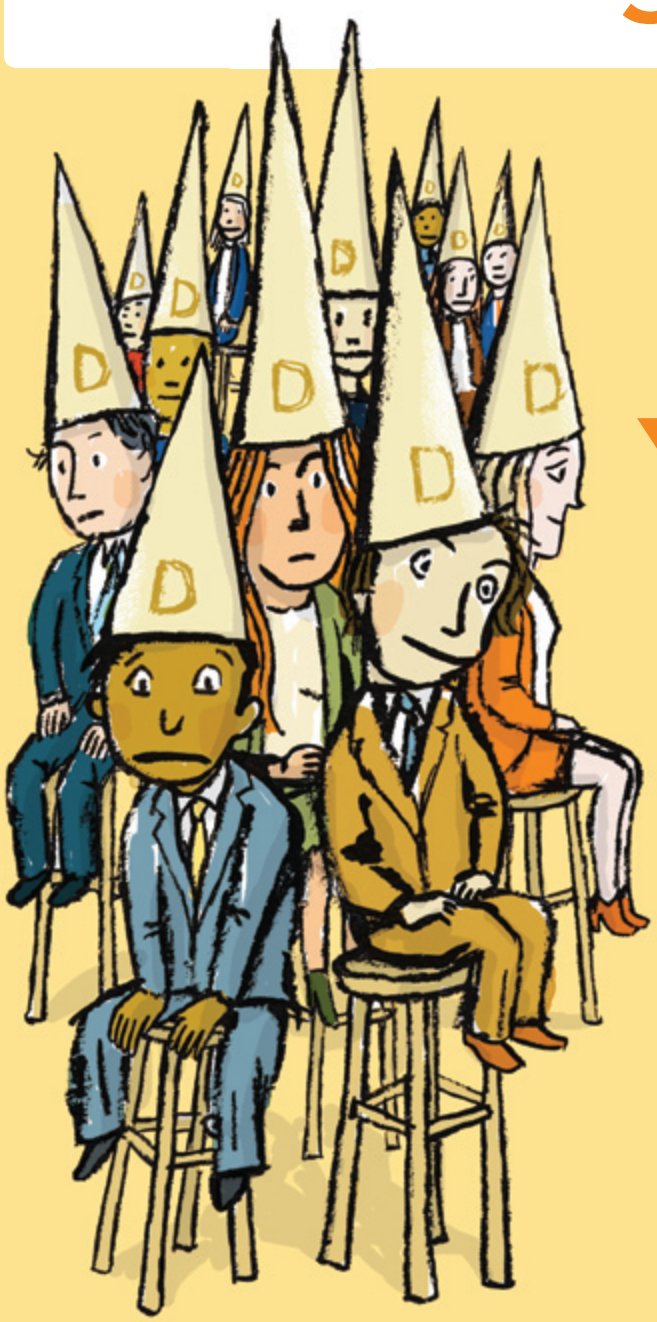
A Report Card for 32 Payers:
Not Making the Grade



Brandi White

ROBERT NEUBECKER

In this survey of physicians' experiences, payers fall short.

You couldn't make up stories like these:

Shane Avery, MD, is a family physician practicing solo in Scottsburg, Ind. Earlier this year, his practice received a contract from a major health insurer offering a fee schedule based on 120 percent of Medicare rates. "It sounded fair, and we were about to sign," Avery said, "but then we read further and found out it was based on *2004* Medicare rates."

"We counteroffered with 120 percent of 2007 Medicare, and they told us they couldn't do that," Avery said. "It wasn't a tough decision for me to throw the contract in the trash."

Alan Falkoff, MD, a family physician practicing in Stamford, Conn., was recently contacted by a major health insurer's disease management program regarding his performance. The health plan had profiled several patients and identified one who was lacking "needed care" – an LDL screening for the previous 12 months and an A1C test for the previous 6 months. "The ridiculous thing is that the patient hasn't belonged to my practice for years. He has been in a persistent vegetative state in a nursing home for many years following an anoxic brain injury after coding for cardiorespiratory arrest," Falkoff said. "I don't even know if this guy is still alive, but apparently his statistics exist in my quality assessment."

