



*Gaining the Inside
Edge: How Payers can
Outpace Competitors
with Competitive
Intelligence*

Healthcare payers rely on detailed intelligence on individual providers and healthcare delivery organizations to make informed decisions about entering new markets, designing new products, negotiating contracts, and identifying potential fraud, waste and abuse.

However, in a fiercely competitive marketplace, having access to the right competitive intelligence at the right time is crucial. Competitive intelligence that provides a complete market view not only gives payers the upper hand in negotiations and planning, it ensures that when negotiating contracts or looking to expand their network that they have as much data (or more) than their competitors – allowing them to make smart and informed decisions and maintain a strong competitive advantage.

To better understand just what types of intelligence payers have access to, and regularly use, LexisNexis, in partnership with Healthcare Dive's studioID, recently surveyed 107 payer professionals in mostly senior management positions. From claims data to remittance data and more, we learned how payers use these types of data — and why these different types of competitive insights are essential to strategic decision-making.

Here's a look at what we learned.



LexisNexis and Healthcare Dive's studioID surveyed 107 payer professionals on claims and remittance data use.



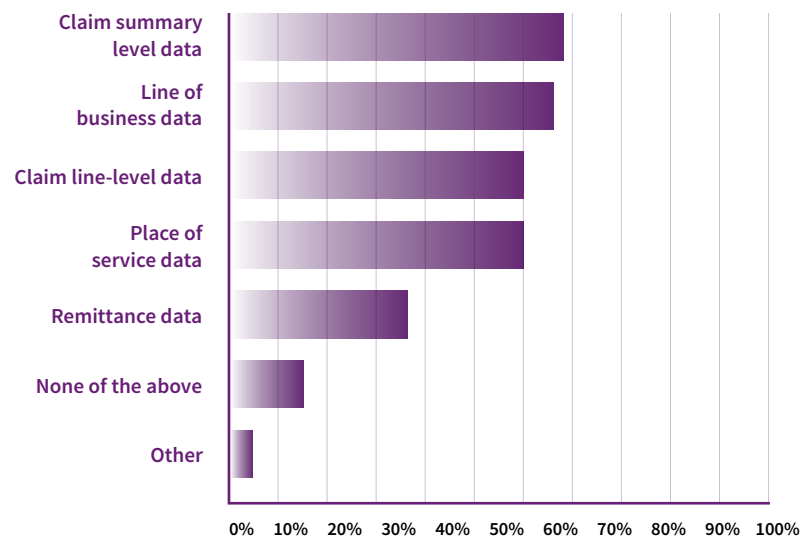
What Competitive Insights Do Most Payers Have?


Our survey asked about a number of different types of competitive intelligence that payers may have access to. Here's what we uncovered.

ACCESSIBILITY TO COMPETITIVE INSIGHTS VARIES

Given the value of claims data, it's not surprising that all but 15% of payers have access to some competitive insights. However, how much, and what types of data varies. Claims summary-level data was the most common type of competitive intelligence payers said they had access to, but even so, more than 40% of payers said they lacked access to it. **Payers were least likely to have remittance data, with only 38% saying they had this type of data.**

Which of the following competitive insights do you have access to make informed business decision (i.e. industry claims)?





“Payers have access to their own remittance data — what they paid to who, for what, or where — but have little to no market metrics, so they don’t know if they’re in line with competitors. Having remittance data outside of their own plan provides that line of sight and allows them to engage in better planning.”

