

## Out-of-Network Fee Schedules Will Soon Need to Change

A recent investigation by the New York Attorney General (NY AG) of Ingenix, a subsidiary of United Health, as a source for establishing the “usual and customary” (U&C)<sup>1</sup> charges for provider reimbursement resulted in settlements with major insurers and preferred provider organization (PPO) networks that could have widespread implications for all group health plans that provide access to non-network provider coverage.

### THE SETTLEMENTS IN BRIEF

The NY AG’s settlements with insurers (Aetna, Cigna and WellPoint in addition to United Health, as of the publication of this *Bulletin*) include the payment of fines and, of greater significance, an agreement to discontinue the use of Ingenix U&C data as the primary source for setting the maximum allowance recognized for processing out-of-network provider claims. Money paid by insurers using Ingenix’s U&C databases to set maximum allowances will instead be used to establish a non-profit organization to develop a new database. The nonprofit organization will, among other things:

- 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,
- Develop a Web site where, for the first time, consumers around the country can find out in advance how much they may be reimbursed for common out-of-network medical services in their area, and
- Make rate information from the database available to health insurers.

The establishment of a new database, independently owned and operated by a nonprofit organization, is intended to remove any conflict of interest. In a January 2009 memorandum, the NY AG’s office indicated it expected the new database to be released in six months, although it acknowledged this date is optimistic. In the interim, Ingenix will continue to license and update the current database. When the new database is ready, Ingenix will close its U&C databases.

### DIRECT AND INDIRECT IMPLICATIONS

The agreement will require all sponsors of self-insured plans to revise the method for setting future allowances for all out-of-network claims because the new source of maximum reimbursement will reflect a plan change and will affect future claim costs. Decision makers should balance the need to contain plan costs with the need to protect plan participants from excessive balance billing when out-of-network providers are used. Too rich a reimbursement and plan costs could spiral further. Too low a maximum could create major hardship for some participants. Plan language should be changed once a new allowable charge is introduced because references to “U&C” could raise concerns.

Some sponsors of self-insured plans have already taken action to move away from Ingenix as the source for setting maximum allowances for out-of-network claims. Some have decided to use the network provider payment amounts as the source of maximum allowance for non-network claims. Others are looking into alternative sources already available to create a valid source for non-network maximum allowance schedules.

Basing payments on Medicare’s well-established Resource-Based Relative Value Scale (RBRVS)<sup>2</sup> system may be a more acceptable approach to many plan sponsors. RBRVS is widely accepted by health care providers, easily accessible to plans and can be modified to increase amounts based

<sup>1</sup> An online supplement to this *Bulletin* provides background on U&C. It is available on the following page of Sibson Consulting’s Web site: <http://www.sibson.com/publications/presentations/U&C.pdf>

<sup>2</sup> Medicare’s RBRVS, which was implemented in 1992, is an alternative to U&C. RBRVS gives a relative value to medical procedures that varies by region. The payment amount is based on the value multiplied by a single conversion factor (updated every year).

on private plans' objectives. Major insurers are beginning to use the RBRVS system of reimbursement with some mark up (e.g., 150 or 200 percent of Medicare) for non-network provider reimbursement maximums. Sponsors of insured plans may have some options for setting the new maximum reimbursement for their plans.

The allegations against Ingenix suggested that the Ingenix database kept reimbursement to non-network providers low. A review of historical data yields some valuable insights. Sibson's analysis of selected Ingenix data, reported in the adjacent table, found that the combined average annual change in billed provider services for the 10-year period examined (4.6 percent) was almost identical to the increase in the medical care component of the CPI over the same period (4.7 percent). However, there were significant differences among both the unique provider services examined and by geographic region. For example, the increase for the chemotherapy intravenous infusion (1 hour) was lower for New York (12.2 percent) and much higher in the two more rural areas studied: Kokomo (29.8 percent) and Fairbanks (16.9 percent). As a result, converting to a new system may create different levels of change across regions and procedures.

The disappearance of Ingenix's database could have indirect implications for plan sponsors that may adversely affect the cost of health coverage over the long term. If the new non-profit entity creates out-of-network maximum allowances that vary significantly from actual network provider reimbursement rates (e.g., if 70 percent coverage of the new maximum exceeds 100 percent of actual network provider reimbursement rates), the change could accelerate health care inflation. In addition, physicians and other providers may be encouraged to terminate their network contracts, which would compromise the ability of managed care networks to offer a wide range of network providers. Such a shift would create potential hardship for patients who would have less network provider choice and be subject to physician balance billing.

## ACTION ITEMS FOR PLAN SPONSORS

All health plan sponsors with out-of-network coverage will need to adapt to this development soon by:

- Reassessing their benefit objectives with respect to participant out-of-network cost sharing,
- Finding out what source and options insurers will offer for setting future maximum reimbursement,
- For self-insured plans, selecting and testing new sources/methodologies for setting new maximums,
- Evaluating the plan cost impact for the new data source/method being considered,
- Reviewing and amending plan documents with assistance from legal counsel to (1) remove references

Average Annual Change in Billed Provider Charges for Selected Services<sup>1</sup> at the 90<sup>th</sup> Percentile<sup>2</sup> from 1999 to 2008 for Three Geographic Areas: New York, NY, Kokomo, IN and Fairbanks, AK<sup>3</sup>

Outpatient Office Visit (15 Minutes)	4.6%
Outpatient Office Visit (25 Minutes)	5.2%
Psychotherapy Office Visit (45-50 Minutes)	3.8%
Complete Blood Count w/ Automated Differential White Blood Count	3.6%
Complete Transthoracic Echocardiography w/o Doppler	5.6%
Tissue Exam by Pathologist	0.0%
Chemotherapy Intravenous Infusion (1 Hour) <sup>4</sup>	14.0%
MRI of Lumbar Spine w/o Dye (Total Charge)	9.7%
MRI of Lumbar Spine w/o Dye (Physician Charge)	7.0%
Cesarean Delivery	3.1%
Coronary Artery Bypass Graft Surgery (One Artery)	4.5%
<b>Combined Average Change</b>	<b>4.6%</b>

<sup>1</sup> These services tend to represent a significant portion of a group health plan's overall charges for physician services.

<sup>2</sup> U&C is used to set maximum reimbursement, typically at the 80<sup>th</sup>, 85<sup>th</sup> or 90<sup>th</sup> percentile of claims submitted for each service in an area.

<sup>3</sup> Data is weighted by the size of the areas. Data for Kokomo and Fairbanks is only available from 2000.

<sup>4</sup> Data for this service is only available from 2006.

to Ingenix or any other obsolete fee schedule and (2) assuring that the plans payment methodology is described appropriately, and

- Communicating changes to plan participants.



*Plan sponsors should rely on their attorneys for authoritative advice on the settlements with the NY AG. Sibson can be retained to help select, implement and communicate a new reimbursement system for out-of-network coverage.*

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