Dean Havron, MD, a family physician in Winchester, Va., who has practiced successfully for more than 15 years, found out in March that a major health insurer had awarded him zero gold stars out of a possible four under its physician performance rating program, which uses claims data to assess physicians' quality and efficiency, a practice many physicians object to because of the unreliability of the data. "Judging medical quality from claims data is like judging a restaurant by looking at its grocery bill," Havron says. ➤

The average overall grade physicians awarded for all 32 health plans was a C-.

In late 2006, the AAFP and *FPM* launched a survey to try to quantify physicians' experiences with health plans.

While the study isn't scientific, its results support previous reports of physicians' troubles.

The survey was completed by 307 AAFP members whose practices total an estimated 1,600 physicians.

So he contacted the insurer to inquire about the data. "They directed me to a Web site to check it out but gave me a password that didn't work. When I complained, they gave me another password that didn't work. Then they gave me an 800 number to call. When my office manager finally got through, she was routed to India and told they would try to find a customer relations rep to talk with us within 10 days." Havron is still waiting for their call.

In response to numerous accounts such as these, *Family Practice Management* decided last year to conduct a *Consumer Reports*-style survey of physicians' experiences with third-party payers.[1] The journal partnered with the AAFP, whose Congress of Delegates had passed resolution No. 304 in October 2005 asking the organization to develop a "national clearinghouse for the purpose of collecting data regarding undesirable business practices of health care insurance companies and use the information to identify trends and to develop effective policy to promote fair payment for physician services."

The survey was conducted between October 2006 and March 2007. It gave AAFP members a chance to grade individual health plans on 11 factors, including their payment rates, their prior authorization process and their contracting process. The results from the survey, while not scientific, provide a snapshot of physicians' experiences. The results are presented in this article in the form of a payer report card.

First, the big picture

Before we get to the results, it's important to understand their context.

In 2006, a comprehensive AMA study of the health insurance market showed "unequivocally that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power,"[2] that is, the power to lower the price paid for services below the price that would prevail in a competitive market. The study concluded, "Because the managed care contracts between physicians and health insurers impact so many aspects of the patient-physician relationship, the severe imbalance in bargaining power demonstrated by this study is an urgent matter that must be addressed by policymakers."

In a statement before the Senate Judiciary Committee in September 2006, Edward L. Langston, MD, a family physician, chairman-elect of the AMA's board of trustees and an AAFP member, shared the study's findings and frankly described the predicament for physicians:[3]

- "Many health insurer contracts are essentially 'contracts of adhesion' ... submitted to the weaker party on a take-it-or-leave-it basis and do not provide for negotiation." In many cases, these contracts contain objectionable provisions, such as "all products" clauses and "most favored payer" clauses, and allow the health insurer to change unilaterally any term of the contract.
- "Many health insurer contracts make material terms, including payment, wholly illusory. They often refer to a 'fee schedule' that can be revised unilaterally by the health insurer, and do not even provide such a schedule with the contract."
- "Despite the improper restrictions and potential dangers these terms pose, physicians typically have no choice but to accept them. ... Choosing to leave the network often means destroying patient relationships and drastically reducing or losing one's practice. Physicians simply cannot walk away from contracts that

About the Author

Brandi White is senior editor of *Family Practice Management*. Author disclosure: nothing to disclose.

constitute a high percentage of their patient base because they cannot readily replace that lost business."

• "Ironically, rather than focus on the health insurance industry, which ... has boasted record profits and increased premiums corresponding to recent waves of consolidation, regulators have focused on physicians, the least consolidated segment of the health insurance industry."

