

Members

Sen. James Smith, Chairperson
Sen. Travis Holdman
Sen. Greg Taylor
Sen. Vi Simpson
Rep. Matthew Lehman, Vice-Chairperson
Rep. Robert Heaton
Rep. Charlie Brown
Rep. Phil GiaQuinta



INTERIM STUDY COMMITTEE ON INSURANCE

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Authority: IC 2-5-33.3

MEETING MINUTES¹

Meeting Date: August 24, 2011
Meeting Time: 10:00 A.M.
Meeting Place: State House, 200 W. Washington St., Room
431
Meeting City: Indianapolis, Indiana
Meeting Number: 2

Members Present: Sen. James Smith, Chairperson; Sen. Travis Holdman; Sen. Greg Taylor; Sen. Vi Simpson; Rep. Matthew Lehman, Vice-Chairperson; Rep. Robert Heaton; Rep. Phil GiaQuinta.

Members Absent: Rep. Charlie Brown.

Sen. Smith called the meeting to order at 10:10 a.m.

History and Benefits of Worker's Compensation in Indiana

Indiana State Senator Karen Tallian provided a handout² containing slides detailing her testimony. She described the: (1) origin of worker's compensation; and (2) three parts of worker's compensation (partial wage replacement; medical payment; and permanent impairment compensation (PPI)), including historical and current information about each part. Following her presentation, Sen. Tallian recommended that: (1) wage replacement and PPI rates be updated; and (2) a standardized basis for adjusting provider claims be established.

In response to questions from Sen. Holdman, Sen. Smith, Sen. Taylor, Rep. Heaton, and Rep.

¹ These minutes, exhibits, and other materials referenced in the minutes can be viewed electronically at <http://www.in.gov/legislative>. Hard copies can be obtained in the Legislative Information Center⁰ in Room 230 of the State House in Indianapolis, Indiana. Requests for hard copies may be mailed to the Legislative Information Center, Legislative Services Agency, West Washington Street, Indianapolis, IN 46204-2789. A fee of \$0.15 per page and mailing costs will be charged for hard copies.

²Attachment 1.

Lehman, Sen. Tallian stated that: (1) wage replacement benefits following employee death are not tied to the number of the employee's dependents; (2) Indiana's loss of limb compensation is based on the loss of a body part, not the loss of the ability to work; (3) different states calculate compensation for loss of limb on various factors and use different calculation methodologies, which makes comparison among states very complex; (4) national loss of limb information is available; (5) there is a statutory limitation on attorney fees related to worker's compensation cases in Indiana; and (6) increased medical costs over the last few decades is a likely cause of the significant increase in worker's compensation medical benefit expenditures as compared with wage replacement and PPI expenditures.

Ronald Cooper, Indiana Compensation Rating Bureau, stated that available information concerning worker's compensation rates in Indiana is aggregated, but that he will check to determine whether it is possible to expand the data to reflect rates based on occupation codes. Sen. Tallian requested the same information for the medical benefits as well. Mr. Cooper also stated that the standard basis used to predict the effect of using different methodologies (such as: the Medicare reimbursement rate for a health care service plus a percentage; or an increase in wage replacement or PPI compensation) of compensation on worker's compensation insurance premium costs is the rate of compensation used today in comparison to the rate determined under each suggested methodology.

Matt Golitko, a worker's compensation attorney of the law firm Golitko and Daly, described his experience with worker's compensation in recent years, including the four parts of worker's compensation: (1) wage replacement; (2) medical benefits; (3) PPI; and (4) permanent total disability, (which he stated is rarely awarded and provides a maximum amount based on occupation for 500 weeks, plus lifetime medical benefits). He noted that attorney fees for worker's compensation claims are determined by statute.

In response to questions from Sen. Holdman; Sen. Taylor, Sen. Smith, and Rep. Heaton, Mr. Golitko stated that:

- (1) if an employee is provided employer sponsored short term disability coverage by a self insured employer, the disability and worker's compensation benefits are frequently blended rather than the employee receiving both, as the benefits come from the same source;
- (2) if an employee is commercially insured for short term disability, the blending noted in (1) above would likely not occur;
- (3) most employees do not purchase short term disability policies for themselves;
- (4) he does not believe that a significant revision of Indiana's current worker's compensation system is necessary, though some increase in the compensation is needed;
- (5) worker's compensation in Indiana is more often based on the employee's disability than impairment because the disability considerations of education, experience, skills, and ability to perform job functions are more easily determined than the physical impairment degrees (upon which physicians may disagree);
- (6) Ohio's worker's compensation system is managed and funded similarly to Indiana's Patient Compensation Fund, rather than being funded by individual insurers and employers as is Indiana's worker's compensation system, which makes the two states' systems difficult to compare;
- (7) Indiana policymakers have many considerations in determining whether to increase worker's compensation benefits and rates, including attraction of business to Indiana, and whether a certain amount of money is sufficient compensation for loss of a body part;
- (8) there is no financial gain to injured employees who are awarded worker's compensation for loss of a body part in Indiana; and
- (9) high technology positions and other similar positions have a low likelihood of resulting in a worker's compensation claim, but rather iron workers, construction workers, and truckers are the main occupations that he represents.

Robert Fanning, Indiana Self-Insurers Association, Inc., provided a copy of his testimony³. He described the two worker's compensation concerns of his Association's members, appropriate care for employees and cost of the care. He shared his experience of being informed by representatives of businesses new to Indiana that Indiana's worker's compensation system is easy to implement and manage as compared to other states.

Mr. Fanning stated that: (1) the intent of the worker's compensation law in 1929 was to prevent medical service overcharges when the price was not negotiated between the employer/insurer and the medical provider; and (2) whether overcharging had occurred was determined by whether the charge was greater than the 80th percentile of all charges for a similar service in the geographic area. He explained that this system is not currently working as it should because medical providers no longer charge the amount they expect as payment in full, but instead inflate charges so that they are eventually paid a "usual and customary payment" which is an amount near the amount they actually expect after application of today's discounts, fee schedules, and other payment reductions. Mr. Fanning noted that the worker's compensation law provides for payment in full of the amount charged for a service in 8 of 10 bills, but current interpretation of the law allows payment in full by payment of the amount that is usual and customary payment in 8 of 10 bill payments, which he describes as a method foreign to current law.

Mr Fanning stated his opinion that an employer/insurer agreement with medical providers is the best solution to the medical benefit payment problem in Indiana's worker's compensation system. However, for instances when such an agreement does not exist, the current statutory method of overcharge prevention should be changed to a percentage discount from the amount charged (i.e., 15% discount from the amount charged).