Rebecca Hauck, Director of Product Strategy at LexisNexis Risk Solutions

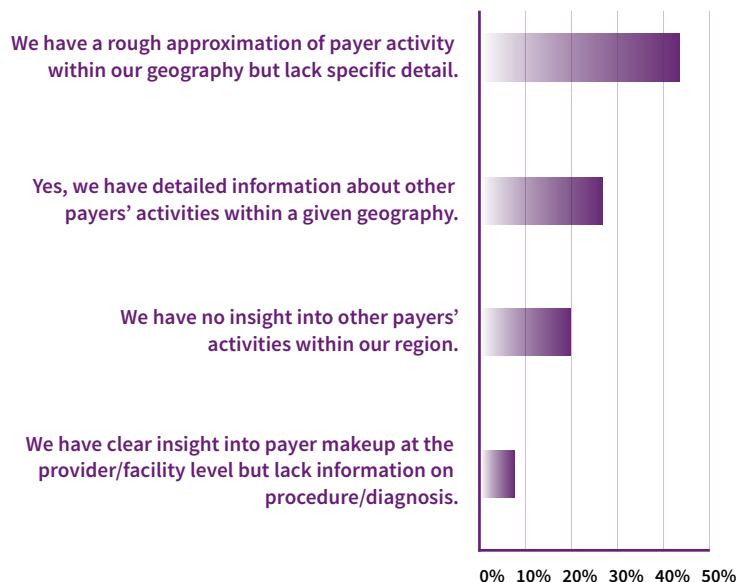
“Payers have access to their own remittance data — what they paid to who, for what, or where — but have little to no market metrics, so they don’t know if they’re in line with competitors,” said Rebecca Hauck, Director of Product Strategy at LexisNexis Risk Solutions. “Having remittance data outside of their own plan provides that line of sight and allows them to engage in better planning.”

Overall, access to comprehensive competitive insights is crucial to payers. Payers need to compare contract costs when negotiating and planning, and to do so, they need a 360° assessment of what their competitors’ contracted rates are and how their rates compare with the market as well as insights into whether a practitioner’s rates are within the market norm. Competitive intelligence that provides a complete market view is the only way to achieve this holistic view.

PAYERS HAVE LIMITED DATA ON PAYER MAKEUP

Another key type of competitive intelligence is having detailed data regarding the payer makeup of each provider, facility, procedure and/or diagnosis. However, only **25% of payers said they had access to detailed payer-makeup data**, and almost one-fifth said they had no access to this kind of data.

Do you know the payer makeup of each provider, facility, procedure, and/or diagnosis in your geography? i.e. both in and out-of-network.



“When you’re talking about market expansion or you’re trying to coordinate with an ACO, it really helps to understand what the conditions are in a particular geography,” said Sean Larson, Senior Director of Healthcare Strategy at LexisNexis Risk Solutions. “You want to know that the conditions are relevant and you want to understand the clinical conditions such as who’s doing the most of a certain procedure from a physician facility standpoint as well as the rate they’re getting paid.”

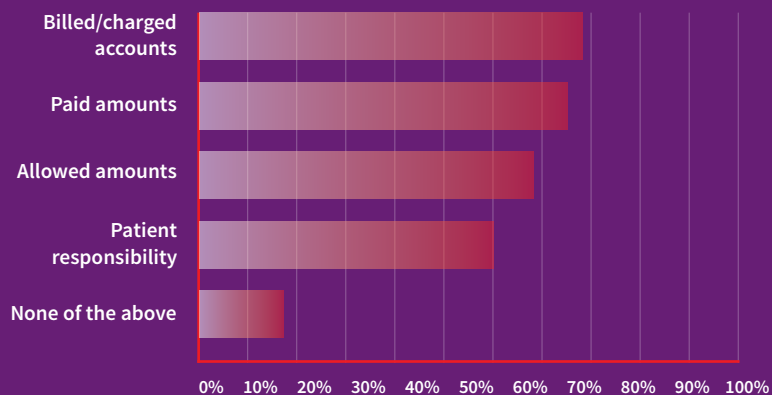
Without access to data on payer makeup of each provider, it is challenging for payers to know whether they have the right providers for their members. It is also difficult for payers to know who the high-value physicians and facilities are that they should contract with and what type of provider or facility volumes they can expect from an acquisition or expansion.



MOST PAYERS LACK PATIENT RESPONSIBILITY METRICS

When looking at competitive remittance data specifically, most payers identified they don't have access to patient responsibility metrics, even though they have access to billed and allowed amounts. However, patient responsibility data is an important part of strategic decision-making, and a lack of insight into this key data point can lead to unintended consequences.

Which of the following external claims rate metrics do you have access to?



“When you look at things from the patient-responsibility standpoint, when you’re negotiating contracts or designing a product offering, you want to make sure you’re not unintentionally disincentivizing members from using a product, so it’s important to know what the patient-responsibility portion is and to make sure it isn’t a disincentive for them to utilize important care,” said Rich Morino, Senior Director of Strategic Solutions at LexisNexis Risk Solutions.

