

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE,
SECURITIES & HEALTH CARE ADMINISTRATION

BISHCA



LEGISLATIVE REPORT

DIVISION OF HEALTH CARE ADMINISTRATION

2008 Provider Reimbursement Report

Primary Care Services

Submitted to the
Vermont General Assembly

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Acknowledgements

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect, prepare and submit the data required for this report.

Executive Summary

Act 71 of the Vermont legislature's 2007 session, "Ensuring Success in Health Care Reform,¹" included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct an annual survey of private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont". This survey of 2008 reimbursement rates for the highest volume primary care services is the second annual report.

Vermont has a concentrated health insurance market. Four insurers – Vermont BlueCross Blue Shield (BCBS), CIGNA, MVP, and The Vermont Health Plan (TVHP) account for about 99 percent of the market as measured by earned premium. TVHP is a wholly owned subsidiary of BCBS and uses the same provider contracts for setting reimbursement rates. In this report, information from BCBS and TVHP is consolidated.

The most frequent primary care services show minimal variation across insurers for the 10 most common procedure codes and little change in rankings between 2007 and 2008.

Summary Table 1 below shows the average reimbursement across insurers, the ratio of highest to lowest reimbursement, and the rank of each insurer for each of the top ten procedure codes for 2008. The highest variation in reimbursement occurred for the procedures with the lowest average reimbursement including venipuncture for a blood sample and immunization.

Summary Table 1 – Average Reimbursement

Procedure Code Ranked by Volume	Average	Hi / Low Ratio	Rank in Reimbursement		
			BCBS	CIGNA	MVP
99213 Office visit, established patient, 15 minutes	\$70.73	1.111	2	3	1
99214 Office visit, established patient, 25 minutes	\$109.02	1.149	2	3	1
36415 Obtaining a sample of blood	\$7.21	1.590	1	2	3
90471 Immunization administration	\$22.93	1.395	1	2	3
99212 Office visit, established patient, 10 minutes	\$47.46	1.104	1	3	2
99396 Preventive care, 40-64 years of age	\$140.34	1.116	1	3	2
99211 Office visit, established patient, 5 minutes	\$27.47	1.082	1	3	2
99203 Office visit, new patient, 30 minutes	\$122.86	1.083	1	2	N/A
90472 Administration of multiple immunizations	\$15.20	1.00	1	N/A	N/A
93000 Electrocardiogram (EKG)	\$42.67	1.287	1	3	2

N/A means Not Applicable wherein the procedure code was included in the top ten ranking based on combined volume for all insurers but was not in the top twenty ranking in the data submitted by that insurer.

¹ See Appendix 1 for statutory language

Summary table 2 shows the comparative ranking based on volume of services and the weighted average reimbursement rates for the top 10 most common primary care service procedure codes for 2008 and 2007. Procedure codes 99203 and 90472 are new additions to the top ten list that replaced procedure codes for two office visits that were in the top 10 list for 2007, 99391 (Preventive care, established patient, infant) and 99392 (Preventive care, established patient, age 1-4).

Summary Table 2 – Weighted Average and Ranking

Procedure Code	Rank 2007	Rank 2008	Wght.Ave 2007	Wght.Ave 2008	% Change 07-08
99213 Office visit, established patient, 15 minutes	1	1	\$68.18	\$70.73	3.7%
99214 Office visit, established patient, 25 minutes	2	2	\$106.07	\$109.02	2.8%
36415 Obtaining a sample of blood	3	3	\$7.54	\$7.21	-4.4%
90471 Immunization administration	4	4	\$22.21	\$22.93	3.3%
99212 Office visit, established patient, 10 minutes	5	5	\$45.15	\$47.46	5.1%
99396 Preventive care, 40-64 years of age	6	6	\$136.77	\$140.34	2.6%
99211 Office visit, established patient, 5 minutes	7	7	\$25.88	\$27.47	6.1%
99203 Office visit, new patient, 30 minutes	N/A	8	\$0.00	\$122.86	0.0%
90472 Administration of multiple immunizations	N/A	9	\$0.00	\$15.20	0.0%
93000 Electrocardiogram (EKG)	10	10	\$45.07	\$42.67	-5.3%

Introduction

Act 71 of the Vermont legislature's 2007 session, "Ensuring Success in Health Care Reform,"² included a requirement that the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) conduct an annual survey of private health insurers doing business in Vermont to provide information comparing reimbursement paid to primary care providers. This information is intended to "improve our understanding of access to care, the cost shift, and workforce issues in Vermont".

