Using Medicare RBRVS for reimbursing out-of-network claims in commercial insurance

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BACKGROUND

Many health plans allow members to receive covered services from providers who are not part of the plan's contracted network. However, a plan will often limit the amount it pays to a specific percentage of an amount called "usual, customary, and reasonable" (UCR). Historically, the UCR amounts have been determined by reference to commercially available schedules representing prevailing physician charges by type of service and geographic region.

Until recently, most health plans have used databases created by Ingenix, Inc., a subsidiary of UnitedHealth Group, to determine UCR amounts. However, in February 2008, New York State Attorney General Andrew Cuomo began an industry-wide investigation into, among other things, "allegations that the Ingenix database intentionally skewed 'usual and customary' rates."[1] In October 2009, Cuomo announced an agreement with UnitedHealth Group, Ingenix, and a number of New York insurers that resulted in the establishment of FAIR Health, an independent not-for-profit corporation. As well as establishing a website to allow consumers to compare prices before choosing doctors, FAIR Health was tasked with developing new data products to support the adjudication of out-of-network claims.[2]

Although FAIR Health began to roll out new databases in 2011, the uncertainty resulting from the investigation, as well as other unrelated factors, has led some plans to move away from schedules based on prevailing provider charges toward Medicare's resource-based relative value scale (RBRVS) schedule.

MEDICARE'S RESOURCE-BASED RELATIVE VALUE SCALE

Medicare's RBRVS is a government-mandated schedule prescribing the fees allowed for services covered under the Medicare program. A payment is determined by the billing procedure's relative value in that physician's area. The relative value takes into account the physician's work, any practice expenses, and malpractice liability costs. Certain services, such as some preventive services, are not covered and reimbursed under the RBRVS.

UNEXPECTED RESULTS BY MOVING TO MEDICARE'S RBRVS

The differences in reimbursement levels between fee schedules based on Medicare's RBRVS and benchmark data based on prevailing charges such as the data modules made available by FAIR Health have led to some unexpected results for both members and physicians. These unexpected results still exist even if the change is designed to produce similar levels of aggregate reimbursement under both methods.

To illustrate this point, the table in Figure 1 shows that, for Albany, New York, the percentage of RBRVS that equates in total to specified percentiles of provider charges as reported by FAIR Health.

FIGURE 1: FAIR HEALTH, COMPARED WITH RBRVS (ALBANY, N.Y.)

FAIR HEALTH PERCENTILE	% OF RBRVS
50TH PERCENTILE	217%
60TH PERCENTILE	228%
70TH PERCENTILE	241%
75TH PERCENTILE	248%
80TH PERCENTILE	255%
85TH PERCENTILE	265%
90TH PERCENTILE	276%
95TH PERCENTILE	309%

1 New York State Office of the Attorney General (January 13, 2009). Attorney General Cuomo announces historic nationwide health insurance reform; ends practice of manipulating rates to overcharge patients by hundreds of millions of dollars. Media Center press release. Retrieved February 6, 2012, from http://www.ag.ny.gov/media_center/2009/jan/jan13a_09.html.

2 New York State Office of the Attorney General (October 27, 2009). Attorney General Cuomo announces historic nationwide reform of consumer reimbursement system for out-of-network health care charges. Media Center press release. Retrieved February 6, 2012, from http://www.ag.ny.gov/media_center/2009/oct/oct27a_09.html.

For example, if a health plan sets the allowable cost of a service at the 50th percentile reported by FAIR Health in the upstate New York region, the plan will need to redefine the allowable cost to approximately 217%[3] of Medicare RBRVS to produce the same level of reimbursement in total (for an average commercially insured member in this area). However, physicians, members, and plan sponsors may be surprised to learn that reimbursement under a plan using a percentage of Medicare's RBRVS compared to billed charges could vary materially by:

- Geographic regions
- Physician specialties
- Specific procedures

These variances between physician billed charges and the reimbursements under Medicare's RBRVS can result in significant differences of member out-of-pocket liability.

These differences may be magnified further if the targeted aggregate level of reimbursement is very different under the two schedule types.

