

The changing landscape of out-of-network reimbursement

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Introduction

Commercial out-of-network (OON) provider reimbursement is a topic of great debate in healthcare. Changes on both the payer and provider sides have produced a large disparity in the OON payment levels pursued by each. Payers seek ways to limit the growth in OON costs while providers look to maintain revenue in a market with increasing pressure to accept lower payments. Members are frequently caught in the middle, resulting in states increasing regulations to protect them and, in the process, restricting payers and providers.

Payers relying on older OON reimbursement methodologies are likely overpaying, considering the persistent increases in billed charge trends, while those that have adopted a much more aggressive strategy may face backlash from members or providers seeking legal action as well as unfavorable media attention. To avoid these unfavorable outcomes, it is important to evaluate the methodology used for setting OON reimbursement levels and to identify savings opportunities.

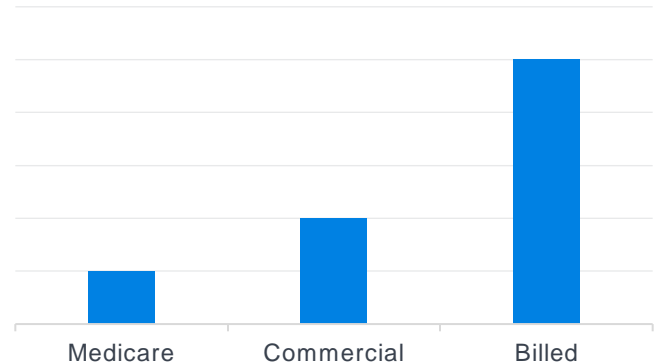
Background

For many years, the market standard for OON provider reimbursement was to determine a usual and customary (U&C) level to pay based on the market. U&C amounts were typically calculated by looking at the distribution of provider billed charge levels and picking a percentile of those charges (e.g., 70th percentile).

As billed charge trends have consistently outpaced in-network reimbursement trends, most billed charge levels are considered out of sync with costs and well above typical in-network reimbursement. For some markets, it is common to see hospital billed charge levels many times those of typical commercial in-network reimbursement with Medicare and other government payers usually much lower. The chart in Figure 1 provides an illustration of the general relationship by line of business for hospitals, although this varies greatly by geography.

For example, Florida has hospital billed-to-Medicare ratios of 10-to-one or higher, meaning that Medicare reimbursement is effectively a discount of 90% or more relative to the billed charges based on Medicare fee-for-service (FFS) hospital data. While the discount percentage appears high, this is driven by the high billed amount.

FIGURE 1: GENERAL REIMBURSEMENT RELATIONSHIP FOR HOSPITALS



Payer OON payment strategies

Given recent changes in the OON payment space, a wide range of savings strategies are being considered by payers. The success of a strategy can vary by market, not only with regard to provider contracting, but also from a legal and member perspective. Several strategies are presented here.

PAY AT A PERCENTAGE OF MEDICARE

Many payers are redefining OON reimbursement as a multiple of Medicare allowable reimbursement. This practice is already common in commercial contracting and benchmarking, and has the advantages of:

- Removing billed charges from consideration
- Setting the reimbursement relationship between services more consistently with the market
- Simplifying the schedule by using percentages by service category (or overall) rather than a detailed schedule where amounts are separately calculated for each code.

Note that this approach of defining a schedule as a multiple of Medicare does not necessarily imply lower payments. The multiple may be set on a revenue neutral basis with a current OON reimbursement schedule or an overall target reimbursement level for OON services. Because Medicare trends are typically much lower than the market, the multiple should be revisited each year to ensure the desired target reimbursement is being achieved.

Whatever OON reimbursement level is used, the equivalent percentages of Medicare can be determined utilizing tools such as the Milliman Medicare Repricer™. Claims experience or fee schedules may be repriced to Medicare levels and equivalent percentages determined. See the article "[Provider reimbursement analytics](#)" for more information about this process and the advantages and disadvantages of Medicare-based reimbursement.