In preparing for the 2008 reporting year, BISHCA and representatives from the major insurance companies agreed to carry over the approach and methods from the initial survey and report that was published in March 2008 using 2007 data. Parties agreed to respect provider confidentiality and follow specifications in the legislation including:

- A requirement that information be sufficiently aggregated so that the amount paid to a specific provider or facility could not be determined
- An exemption of any provider or facility-specific information from disclosure under a public records request
- A requirement that data be at least 90 days old at time of release of the report

Methodology

In implementing the requirements of the relevant sections of Act 71, several principles were carried forward from the initial survey and are listed below.

Which insurers to include in the survey? The Vermont health insurance market is concentrated. Measured in terms of earned premiums in 2007 for comprehensive major medical products, the top four companies represent over 99% of the market. Because of this concentration, the survey focused on Vermont BlueCross BlueShield (57.6%), CIGNA (14.8%), MVP (13.4%) and TVHP (13.2%). Note that these figures do not include any third-party administrator (TPA) business. (As will be explained later in this report, CIGNA chose to include TPA business in the reporting of average reimbursement rates).

Define primary care. The following physician specialties were used to define primary care for the purpose of this report addressing reimbursement for primary care services: Family Practice, General Practice, Internal Medicine, Obstetrics & Gynecology, and Pediatrics. For the purpose of this survey, OBGYN providers were included only if they had been identified as a primary care provider by a beneficiary (extremely rare).

Identifying the top 10 procedure codes Claims submitted by health care professionals most frequently identify the services provided using a coding

² See Appendix 1 for statutory language

system called Current Procedural Terminology (CPT)³. A description of CPT codes used in this report can be found in Table 1. To identify the top 10 codes, BISHCA conducted a preliminary survey to identify the 20 most common primary care procedure codes at each insurer based on claims volume. Data submitted included the total allowed charges and average reimbursement (payment) for each code. Determination of the top 10 codes was based on combining this information across the four insurers.

Data universe The information provided by the insurers was based on the claims incurred by Vermont residents. Although the vast majority of these claims were paid to Vermont providers, claims paid to non-Vermont providers were also included in counts and averages.

Self-insured / Administrative Services Only business One concern in developing this survey was that in some cases, insurers may provide administrative services between insurers and providers (pay claims), but not have a contractual relationship with providers. Information included in this survey is limited to transactions based on a contract between the insurer and the provider. BCBS and CIGNA included self-insured business where reimbursement was based on the same contracts as insured business.

Data Collection Process

To ensure comparability among insurers and to comply with the requirement that data be at least 90 days old at time of publication, averages were to be based on claims incurred (date of service) between January 1, 2008 and June 30, 2008 and paid through September 30, 2008.

The figure used in calculation of reimbursement was "allowed charges." This is the amount set in a provider contract, prior to any reductions for cost sharing (deductibles, coinsurance, or copayments). Any pay-for-performance or other quality-based reimbursement was excluded. This was done to ensure comparability, because some carriers include this type of payment reimbursement for individual services, while others make a periodic aggregate payment.

Services that were covered under a direct capitation agreement were excluded, but services that were reimbursed under any form of aggregate agreement such as a per-member-per-month target and settlement contract were included.

BISHCA relied on the accuracy of the information provided by the insurers. No external validation of the data was attempted.

³ CPT codes, descriptions, and other data are copyright 1966, 1970, 1973, 1977, 1981, 1983-2007 by the American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

This report makes use of weighted averages in both the data collection process and analyses. Weighted average is a way of computing averages that recognizes the different counts of services at different reimbursement levels. For example, if an insurer paid 10 claims at \$20 and 5 claims at \$30, the weighted average would recognize that twice as many claims were paid at \$20 than at \$30. The calculation is $((10 \times \$20) + (5 \times \$30)) / (10 + 5)$, or \$23.33, rather than $(\$20 + \$30) / 2$.

