The Consumer-Purchaser Disclosure Project

Physician Payment by Private Health Plans

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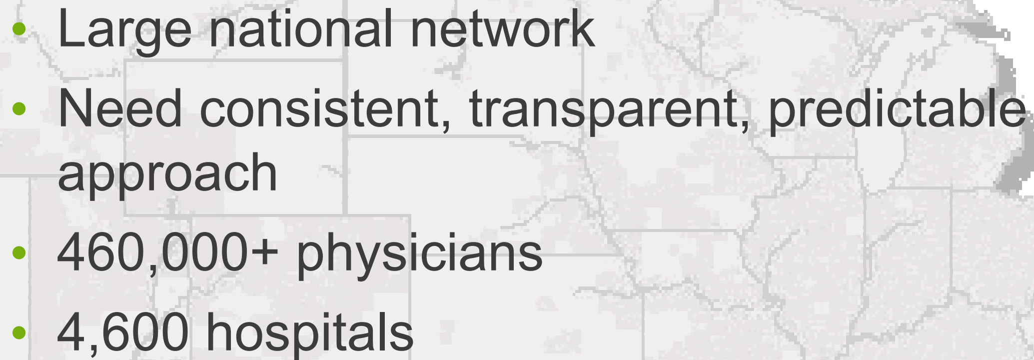
Context



- Large national network
- Need consistent, transparent, predictable approach
- 460,000+ physicians
- 4,600 hospitals

Basic Payment Structure

Two general types:

- Capitation
- Fee for service

Fee for service is most common:

- Fee schedule: defined payment for each service (CPT code)
- Percent of charges

Fee Schedules

Two components:

- Structure, such as a relative value scale
- Rate, such as a conversion factor

CMS relative value scale: work, practice expense, geography (NY/MN)

CMS conversion factor: annual rate adjustment (up or down)

One approach

Over 90% of UnitedHealthcare's fee schedules are:

- Current year CMS (RVS and conversion factor)
- Progressive (current CMS RVS and negotiated conversion factor)
- Stated year CMS RVS (e.g., 2003) and negotiated conversion factor

Reimbursement policies (largely based on CMS) also determine final payment amount

The Ripple Effect

Payment decisions by CMS reverberate across the private sector in two ways:

- Changes in CMS payment levels greatly affect physician revenue and therefore demand on private payers (brief 4.4% reduction in 2006)
- Changes in the CMS RVS affect every private fee schedule based on that RVS and shift physician expectations

Evolution

Physician payment has historically been driven by differences in negotiating leverage rather than objective assessment of value. Dependent on the availability of appropriate standards and data, physician payment should be determined by:

- Quality of care
- Clinical efficiency
- Administrative efficiency

Finally…

Questions?