To illustrate these differences, we compare the 50th percentile of FAIR Health[4,5] with 220% of Medicare's RBRVS.[6] As can be seen from Figure 1, both schedules used will result in similar levels of aggregate reimbursement. Our intention is not to endorse either method, but rather to highlight some of the less obvious consequences of making a change from a traditional UCR method to one based on Medicare for out-of-network reimbursement.

Geographic

FAIR Health's data captures local practice patterns by distinguishing charges between specific three-digit zip codes, resulting in 491 distinct regions. In comparison, Medicare's RBRVS differentiates payments using wider geographic areas. In 2011, Medicare used 90 geographic practice cost indices (GPCIs) to differentiate payment levels.

New York, for example, contains five Medicare localities in total, and furthermore, upstate New York contains one. FAIR Health's data indicate wide variation in billed amounts within this region. As a result, while a schedule based on Medicare's RBRVS will reduce variations in plan payment amounts across broad geographic areas, it will typically reimburse a different proportion of prevailing physician charges within an area covered by the same GPCI. The table in Figure 2 illustrates the impact of this difference.

Figure 2 illustrates the wide range of total reimbursements occurring in one Medicare locality—in this case, upstate New York. The result is that, on average, physicians in Buffalo will likely be paid significantly more of their billed charges than physicians in Kingston under a Medicare RBRVS-based schedule. This will result in different member out-of-pocket liabilities in Kingston and Buffalo.

Specialty and service type differences

Medicare's RBRVS pays the same amount for a service in a particular GPCI. However, the impact on a physician's total reimbursement will vary by specialty and type of service under a Medicare-based schedule and one based on prevailing charges, even if both produce similar levels of aggregate reimbursement. This is because the range of codes billed by specialty and service type is different.

The tables in Figures 3 and 4 provide estimates of these differences in Albany, New York, for specialty and type of service, respectively. The tables aggregate fees under each alternative by typical utilization rates for an average commercially insured population. Similar differences are likely to occur in most areas.

FIGURE 2: GEOGRAPHIC REGION FEE DIFFERENCES

AREA	ZIP CODES	220% RBRVS/ 50TH PERCENTILE OF FAIR HEALTH
ALBANY	122	101%
KINGSTON, MONTICELLO	124-127	98%
SYRACUSE	132	111%
BINGHAMTON, VESTAL, ONEONTA	137-139	101%
BUFFALO	142	126%

3 Utilization rates from Milliman's 2011 Health Cost Guidelines™ (HCGs) were used to estimate aggregate payment amounts for regions, specialties, and service categories. All estimates are provided for an average commercially insured population.

4 FAIR Health's November 2011 FH benchmarks were used to determine percentile of charges. In the limited cases where the FH benchmarks did not have data points, we defaulted to the November 2011 FH RV benchmarks.

5 Milliman licenses the FH RV benchmarks. For the purpose of this analysis and paper, FAIR Health gave us access to the FH benchmarks.

6 Unless otherwise noted, 2010 Medicare RBRVS was used, supplemented by 2010 Ingenix's RBRVS for services not covered under Medicare. Medicare's 2010 conversion factor was approximately 6% higher than the 2011 conversion factor, which generally results in a fee 6% higher.

FIGURE 3: FAIR HEALTH COMPARED WITH RBRVS BY SPECIALTY (ALBANY, NY)