With respect to PPI, Mr. Fanning stated that he does not believe an annual increase in PPI rates is necessary as the loss to the employee does not change from year to year. He cautioned that the PPI benefit is arbitrary as it is not necessarily tied to an employee's occupation. Mr. Fanning also stated that comparison of Indiana's worker's compensation rates to other states is difficult as other states consider different factors in determining rates.

In response to questions from Sen. Smith, Mr. Fanning stated that: (1) his suggested statutory change to a percentage discount from the amount charged would potentially be subject to overcharging by medical providers, but is better than a determination based on "usual and customary" payment; and (2) employer/insurer contracting with medical providers is more difficult today than in 1929 due to today's more specialized providers and geographic distance between employees and specialists, but the difficulty may be eased by preferred provider networks and other methods of contracting.

Worker's Compensation Databases

Robin Gelburd, President, Fair Health, provided a handout⁴ detailing her testimony and the testimony of other representatives of her company. She described the history of Fair Health, the source and organization of its database, and the availability of health care service charge information from its database to: (1) payors with which Fair Health contracts; and (2) the public. She noted that Fair Health is an independent organization that provides information for consumers' and payors' use in accordance with the consumers' and payors' individual needs. She stated that she believes that use of database information to determine appropriate worker's compensation benefits is more appropriate

³Attachment 2.

⁴Attachment 3.

than use of a method such as the Medicare rate plus a percentage because Medicare: (1) was created for a different population than the worker's compensation population; and (2) pays for different types of services.

Ray Agostinelli, Director of Operations, Fair Health, provided information concerning Fair Health's data warehouse, which contains claims data from 2002 to present. He discussed technology, quality control, privacy procedures, etc., related to Fair Health's database.

Randy Devereaux, Statistical Support Manager, Fair Health, provided information reflected in a handout⁵ concerning Fair Health's benchmark databases for charge methodologies in pricing of health care services.

In response to questions from Rep. Lehman, Sen. Holdman, Sen. Smith, and Rep. GiaQuinta, Ms. Gelburd stated that: (1) Fair Health operates in 50 states and no other neutral company has the extent of data that Fair Health possesses; (2) Fair Health has payors with which it contracts in Indiana; (3) Fair Health's compensation is based on billings, claims, national module or local module use, etc., and is different for each payor with which Fair Health contracts; (4) Fair Health contracts with employers, insurers, third party administrators, the Veteran's Administration, and others; and (5) Fair Health provides to payors an array of data received by Fair Health from health providers within a geozip area and each payor determines the payment rate based on the data and the individual payor's policies.

In response to questions from Rep. GiaQuinta, Mr. Fanning stated that: (1) a self-insured business representative had recently compared Indiana's worker's compensation system to Pennsylvania's and told Mr. Fanning that Indiana's was preferable in ease of compliance; and (2) repricing of worker's compensation billings is currently performed using a percentage of "usual and customary payment" rather than as a percentage of charges, so it is not currently following Indiana law; and (3) if repricing were performed using a percentage of a database amount of charges, that would be preferable to the current process.

Sen. Smith informed those present that the Committee will meet again in approximately 4 weeks, with notice to follow.

With no further business to discuss, Sen. Smith adjourned the meeting at approximately 12:35 p.m.

⁵Attachment 4.

Worker's Compensation Issues I.C. 22-3

Interim Study Committee on Insurance
August 24, 2011

State Senator Karen Tallian

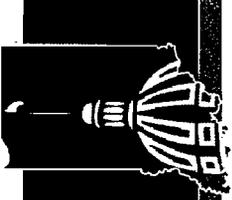


Worker's Compensation: The Social Contract



- The original “tort reform” legislation
 - An employee gives up the right to sue an employer for “negligence” or “fault” in exchange for assured, but limited coverage.
- Every state has some form of Worker's Compensation and most were enacted in the early 1900s
- Indiana's WC law was enacted in 1929
- Most laws provide that WC is the “exclusive remedy” for injuries on the job, and employers may not be sued except in special circumstances
- Indiana worker's compensation claims are under the jurisdiction of the Worker's Compensation Board established under I.C. 22-3-1

Three Parts of Worker's Compensation Benefits



1. Partial Wage Replacement
2. Medical Bills
3. Compensation for permanent injury/impairment

Wage Replacement



- Temporary Total Disability (TTD)
 - An employee is considered to be totally disabled during the period of injury when he or she is temporarily unable to work.
- Benefits are calculated as 66 2/3% of weekly wages, with a wage cap of \$975 per week. (I.C. 22-3-3-8)
 - Even if an employee's wages are \$1500/ week, the maximum benefit they can receive is 2/3 of \$975, which equals \$650/ week.
 - Historically, this cap has been updated regularly, but the last update was in 2006
- Benefits are not to exceed 300 weeks. (I.C. 22-3-3-10 (12))
- Wage Replacement is an element of WC benefits in nearly every state and the 2/3 replacement rate is fairly common

Maximum Wage Replacement for PPI



| Year | Max. Wage-Replacement Amount |
|------------------------------|------------------------------|
| July 1, 1997 to July 1, 1998 | \$672 |
| July 1, 1998 to July 1, 1999 | \$702 |
| July 1, 1999 to July 1, 2000 | \$732 |
| July 1, 2000 to July 1, 2001 | \$762 |
| July 1, 2001 to July 2, 2002 | \$822 |
| July 1, 2002 to July 1, 2006 | \$882 |
| July 1, 2006 to July 1, 2007 | \$900 |
| July 1, 2007 to July 1, 2008 | \$930 |
| July 1, 2008 to July 1, 2009 | \$954 |
| On or after July 1, 2009 | \$975 |

IC 22-3-3-10(12)(k)(5-14)

Worker's Compensation Claims



- In 2009, Indiana paid \$424.8 million in WC benefits and \$427 million in 2010
- Medical benefits accounted for 71.1% of total Indiana benefits in 2009
 - Medical Payments = 71 %
 - TTD/ Wage Replacement = 8%
 - Permanent Injury = 20%
- No other state topped 70%
- No neighbors reached 60%

Medical Bills



- Medical bills are fully covered in Indiana.
 - All states are believed to have nearly unlimited medical coverage
- Employer-Directed Care
 - Allows an employer (or its insurance carrier) to negotiate rates and direct treatment for an injured employee
 - Costs are projected to be reduced by 7 – 10% in states currently implementing employer directed care
- Indiana has no “medical fee” schedule for WC medical payments
- Generally, services are to be paid at a rate of no more than 80% of the going rate in the community (I.C. 22-3-3-5.2)
 - “Community is defined by a “Geo-Zip” system that will be explained later

