

*Although a new way to determine reimbursements for out-of-network services is intended to be fairer to consumers, multiemployer health funds could see higher costs because of it. This article explains the possible consequences to insured and self-insured health plans of an independent database being developed to determine “usual and customary” rates for out-of-network provider payments. It also suggests alternatives, as well as steps to take now.*

# Health Care Provider Reimbursement: *A Better Way to Determine What’s Fair?*

by Edward A. Kaplan

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**A** new method for determining how much consumers are reimbursed for treatments and services by out-of-network providers (hospitals, physicians and others) is now being put into effect, changing how the health care insurance industry handles these expenses. Although the change is intended to ensure that these reimbursements are “fair” to health

care consumers (see the sidebar, “What’s Fair? An Example”), implications of this move may prove to be inflationary to the sponsors of multiemployer health funds.

This article will address the immediate practical implications to plan sponsors as well as the potential long-term consequences to insured and self-insured health plans. But first, a

look at what is happening in the area of health provider reimbursement and a brief history of how reimbursement amounts have been set in recent times.

## FAIR Health Is Born

Following an investigation and settlement spearheaded by New York State Attorney General Andrew Cuomo, Ingenix—the former primary provider of out-of-network fee data—is being replaced by a new not-for-profit organization, FAIR Health Inc. Using a research network headquartered at Syracuse University, FAIR Health will develop an independent database that will be used to determine industry standards for “usual and customary” rates for out-of-network provider payments.

Ingenix, a subsidiary of UnitedHealth Group (UHG), one of the nation’s largest health care insurance companies, was charged with intentionally skewing these rates downward, resulting in larger out-of-pocket increases for consumers. UHG and other health insurers—including Aetna, CIGNA and WellPoint—settled the case for a total of nearly \$100 million without admitting any wrongdoing. As part of the settlement, Ingenix has agreed to discontinue its medical pricing databases as soon as a new source of payment data is available.

FAIR Health, which is being financed by settlement money, will own and operate the new database and will be the sole arbiter and decision maker with respect to all data contribution protocols and all other methodologies used in connection with the database. It will update the data twice a year. The FAIR Health database will not apply to Medicare or Medicaid enrollees and is intended only for out-of-network claims since network provider payments are based on privately negotiated contracts between provider network organizations and providers. The settlement agreement prohibits insurers from creating their own competing source of non-network provider maximum reimbursement for at least five years.

FAIR Health will be run by a board with representatives from the medical community, including physicians. In addition to Syracuse University, its database will be developed and maintained by a research network that includes the State University of New York (SUNY) at Buffalo, Cornell

University, University of Rochester and SUNY Upstate Medical University. The organization indicated that it would begin work in January and launch the new database in the fall of 2010. In the interim, Ingenix will continue to license and update its own database.

## Issues and Consequences

The launching of FAIR Health will have widespread implications for all group health plans that provide coverage for non-network-provider access. One thing to consider is that the change could lead to greater increases in medical plan costs. For many years, there has been a tension between those setting reimbursement rates and those seeking reimbursements, and it is possible that allowing the provider community too much say in setting and managing reimbursement amounts may be inflationary.

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In the 1980s, before preferred provider organization (PPO) networks were well-established, insurers realized that providers had figured out how to influence future reimbursements. The Health Insurance Association of America (HIAA) and other state payer associations (especially California’s) were the original provider charge clearinghouses. They took collected data on providers’ charges and divided it into percentiles for insurers to use. Looking for ways to cap their claim liabilities, insurers decided patients would be responsible for any amounts in excess of the insurer’s maximum allowance. The industry quickly adopted maxi-

mums that would set the new “usual and customary” amounts at the 80th or 90th percentiles of all submitted charge data in an area.

Providers understood that if they submitted ever-increasing charges for services rendered, they could influence the next year’s maximum allowance for “usual and customary” amounts. A provider group that controlled a region for a specialty service could influence its future reimbursements by submitting charge amounts that were substantially higher than what they required. This practice quickly became inflationary, since insurers must pass these costs on to the insured, and led to some of the highest health insurance premium rate increases ever experienced (nearly 20% in some years). The fees that providers submitted for payment did not have to be based on inflation, the cost of doing business or any other market force, and there was no penalty for submitting overinflated prices. This was one of the driving factors in the broad-based creation of managed care networks that employed such techniques as prenegotiating contractual prices for services and setting capitation rates for physicians.

In the late 1990s, Ingenix acquired HIAA and other publishers of provider claims data, including St. Anthony Publishing. Ingenix became the dominant source of maximum provider allowances for more than 90% of claim payers. During this time, most purchasers (employer groups) focused on the network side of the cost equation rather than on the reimbursement side because network claims accounted for most of their health care spending. However, in the 2000s, more and more plan sponsors began to reduce the coverage levels of out-of-network benefits to help reduce cost increases. This created more sizable out-of-network claim liabilities to patients that used non-network providers. As patient balance billing amounts (the amount providers charge patients directly after insurance payments are considered) became more sizable, it was only a matter of time before the way that these insurance payments were developed came under scrutiny. Fast forward to 2009, and we have a settlement between UHG and the New York attorney general.

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### What's Fair? An Example

While everyone wants physicians to be fairly compensated for their expertise and a system that has adequate incentives to attract and retain talented people to the health care industry, it is important to have a rational methodology when deciding what is fair and reasonable.