PAY AT IN-NETWORK LEVELS

This approach sets OON reimbursement at a payer's in-network reimbursement levels for a market, where the in-network levels may be determined as an average for providers in the market, or as a standard base schedule. Providers may elect to balance bill the patient for the difference between the amount they bill and the payer's in-network payment level. Payers using this approach view the balance billing as a financial penalty to the patient for using an OON provider in addition to higher member cost sharing for the OON benefits. As mentioned later on, there are potential drawbacks to balance billing that should be considered.

Some payers have taken this OON payment approach a step further and pay less than in-network amounts for nonemergency OON services, even as low as 100% of Medicare. A side effect of this approach is that benefit plans with an OON option can end up costing less than benefit plans that are in-network only. This is counterintuitive to the traditional plan design with an OON option. The addition of the OON option was typically seen as increasing rates-- for example, moving from health maintenance organization (HMO) to point-of-service (POS) levels, but by having OON provider reimbursement that is lower than in-network, the rate decreases.

Whatever form of OON reimbursement approach is used, it is recommended that a payer benchmark its reimbursement levels to the market to assess its position. Milliman has multiple benchmark databases, internally developed and externally leased, which have de-identified group commercial reimbursement information.

DEVELOP A PERCENTILE-BASED U&C SCHEDULE

The standard of a percentile-based U&C schedule is still used by some payers today, although variations have developed such as:

- Defining the schedule as a percentage of Medicare by service category versus developing amounts by individual procedure
- Basing reimbursement on in-network allowed amounts versus billed in a market

To develop a U&C schedule, data must be available to determine the distributions. If the schedule is based on billed amounts, this can be a payer's internal data if it covers enough of the market, or external data sources like Medicare FFS data. Although based on Medicare services, Medicare FFS data contains billed charge levels with a reasonable representation of the distribution of

providers in a market. Alternatively, third-party data may be purchased directly that has billed charge information for the market already at the percentile level. If the schedule is based on in-network allowed amounts, Milliman's Consolidated Health Cost Guidelines™ Source Database (CHSD) with group commercial reimbursement may be used.

Milliman has the ability to develop different forms of these schedules, either with using code-level amounts or putting a schedule on a percentage of Medicare basis. Existing code-level schedules can even be converted to a category percentage of Medicare basis to simplify its administration.

NEGOTIATE OON PAYMENTS BY CASE

Along with having a U&C schedule, some payers also negotiate payment for large OON claims directly with providers. The focus is on large claims where the financial impact to the payer or patient is the greatest. This approach may also be used for settling a complaint or lawsuit over OON payments.

If a payer commonly has negotiations with a particular OON provider, it may have a reimbursement agreement in place. Although this is a contract with an OON provider, it differs from an in-network arrangement because its purpose is to avoid balance billing to the patient.

Provider OON payment strategies

Similar to payers, providers have different strategies that are employed, several of which are presented here.

AVOID JOINING NETWORKS

Providers typically join networks to increase utilization through member steerage. If a provider is highly sought after (e.g., specialized or unique within a geography), it may be able to remain OON and still be heavily utilized. Even if the provider elects to be in-network, having a strong negotiation position may permit it to achieve higher in-network reimbursement.

Many hospital-based physicians elect to remain OON. These physicians are attached to the hospital, but do not typically take part in the hospital's contract negotiations. Patients may be steered to the hospital as an in-network provider, but because hospital-based physicians contract separately the physicians may be OON. This is most common with hospital-based pathologists, emergency room physicians, anesthesiologists, and radiologists (known as PEAR physicians based on the initials), but may also happen with other physician types such as assistant surgeons.

If a provider is currently in-network and considering going OON, it is important to get a realistic assessment of what reimbursement it may receive as an OON provider and the utilization impact. Milliman can help by modeling different scenarios based on examining the market, patient usage patterns, and other factors.

ASSESS BILLED CHARGE LEVELS

For providers receiving OON reimbursement on a billed charge basis, maintaining high billed levels is important to maximize OON revenue. This also benefits in-network reimbursement terms that are based on billed charges. Most commercial hospital in-network provider contracts typically have at least some services paid as a percentage of charge—for example, inpatient stop loss reimbursement is commonly based on a percentage of billed charges.