Permanent Injury Payments



- Employees are paid a final sum of money based on the permanent impairment of their ability to function in the workplace
 - States differ significantly in their respective methods for awarding permanent injury benefits
- Indiana: I.C. 23-3-3-10 (11)
- Awards are made for
 - Permanent Partial Impairment (PPI)
 - Permanent Total Disability (TD)
 - Fatalities

Permanent Injury Payments



- Permanent Partial Impairment (PPI)
 - Awards are based on “Degrees of Impairment” and paid on a sliding scale
 - An injured employee receives a certain amount of money “per degree” of impairment (see chart)
- Example: 19 Degrees Impairment:
 - First 10 Degrees \$ 14,000 +
Next 9 Degrees $\frac{\$ 14,400}{9} =$
\$ 28,400
- Degrees of impairment are not defined but are generally determined by a physician

Partial Permanent Impairment Degrees

| Degrees | Amount per degree |
|---------|-------------------|
| 1-10 | \$1,400 |
| 11-35 | \$1,600 |
| 36-50 | \$2,700 |
| 50+ | \$3,500 |

Separation / Loss of Body Parts



- A separate additional amount is awarded to an employee who loses a body part, set forth in (I.C. 22-3-3-10 (i))
- In the event of a fatality, the dependent(s) get a wage replacement of $\frac{2}{3}$ the deceased worker's average weekly wage for up to 500 weeks (IC 22-3-3-17)
 - This is a maximum of approximately \$325,000

Compensation Rates



- Historically, the Indiana PPI payment schedule has been updated every few years.
- The last legislation passed in 2008, and the last rate change was through 2009. (I.C. 23-3-3-10)
- Indiana has some of the lowest compensation rates for permanent injury in the country.

PPI Yearly Increases from 1997 - 2000

| Year | Degrees | \$/Degree | Yearly % Change |
|--------------------|---------|-----------|-----------------|
| 07/01/1997 | | | |
| IC 22-3-3-10(j)(5) | 1-10 | \$750 | |
| | 11-35 | \$1,000 | |
| | 36-50 | \$1,400 | |
| | 51-100 | \$1,700 | |
| 07/01/1999 | | | |
| IC 22-3-3-10(j)(6) | 1-10 | \$900 | +20% |
| | 11-35 | \$1,100 | +10% |
| | 36-50 | \$1,600 | +14% |
| | 51-100 | \$2,000 | +17.6% |
| 07/01/2000 | | | |
| IC 22-3-3-10(j)(7) | 1-10 | \$1,100 | +22% |
| | 11-35 | \$1,300 | +18% |
| | 36-50 | \$2,000 | +25% |
| | 51-100 | \$2,500 | +25% |

PPI Yearly Increases from 2001 - 2008

| Year | Degrees | \$/Degree | Yearly % Change |
|------------------------------|---------|-----------|-----------------|
| 07/01/2001-06/31/2007 | | | |
| IC 22-3-3-10(j)(8) | 1-10 | \$1,300 | +18% |
| | 11-35 | \$1,500 | +15% |
| | 36-50 | \$2,400 | +20% |
| | 51-100 | \$3,000 | +20% |
| 07/01/2007 | | | |
| IC 22-3-3-10(j)(9) | 1-10 | \$1,340 | +3% |
| | 11-35 | \$1,545 | +3% |
| | 36-50 | \$2,475 | +3% |
| | 51-100 | \$3,150 | +5% |
| 07/01/2008 | | | |
| IC 22-3-3-10(j)(10) | 1-10 | \$1,365 | +2% |
| | 11-35 | \$1,570 | +1.6% |
| | 36-50 | \$2,525 | +2% |
| | 51-100 | \$3,200 | +1.6% |

PPI Yearly Increases from 2009 - 2010

| Year | Degrees | \$/Degree | Yearly % Change |
|---------------------|---------|-----------|-----------------|
| 07/01/2009 | | | |
| IC 22-3-3-10(j)(11) | 1-10 | \$1,380 | +1% |
| | 11-35 | \$1,585 | +0.009% or <1% |
| | 36-50 | \$2,600 | +3% |
| | 51-100 | \$3,330 | +4% |
| 07/01/2010 | | | |
| IC 22-3-3-10(j)(12) | 1-10 | \$1,400 | +1% |
| | 11-35 | \$1,600 | +0.009% or <1% |
| | 36-50 | \$2,700 | +4% |
| | 51-100 | \$3,500 | +5% |

- **Average Yearly % Change by Degree: '97 – '10**

- 1 - 10: +9.5%
- 11 - 35: +7%
- 36 - 50: +10%
- 51 - 100: +11%

Loss of Limb Schedule



| <i>Income Benefits</i> | Indiana | Ohio | Michigan | Illinois |
|------------------------|-------------|------------|------------|------------|
| Arm at Shoulder | \$ 86,500 | \$ 168,975 | \$ 198,791 | \$ 314,380 |
| Hand | 62,500 | 131,425 | 158,885 | 238,696 |
| Thumb | 16,000 | 46,060 | 48,035 | 88,720 |
| 1 st Finger | 10,400 | 26,285 | 28,082 | 80,197 |
| 2 nd Finger | 9,100 | 22,530 | 24,387 | 44,360 |
| 3 rd Finger | 7,800 | 15,020 | 16,258 | 31,519 |
| 4 th Finger | 5,200 | 11,265 | 11,824 | 22,682 |
| Leg at hip | 74,500 | 150,200 | 158,885 | 345,542 |
| Foot | 50,500 | 112,650 | 119,718 | 194,951 |
| Great toe | 16,000 | 22,530 | 24,387 | 44,360 |
| Other toes | 2,600-7,800 | 7,510 | 8,129 | 15,176 |
| One eye | 50,500 | 93,875 | 119,718 | 201,955 |
| One ear | 20,500 | 18,775 | -- | 63,038 |
| Both ears | 62,500 | 93,875 | -- | 250,985 |

Source: National Academy of Social Insurance and NCSL, 2008.

Worker's Compensation Insurance Policies



Employers are required to provide WC benefits, but they have two options for providing them: Commercial Policies or an approved program for Self Insurance.

