# Money Map Math White Paper


## Abstract

The real price paid for medical care, referred to as the claim allowable, is known to vary by as much as 1,000% per care item in the same city, in the same network. This is analogous to paying $3 per gallon of gas or $30 per gallon of gas in a gas station network or paying $30,000 for a car versus $30,000,000 for the same car in a car-purchasing network.

There has also been cultural acceptance, promulgated by the insurance companies, that staying within an insurance company network, referred to as in-network, is financially advantageous. This study sought to quantify a savings technique using preferred in-network medical providers for routine medical care in the categories of blood work, imaging, surgery center care and urgent center care. The author defines preferred in-network providers as facilities with pricing that is generally 500 – 1,000% lower than higher-cost, in-network providers for the same care item, and refers to these facilities as Money Map preferred providers. These providers comprise the pool of providers used in what the author refers to as the Money Map Savings Technique.

In a prior analysis by Pratter, it was proven to be common for a routine, in-network care item to have 1,000% pricing variation. A few examples of this pricing variation from Blue Shield claims data are below and listed with their five digit CPT (Current Procedural Terminology) billing codes:

**99214** Follow up doctor visit: $60 to $573. Price variation: 955%
**45380** Colonoscopy: $600 to $6,821. Price variation: 1,136%
**73721** Lower limb joint MRI: $410 to $3,509. Price variation 856%
**80053** Comprehensive metabolic panel (blood test): $5 to $1,260. Price variation: 2,520%

The names of the medical providers with relatively-lower, in-network pricing for routine care (as defined above) are known. Subsequently, Pratter established these medical providers per carrier network on Money Maps using proprietary Money Map Techniques. The purpose of this study was to measure the potential medical cost savings that can be achieved by empowering and incentivizing employees to receive care at lower-priced, Money Map providers.

This white paper addresses the logic surrounding the reduction of in-network pricing variation for routine outpatient care in the categories of blood work, imaging, surgery center care and urgent care, and its application to self-funded plans.

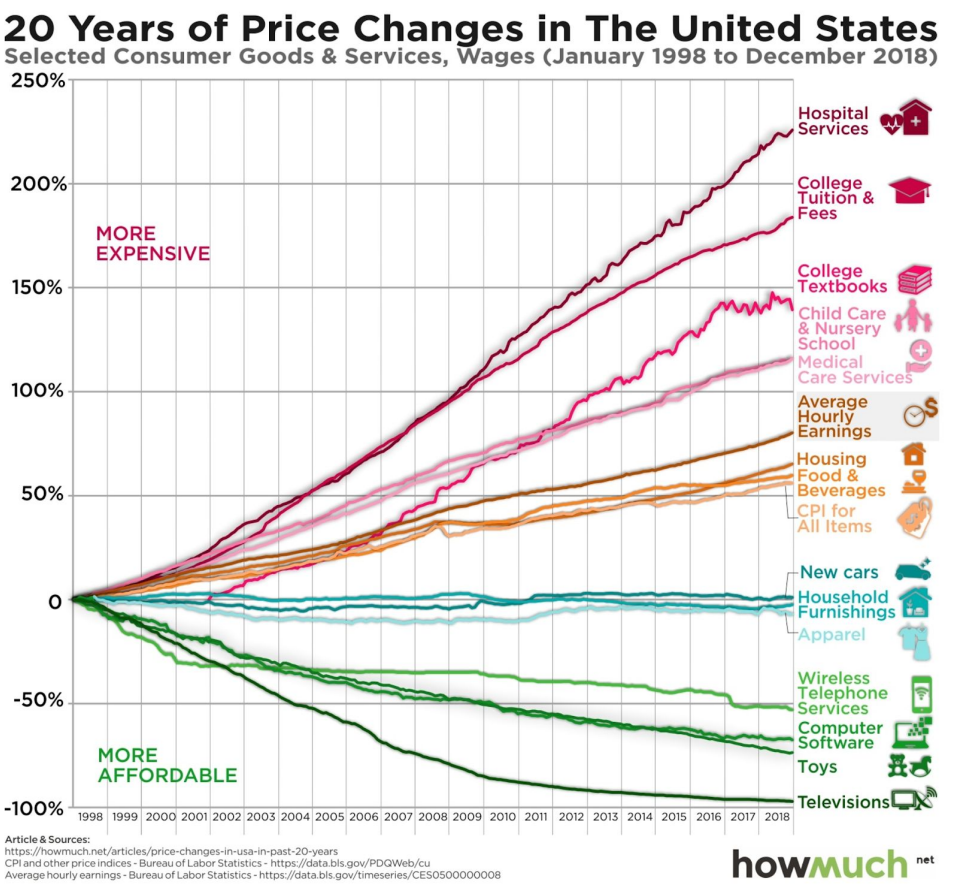
**Conclusion:** Enhanced utilization of Money Map preferred providers within the Blue Shield network result in an average savings of approximately 60% per claim. The end result of utilizing preferred in-network, Money Map providers for routine care would generate $23,108,387 in one calendar year for the 54% of medical claims that could be properly analyzed for a 30,000-member organization. This amounts to $114 per blood work item, $1,617 per imaging study, $4,126 per surgery center care claim item, and $424 per urgent center care claim.