It is also important for a provider to consider how its billed charge levels compare to other providers. Billed charges can vary dramatically among providers, especially hospitals.

Reimbursement based on billed charges can produce notably different payments by provider if the payer does not adjust for the billed charge differences. Providers should determine how their billed charges compare to other providers in their markets to ensure they are not being disadvantaged.

The Centers for Medicare and Medicaid Services (CMS) is considering requiring hospitals to publish their billed chargemasters in 2019. While a useful source, this will be at the code level and make aggregate comparisons difficult. The Milliman Billed Charge Index™ (BCI) is a tool that aggregates hospital billed relativities at the inpatient and outpatient levels. Relying on Medicare FFS data by hospital, the BCI normalizes billed charges for the case mix and severity of services using a system of internally developed relative value units called Milliman GlobalRVUs™, and summarizes results by type of service.

NEGOTIATE OON PAYMENTS ON A CASE-SPECIFIC BASIS

As with this same strategy for payers, providers may elect to negotiate payment with payers for large OON claims. This may increase the payment the provider receives from the payer and result in faster payment. It can also help minimize or eliminate the balance bill to the patient, which helps avoid potential bad debt with patients.

Balance billing backlash

Although payers and providers are adopting different strategies, a trend is clearly emerging of increased balance billing to patients. While the bill comes from the provider, the amount of the balance bill is driven by the difference between the provider's bill and what the payer is covering.

Often balance billing is a surprise to patients because they believed they were using in-network providers but unknowingly received some services from other providers, such as PEAR physicians, that were OON. Figure 2 provides an example of a hospital-based surgery where the hospital and surgeon were in-network and the anesthesiologist was not. The member portion is 10% of the covered amount, but the anesthesiologist also

balance bills the patient \$12,000 (\$15,000–\$3,000) for the amount not covered by the payer.

FIGURE 2: SAMPLE SURGICAL BILLING

PROVIDER TYPE	BILLED CHARGE	COVERED AMOUNT	MEMBER PORTION
Hospital (in-network)	\$50,000	\$10,000	\$1,000 (10% of \$10,000)
Surgeon (in-network)	\$25,000	\$5,000	\$500 (10% of \$5,000)
Anesthesiologist (out-of-network)	\$15,000	\$3,000	\$12,300 [(10% of \$3,000) + (\$15,000 - \$3,000)]

In this instance, the patient was unaware that the anesthesiologist was OON until that person received the bill. This can happen under situations such as:

- Hospital-based physicians (e.g., PEAR)
- OON ambulance
- Patient is transferred to an OON facility
- In-network physician utilizing an OON provider, such as an OON lab to process a test

Balance billing is generally not permitted (or is limited) for patients with government coverage, but is becoming more common for commercial. Federal regulations provide some limits on balance billing for emergency services, such as minimum payment levels for emergency services, which may decrease the size of a balance bill but does not eliminate it. These regulations focus on emergency services because a patient's ability to select in-network versus OON providers in an emergency is limited. Federal regulations are not in place, however, for nonemergency services, leaving states to determine regulations on their own.

The magnitude of many balance bills, as well as the surprise factor to the patient, is producing a growing list of complaints to state regulators and increases in lawsuits. Several states have already put new regulations in place designed to protect patients. For example, California and Florida prohibit any balance billing by providers for emergency services, with Florida also prohibiting it from OON providers at in-network facilities (e.g., PEAR). Many other states either have or are considering legislation.

Moving forward

There are many implications to the changes happening in the OON reimbursement space, but the most far-reaching and fundamental may be the increase in patient dissatisfaction. This has consequences in many areas: public opinion and negative media, legal risks and expenses, and more regulations. At a minimum, increased patient communication can help with this situation. Payers and providers giving patients better and earlier information on potential balance bills could help minimize the surprise and ensure the patient makes an informed decision regarding their OON care.

Payers and providers should evaluate their current OON reimbursement policies, or, if none is in place, establish one. The OON reimbursement space is in flux, and there could be payers overpaying or providers being underpaid. Evaluating where you are in relation to your market is critical for current financial success and positioning yourself moving forward.



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