Overall, remittance data provides a crucial starting point to determining whether a network expansion or new product design is viable. Without this type of competitive intelligence, payers are making decisions with an incomplete picture, making it difficult to know if their decisions are on target with the needs of their population.

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How Are Payers Using This Intelligence?

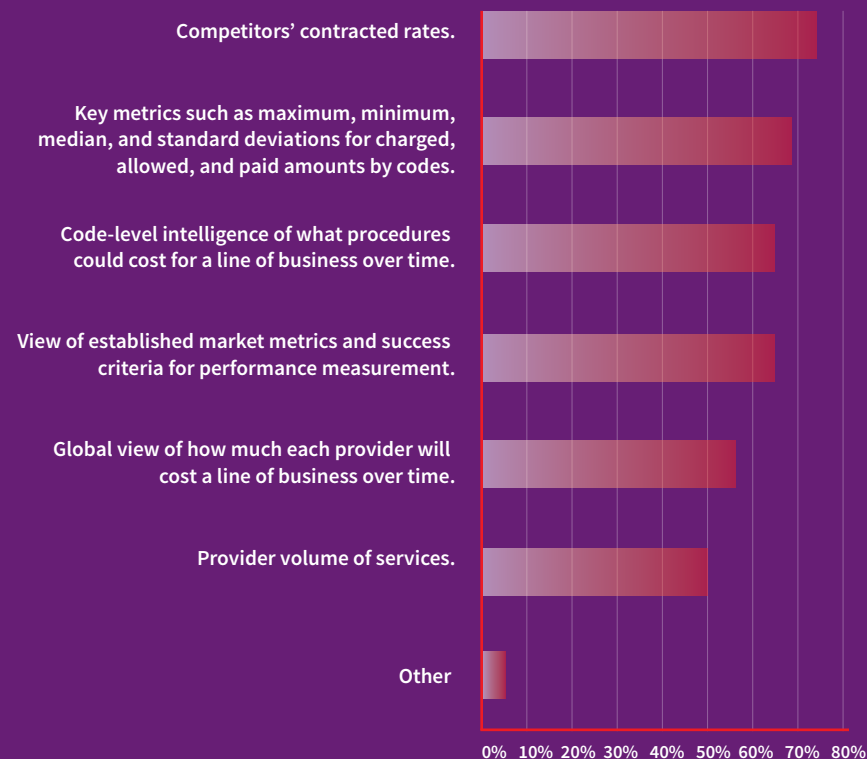
There are four main areas where competitive intelligence can play an important role for payers — and in many cases having this intelligence has become a must-have rather than a nice-to-have.

CONTRACT NEGOTIATIONS

Every payer wants to negotiate effectively so that they aren't overpaying for services, can attract the right mix of facilities and practitioners, and can close the deal as quickly as possible. To improve contract negotiations, payers listed as the most helpful insights:

- **Competitors' contracted rates (64%)**
- **View of established market metrics and success criteria for performance measurement (59%)**
- **Key metrics such as maximum, minimum, median and standard deviations for charged, allowed and paid amounts by codes (58%)**

To improve contract negotiations, what competitive intelligence would be most helpful to have?



Having data such as competitors' contracted rates provides an opportunity for payers to gain a market-level cost comparison, enabling payer executives to enter contract negotiations with the insights they need to negotiate terms that are most favorable to their business and members. These insights can also help speed negotiations.

Additionally, remittance information allows payers to compare reimbursement rates across payer contracts to understand how they rank against competitors and negotiate more effectively.

“If you’re looking to drive the absolute best rate, you now know what the best rate is. You also have a sense of how far away from the average rate or the median rate, you are,” said Jay Sultan, Vice President of Healthcare Strategy at LexisNexis Risk Solutions. “On the other hand, if your goal is to take the friction out of the process and go fast, you now have a sense of what offers are probably going to be easy for providers to accept.”

Ultimately, the more data payers have that can provide a 360-degree view of rates, market saturation and workload, the more effectively and strategically they can negotiate and evaluate provider contracting decisions.