- Commercial Policies

- 89% of benefits paid by these policies

- Self Insurance

- 11% of benefits paid by these policies
- Includes the State of Indiana and certain large business employers
- There are 170 self-insured businesses in Indiana

- Footnote

- ❖ Railroad worker's are excluded because they come under Federal law
- ❖ Fire and Police are excluded because they come under PERF

Premium Costs



- A national system of business categorization provides the initial basis for rate determination
- Categories are broadly broken down into:
 - Manufacturing
 - Construction
 - Retail
 - Clerical
 - Miscellaneous
- There are approximately 600 job-type classifications within those broad categories

Premium Costs



- The Indiana Worker's Compensation Ratings Bureau was established by statute in 1935
 - Insurance Companies writing WC policies in Indiana belong to it
 - The Bureau keeps statistics on WC claims based on total payroll, total losses, and total premiums, as well as types of injuries
- Rates for Premiums are based on numbers set by the Ratings Bureau for various businesses
- Indiana has the 2nd lowest premium rates in the country

Premium Costs



- Indiana Ratings Bureau was asked to calculate the effect on Premiums for two scenarios:
 1. Raise the Permanent Injury payments by 10%, or 20%
 2. Limit the Medical payments to hospitals based on a Percentage of Medicare payments with the percentage set at 200%, or 300%

❖ Footnote:

- ❖ The numbers provided by the Ratings Bureau result from data supplied based on commercial policies. The Ratings Bureau does not compile actuarial data from the self-insured population. However, they believe that, because of the significantly larger number of employers and employees falling under the Commercial policy category, these calculations are likely statistically similar to self-insured groups.

Impact of decreasing hospital reimbursement while increasing PPI

| Item | Value | Impact % | Impact \$ |
|------------------|--------------|--------------|-----------|
| Med Fee Schedule | 200% | -4.3 to -5.0 | 32-37m |
| Med Fee Schedule | 300% | -1.9 to -2.5 | 14-19m |
| PPI table | 10% increase | +1.1 to +1.3 | 8-9m |
| PPI table | 20% increase | +2.2 to +2.6 | 16-18m |



Jurisdiction over Employee and Reimbursement Claims (IC 22-3-1)

Employee Claims

- Undisputed claims
- Disputed claims reviewed by ALJs
 - Disputes most often arise out of issues involving amount of impairment, final PPI rating, whether an injury was work-related
- # of cases in 2009: 3510
2010: 3127

Provider Claims

- Dispute between providers and the amount paid or allowed by the insurance company
- WC Board has no schedule of allowable fees
- Prior to 2011, no fee charged for review – now a fee to discourage appeal of minor claims
- # of cases in 2009: 1861
2010: 1402

Special Hospital Reimbursement Issues



Problem

- Rule: Not more than 80% of the going rate in the community (IC 22-3-3-5.2)
 - Rate is determined by a Geo-Zip
- Doctors: Numerous providers can establish a local rate
- Hospitals: Few hospitals in an area make it difficult to determine a fair price

Proposals for Solutions

- Medicare Based Percentage
- Certified Database
- Discontinue Geo-Zip and use 1-3 categories

Conclusions/Recommendations



- The normal “cost of living” periodic adjustments on the benefits side have expired. These need to be updated.
 - The last wage cap increase was July 1, 2009
 - The last impairments increase was July 1, 2010
- The WC Board requires a standardized basis for adjusting hospital provider claims.
 - Percentage of Medicare
 - Percentage of common charges as determined by an independent database

INTERIM STUDY COMMITTEE
ON INSURANCE
AUGUST 24, 2011

ROBERT FANNING,
EXECUTIVE DIRECTOR,
INDIANA SELF INSURERS ASSOCIATION, INC.

The Indiana Self Insurer's Association, Inc. represents Indiana employers who have qualified to self-insure their worker's compensation liability in Indiana. Generally speaking, such self insured employers are larger employers in the manufacturing and medical services sections of the Indiana economy. As such, these employers pay directly the medical bills for services rendered to their injured employees.

In Indiana, the employer (or the worker's compensation insurer, if there is one) has the right to chose the medical providers for the treatment of an injured employee. And, the employer/insurer thereby has the right to agree with its medical providers as to the amount to be paid for the medical treatment. This process is the way by which employers/insurers may contain the costs of medical services and has been in place since 1929. It is a free market process, with one proviso. That proviso is that if an agreement as to payment was not made, then the employer/insurer may not be over-CHARGED. A over-CHARGE is that which is greater than the 80th percentile of all charges within the geo-zip code for a similar service. Thus a bill for services which is less than the 80th percentile should be paid in full. The 80th percentile provision means that eight of ten bills are to be paid in full.

In 1929, medical providers charged what they expected to be paid. In 2011, because of preferred provider organizations, volume discounts, health insurance contracts, government fee schedules and hundreds of other agreements, medical providers are almost never paid what they charge and as a result the charge has been inflated in consideration of the fact that virtually all payments are less the amount charged.

Eight to ten years ago cost containment concepts from states other than Indiana began to be used in order to the reduce the amount paid for Indiana worker's compensation services. The amount paid was referred to as the "usual and customary" PAYMENT, based upon an analysis of the amount which medical providers were being paid as PAYMENT in full by virtue of a myriad of contracts, discounts and fee schedules to which they had agreed or were subjected. But, nowhere within the Indiana Worker's Compensation Act is the concept of usual and customary PAYMENT authorized.

Nearly 100% of the provider fee disputes pending with the Worker's Compensation Board are the result of an underpayment of the amount CHARGED on the basis that the amount paid was the "usual and customary" PAYMENT, not the 80%

percentile of all CHARGES in that geo-zip code for a similar services. Again, there is no statutory basis for a usual and customary PAYMENT as a cost containment process for worker's compensation CHARGES.

The problem with the Indiana Worker's Compensation Act is twofold:

1. The reality of medical charges today is different than it was in 1929. As a result, worker's compensation payors of medical services who have not agreed with their providers as to the amount to be paid are being CHARGED too much and must therefore pay more than anyone else.
2. Employers/insurers are not exercising their right to contain medical costs by contracting with their providers as to the amount to be paid. Instead, they are relying upon on a 3rd party re-pricer to contain medical costs by way of an unauthorized "usual and customary" payment. The result is thousands of disputes pending at the Worker's Compensation Board.

A Medicare based fee schedule is not the solution. The imposition of such a fee schedule would force employers/insurers to hire vendors to review and pay bills in accordance with that complicated and changing schedule. And, just as there are disputes between providers and payors of Medicare services, there would be disputes when that fee schedule is imposed upon the worker's compensation system.

Speaking for the Indiana Self Insurers Association and its members, we believe first and foremost that employer choice of medical is the best method for medical cost containment and thus the Worker's Compensation Act should encourage agreement as to the amount to be paid for medical services under the Act. In the absence of an agreement, a modest discount from the amount CHARGED; say 15%, will protect the employer/insurer from paying too much in a world of artificially inflated medical charges. Such a discount would not be so large as to discourage employers/insurers from agreeing to other more advantageous contractual arrangements. By preserving the free market right to contract and by protecting employers/insurers from artificially inflated charges by a statutory discount, the simplicity of the Indiana Worker's Compensation System will be preserved. Such simplicity would result in lower costs to employers, reduced litigation and prompt payment to medical providers.