Findings – Primary Care

Using the service count information provided by the insurers, the aggregate top 10 primary care codes were identified. Table 1 shows the codes and their descriptions. Figure 1 shows the proportion of the top 10 that each code represents.

Table 1

Code	Description
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem-focused history; An expanded problem-focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
36415	Collection of venous blood by venipuncture
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision-making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient; 40-64 years old.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history, A detailed examination; Medical decision making of low complexity. Counseling and /or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
90472	Administration of multiple immunizations (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); multiple vaccines (two or more combination vaccine/toxoid).
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report.

Figure 1 shows the distribution of specific codes among the top 10. The most common code, 99213, accounts for nearly 45 percent of services among the top 10 codes.

Figure 1

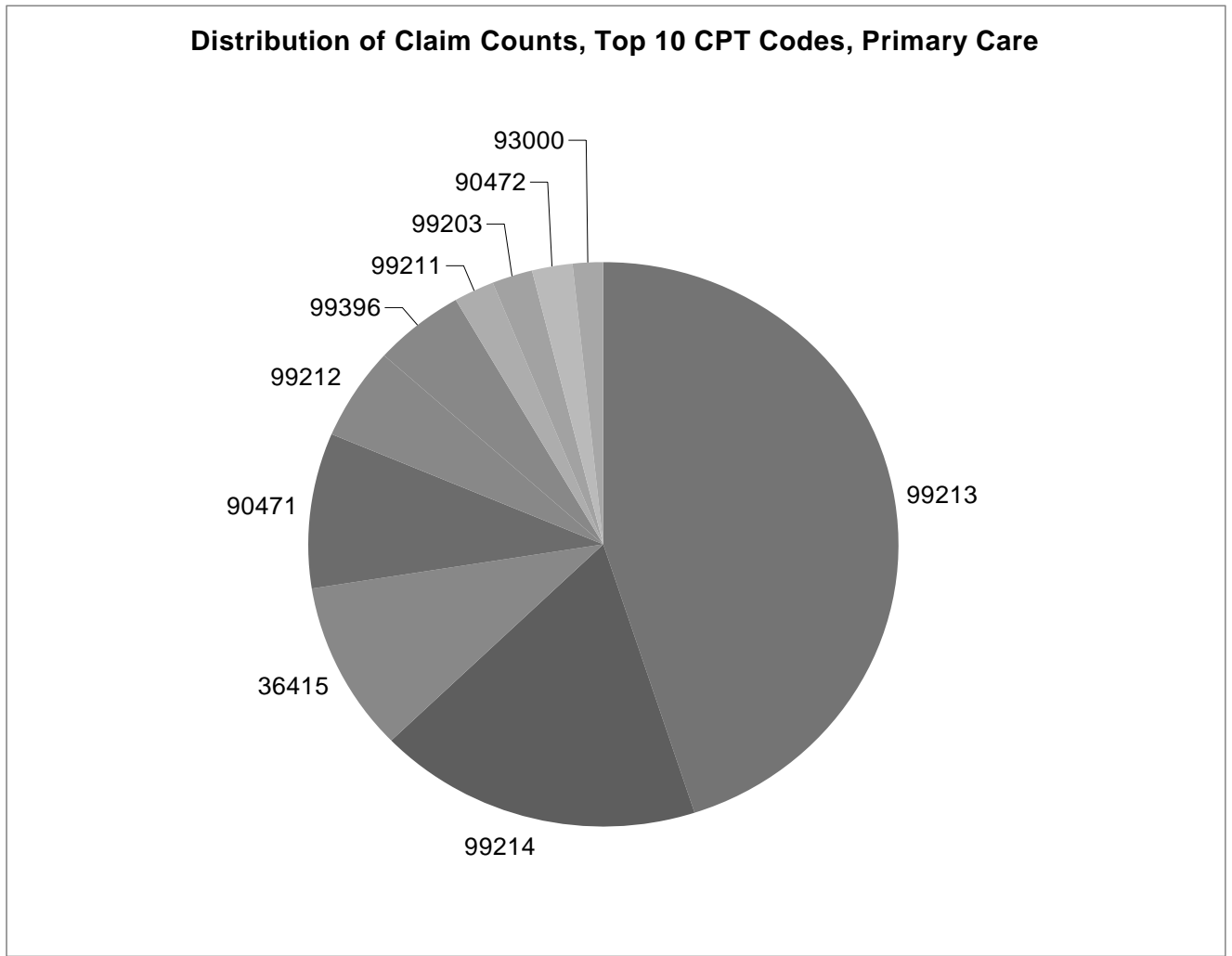


Table 2 shows the reported average allowed charge for each insurer for each of the top 10 primary care CPT codes, the percent that each code represents of the top 10 codes, and the weighted average allowed charge across insurers.

Table 2 – Allowed Charges for Top 10 Primary Care Procedure Codes

CPT Code	BCBS/TVHP	CIGNA	MVP	Percent of top 10 claims	Weighted average
99213	\$ 70.43	\$ 69.31	\$ 76.99	44.9%	\$ 70.73
99214	\$ 110.65	\$ 104.00	\$ 119.50	18.0%	\$ 109.02
36415	\$ 9.12	\$ 6.00	\$ 5.73	9.6%	\$ 7.21
90471	\$ 26.07	\$ 20.03	\$ 18.70	8.8%	\$ 22.93
99212	\$ 51.07	\$ 46.26	\$ 48.20	5.4%	\$ 47.46
99396	\$ 149.99	\$ 134.38	\$ 135.95	5.0%	\$ 140.34
99211	\$ 28.78	\$ 26.60	\$ 26.80	2.3%	\$ 27.47
99203	\$ 130.23	\$ 120.28	\$ -	2.2%	\$ 122.86
90472	\$ 15.20	\$ -	\$ -	2.2%	\$ 15.20
93000	\$ 48.20	\$ 37.44	\$ 43.43	1.7%	\$ 42.67

Missing values for MVP for 90472 and 99203 and CIGNA for 90472 occurred because these codes are not in their top 20 lists that were used to determine the top 10 codes across all three insurers.

Figures 2 and 3 show the distribution and variation of average reimbursement rates among the insurers for each of the top 10 codes. Two different approaches are taken to show variation. Figure 2 shows the actual average for each insurer for each procedure code. Figure 3 shows variation relative to the overall average payment for each service. In Figure 2, a 10 percent variation in a procedure code with higher reimbursement will look larger than the same percentage variation in a procedure code with lower reimbursement. In Figure 3, the same percentage variation will look the same regardless of the underlying dollars.

For example, look at procedure code 36415, venipuncture. In dollar terms, it is a low-variation code (Figure 2), but on a percentage basis, it is the highest-variation code (Figure 3).

As reported last year, again the most frequent code, 99213, office visit for evaluation and management of an established patient, is among the least variable, both on a dollar and on a percentage basis.