Survey results

The results of the AAFP/*FPM* survey of physicians' experiences with third-party payers are based on 307 valid responses from AAFP members. These physicians belong to groups that total an estimated 1,600 physicians, according to the demographic data they provided. The majority of respondents were either in solo practices (50 percent) or small groups of two to six physicians (33 percent). Because the sample size is small, physicians should be cautious with the results. Think of them as the advice you might receive if you were to ask your colleagues for input regarding their experiences working with health plans.

Each respondent was allowed to grade up to 10 health plans. Overall, the 307 respondents graded 254 different health plans; however, this article shows grades for only the 32 plans that were rated by 10 or more respondents. While many plans were graded by a small number of respondents, a few particularly large plans were graded by at least 200: Aetna, CIGNA, Medicare and United Healthcare.

Respondents were asked to grade each health plan from "A" (excellent) to "F" (failing) in 11 areas:

1. Payment rates (whether they are adequate or too heavily discounted);
2. Adherence to Current Procedural Terminology (CPT) in claims processing (whether the payer recognizes modifiers, inappropriately bundles or downcodes services, etc.);
3. Timeliness of payments (whether clean claims are paid within an appropriate amount of time);
4. Accessibility, knowledge and responsiveness to your practice's concerns (whether payer representatives are easy to reach, helpful, etc.);
5. Member eligibility and benefits information (whether it is accurate and easy to access);
6. The payer's Web site (whether it provides accurate information and smooth transactions);
7. Formularies (whether the information is easy to access, how often it changes, etc.);
8. Prior authorization (how often it is required, how reasonable the decisions are, etc.);
9. The appeals process (whether decisions are timely, reasonable, etc.);
10. The contracting process (whether the payer is willing to negotiate, disclose its fee schedule, etc.);
11. Physician performance data (whether data is accurate, valid and used fairly).

Grades assigned by respondents were converted to point values (A = 4.0, B = 3.0, C = 2.0, etc.) so that they could then be averaged in each of the 11 categories and used to compute an overall grade for each health plan.

Overall grades. The average overall grade physicians awarded for all 32 health plans was a C- (see the report card on page 46). They performed best (earning a C average) in three categories: "timeliness of payments," "member eligibility and benefits information" and "the payer's Web site." The category in which they received the lowest grade (a D average) was "the contracting process."

Of the 32 most commonly rated plans, the three graded highest were MVP Health Plan

Health plans received the highest grades for timeliness of payments, member eligibility and benefits information, and their Web sites.

Health plans received the lowest average grade, a D, for the contracting process.

TOP CONCERNS

The survey asked respondents "Which of the following issues are you most concerned about in your dealings with third-party payers?" Payment issues received the highest number of votes.

Issue	Percentage of respondents who selected it
Payment rates	86%
Timeliness of payments	44%
Adherence to CPT	32%
Prior authorization	31%
Payer accessibility, knowledge and responsiveness	30%
Formularies	22%
The contracting process	17%
Physician performance data	12%
Member eligibility and benefits information	11%
The appeals process	7%
Payer Web site	2%

PAYER REPORT CARD

The following report card shows health plans' grades in 11 key categories (listed left to right in order of greatest importance, according to respondents), as well as overall grades.

In each column, the highest grade received is highlighted green and the lowest grade received is highlighted red.