My daughter recently sustained a hairline fracture to her finger playing basketball. We took her to her primary doctor who recommended we see a pediatric orthopedic specialist to be sure she had not breached the growth plate in her finger. The in-network specialist examined her hand and the x-ray in about three minutes (I timed it) and said everything was fine.

Although my network copay was \$30 (a bargain for me), I was curious about the submitted billed charge from the specialist and the network discount amount charged to my employer. Upon examining the explanation of benefits, I was shocked to see the billed charge was \$460. Even if we assume the doctor spent five minutes with the patient, that would convert to more than \$5,000 per hour! I realize that overhead expenses are built into a doctor's time, but the charge would not seem reasonable by most market standards. While my copay was only \$30 because it was a network visit, my cost after insurance payments would have been a multiple of this—probably more than \$150 for the visit—if the doctor had been a nonnetwork provider, even if the \$460 charge was entirely within the insurance company's "usual and customary" reimbursement limit for out-of-network claims.

There are other examples where providers (i.e., suppliers of health services or supplies) have established inflationary reimbursement rates. For example, a court recently found that the suppliers of prescription drugs (manufacturers and drug wholesalers) had manipulated the average wholesale price (AWP) databases (e.g., First Databank) that are the source of prescription drug reimbursement rates. As a result, the publishers of the data have agreed to discontinue publishing these prices as a source for prescription drugs sometime in 2011.

There is also some concern that FAIR Health could create unintended consequences. Will lower cost providers raise their rates once they recognize that their fees are well below the new norms published by FAIR Health? What if payments become so generous that providers begin to leave network panels and accept partial payments on an out-of-network basis? For example, a 70% reimbursement of a generous out-of-network allowance could be more than the 100% network coverage of

discounted contractual network amount. Such a relationship may compromise the ability of managed care networks to offer a wide range of network providers and may ultimately create potential hardship for patients who would have less network provider choice and be subject to *physician balance billing* (charging the patient for the difference between the doctor's invoice and the insurance company's reimbursement). One of the primary attractions of network contracts is their ability to protect members from balance billing beyond the negotiated prices.

Plan sponsors will need to balance containing plan costs with protecting plan participants from excessive balance billing when nonnetwork providers are used. A reimbursement that is too rich could cause plan costs to soar while one that is too low could create major hardships for some participants.

On the positive side, FAIR Health will develop a new Web site that consumers can use to compare prices before they choose their doctors. The fact that the

new database will be transparent to both providers and patients may be an excellent way to improve competition among health care providers and eventually reduce cost increases. Because most employers and multiemployer health funds require cost sharing, having participants know their potential out-of-pocket costs before they see a provider and offering an easy way to look at other provider costs may encourage comparison shopping.

What about health care reform? Unfortunately, neither the House nor the Senate bills under consideration as this article was being written address the setting of reimbursement rates in the private sector.

### Alternatives to FAIR Health

Although UHG and other major insurers have agreed to discontinue using Ingenix, it is not clear if they will use the new database. Among the alternatives some sponsors are exploring are

- Purchasing an alternative source of prevailing charge data for setting maximum allowances. Although EMC Captiva, IMS and the National Dentistry Advisory Service sell database products that track "usual and customary" rates, there is no guarantee that their use will go unchallenged by public regulators.
- Basing payments on a factor of Medicare's resource-based relative value scale (RBRVS) system. Providers may balk at such a move and create political hardship for plans that take this approach. However, since most providers accept Medicare payment allowances, a payment structure that is set at multiple of Medicare (e.g., 150%) might prove to be effective and acceptable.
- Using the network provider payment amounts as the source of maximum allowance for nonnetwork claims. While this would produce substantial savings for plans, it would also generate substantial out-of-pocket increases for members.
- Eliminating all or most out-of-network coverage. This option will likely be unpopular with most plan sponsors as they recognize their workforce wants greater provider choice.
- Reducing benefit coverage for non-network claims. This may be one

likely outcome if the new provider reimbursement data proves to be highly inflationary.

- Eliminating all provider reimbursement limits. This would likely result in substantial cost increases for plans.

### Steps to Take

Regardless of how they decide to proceed, sponsors of insured plans need to find out what sources and options insurers will offer for setting future maximum reimbursements. Sponsors of self-insured plans need to select and test new sources/methodologies for setting new maximums. All plan sponsors also need to

- Reassess their benefit objectives with respect to participant nonnetwork cost sharing
- Evaluate the cost impact of the new data source/method being considered
- Review and amend plan documents with assistance from legal counsel to—Remove references to Ingenix or any other obsolete fee schedule

—Assure that the plan's payment methodology is described appropriately

- Communicate changes to plan participants.

### Conclusion

While the creation of FAIR Health may be a step in the right direction, it is unclear what the cost impact will be for plan sponsors. If the balance for price setting tilts toward suppliers, an unintended consequence might be health care inflation. A counterbalance to this is the pricing

transparency that FAIR Health will provide to both providers and participants. It remains to be seen if patients can be rational consumers of health care services—whether they can and will compare and shop based on price and quality. Otherwise, this change in setting provider payments may lead to even higher medical costs, which will ultimately get passed on to patients and further hamper real gains to wages. **B&C**

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