There are other billing processes which need to be addressed-- multiple procedures, fragmenting or unbundling of charges--and CPT and APC codes may need to be required for appropriate review. Those issues are better addressed by experts familiar with those processes. But, the clear goal of any statutory change should be simplicity and certainty so that additional administrative costs are not introduced into the system and disputes may be avoided.



Bringing Fairness And Transparency To Health Insurance Information



Thank you for the opportunity to address the Indiana Interim Committee on Insurance. FAIR Health is an independent, not-for-profit organization established to provide fairness and transparency in health insurance information. We look forward to introducing you to our capabilities and our mission.

History of FAIR Health

Origins

FAIR Health was established in October of 2009 as the result of an investigation led by the New York State Attorney General (then Andrew Cuomo) into the health insurance industry's methods for determining out-of-network reimbursement. The investigation found that there was an impermissible conflict-of-interest in one of the common methods used to determine "usual, customary and reasonable" (UCR) charges for out-of-network services; the conflict of interest arose because Ingenix Corporation, the company that operated the database used by many insurance companies to determine UCR rates, was wholly-owned by UnitedHealth Group. In addition, the Attorney General's investigation asserted that the out-of-network adjudication process based on the Ingenix benchmark data was potentially flawed and opaque to patients seeking cost information. FAIR Health was formed to provide a solution.

Mandate

The settlement agreement reached in the Attorney General's investigation provided for the establishment of a new, independent not-for-profit corporation—namely, FAIR Health. FAIR Health was charged with the following clear mandate:

1. Create and manage a new, independent database of healthcare charge information with the support of healthcare research experts from the academic community
2. Develop a website to educate consumers about the insurance reimbursement process
3. Make data available to policymakers and researchers

To fulfill this mandate, FAIR Health has partnered with a team of research universities, known as the Upstate Health Research Network (UHRN), to develop and maintain the database of healthcare charges. This team includes some of the best and brightest minds in healthcare policy, medicine, economics and statistics from New York State and across the country. Led by Syracuse University, the UHRN includes researchers from Cornell University, University of Rochester, University at Albany (SUNY), University at Buffalo (SUNY), and SUNY Upstate. The University of Illinois, Indiana University, University of Colorado Denver and Arizona State University round out the UHRN as adjunct research institutions. The research conducted by the UHRN is then evaluated and further refined by an independent, national panel of leading experts in health care policy and economics.

Stakeholder Neutrality

The FAIR Health mission is to provide objective and unbiased information to both the commercial and consumer communities. Our database is made up of claims for over 10 billion services performed in every state in the nation. All identifying information has been stripped from the claims data, which is arrayed according to nearly 500 geozips (areas generally based on a 3-digit zip code). For example, the Indianapolis area zip codes 46201, 46202 and 46222 are all part of the “462” geozip.

FAIR Health products are used by a variety of stakeholders in different ways:

- **Insurance companies, TPAs, self-funded employers and other payors** use the data to make claims adjudication decisions, perform actuarial analyses, determine plan design and engage in other operational planning
- **Providers and health care institutions** may use FAIR Health data to understand trends in healthcare pricing, set system-wide fee schedules, inform negotiations with health insurers, and help manage risk assumed under the auspices of an accountable care organization
- **Consumers** use our website to research medical and dental charges for services in their local areas and estimate their level of reimbursement based on their plan provisions. This information helps them make informed decisions when considering out-of-network care. Consumers who have no insurance or high deductible health plans can use the FAIR Health tools for financial planning when seeking health care services. Consumers can also use the website to access educational articles and videos and find links to helpful healthcare resources. These features enhance health care literacy and help consumers become effective advocates for themselves in this complex healthcare reimbursement environment
- **Researchers** can license FAIR Health data to inform their work on a range of topics such as comparative effectiveness studies, epidemiological trends and health disparities, and the design of, and adherence to, clinical best practices
- We also make our benchmark data products available to **policymakers, consultants and government officials** to support premium review activities, development of workers' compensation and auto liability rate tables and for other policymaking and regulatory purposes
- **Employers and trade unions** can take advantage of numerous FAIR Health consumer resources to educate their employees and members and thereby add value to the benefit plans they sponsor

Advisors

To ensure that we maintain our stakeholder neutrality, independence and transparency, FAIR Health has enlisted the help of members of all our stakeholder groups through our Board of Directors and various advisory panels. The FAIR Health Board of Directors is made up of representatives with deep experience in provider, payor, consumer, academic and government organizations.



In addition, FAIR Health relies on several advisory boards to inform our research methodology, product development and marketing efforts including a Scientific Advisory Board (referred to above) and Medical Advisory Board. A Dental Advisory Board and Consumer Advisory Board are also currently in development.

Industry Acceptance

Our first full year, 2010, was spent building infrastructure, transferring the database from Ingenix, establishing a state-of-the-art technology center, and developing an innovative consumer web-based portal. We also evaluated and adopted new statistical methodologies for the database and have committed ourselves to continuous review and improvement of our processes. We began product distribution in January 2011 starting with dental and outpatient modules. Since that time we have added medical/surgical, inpatient, anesthesia and other modules to our release schedule.

While only 12 insurance companies were party to the settlement agreement with the New York State Attorney General that *required* them to use the FAIR Health database, we are proud that our products have been widely adopted by the insurance industry nationwide. Although we have only been in existence for approximately one and a half years, we have already gained wide industry acceptance as a source of unbiased, independent and transparent healthcare charge data.



Indeed, as of the end of July, only seven months after our first product releases, FAIR Health has licensed data products to over 400 insurance carriers, health plans, TPAs and other payors in New York and across the United States. These carriers collectively have subscribers totaling more than 150 million covered lives.

Consumer Resources

FAIR Health operates a website, www.fairhealthconsumer.org, which offers a broad range of resources to consumers:

- Free, easy-to-use cost lookup tools: consumers can use the FHSM Consumer Cost Lookup to find the cost of medical and dental services in their local area
- Educational materials – the FH Reimbursement 101 series offers articles on a range of topics including understanding your explanation of benefits form (“EOB”), in-network vs. out-of-network care, distinguishing HMOS from PPOs, flexible spending plans and much more
- Videos on a variety of topics including how to use the cost estimation tools and deconstructing an EOB
- Glossary of terms
- Links to healthcare resources

There is no cost to use the website and FAIR Health offers full support for the tools and content on the site through a toll-free phone number.

The FAIR Health consumer site can be a valuable asset to states, employers and health plans to help teach their constituents, employees and plan participants to become better educated, informed consumers of healthcare services. When they are better-informed, consumers experience less confusion and anxiety and pose fewer questions which leads to reduced administrative costs for state agencies, employers and plans.