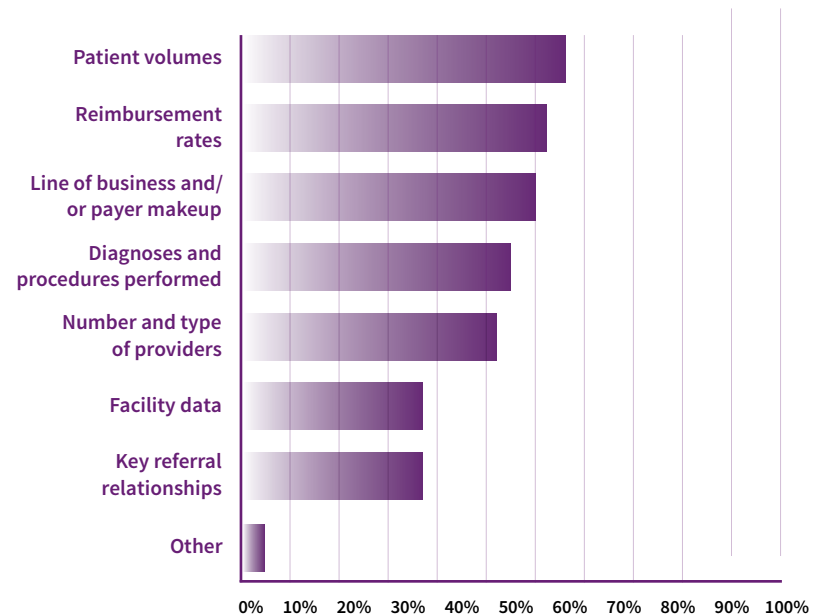
NETWORK EXPANSION

Fierce competition exists in every market, meaning healthcare payer executives want to have a comprehensive view of the market before they make any move to expand — either organically or through acquisition. This requires having a view of everything from reimbursement rates to patient volumes to lines of business and payer makeup.

To make better decisions regarding network expansions, the three data sources payers said were most important included:

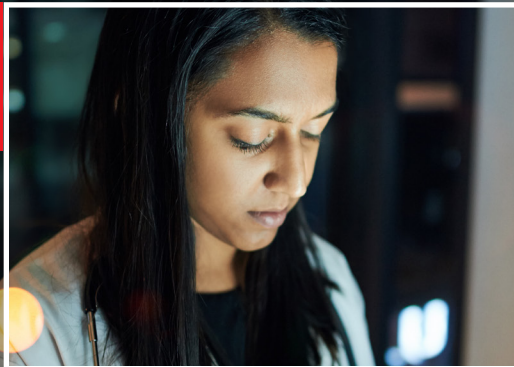
- **Patient volumes (65%)**
- **Reimbursement rates (63%)**
- **Lines of business and payer makeup (60%)**

When evaluating network expansion or acquisition opportunities, which of these is most important to your organization?



To expand market share by offering specialty services, payers need to know where gaps exist and who can fill them. Having access to data, even submitted-claims data, gives payers valuable information on volume and location of services performed and can help identify key physicians payers may want to recruit into their network.

“When looking at network expansion, payers often look to fill an existing gap with certain kinds of specialists,” Hauck said. “But looking at their own medical claims, they are going to have blind spots because those specialists aren’t in-network, so either a payer won’t see a specialist at all or they won’t see the specialist’s full workload across payers to accurately assess fit for their network.”



Using external claims data, i.e. data that includes other payers, you can see additional physicians or locations you may want to bring in-network based on their volumes of care, their networks, and the affiliations between them, which is really valuable when assessing specialist expansion.”

For acquisitions, reimbursement-rates data is crucial to assessing the potential return on investment. Likewise, it’s important for risk-sharing agreements to understand whether your potential partners’ volumes, procedures and breadth of specialty are sufficient to meet your needs. “Anytime you’re entering into a risk-bearing contract, this type of due diligence should be done to ascertain whether or not you’ll be successful,” Morino said.

Finally, when looking to enter a new market, payers need to know what services can be provided to meet their new member base’s needs. Payers need to know who in the new area provides the necessary services and how many they perform. They often also need to move quickly in closing deals and ensuring they have the right mix of providers and services.