32 Most Commonly Rated Payers	n	Payment rates	Timeliness	Adherence to CPT	Prior authorization	
Aetna	227	C-	C+	C-	D+	
AmeriGroup	10	D+	C+	B-	D+	
Anthem Blue Cross Blue Shield (WellPoint)	54	C	C+	C-	D+	
Blue Cross Blue Shield of AZ	13	C	C+	C+	C+	
Blue Cross Blue Shield of FL	40	C	B-	C+	B-	
Blue Cross Blue Shield of TX (HCSC)	23	C-	B-	C-	D+	
Blue Cross of CA (WellPoint)	12	D+	C-	C-	D+	
Blue Cross/Blue Shield of NE and W NY	12	C	C+	B-	D+	
Blue Shield of CA (California Physicians' Service)	13	D+	C	C	C-	
CareFirst Blue Cross Blue Shield	12	C+	C+	C+	C+	
CIGNA	200	C-	C	C-	C-	
Coventry	26	C-	C	C-	D+	
Empire Blue Cross Blue Shield (WellPoint)	17	D	C	D	D-	
GHI (Group Health Incorporated)	15	D	C-	D+	D	
Great-West Healthcare	46	C-	C	C	C	
Health Net	45	D+	C-	C-	D+	
Health Options (subsidiary of Blue Cross Blue Shield of FL)	17	C-	B-	C+	C+	
HealthAmerica/HealthAssurance (Coventry)	10	C	C+	C	D	
Humana	77	C-	C	C-	C-	
Independence Blue Cross/Keystone East	10	F	C	D	F	
Kaiser	12	C-	C-	D+	D+	
MAMSI/MD IPA/Optimum Choice (UnitedHealth Group)	22	D-	C-	D+	D	
Medical Mutual of OH	14	D+	C	D+	D	
Medicare (traditional, not Medicare Advantage)	230	D+	C+	C	C+	
MVP Health Plan	13	B-	B	C+	C+	
Oxford Health Plans	23	D	C	D	D+	
PacifiCare	45	C-	C	D+	C-	
Private Healthcare Systems (PHCS)	103	C-	D+	C-	C	
Regence Blue Cross and/or Blue Shield	20	B-	B-	C+	C+	
Tricare	12	D	C-	C-	D+	
UniCare (WellPoint)	17	D+	C-	C	C-	
United Healthcare	257	D+	C	D+	C-	
Average grades for all 32 payers	**1647**	**C-**	**C**	**C-**	**C-**	

(available in portions of Connecticut, New Hampshire, New York, Massachusetts, Pennsylvania and Vermont), Regence Blue Cross/Blue Shield (available in Idaho, Oregon, Utah and Washington) and Blue Cross Blue Shield of Florida. They each earned a C+.

Medicare (traditional, not Medicare Advantage) received a C- overall, as did national insurers Aetna, CIGNA and Humana. Industry giant United Healthcare received a D+, as did several WellPoint-affiliated health plans. Of the 32 plans, the four that received the lowest overall grade were MAMSI/MD IPA/Optimum Choice (subsidiaries of UnitedHealth Group), Empire Blue Cross Blue Shield in New York (a subsidiary of WellPoint), GHI (Group Health Incorporated) in New York, and Independence Blue Cross/Keystone East in Pennsylvania. They each got a D.

Top concerns. The survey asked respondents to

	Payer accessibility	Formularies	Contracting	Physician performance data	Member eligibility	Appeals	Web site	Overall letter grade
	D+	D+	D+	D+	C+	D+	C+	C-
	D+	D+	D+	C-	C+	C-	B-	C
	D+	D+	D	D	C	D	C-	D+
	D+	C	C-	C	C+	C-	C-	C
	C	C	D+	C+	B-	C-	C+	C+
	D+	C-	D	D	C-	C-	C-	C-
	C-	D+	D-	D-	C-	D	C	D+
	C	C	D+	D+	C+	D+	C+	C
	D+	D+	D+	D	C	C-	C+	C-
	C-	C	D+	C	C+	C-	C	C
	D+	D+	D	D+	C	D+	C	C-
	C-	D	C-	C-	C-	D+	C-	C-
	D	D+	D-	F	D+	F	C	D
	D-	D-	D-	D-	D+	D-	D+	D
	C-	D+	D	D-	C-	D+	C-	C-
	D+	D+	D	D	C-	D	C-	D+
	C	D+	D+	B-	B	C-	C+	C
	D+	D-	D	D-	C+	D+	D	D+
	C-	C-	D+	C-	C+	D+	C-	C-
	F	D-	F	F	D+	D	C	D
	C-	D-	D+	C-	C-	D+	D	D+
	D+	D-	F	D-	C-	D-	C	D
	D+	D	D+	C-	C	D	C	D+
	C-	D+	D+	D+	C	D+	D+	C-
	C+	C+	C-	C-	B	C-	B-	C+
	D	D+	D-	D-	C-	F	C-	D+
	D+	D+	D+	D+	C	D+	C-	D+
	D+	D+	D-	D	D+	D	D+	D+
	C+	C	C-	D+	C+	C+	B-	C+
	D	C+	D	D	D	D	D+	D+
	D+	C-	D-	D+	C-	D+	C-	D+
	D+	D+	D	D+	C	D	C	D+
	D+	**D+**	**D**	**D+**	**C**	**D+**	**C**	**C-**