Figure 2

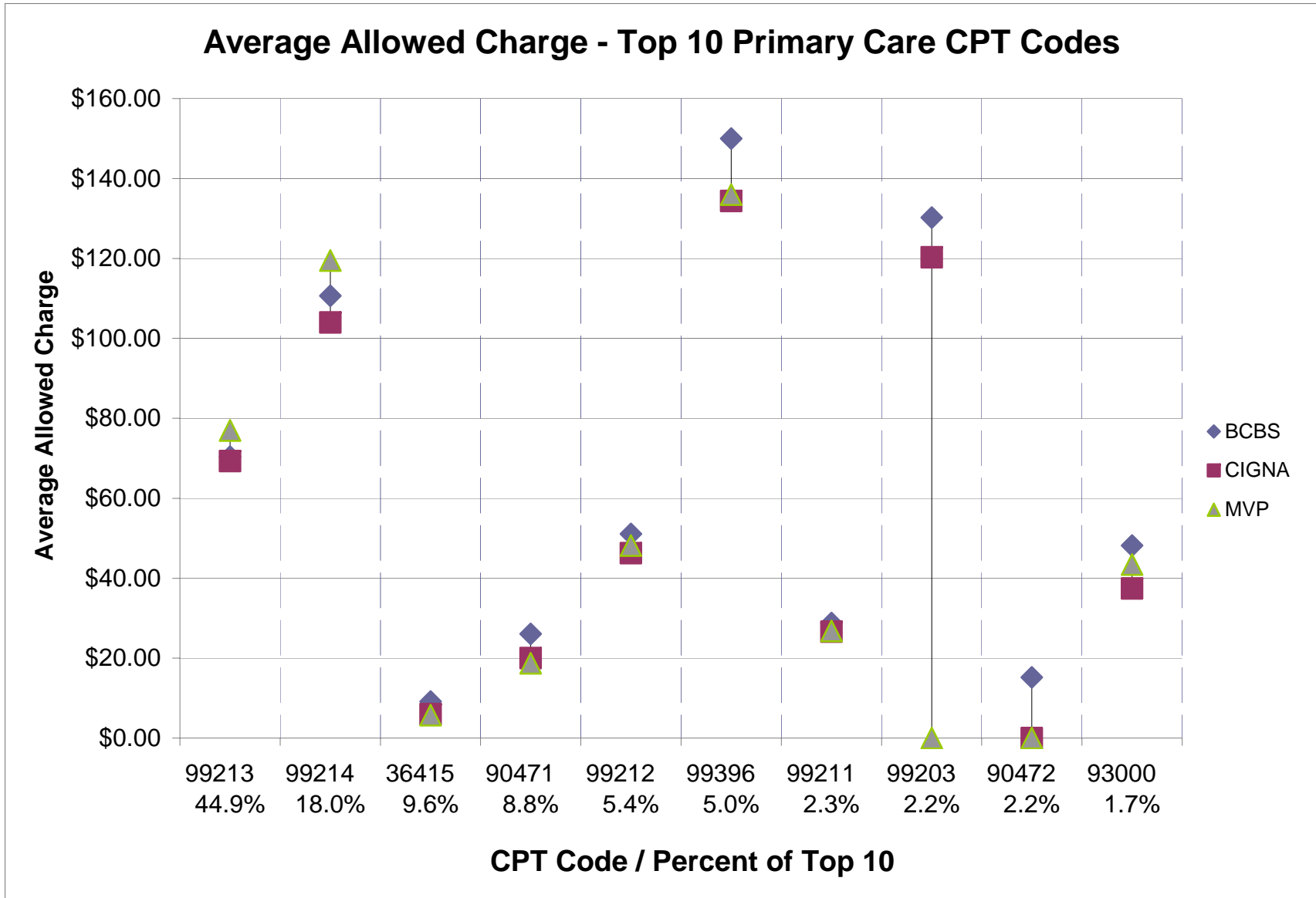