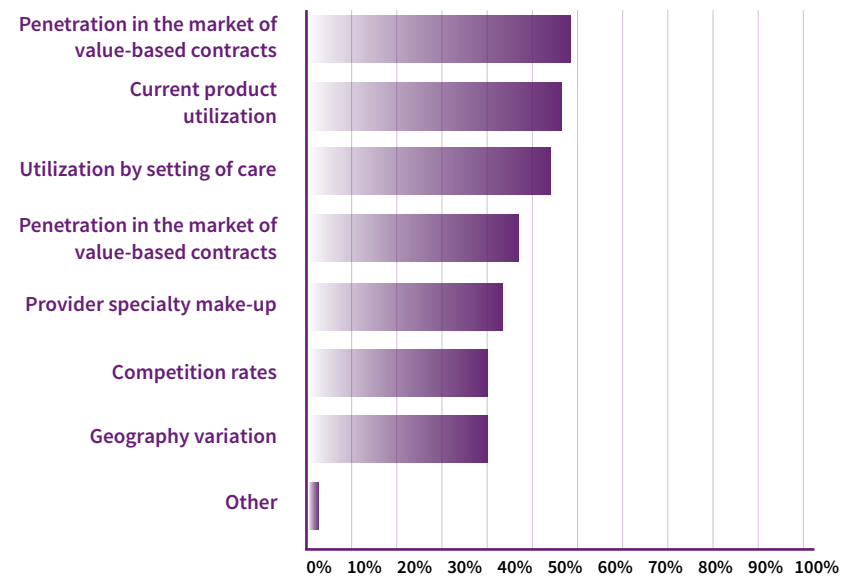
“For payers who are growing and are expanding into new states, the ability to analyze the market matters a lot,” Sultan said. “They have to assemble the right blend of oncologists, radiologists, hospitals and outpatient clinics, and everything else so that they can provide all the services they need to provide. It’s a lot of contracting. Having the volume metric data, the pricing data and also the network data, which shows you all the affiliations, can make the negotiation process faster.”

NEW PRODUCT OFFERINGS

Payers are extremely interested in generating new revenue sources through innovative new product and service development. In fact, **80% of health payer leaders listed new product offerings as being in their top five priorities**, according to Healthpayer Intelligence.¹

While payer executives indicated they frequently used a number of different competitive insights when determining whether a new product offering was viable, **the three data sources payer executives said were most important were network coverage gaps (58%), current product utilization (57%) and utilization by the setting of care (51%).**

When designing your products or offerings, which of these is most important to your organization?



The right product, with the right coordination with providers, not only allows payers to manage people's health effectively to improve their health condition but can also be financially beneficial. Yet successful product design requires a clear view of community needs within a target market. Payers must ensure not only that members will have access to the right practitioners, facilities and much-needed ancillary support services, but also that contracted rates are within a range that will allow the product to be financially successful.

"Payers need to know what the prominent conditions are in the area they want to go into. Are they aligned with the people that they are looking to contract with? Can they get in at a competitive rate? And will they be able to make sure that the patient-responsibility portion isn't a disincentive for members to utilize this important care?" Morino noted.

It is also vital that payers understand what the typical clinical conditions are in a particular territory. For example, if diabetes is the number one chronic condition and congestive heart failure is number 10, and a payer is considering adding either a new center of excellence for cardiac care or a new endocrinology practice, knowing the volumes for the population may influence their decision between the two design choices.

As the example above illustrates, when designing a new product offering, payers require a complete understanding of the community at large, not just their own consumer metrics, in order to create a more enticing product offering.

"Even the largest payers are never going to have enough claims volume in a given market. Their reach is broad but not deep. To truly understand what's occurring there, they need outside data to make those decisions."