## Introduction

Every year the cost of  healthcare goes up for employers, membership organizations, plan members and their dependents. For employers and organizations, an alarming percentage of this increase is paid blindly, due to the fact that carrier reports do not provide the names of the medical providers, the names of the medical tests and the real prices paid necessary to generate a line-itemized medical bill.  As a consequence, egregious 1,000% pricing variance among in-network providers for the same care item remains hidden from the employer/organization, effectively denying them the awareness and information they would need to create effective and sustainable cost-saving solutions. Employers and organizations have no alternative but to shift a portion of the growing cost burden onto their employees/members at a rate that is higher than the growth rate in wages and salaries (Figure 1).

In 2015, the Kaiser Family Foundation found that medical bills were a contributing factor for 1 million adults who declared bankruptcy. Its survey also found that 26 percent of Americans age 18 to 64 struggled to pay medical bills. According to the U.S. Census, that represents 52 million adults.

**Figure 1.** Rising health care costs ("Hospital Services" and "Medical Care Services") versus average hourly wages.



## Problem Defined

Employers and membership organizations experience increasingly-burdensome increases in healthcare costs each and every year without a full and understandable explanation. Most importantly, they have been powerless to deal with these skyrocketing healthcare costs. Health plan self-funding represents a conscious decision to undertake risk for financial reward. This financial risk cannot be managed without an awareness of the 1,000% in-network pricing variation for the same care by medical provider name.

The Employee Retirement Income Security Act of 1974 (ERISA) requires self-insured plans to prudently manage and account for their health spend. Proactively engaging in medical cost savings solution(s) is necessary to satisfy this federal obligation. Self-insured plans have experienced a lack of objective evidence with what the author refers to as medical money math, to engage in effective medical cost savings solutions.

Purchasing in-network care has not kept healthcare costs from skyrocketing. This disproves the claims carriers make of the financial benefit of their networks and instead proves the inefficacy of their networks brought about by 1) their extreme pricing variance per care item, 2) pricing opacity, and 3) "gamed" discounts. The status quo whereupon businesses and organizations pay larger medical bills each year blindly, must be addressed with practicable solutions for the financial health and wellbeing of employers, organizations and their plan members.

## Purpose

The purpose of performing a preferred in-network Money Map analysis on outpatient care was to quantify in-network, same-geography medical savings opportunities that are actionable and within the control of the self-insured entity and its members. This technique was chosen due to its simplicity. Plan members are not required to know the full name of the medical test or understand complex pricing structure terminology. The member is instead pointed to financially-advantageous blood work, imaging, surgery and urgent care centers.

## Methodology

1,000,000 medical claims for an organization of approximately 30,000 members with health benefits were analyzed.[1] Only 54% could be intently studied to provide conclusions, based on five-digit CPT (Current Procedural Terminology) codes. The other 46% of claims was revenue-coded, meaning four-digit codes were used, which cannot be itemized to the specificity of CPT codes at the care-item level.

The eight most common CPT codes for blood work, imaging and surgery center care comprised over 95% of the health plan spend in each of their respective categories. Therefore, these CPT codes were used to determine the average facility fee for each category. For lower level emergency room visits, specifically level 1, 2 and 3, it was assumed that such care could have occurred at urgent care centers. All level 4 and level 5 emergency room visits were assumed to require emergency room care and were not considered for potential money savings. The average emergency room facility fees were determined to compare to the average urgent care center fee.