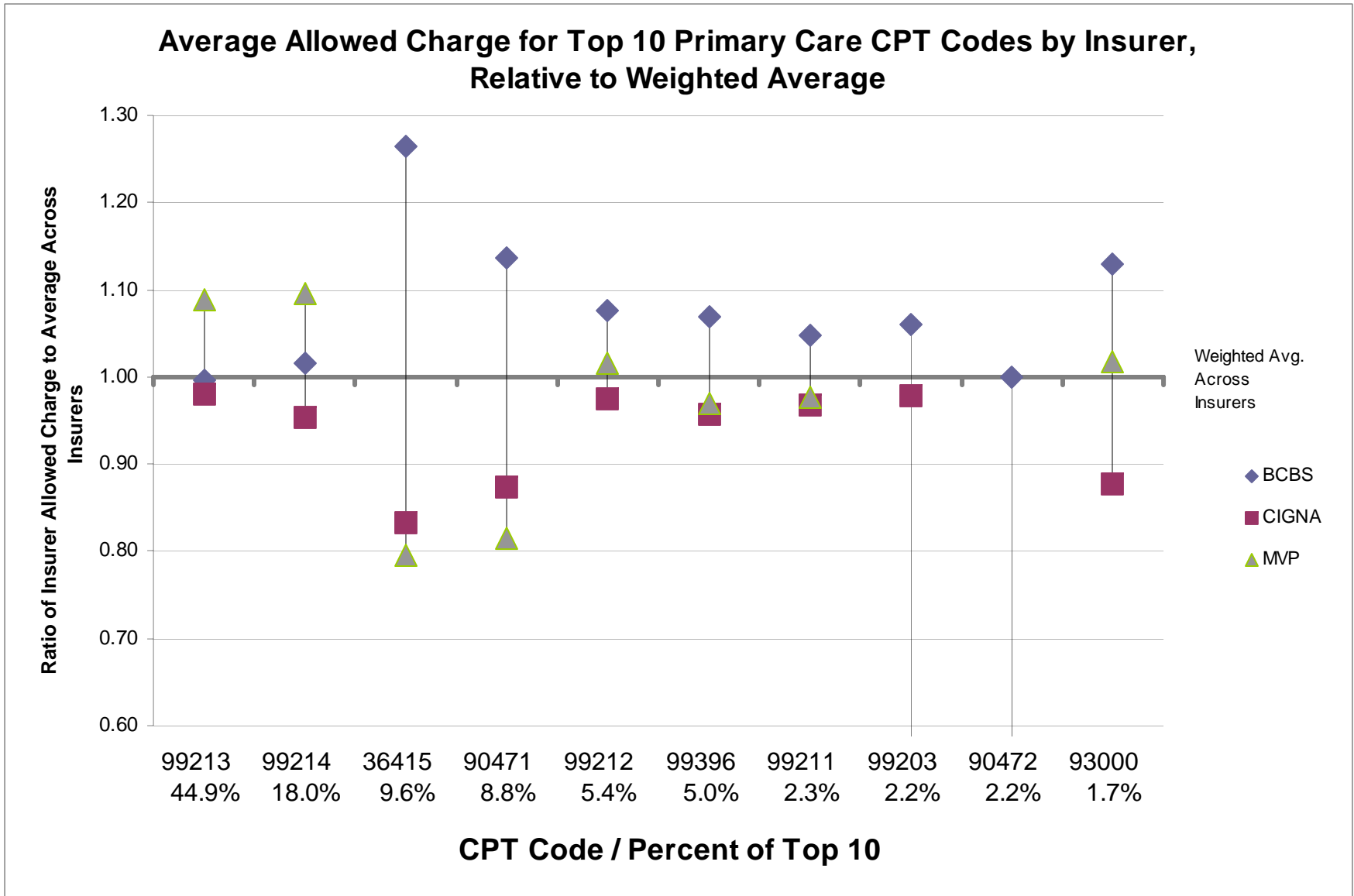