In the five most important categories, Medicare was rated better than the large national health plans the majority of the time.

identify the issues of greatest concern in their dealings with third-party payers (see page 45). The top five issues were as follows, in order of priority:

1. "Payment rates," in which payers earned a C- grade overall;
2. "Timeliness of payments," in which payers earned a C overall;
3. "Adherence to CPT in claims processing," in which payers earned a C- overall;
4. "Prior authorization," in which payers earned a C- overall;
5. "Payer accessibility, knowledge and responsiveness to your practice's concerns," in which payers earned a D+ overall.

Individual payer performance in each of these areas is shown in the grade card on page 46.

Respondents rated payment issues as their greatest concern.

Timeliness of payments and adherence to coding rules were also problem areas.

Medicare outperformed the large national health plans in many categories.

Interpreting the results

The results of the survey should be viewed with caution, as pointed out earlier, because they are based on physicians' perceptions of their health plans and the number of responses is limited. In addition, because the sample was self-selected, it is likely that those physicians who feel strongly about these issues were more inclined to complete the survey. Still, the survey offers some clear messages:

1. Respondents are dissatisfied with the performance of the large national health plans. In the five most important categories (mentioned above), Medicare was rated better than Aetna, CIGNA, Coventry, Humana, United Healthcare and the WellPoint-affiliated plans the majority of the time. This is not to suggest that physicians are satisfied with Medicare. As one respondent noted, "The latest fiasco with Medicare not paying for services at the end of September is an example of how bad it can get. Imagine if I tried to tell my creditors that I couldn't pay for a month."

It's possible that Medicare outscored the other payers because physicians have lower expectations for the program and expect higher levels of performance from large commercial payers that post billions of dollars of profit each year.[3]

2. Inadequate payment rates are a major concern for physicians. Inadequate payment has been shown to affect primary care physicians to a greater degree than other specialists because procedural services tend to be valued more highly by payers than evaluation and management services.[5,6] In the verbatim section of the survey, several respondents noted that health plans routinely pay less than Medicare. A Florida physician wrote: "In my area, Tampa Bay, [insurers] are colluding to drive down rates. Within a three-month period, I was notified by Aetna, CIGNA, Blue Cross Blue Shield, United Healthcare and Humana that my fee schedule had been updated to a 'take it or leave it' lower rate of 85 percent of 2006 RBRVS. I find it hard to believe that it is coincidence."

One California physician wrote: "Most of the PPOs have announced rates that are now 80 percent of Medicare. We were getting 130 percent of Medicare up until 2002, and in recent years they are paying less. ... We will not be in business by 2008 if this continues."

3. Physicians in solo practices or small groups need greater support on these issues. While 26 percent of AAFP members are in solo or two-person practices,[4] half of respondents to the survey said they were in solo practice, and a third said they belong to small groups of two to six physicians.

