is standard procedure for Risk Strategies Consulting in our payor relationships whenever we form an analysis utilizing their data. We also review all findings with the payor prior to the release of the findings. These are basic quality control and validation methodologies standardly utilized in performing and publishing most statistical analysis.

Consultants

Need to compile and *audit* results including administration and other extraneous costs such as provider buy downs, new-network discounts, value-based reimbursement (VBRs), and other bank account transactions. It is the consultants' responsibility to ensure that the established lack of clarity is not being optimized to payor advantage. Consultants should consider the totality of data and information more judiciously that is relevant to a network's total value and not accept broad statements of value that are mentioned separately as adjustments or in an appendix (e.g., Appendix I) that is not a part of the core data under consideration. This should not be a concern over discovery of proprietary information, as the assessment is more broad-based than rate specific, even with said improvements. Data usage, rules, and methods should be consistently applied across consulting firms. Furthermore, consultants should fully disclose to their clients and the payors any concerns they have with the validity of the UDS data. A third-party analysis validation is also recommended by some in the industry as an important control. Retro verification of submission to actuals needs to become routine process. For example, today, we could satisfactorily review 2022-2023 predictions. It is crucial to note that having an actuarial certification does not negate the need to perform these important functions.

Overall Consultant Implications

Consultants need to consider the totality of data and information more judiciously to ensure relevancy to a network's *total value* and *not* accept broad statements of value. We also need to insist upon reaching agreement on the most appropriate methods of capturing those elements outside of claims activity that impact total costs. The core takeaway is that consultants need to be held accountable for what appears to be data submission manipulation by payors and to hold payors accountable in supporting plan sponsor adherence to fiduciary obligations. Initially, they should utilize all of the detail in the UDS data set, as is, to normalize for consistency across payors where the detail already exists. Next, push for other data elements that would give more insight into true unit cost, payment integrity, and medical management that also influence utilization. Best in class consultants must focus their questions to their clients and payors to ensure they are adeptly asking the *right* questions, while also illuminating those they have *not* been asking but *should have* asked.

Knowing consultants bring expertise and experience to help payors and plan sponsors navigate network valuation, both need to set expectations that consultants should be transparent and steer clear of consulting relationships where disclosure of professional relationships may present conflicts of interest. Moreover, because consultants are *the distribution channel* for payors, this sometimes results in their becoming a customer of sorts, whose needs like any customer's must be met, which can essentially usurp the standing of the *actual customer*, the plan sponsor.

Unlike our competitors, Risk Strategies Consulting does not receive direct or indirect third-party monies tied to any project, client, or book of business. This ensures our objectivity and avoids the perception or appearance of any conflicts of interest. Additionally, we do not sell any services other than consulting, and we have no preferred arrangements with anyone in any market segment. This fact distinguishes us from nearly all of our competitors and ensures our objectivity, while also enabling us to avoid any appearance of conflict of interest.