Figure 3



Conclusion

This report compares reimbursement for the highest volume primary care services among Vermont's major health insurers. Seven of the top ten codes remained at the same ranked position from the prior year. Overall Blue Cross / TVHP had the highest reimbursement for eight out of the top 10 procedure codes. While the most substantial variation among insurers occurred with the lower cost procedures such as routine venipuncture, there was less variation in reimbursement for higher cost codes such as office visits.

BISHCA would like to acknowledge the effort made by the participating insurers to define, collect, prepare and submit the data required for this report.

Appendices

Appendix 1 – Excerpt from Act 71 (2007)

Sec. 9. 18 V.S.A. § 9409a is added to read:

§ 9409a. HEALTH CARE INSURANCE REIMBURSEMENT SURVEY

In order to understand the impact of reimbursement on access to health care, the cost shift, the workforce shortages and recruitment and retention of health care professionals, the commissioner shall annually survey health insurers to determine the reimbursement paid for the ten most common billing codes for primary care health services. Each insurer shall report the average reimbursement paid for a specific service. The survey shall be managed by the department of banking, insurance, securities, and health care administration, and any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. When published, survey data will be at least 90 days old. Only the department will have access to the underlying survey responses. The department shall provide a copy of the survey results to the house committee on health care and the senate committee on health and welfare.