FAIR Health Operations

Data Center

The FAIR Health technology center operates in a state-of-the-art data warehousing environment. Our data repository of health claims dates back to 2002 and contains nine terabytes of information. The data warehouse, built using proven, reliable hardware and software from IBM and Oracle, among others, includes redundancy and back-up systems to ensure we can continue operating in the event of an emergency or natural disaster.

All systems and processes comply with HIPAA standards and our data processing is rigorously tested to meet strict internal quality assurance standards. In addition, our data processing operations and technology development are subject to periodic auditing by external parties to ensure quality and accuracy.

Business Units

FAIR Health and its partners employ approximately 40 staff to support a range of functions including information technology infrastructure and development, data contribution and validation, product development and delivery, customer support, sales, communications and marketing. Some of these roles are fulfilled through third-party relationships.



Customer Support

FAIR Health offers personalized customer support by phone, email and web. In addition, to ensure all questions are addressed in a timely manner, we use a customer relationship management system to route and track issues throughout the organization.

Data Products

FAIR Health offers a suite of comprehensive data products. Our benchmark charge data include modules for medical/surgical, hospital inpatient, hospital outpatient, anesthesia, HCPCS and allowed medical charges. We offer two series of data modules. One series, the FH Benchmark data, is made up of actual charges (with derived data used when there are a small number of claims in a given geozip) and the FH RV Benchmark series where data is based on relative values. In all our data products, we are committed to providing transparency into how the data is compiled.

The FH Benchmark series of modules are distributed twice a year and RV Benchmark products are distributed quarterly, on a rolling schedule. Data is distributed in a variety of ways: customers can download data from our secure site or they can request physical media such as a CD or DVD. Data can be delivered in a variety of technical formats.

The exhibits at the end of this overview illustrate how data is presented in both the actual charge and relative value modules. If you would like more information about the methodologies used in both the FH Benchmark and FH RV Benchmark modules, please contact FAIR Health.

Data Contribution Program

Where does our charge data come from? We run a data contribution program where payors contribute their claims information in return for a discount on database products. Currently, we have 45 companies contributing claims data to the FAIR Health repository; we expect 40 more payors to begin data contribution shortly under the auspices of our data contribution program. The database currently includes de-identified claims for 125 million covered lives and represents more than 10 billion billed services from around the country. We expect this number to continue to grow.

Data contributors are required by contract to meet certain validation standards, including identifying the location of the practice or where the service was provided, listing the actual charge – not the discounted fee-for-service, and representing that the claims submitted reflect all the charge data for the submission period.

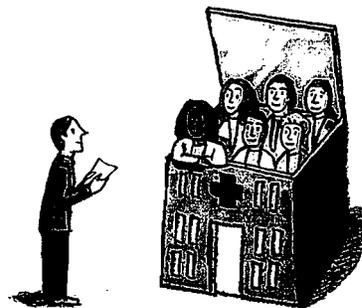
Claims data is transmitted through a secure FTP site. Once received, FAIR Health systems convert data from disparate sources into a common data repository.

Methodology

FAIR Health inherited a database of charge data pursuant to an asset transfer agreement resulting from the settlement with the New York State Attorney General's office. Our academic research partners at the UHRN studied this data carefully and made several recommendations for changes to the methodologies used to develop the data. The FAIR Health Scientific Advisory Board and our Board of Directors reviewed and approved these changes before they were implemented in our database. These changes include:

- **Eliminated High/Low Screens**

When we inherited the data, high and low screens were applied to the data to remove “outliers”. In addition, a cap was imposed that limited the difference between data in adjacent cells to 200%. FAIR Health recognizes that outliers can be accurate representations of costs within a geographical area and should not be removed arbitrarily from the database. Instead, the UHRN is using standard statistical methodologies to identify results that appear questionable and require extra review.



- **Small Cell Methodology**

Prior to FAIR Health's management of the database, a small cell was considered to be any code for which there were fewer than 9 occurrences within a specific geozip area. Working with the UHRN and the Scientific Advisory Board, the definition of a small cell was revised to reflect a cell with fewer than 40 occurrences. In order to reach this threshold of 40 data points, the methodology will go back in time for up to 2 years to find prior occurrences and then search in adjacent geographical areas. As part of our mission to provide transparency, the details of this change to the methodology are available to customers.

FAIR Health is currently reviewing other suggested changes to the methodology and continues its commitment to partner with the UHRN to investigate ways to enhance the database and improve its utility to customers.

Determining Out-of-Network Reimbursement

A common way for health insurance carriers and other payors to use FAIR Health data is to help them set reimbursement rates for plan members who access care from non-network providers. Typically, insurers apply the plan's reimbursement percentage to provider fees that are measured against UCR rates. For example, a plan may reimburse a participant 70% of the medical charge as long as the amount of the charge falls within the 80th percentile of the UCR. That means that the maximum charge that will be considered for reimbursement must be equal to or less than 80% of the charges billed for that service in the given geozip area. FAIR Health is an excellent source of data for customers seeking to set their UCR rates because its database contains actual charges organized by locality for over 10 billion services for which claims have been submitted across the country.

Actual Charge Data vs. Medicare Fee Schedules

It should be noted that certain healthcare payors elect to base out-of-network reimbursement decisions on Medicare fee schedules. Instead of taking the UCR approach, some insurers are basing reimbursement upon a percentage, such as 140%, of the charge for the service according to the Medicare fee schedule.

Using Medicare for this broad “off-label” use raises a number of concerns:

- Medicare was developed to serve specific populations – generally the elderly - people over the age of 65, individuals with certain disabilities and those with end-stage renal disease, rather than the general population
- Medicare is a government-determined fee schedule that embodies certain policy determinations and considerations rather than reflecting actual charge data and market practices; hence, in many areas of the country, Medicare rates are substantially different (often much lower) than the fees commonly charged for the same service to non-Medicare patients
- Because it is geared to the elderly, Medicare fee schedules do not include certain important and widely-used services, such as obstetrics and pediatrics, leaving critical gaps in rate coverage
- Medicare fee schedules serve much wider geographical areas than the geozips typically used to set UCR rates. Medicare divides the country into approximately 90 areas, whereas FAIR Health reports on 491 distinct geozip areas
- Consumers lack an understanding of the difference between what providers may charge the general public vs. the same service for a Medicare patient; this misunderstanding may lead patients to seek out-of-network care without a full appreciation of the financial impact of this decision



Specialized Support for State Governments

- **Education**
States can take advantage of FAIR Health’s extensive menu of consumer resources to educate residents to better understand the financial components and implications of their healthcare decisions. Most resources are available as free services. Fees may apply if states choose to offer customized educational content, videos and/or cost estimation tools.
- **Custom Analytics**
FAIR Health can provide customized “slices of data” based on geographical criteria, clinical specialties, and specialized treatment scenarios to support epidemiological studies, public health interventions or to meet other targeted needs
- **PPACA Offerings**
Consider making FAIR Health a partner to help state agencies fulfill obligations under the Patient Protection and Affordable Care Act (PPACA):
 - **MRDCs**
FAIR Health will work with states to adapt the robust charge information in our database to meet state requirements and play an important role in helping states establish

Medicare Reimbursement Data Centers (MRDC) – the state-level entities responsible for conducting premium reviews and ensuring that consumers get value for their healthcare dollars.

