

Benefit Fact Sheet

How do third-party payers determine how much will be paid for services reimbursed under a medical plan?

For services incurred within the contracted provider network, total reimbursement is contractually agreed upon between the insurance carrier and provider. The member will pay a copayment or percentage of the agreed upon charge (called coinsurance) based on the product type and applicable plan design of the plan they are enrolled in.

For services incurred outside of the contracted provider network, the insurance carrier and the provider have no set agreement for reimbursement and the provider may charge whatever they choose (called a "billed charge"). While the provider may bill whatever they want, the insurance carrier is not obligated to base its reimbursement on the billed charge. In medical PPO, POS and HDHP or dental PPO plans, the carrier (or TPA) determines the amount of the billed charges that are eligible for reimbursement based either on a scheduled fee basis, or based on a usual, customary and reasonable (UCR) schedule, also known as reasonable and customary (R&C).

What is Usual, Customary and Reasonable (UCR)?

Usual, customary and reasonable is the maximum amount the insurer will consider eligible for reimbursement under a health insurance plan. This amount is determined based on a review of the prevailing charges made by peer physicians for a particular health service within a specific community or geographical area. Commonly UCR is set at a certain percentage of all charges made by providers of similar services or supply, often at the 80th-90th percentile. Therefore, if 10% of physicians within a specific geography charge more than \$80 for an office visit and 90% charge \$80 or less, the maximum covered amount would be \$80 for an office visit.

Remember that the UCR percentile is not the same as the coinsurance percentage that is applied to the covered charge. For non-network claims the UCR application comes first, and then coinsurance is applied.

Example:

A member is enrolled in a PPO plan that pays 90% in network and 70% out of network (assume no deductibles apply). The member is injured and needs surgery out of network and the hospital and surgeon charges are \$4,000. The carrier determines that the maximum allowable UCR charge for the surgery is \$3,000 (90% of providers in the members geographical area charge \$3,000 or less for this type of surgery). How much will the member end up paying out of his/her own pocket?

The insurance carrier will reimburse the member 70% of \$3,000 (or \$2,100). The member will pay 30% of \$3,000 (\$900), PLUS the \$1,000 difference between the billed charge of \$4,000 and UCR of \$3,000. This additional \$1,000 cost to the member is called "balance billing". In total, the member is responsible for paying \$1,900 of the \$4,000 billed charge, or 48%.

Keep in mind that in applying the UCR schedule, the carrier will base its reimbursement on the lesser of actual billed charges or the UCR schedule. If in our above example the 90th percentile UCR was \$4,400, the carrier would have calculated the amount it paid from the \$4,000 billed charge.

How is UCR set by the insurance carrier?

ERISA does not regulate how UCR reimbursements are calculated, however the Centers for Medicare and Medicaid Services (CMS) provides general guidelines, including criteria, comparable service limitations and application of the criteria that the insurance carriers must follow. Ultimately the insurance company has flexibility when setting the maximum charge.

How do I obtain UCR rates?

Most carriers take the position that their method of calculating UCR is proprietary data, and therefore it is often difficult to determine what the maximum reimbursement will be prior to the actual processing of a claim. To complicate matters further, it can be equally difficult for consumers to determine what a physician will charge for a specific service or procedure. Therefore, the consumer is often left with little or no information regarding what the covered cost of medical services will actually be until after the services have been performed and the claim adjudicated. This creates a significant

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incentive for members to make every attempt to seek healthcare treatment within the provider network since the member pays coinsurance on a discounted charge and is not subject to balance billing.

However, when it is necessary to go out of network, members should always attempt to obtain information regarding UCR rates and physician fees, as well as use the UCR rates to negotiate a reduction in the billed charges that exceed UCR. According to ERISA, plan enrollees who wish to appeal reimbursements based on what the plan considered usual, customary and reasonable have a right to be given the information that was used to determine how the UCR was derived and that the charge was in excess of UCR.

An independent organization (Fair Health) captures and maintains data for consumers and health insurers. The FAIR Health Consumer Cost Lookup provides consumers a free, user-friendly website where they can estimate out-of-pocket expenses they would incur if they seek out-of-network care.

What is new in this area?

- As a means of further reducing costs, many carriers are now routinely offering products that reimburse members based on a scheduled fee basis rather than UCR. Most common is to set their schedule of reimbursement as a percentage of Medicare reimbursements, or RVRBS (Resource Based Relative Value Studies). These schedules can pay providers approximately 30-50% less than the average UCR reimbursements.
- Fair Health, a not-for-profit and independent organization has been established to create and maintain databases of usual customary and reasonable charges.

Informational links:

- [Families USA](#)
- [Fair Health](#)
- [Resource Based Relative Value Studies \(RVRBS\)](#)

This Fact Sheet is designed to provide a general overview of the benefit program, service, or regulatory act it describes. The information included in this document is not a substitute for legal or professional opinion relative to a plan sponsor's particular fact pattern. Your ArlenGroup consultant can answer more specific questions relative to its application for your organization. A menu of additional topics is available online at: www.arlengroup.com/facts.