Sec. 15. MENTAL HEALTH AND OTHER NON-PHYSICIAN PROVIDER

REIMBURSEMENT SURVEYS

(a) In order to understand the impact of reimbursement on access to mental health care providers, the cost shift, the workforce shortages, and recruitment and retention of health care professionals, the commissioner of banking, insurance, securities, and health care administration shall administer a one-time survey of health insurers to determine the reimbursement paid for the ten most common billing codes for mental health services, along with differences in reimbursement based on the provider's level of education or licensure. Each insurer shall report the average reimbursement paid for a specific service for each applicable provider level of education or licensure.

(b) In order to understand the impact of reimbursement on access to other non-physician health care providers, the cost shift, the workforce shortages, and recruitment and retention of health care professionals, the commissioner of banking, insurance, securities, and health care administration shall administer a one-time survey of health insurers to determine the reimbursement paid for the most common billing codes for non-physician health care provider services. Each insurer shall report the average reimbursement paid for a specific service for each provider level of education or licensure, when applicable. The department may limit the survey to a total of 20 billing codes except that it shall ensure that the survey includes reimbursement for at least two common billing codes for each major class of provider.

(c) The surveys shall be managed by the department of banking, insurance, securities, and health care administration. Any public reports shall be sufficiently aggregated so that they would not enable readers to determine the amount of reimbursement paid for specific services to any particular provider or facility. No provider-specific or facility-specific reimbursement information shall be included in the public survey reports, or be available through public records requests. Only the department will have access to the underlying survey responses. Neither survey shall include hospital reimbursements.

(d) No later than December 15, 2008, the department shall provide the results of the surveys to the commission on health care reform, the house committees on health care and human services, and the senate committee on health and welfare. In addition, the department shall also provide the results of the survey conducted pursuant to subsection (a) to the mental health oversight committee.

Appendix 2–Primary Care Reimbursement Survey - Instructions

General

Allowed Charges - report the amount set in a provider contract, prior to any reductions for cost sharing (deductibles, coinsurance, or co-payments). Exclude any pay-for-performance or other quality-based reimbursement.

Calculation of Average Payment – averages are to be computed across all provider contracts and all lines of business that use fee-for-service reimbursement. In cases where services are paid at different reimbursement levels, report the average payment rate using one of the methods below.

Calculations of Averages for a specific CPT code.

<u>Contract</u>	<u>Claims Paid</u>	<u>Allowed</u>	<u>Total Allowed</u>	<u>% of Claims</u>	<u>% of Dollars</u>
1	500	\$70	\$35,000	17.9%	22.2%
2	800	\$60	\$48,000	28.6%	30.4%
3	1500	\$50	\$75,000	53.6%	47.5%
Totals	2800		\$158,000	100.0%	100.0%

<u>Acceptable Calculations</u>	<u>Result</u>	
1 Summation	$158,000 / 2800$	\$56.43
2 Weighted Average	$\frac{((500 * \$70) + (800 * \$60) + (1500 * \$50))}{(500 + 800 + 1500)}$	\$56.43

Data Survey Period - include all services provided (incurred) between January 1, 2008 and September 30, 2008. Paid dates should be as current as possible. Do not include IBNR estimates. (Any reports based on these data will be at least 90 days old at the time of publication.)

Data Universe - include all paid claims incurred by Vermont residents for the procedure codes listed below under Primary Care CPT codes. Include claims paid to Vermont providers and non-Vermont providers.

Lines of Business - include all business for which you have a direct contractual relationship with providers. Exclude any business for which you do not have a contractual relationship with providers.

Self-Insured Business - include any self-insured business where reimbursement was based on the same contracts as fully insured business.

Primary Care Providers - include physicians whose specialties are general practice, family practice, pediatrics, or internal medicine (CMS specialty codes 01, 08, 37, or 11). Include advanced practice RNs and physician assistants associated with physicians with these specialties. Exclude OBGYNs unless they have agreed to act as primary care providers

Primary Care CPT codes - report the count of services, the total allowed amount and the average payment for the top 20 CPT codes that meet the criteria of primary care providers listed above. Counts will be used to determine the top 10 CPT codes across payers and will not be included in any reports.

Reimbursement/ Service Payments – include services that were reimbursed under any form of aggregate agreements such as a per-member-per-month target and a settlement contract. Exclude any services for which no fee-for-service payment is made, such as a capitation payment.