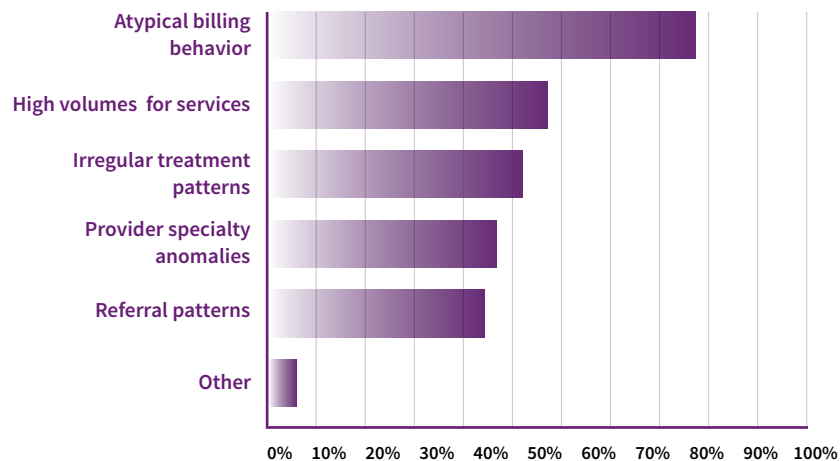
Rich Morino, Senior Director of Strategic Solutions at LexisNexis Risk Solutions

DETECTING FRAUD, WASTE AND ABUSE

The National Health Care Anti-Fraud Association estimates that the financial losses due to healthcare fraud are in the tens of billions of dollars each year, or conservatively, 3% of total healthcare expenditures.² Reducing fraud, waste and abuse (FWA) can help improve payers' bottom lines as well as help bring down the cost of healthcare for everyone.

To identify potential FWA, **payers said they looked closely for indications of atypical billing behavior (78%), high volume for services (58%) and irregular treatment (52%).**

When detecting fraud, waste, and abuse, which of these is most important to your organization?



While payers can use their plan data to identify atypical billing behaviors, including high volumes of service or irregular treatment, a payer's data provides only a small window into a providers' overall behavior. For example, a provider may bill for a high volume of services, but if it's done across a number of plans, it may be more difficult to identify that the provider has billed for 40 hours of services within a 24-hour time frame.

"When you collectively look at a doctor's claim on a specific day among all of the different payers, you would see that he has more transactional claims than is possible in 24 hours. But it might pass each individual payers' lens without a red flag," said Sean Larson, Senior Director of Healthcare Strategy with LexisNexis Risk Solutions. Similarly, a rules engine might flag a practitioner for atypical billing behaviors — such as a Podiatrist billing for mammograms or a doctor who is billing for services outside of their area of expertise. However, without a broader lens into an individual provider's behavior across multiple plans, it may be difficult to identify how great a source of risk they are for the plan.

"If a payer doesn't have access to a broader set of data, they're not going to be as proficient as they can be at finding fraud, waste and abuse in-house," Larson said. But he noted that even with rules-based engines and AI technology, potential FWA discoveries will often be in the past tense. "AI technology and engines tell a payer, 'we have already found this and investigated it,' which means they're behind the learning curve. Sharing insights in an aggregate fashion could save plans upfront by being able to proactively see that data across the board and take corrective action sooner."

To identify potential risks and make the most of investigative efforts, special investigative units will be most successful when they have a complete market view of a provider's activity and billing practices outside of their networks.



Stay Competitive with Comprehensive Intelligence

All payers have access to their own network claims and activity, making them the key source of insights on their own member population. Additionally, the new Centers for Medicare & Medicaid Services' rule on hospital price transparency makes access to provider rates publicly available, opening up a new source of intelligence for all payers. However, there are key metrics not included in this rule or available by looking solely at one's own claims capture that are crucial for payers to remain competitive when contracting, expanding, designing, and assessing FWA. A more holistic view of the market, such as volume metrics data, network and affiliation analytics, patient responsibility/out-of-pocket costs for care, denial codes, historical rate data and more, is essential to remain competitive and at an advantage.

Some payers have this intelligence already and use it to make better business decisions. This leaves payer organizations that don't have these insights at a significant disadvantage, especially because those payers with the most breadth and depth of intelligence will make the most strategic decisions, negotiate the best rates, and reduce their exposure to fraud, waste and abuse. In a fiercely competitive marketplace, payers can't afford to overlook competitive intelligence because access to the right data at the right time is crucial to continue to grow, innovate, and outpace the competition.



Sources

1. Kyle Murphy, "[Health Payers Targeting Improved Consumer Experiences in 2019](#)," Healthpayer Intelligence, Dec. 10, 2018.
2. Louis Saccoccio, "[Trends in Healthcare Fraud, Waste and Abuse](#)," National Health Care Anti-Fraud Association, May 20, 2020.



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