The disproportionate involvement of physicians in smaller settings may suggest that they feel the effects of payers' contracts and policies more acutely, and it may also mean that physicians in larger groups are relatively uninvolved in dealings with health plans and have less to say about them. Some respondents' comments give anecdotal support to the former hypothesis, however. An Illinois

physician wrote: "As a solo doctor, none of the health plans will negotiate with me for improved payment rates. Aetna, CIGNA, GHP, Healthlink and United Healthcare all pay me less than the other area primary care doctors are getting. They tell me to take it or leave it when it comes to fees. ... My costs increase, and the payers keep their fees relatively constant. About half are right at Medicare."

While physicians in large groups are more likely to be insulated from the contracting and payment processes, they are not necessarily faring well either. One respondent noted, "Even in a large group we feel powerless against payers, with no real increase in reimbursement for three to five years. I wonder if they have thought out who will see their patients when we are driven out of business?"

What can be done?

In many ways, the results of this survey may seem predictable: Physicians believe that health plans hold all the power, make complex rules and pay physicians as little as possible, while physicians are unhappy with the relationship but feel powerless to change it. You probably didn't need a survey to tell you that. The question is, can anything be done to correct the situation? As noted previously, opting out of insurers' contracts is not always a viable option, particularly if an insurer represents a large portion of a physician's practice.

In 2002, physicians tried to bring about change via a class-action lawsuit against 10 of the nation's largest health insurers (Aetna, Anthem, CIGNA, Coventry, HealthNet, Humana, PacifiCare, Prudential, United Healthcare and WellPoint), alleging conspiracy to deny or delay payment to physicians for legitimate claims. Most of the defendants settled their cases; United Healthcare and Coventry had their cases dismissed on the argument that there was no conspiracy. The insurers that settled have been instructed by the court to improve their dealings with physicians, for instance by following proper coding standards, ceasing the practice of automatically downcoding services billed, paying clean claims in a timely manner, providing complete fee schedules, recognizing valid assignment of benefits and providing sufficient notice to physicians when changes are made to the health plan's policies or fee schedules. (Physicians can report a health plan's noncompliance with the settlement agreement by following the process outlined at http://www.hmosettlements.com/Detail.aspx?PID=8.)

While physicians may have realized some gains in the wake of the lawsuits, significant concerns persist,[2,3,5,6] and there appears to be little that individual physicians can do.

"My experience has shown that insurance companies have little or no interest in negotiating or responding to individual practice needs," said one respondent. "Most gains have come from legislation resulting from pressure from groups such as AAFP."

The AAFP has said it will use the results of this survey to bolster its private-sector advocacy activities.

"The physician comments from this survey are particularly telling," said Rick Kellerman, MD, AAFP President and a family physician from Wichita, Kan. "The AAFP wants physicians to detail specific instances of problems with health plans and to let us know about them. We need to aggregate the problems, as this report card does, and let payers know that physician complaints are not isolated. Furthermore, physicians need to know their complaints are not isolated.

"As member complaints have increased in recent years, the AAFP has increased its private-sector advocacy. The Academy meets biannually with major health plans, and we will use the results from the report card survey to frame our discussions." FPM

Send comments to **fpmedit@aafp.org.**

1. Grade your payers: The AAFP/*FPM* survey of physicians' experiences with third-party payers. *Fam Pract Manag.* October 2006:55-59.

2. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2005 Update.* Chicago: AMA; 2006.

3. Langston EL. *Statement of the AMA to the Senate Committee on the Judiciary, United States Senate, re: Examining Competition in Group Health Care.* Chicago: AMA; Sept. 6, 2006.

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5. Bodenheimer T, Berenson RA, Rudolf P. The primary care - specialty income gap: why it matters. *Ann Intern Med.* 2007;146:301-306.

6. Felger TA. Are your payers' fee schedules fair? *Fam Pract Manag.* April 2007:13-15.

Respondents expressed concern about health plan payment rates often being less than Medicare's rates.

A disproportionate number of respondents said they practice solo or in small groups, suggesting that these issues are a bigger problem for those in smaller settings.

Many believe change is not likely to come through individual negotiations but may be possible through measures such as legislative action.