– **Navigator**

FAIR Health is also poised to take on the role of “Navigator” as described by the law. In this role, which closely aligns with FAIR Health’s core mission, FAIR Health can serve as a neutral and trusted guide to help educate consumers about qualified health plans, distributing information about premium tax-credits and cost-sharing programs and facilitating enrollment.

• **All Payor Claims Database**

FAIR Health can be a critical resource to help states considering the creation of an all payor claims database (“APCD”). The comprehensive data collected from payors pursuant to an APCD aids states as they try to study and/or implement initiatives seeking to reduce healthcare costs, increase healthcare value, improve public health indices, counter emerging epidemics (e.g., type 2 diabetes), or eliminate existing health care disparities within a state’s borders. FAIR Health technologies, its scalable database center, existing data and know-how can greatly advance the launch and operation, or contemplation, of an APCD.

Thank you for the opportunity to introduce FAIR Health to the Indiana Interim Committee on Insurance. Please contact us if you would like to continue the discussion into ways FAIR Health can uniquely help the State of Indiana meet its various goals.

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Attachment: EXHIBIT I - Methodology

FH Benchmark Modules

Actual Charge Methodology

➤ **Step One**

| Count 29823 | | Count 29823 | |
|-------------|---------|-------------|---------|
| 1 | \$1,232 | 10 | \$1,700 |
| 2 | \$1,333 | 11 | \$1,800 |
| 3 | \$1,360 | 12 | \$1,806 |
| 4 | \$1,573 | 13 | \$1,850 |
| 5 | \$1,600 | 14 | \$1,850 |
| 6 | \$1,600 | 15 | \$1,850 |
| 7 | \$1,600 | 16 | \$1,850 |
| 8 | \$1,680 | | |
| 9 | \$1,680 | | |

➤ **Step Two**

| %tile 29823 | | %tile 29823 | |
|------------------|---------|-------------------------------------|---------|
| | \$1,232 | 60 th | \$1,700 |
| | \$1,333 | 70 th | \$1,800 |
| | \$1,360 | 75 th | \$1,806 |
| | \$1,573 | 80 th | \$1,850 |
| | \$1,600 | 85 th , 90 th | \$1,850 |
| | \$1,600 | 95 th | \$1,850 |
| | \$1,600 | | \$1,850 |
| 50 th | \$1,680 | | |
| | \$1,680 | | |

Sample Data



FH Benchmark Modules

Actual Charge Methodology

➤ Step Three

| <u>Percentile</u> | <u>29823</u> |
|-------------------|--------------|
| 50 th | \$1,680 |
| 60 th | \$1,700 |
| 70 th | \$1,800 |
| 75 th | \$1,806 |
| 80 th | \$1,850 |
| 85 th | \$1,850 |
| 90 th | \$1,850 |
| 95 th | \$1,850 |

Sample Data



FH RV Benchmark Modules

Relative Value Methodology

Step 1: Identify data for the specific geoZIP and range
 All CPT codes are divided into related groups called "ranges." Data for each CPT code in the range are identified and sorted by code.

| CPT | 36400 | 36405 | 36406 | 36410 | 36415 | 36416 | 36420 | 36425 |
|-----|-------|-------|-------|-------|-------|-------|-------|-------|
| 1 | \$45 | \$70 | \$80 | \$23 | \$5 | \$8 | | \$77 |
| 2 | \$50 | \$70 | \$80 | \$23 | \$6 | \$8 | | \$80 |
| 3 | \$50 | \$75 | | \$24 | \$7 | \$11 | | \$100 |
| 4 | \$65 | \$84 | | \$36 | \$8 | \$11 | | \$120 |
| 5 | \$75 | \$84 | | \$47 | \$8 | \$11 | | |
| 6 | \$75 | \$85 | | \$50 | \$9 | \$11 | | |
| 7 | \$80 | | | \$50 | \$9 | \$15 | | |
| 8 | \$80 | | | \$50 | \$10 | \$17 | | |
| 9 | \$95 | | | \$50 | \$10 | \$17 | | |
| 10 | \$100 | | | \$50 | \$10 | \$17 | | |
| 11 | | | | \$50 | \$12 | | | |
| 12 | | | | \$50 | \$12 | | | |
| 13 | | | | \$50 | \$15 | | | |
| 14 | | | | \$50 | \$15 | | | |
| 15 | | | | \$50 | \$16 | | | |
| 16 | | | | \$52 | \$18 | | | |
| 17 | | | | | \$18 | | | |
| 18 | | | | | \$20 | | | |
| 19 | | | | | \$22 | | | |
| 20 | | | | | \$22 | | | |

Sample Data



FH RV Benchmark Modules

Relative Value Methodology

Step 2: "Normalize" the data by dividing each charge by the corresponding relative value. For example, code 36400 has as its highest dollar value, \$100. This amount is divided by the relative value of 2.75. The result is 36.364. This result, as well as the values in Step 2, are called conversion factors. A conversion factor is a dollar amount that can be applied to each relative value unit.

| CPT RV | 36400 2.75 | 36405 2.50 | 36406 2.50 | 36410 2.00 | 36415 0.41 | 36416 0.41 | 36420 5.25 | 36425 4.50 |
|-----------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| 1 | 16.364 | 28.000 | 32.000 | 11.500 | 12.195 | 19.512 | | 17.111 |
| 2 | 18.182 | 28.000 | 32.000 | 11.500 | 14.634 | 19.512 | | 17.778 |
| 3 | 18.182 | 30.000 | | 12.000 | 17.073 | 26.829 | | 22.222 |
| 4 | 23.636 | 33.600 | | 18.000 | 19.512 | 26.829 | | 26.667 |
| 5 | 27.273 | 33.600 | | 23.500 | 19.512 | 26.829 | | |
| 6 | 27.273 | 34.000 | | 25.000 | 21.951 | 26.829 | | |
| 7 | 29.091 | | | 25.000 | 21.951 | 36.585 | | |
| 8 | 29.091 | | | 25.000 | 24.390 | 41.463 | | |
| 9 | 34.545 | | | 25.000 | 24.390 | 41.463 | | |
| 10 | 36.364 | | | 25.000 | 24.390 | 41.463 | | |
| 11 | | | | 25.000 | 29.268 | | | |
| 12 | | | | 25.000 | 29.268 | | | |
| 13 | | | | 25.000 | 36.585 | | | |
| 14 | | | | 25.000 | 36.585 | | | |
| 15 | | | | 25.000 | 39.024 | | | |
| 16 | | | | 26.000 | 43.902 | | | |
| 17 | | | | | 43.902 | | | |
| 18 | | | | | 48.780 | | | |
| 19 | | | | | 53.659 | | | |
| 20 | | | | | 53.659 | | | |