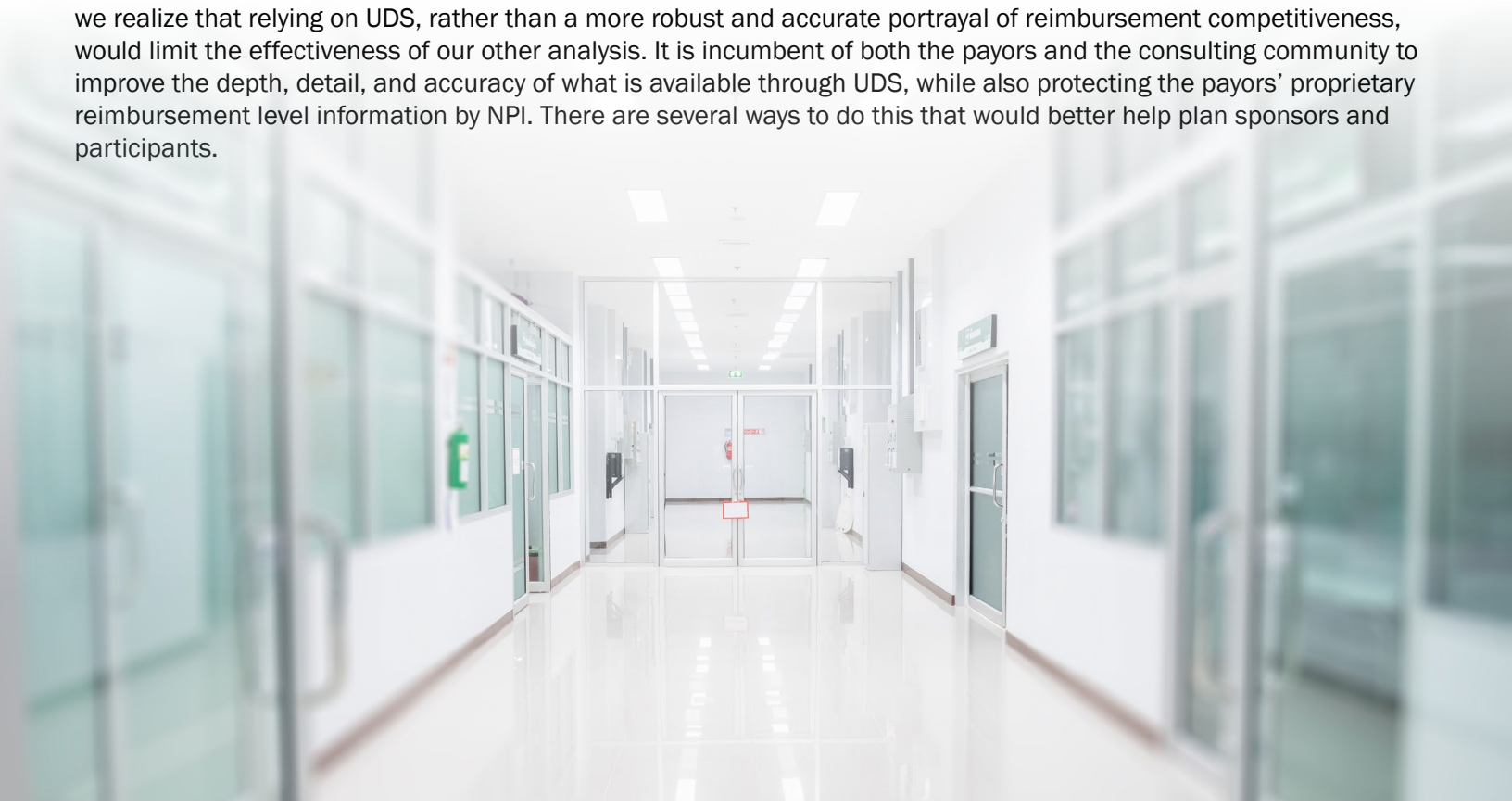
Our Detailed Approach

Risk Strategies Consulting undertakes a thorough and detailed process in assessing the key components of network valuation.

- While Risk Strategies Consulting acknowledges the limitations of even discounts as a measure of cost, we do perform a complete analysis of discounts achieved for each MSA by carrier. In performing our work, we utilize our proprietary data set that uses full-claim line detail, by National Provider Identifier (NPI), for all diagnostic, procedure, and revenue codes. This data set covers almost 70 million participants and is updated on a quarterly basis. Each year, we agree to a detailed uniform methodology with all payors, comparing our findings to their internal results. In the last five years, we have had a difference of opinion in 2% or less of results on fewer than 3% of the MSAs. **In speaking with a number of the payors, they state that the UDS results they receive from the various consulting firms vary up to 350bps by MSA. This is a serious issue that illustrates the inconsistency of the methodologies being utilized by the consultants to calculate discounts under UDS.**
- Risk Strategies Consulting utilizes a proprietary risk-adjustment methodology that we share with each of the payors. It takes into account such considerations as case mix, provider mix, and service mix. We recognize that there are many acceptable risk-adjustment methodologies but have reached agreement on our tool with each of the payors. When applied to the various books of business by payor, by MSA, we have consistently found that the Blue Cross Blue Shield entities have a risk-adjustment disadvantage of 150-275 bps. This is likely the result of the Blues possessing greater levels of small group insured blocks of business than other carriers. Given the Blues "large, friendly networks" they also typically attract other types of risk containing adverse selection.
- Risk Strategies Consulting utilizes our data set and risk adjustment methodology to create PMPM values. Achieved PMPMs are a more accurate and important measure of network financial results. Both insurers and self-funded plan sponsors build their accruals in the resulting rates, as well as rate equivalents, on a PMPM basis.