SPECIALTY	220% RBRVS/ 50TH PERCENTILE OF FAIR HEALTH
ALLERGY / IMMUNOLOGY	129%
ALTERNATIVE MEDICINE	138%
ANESTHESIOLOGY	71%
AUDIOLOGY	114%
CARDIOLOGY / CARDIAC SURGERY	93%
CERTIFIED NURSE MIDWIFE	107%
CERTIFIED REGISTERED NURSE ANESTHETISTS	69%
CHIROPRACTIC MEDICINE	153%
COLORECTAL SURGERY	74%
DERMATOLOGY	87%
EMERGENCY MEDICINE	66%
ENDOCRINOLOGY	112%
FAMILY PRACTICE	119%
GASTROENTEROLOGY	82%
GENERAL SURGERY	75%
HEMATOLOGY / ONCOLOGY	92%
INTERNAL MEDICINE	114%
LABORATORY	90%
LICENSED CLINICAL SOCIAL WORKER	185%
MINOR SPECIALTY	102%
NEONATOLOGY	108%
NEPHROLOGY	109%
NEUROLOGY	108%
NEUROSURGERY	71%
NUCLEAR MEDICINE	82%
OBSTETRICS / GYNECOLOGY	96%
OPHTHALMOLOGY	126%
OPTOMETRIST	155%
ORTHOPEDIC SURGERY	82%
OTOLARYNGOLOGY	85%
PATHOLOGY	61%
PEDIATRICS	131%
PHYSICIAN ALTERNATIVE - PRIMARY CARE	88%
PLASTIC AND RECONSTRUCTIVE SURGERY	70%
PODIATRY	88%
PROCTOLOGY	75%
PSYCHIATRY	176%
PSYCHOLOGY	184%
PULMONARY MEDICINE	112%
RADIOLOGY	77%
RHEUMATOLOGY	99%
SPEECH/PHYSICAL/OCCUPATIONAL THERAPY	174%
THORACIC SURGERY	69%
UROLOGY	81%
VASCULAR SURGERY	78%

FIGURE 4: FAIR HEALTH COMPARED WITH RBRVS BY SERVICE TYPE (ALBANY, NY)

SERVICE CATEGORY	220% RBRVS/ 50TH PERCENTILE OF FAIR HEALTH
ALLERGY TESTING & IMMUNOTHERAPY	134%
CARDIOVASCULAR	100%
CHIROPRACTOR	160%
CONSULTS	139%
ER VISITS AND OBSERVATION CARE	58%
IMMUNIZATIONS	150%
INPATIENT SURGERY	64%
INPATIENT VISITS	110%
MATERNITY	104%
MISCELLANEOUS MEDICAL	105%
OFFICE ADMINISTERED DRUGS	90%
OFFICE/HOME VISITS	141%
OUTPATIENT ALCOHOL & DRUG ABUSE	183%
OUTPATIENT PSYCHIATRIC	185%
OUTPATIENT SURGERY	65%
PATHOLOGY/LAB	83%
PHYSICAL EXAMS	117%
PHYSICAL THERAPY	186%
RADIOLOGY	79%
URGENT CARE VISITS	140%
VISION, HEARING, AND SPEECH EXAMS	161%
WELL BABY EXAMS	135%

Individual procedure

The differences outlined above will result in variable member liability for an out-of-network service. In many cases the impact can be significant.

For example, in Manhattan, New York, the 50th percentile of FAIR Health for a knee arthroscopy surgery (CPT code 29883) is $8,008. The payment amount for the same code in Manhattan, New York, at a level of 220% of 2011 Medicare's RBRVS is $2,122. The table in Figure 5 compares a member's out-of-pocket payment using a benefit plan that reimburses an eligible out-of-network procedure at 70% of allowable charges under different UCR definitions, assuming the physician billed an amount equal to the 50th percentile of FAIR Health.

FIGURE 5: A MEMBER'S OUT-OF-POCKET COST UNDER FAIR HEALTH AND RBRVS

	FAIR HEALTH	MEDICARE
UCR DEFINITION	50TH PERCENTILE OF BILLED CHARGES	220% OF MEDICARE
UCR AMOUNT	$8,008	$2,122
PHYSICIAN'S CHARGE	$8,008	$8,008
MEMBER'S COINSURANCE (30%)	$2,402	$637
DIFFERENCE BETWEEN BILLED AND UCR	$0	$5,886
TOTAL MEMBER'S LIABILITY	$2,402	$6,523

The member in this example will pay $4,121 more if the health plan uses a percentage of Medicare rather than a percentile of FAIR Health.

CONCLUSION

As this paper illustrates, a change in the basis for determining out-of-network reimbursement may change the health plan member's out-of-pocket expenses significantly. We are concerned that, more often than not, the impact of these changes is not anticipated. Consideration of the issues outlined above and member/physician education should be undertaken before such a change is made.

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