[1] While 1,000,000 medical claims on 30,000 members (covering 100,000 lives) over a 12-month period may seem uncommon, it is important to note that when blood work is ordered, four tests are commonly ordered which results in four

(Footnote continued on next page.)
claims and a phlebotomist fee for a total of five claims. A colonoscopy typically results in five claims: 1) facility fee, 2) professional (doctor) fee, 3) surgical tray fee, 4) anesthesiologist fee, and 5) anesthesiology tray fee.

Next, the average facility fee was calculated for the preferred Money Map providers in each of the four categories in this applicable claims cost data set. A delta was established per category of care between the average of what was actually spent and the average of what could have been spent based upon the Money Map providers. Note that already 30% of members received care at Money Map providers. Therefore, the applicable savings math ultimately reflects on how much money could have been saved if the other 70% of members received their routine care at Money Map provider facilities.

All CPT codes for care items in each category, including blood work, imaging and surgery center care were totaled to a number of claims in each category. The number of claims was multiplied by the delta minus the number of claims that already occurred at preferred Money Map providers.

**Results**

The results for each of the four categories is displayed in Figure 2. This demonstrates what was spent versus what the preferred Money Map provider spend would have been.

**Figure 2.** Total current health plan spend versus Money Map preferred provider spend.

| | Total Spend | Money Map Spend |
|---|---|---|
| Blood Work | $4,889,471 | $1,906,894 |
| Imaging | $14,491,775 | $5,072,121 |
| ER/Urgent Care | $3,485,024 | $940,956 |
| Surgery Center | $14,319,453 | $6,157,365 |

The end result of utilizing preferred in-network, Money Map providers for routine care would generate $23,108,387 in one calendar year for the 54% of medical claims that could be properly analyzed. Given that the other 46% of medical claims occurred at higher-cost providers, namely hospitals, the quoted figure of total potential savings via enhanced utilization of preferred Money Map providers is believed to be significantly underestimated by several millions of dollars.

**Incentives**

Financial incentives are an effective way to drive utilization of any program or tool. This holds true for Money Map preferred providers. To quantify the dollar savings using common markers for levels of participation, Figure 3 was created.

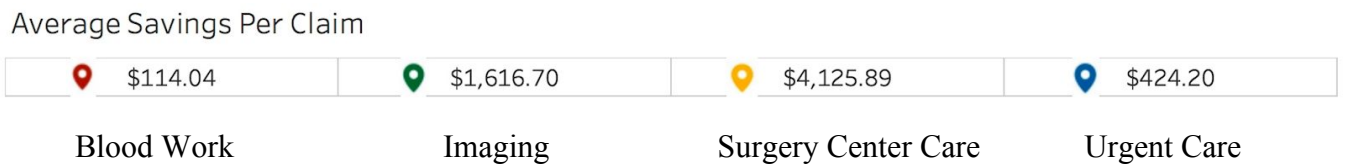
**Figure 3.** Bottom-line savings based on level of participation.[2]

| Participation | 25% | 50% | 75% | 100% |
|---|---|---|---|---|
| **Savings** | $12,550,384 | $16,069,718 | $19,589,052 | $23,108,387 |

[2] Savings are weighted and derived from five calculations per procedure.

In general, higher utilization can be expected when the financial incentive is at a dollar amount that triggers use. To help determine a dollar-amount incentive for each category of care, the average savings per claim in each category was calculated and displayed in Figure 4. Note that although $114 per blood work item is the average savings by using a Money Map provider, it is most common for a physician to order four blood tests at one time, creating a $456 savings per visit to a blood work laboratory. With potential savings of this magnitude, employers/organizations can be quite generous with financial incentives, even waiving a co-pay or coinsurance or paying an employee $200 for utilizing a Money Map imaging center (MRI/CT) center.

**Figure 4.** Average savings per claim.




**Summary**

Affordable access to medical care is achieved by incentivizing employees/members to choose wisely when receiving routine outpatient care. This is referred to as tiering of the health benefit. Healthy employees/members are more productive employees/members. A better health benefit assists with employee/member retention.

ERISA health benefit compliance is achieved by implementing a medical cost savings solution supported by medical money math. Failure to do so remains a significant compliance risk.

Employers and membership organizations stand to save millions of dollars by reducing the 1,000% pricing variation in-network for the same care in the same geography. This is done by increased utilization of an established preferred Money Map national provider network. Staying in-network and paying medical bills blindly does not financially protect the employer or organization or its employees or members.

**Call to Action**

Email Mark Robinson mark.robinson@pratter.us, Chief of Business Strategy, to activate a medical cost savings solution within your network using Money Map.

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