- Risk Strategies Consulting has taken significant epidemiological research to examine the public health risks of various health population segments by MSA. Due to statistical validity, a given plan sponsor's covered population may not reflect the morbidity and disease/condition mix of the overall MSA in any given year. However, Risk Strategies Consulting takes great care to analyze and measure results with the expectation that a given subpopulation, when adjusted for demographic, economic, and other key factors, will likely regress or progress to the mean over a given period of time.
- Risk Strategies Consulting has performed substantial work around the measurement of high-performance providers by examining both patient-centric and provider-centric machine-based analytics. Our proprietary grouper enables us to create individualized episodes of care. In doing so, we take into consideration the full period for which we have claims and other data for a given member. This enables us to look at true cost of care for an instance. While some may consider a cardiac bypass surgery as an episode of care, we consider the surgery as an encounter. We define the episode of care to include the pertinent care received leading up to the surgical encounter, as well as all related care received after the surgical encounter.
- When working with the payors in determining the overall value of their network offering, we ask for specific information around their views of strengths, flaws, and overall dynamics of the healthcare delivery system by MSA. We compare that information to that which we have been able to discern from our own work. We then ask the payors for the specific strategies and approaches that they undertake contractually and clinically to best address shortfalls in the delivery system, the common epidemiological-based findings previously described, as well as the definition, use, and steerage, of high-performance providers.

While major parts of our methodology go beyond accurately assessing the competitiveness of reimbursement levels, we realize that relying on UDS, rather than a more robust and accurate portrayal of reimbursement competitiveness, would limit the effectiveness of our other analysis. It is incumbent of both the payors and the consulting community to improve the depth, detail, and accuracy of what is available through UDS, while also protecting the payors' proprietary reimbursement level information by NPI. There are several ways to do this that would better help plan sponsors and participants.



Conclusion

The current industry UDS process is as much, if not more of, a marketing tool rather than an actuarial exercise. The implied actuarial precision is illusive, as data for UDS which is either utilized or missing, taints outcomes materially and renders the output of UDS modeling to be potentially not even directionally correct. Relying on a flawed discount calculation methodology places plan sponsors and participants at undue risk. Risk Strategies Consulting is highly concerned that failure to address the issues at hand will put all parties involved in jeopardy of properly fulfilling the fiduciary responsibilities involved. We have laid out additional methodologies to better measure reimbursement and cost, as well as deeper needed consideration of access, quality, and affordability. The industry can do much better; the time is now to collaboratively create a more transparent and accurate method of evaluating provider network value.

Citations

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2. Myers, L. (2012). Determining discounts. Milliman. https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/healthreform/pdfs/determining-discounts.ashx
3. Transparency in Coverage, 85 FR 72158 (2020). https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage

Get to know us.

Risk Strategies Consulting is comprised of experienced consultants, actuaries, data scientists, auditors, pharmacists, accountants, and other experts able to help payors, providers, and plan sponsors clearly understand the risks of their business and ways to minimize and manage them.

As a national consulting and actuarial business, Risk Strategies Consulting provides high-touch consulting and state-of-the-art analytics services including strategy and consulting (encompassing health and welfare with deep pharmacy expertise, as well as mergers and acquisitions): actuarial services for plan sponsors, providers, and insurers; and benefit and claim audit services. Services are provided for a wide variety of industry segments including government entities, manufacturing and distribution, and self-funded organizations including corporations and trusts, healthcare organizations, national and regional insurance companies, and private equity firms, among others.

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