Sample Data



FH RV Benchmark Modules

Relative Value Methodology

Step 3: Array the resulting conversion factors in order, irrespective of procedure code

| CF | CF | CF | CF |
|--------|--------|--------|--------|
| 11.500 | 23.636 | 27.273 | 41.463 |
| 11.500 | 24.390 | 27.273 | 41.463 |
| 12.000 | 24.390 | 28.000 | 41.463 |
| 12.195 | 24.390 | 28.000 | 43.902 |
| 14.634 | 25.000 | 29.091 | 43.902 |
| 16.364 | 25.000 | 29.091 | 48.780 |
| 17.073 | 25.000 | 29.268 | 53.659 |
| 17.111 | 25.000 | 29.268 | 53.659 |
| 17.778 | 25.000 | 30.000 | |
| 18.000 | 25.000 | 32.000 | |
| 18.182 | 25.000 | 32.000 | |
| 18.182 | 25.000 | 33.600 | |
| 19.512 | 25.000 | 33.600 | |
| 19.512 | 25.000 | 34.000 | |
| 19.512 | 26.000 | 34.545 | |
| 19.512 | 26.667 | 36.364 | |
| 21.951 | 26.829 | 36.585 | |
| 21.951 | 26.829 | 36.585 | |
| 22.222 | 26.829 | 36.585 | |
| 23.500 | 26.829 | 39.024 | |

PERCENTILE DEFINITION

The pth percentile is the value that has p% of the data below it and (100-p)% above it

The total number of charges in our example is 68. Therefore, the 95th percentile is the value corresponding to the $(68 * 0.95) = 65$ th record. The 90th percentile is the value corresponding to the $(68 * 0.90) = 61$ st claim, etc.

Sample Data



FH RV Benchmark Modules

Relative Value Methodology

Step 4: Identify which conversion factors correspond to the various percentiles

| Count | Percentile | CF | Count | Percentile | CF | Count | Percentile | CF |
|-------|------------|--------|-------|------------|--------|-------|------------|--------|
| 1 | | 11.500 | 24 | | 24.390 | 47 | | 29.268 |
| 2 | | 11.500 | 25 | | 25.000 | 48 | 70th | 29.268 |
| 3 | | 12.000 | 26 | | 25.000 | 49 | | 30.000 |
| 4 | | 12.195 | 27 | 40th | 25.000 | 50 | | 32.000 |
| 5 | | 14.634 | 28 | | 25.000 | 51 | 75th | 32.000 |
| 6 | | 16.364 | 29 | | 25.000 | 52 | | 33.600 |
| 7 | | 17.073 | 30 | | 25.000 | 53 | | 33.600 |
| 8 | | 17.111 | 31 | | 25.000 | 54 | 80th | 34.000 |
| 9 | | 17.778 | 32 | | 25.000 | 55 | | 34.545 |
| 10 | | 18.000 | 33 | | 25.000 | 56 | | 36.364 |
| 11 | | 18.182 | 34 | 50th | 25.000 | 57 | | 36.585 |
| 12 | | 18.182 | 35 | | 26.000 | 58 | 85th | 36.585 |
| 13 | | 19.512 | 36 | | 26.667 | 59 | | 36.585 |
| 14 | | 19.512 | 37 | | 26.829 | 60 | | 39.024 |
| 15 | | 19.512 | 38 | | 26.829 | 61 | 90th | 41.463 |
| 16 | | 19.512 | 39 | | 26.829 | 62 | | 41.463 |
| 17 | 25th | 21.951 | 40 | | 26.829 | 63 | | 41.463 |
| 18 | | 21.951 | 41 | 60th | 27.273 | 64 | | 43.902 |
| 19 | | 22.222 | 42 | | 27.273 | 65 | 95th | 43.902 |
| 20 | 30th | 23.500 | 43 | | 28.000 | 66 | | 48.780 |
| 21 | | 23.636 | 44 | | 28.000 | 67 | | 53.659 |
| 22 | | 24.390 | 45 | | 29.091 | 68 | | 53.659 |
| 23 | | 24.390 | 46 | | 29.091 | | | |

Sample Data



FH RV Benchmark Modules

Relative Value Methodology

Step 5: Calculate normalized dollar amounts for the individual procedures in the range by multiplying the relative values and conversion factors. You will notice this methodology allowed derived data to value CPT code 36420. In previous graphs, this code had no data frequency.

| Percentile | CPT RV | 36400 2.75 | 36405 2.50 | 36406 2.50 | 36410 2.00 | 36415 0.41 | 36416 0.41 | 36420 5.25 | 36425 4.50 |
|------------|-----------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| 25th | 21.951 | \$60 | \$55 | \$55 | \$44 | \$9 | \$9 | \$115 | \$99 |
| 30th | 23.500 | \$65 | \$59 | \$59 | \$47 | \$10 | \$10 | \$123 | \$106 |
| 40th | 25.000 | \$69 | \$63 | \$63 | \$50 | \$10 | \$10 | \$131 | \$113 |
| 50th | 25.000 | \$69 | \$63 | \$63 | \$50 | \$10 | \$10 | \$131 | \$113 |
| 60th | 27.273 | \$75 | \$68 | \$68 | \$55 | \$11 | \$11 | \$143 | \$123 |
| 70th | 29.268 | \$80 | \$73 | \$73 | \$59 | \$12 | \$12 | \$154 | \$132 |
| 75th | 32.000 | \$88 | \$80 | \$80 | \$64 | \$13 | \$13 | \$168 | \$144 |
| 80th | 34.000 | \$94 | \$85 | \$85 | \$68 | \$14 | \$14 | \$179 | \$153 |
| 85th | 36.585 | \$101 | \$91 | \$91 | \$73 | \$15 | \$15 | \$192 | \$165 |
| 90th | 41.463 | \$114 | \$104 | \$104 | \$83 | \$17 | \$17 | \$218 | \$187 |
| 95th | 43.902 | \$121 | \$110 | \$110 | \$88 | \$18 | \$18 | \$230 | \$198 |

Sample Data

