Out-of-Network Billing in Massachusetts

A chartpack featuring expanded data, analyses, and insights

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Introduction

This chartpack provides an update on **out-of-network billing in Massachusetts**, building off past work by the Massachusetts Health Policy Commission (HPC). Using the most recent commercial claims data available from the All-Payer Claims Database, this chartpack examines: (1) the type of services that are prone to "surprise billing," (2) the potential increased spending for patients and insurers, and (3) particular provider types that have high volumes of out-of-network claims.

Out-of-network billing was first identified as an area of policy interest for the HPC in its 2015 Annual Health Care Cost Trends Report. The HPC has published an out-of-network policy brief, analyses examining the characteristics of out-of-network billing in Massachusetts, and a DataPoints issue visualizing various out-of-network provider payment benchmarks.

Out-of-network billing not only harms consumers faced with unexpected and excessive "surprise" medical bills, but it also impacts market functioning, leading to higher spending and premiums. The HPC has consistently recommended a comprehensive solution to out-of-network billing issues to protect Massachusetts consumers and address significant market implications, as further detailed in the 2019 Annual Health Care Cost Trends Report.

Most recently, federal and state policymakers have taken action in the **COVID-19 pandemic** to protect patients from financial exposure, including balance bills related to COVID-19 testing and treatment by out-of-network providers. In particular, action taken by the Baker-Polito Administration aligns with recent HPC recommendations and could serve as a framework for enacting a more comprehensive Massachusetts solution following the COVID-19 pandemic.

Key Findings

As compared to the HPC's 2017 analysis of 2014 data, **many indicators of surprise billing in Massachusetts have gotten worse over time**, including the number of claims with a potential balance bill and amounts charged by out-of-network providers.

- The HPC identified 68,342 distinct out-of-network claims in 2017 among 650,000 patients insured by one of three commercial payers in the Commonwealth. These claims represented 30,332 Massachusetts residents during 44,689 encounters in which patients most likely received care from out-of-network providers that they did not choose.
- Among these encounters, 10,590 (23.7 percent) were ambulance services, and 34,099 (76.3 percent) were professional services, primarily from ERAP providers (emergency, radiology, anesthesiology, or pathology).
    - Among all out-of-network professional services, encounters within the emergency department (ED) accounted for 29.3 percent of the total (9,984).
    - Outside of the ED, radiology had the most out-of-network claims (15,093), followed by pathology (9,756), and anesthesiology (8,187).
- Across a range of procedures and ambulance services, the average **spending on out-of-network claims far exceeded the average spending on in-network claims**.

Key Findings, Continued

- While it is not possible to determine if a patient actually received a “balance bill” for any given encounter, the HPC observed the **potential for balance billing in more than 90 percent of out-of-network claims** from professional services.
- The average balance potentially billed to patients for these out-of-network professional claims was $167 per claim. However, the amount on individual claims varied widely, ranging from $5 at the 5th percentile to $749 at the 95th percentile.
- Among the three payers examined, 7.2 percent of ED visits in 2017 resulted in at least one out-of-network claim.
- Yet, the share of out-of-network ED visits varied substantially by hospital. In a three-year span (2015-2017), the percent of ED visits that resulted in at least one out-of-network claim by hospital ranged from less than 1 percent to 74 percent.
    - Among hospitals with the highest percentage of ED visits with an out-of-network claim, four out of the top five hospitals reported complete or substantial outsourcing of their ED staff.
- Among out-of-network visits billed by ED physicians, **charges and payer-paid amounts rose substantially** between 2015 and 2017.
    - For example, for a moderate severity ED evaluation and monitoring (E&M) visit, the out-of-network charge on this procedure grew 11 percent from $294 to $325.

Background on Out-of-Network Billing

When a patient receives care from an **in-network provider**, the patient pays a cost-sharing amount (e.g., a co-payment) pursuant to the terms of their health insurance plan, and the insurer pays the provider the negotiated price for services rendered. When a patient receives care from an **out-of-network provider**, the insurer may pay nothing, the full list price (or charge amount), or some amount in between. As a result, the patient may be required to pay the remaining balance to the provider directly (known as "**balance billing**").

While patients may occasionally seek out-of-network care intentionally, out-of-network billing issues often arise after an emergency or when patients are unknowingly treated by out-of-network providers (e.g., by an out-of-network anesthesiologist during a surgery at an in-network facility). These scenarios may result in a "**surprise bill**" for the patient, the financial consequences of which can be significant. Surprise bills may account for some portion of the 17 percent of individuals in Massachusetts that currently have medical debt.[1]

In addition to patient financial burdens, out-of-network billing has implications for health care market functioning and the viability of innovative health insurance products. When insurers pay higher rates to out-of-network providers (as is often the case), those costs are passed along through higher premiums. Further, providers can use those higher rates as leverage to negotiate higher in-network rates. As a result, the costs of out-of-network billing may diminish or even surpass any savings the insurer may be able to achieve through limited network products.

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[1] Massachusetts Center for Health Information and Analysis, Massachusetts Health Interview Survey, 2019. Released April 2020.

Out-of-Network Billing in the COVID-19 Pandemic

Efforts to enact comprehensive protections against out-of-network or "surprise billing" have increased in recent years, as states and the U.S. Congress have sought to tackle this important policy issue.[1] The COVID-19 pandemic casts additional light on out-of-network billing, underscoring the issues associated with unintentional out-of-network care and **likely increasing the number of Americans who receive a balance bill or surprise bill**. Patients may be likely to receive such a bill from COVID-19 *testing* (e.g., the available lab or pathologist is out-of-network) as well as *treatment* (e.g., the emergency physician or infectious disease specialist at the in-network hospital may be out-of-network).[2]

The pandemic has prompted **swift action at the federal and state levels** to limit the financial exposure of COVID-19 patients. The Families First Coronavirus Response Act (H.R. 6201, 3/18/20) and the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act", H.R.748, 3/27/20) include provisions on cost-sharing and payment for COVID-19 testing, but balance billing is not explicitly prohibited.[3] Notably, the Trump Administration targets surprise billing in the implementation of the CARES Act by prohibiting providers who accept reimbursement from the Provider Relief Fund from balance billing COVID-19 patients.[4]

[1] See, e.g., Jack Hoadley et al, "States are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action is Necessary to Fill the Gaps", The Commonwealth Fund (Jul. 31, 2019), https://www.commonwealthfund.org/blog/2019/states-are-taking-new-steps-protect-consumers-balance-billing-federal-action-necessary (noting that 28 states have at least some level of out-of-network consumer protections).

[2] Jack Hoadley et al, "Keeping Surprise Billing Out of Coronavirus Treatment", Health Affairs (Apr. 2, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200330.353921/full/.

[3] However, some experts argue that the provision in the CARES Act can be thought of as similar to a prohibition on surprise billing. Loren Adler, "How the CARES Act Affects COVID-19 Test Pricing, USC-Brookings Schaeffer On Health Policy (Apr. 9, 2020), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/09/how-the-cares-act-affects-covid-19-test-pricing/.

[4] U.S. Department of Health & Human Services, CARES Act Provider Relief Fund, https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html (last visited Apr. 29, 2020).

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Out-of-Network Billing in the COVID-19 Pandemic, Continued

Several states have taken action to prohibit balance billing for COVID-19 testing and treatment.[1] In Massachusetts, the Baker-Polito Administration issued an executive order requiring insurers to cover all medically necessary emergency department and inpatient services (including all professional, diagnostic, and laboratory services) related to COVID-19 at both in-network and out-of-network providers, with no cost-sharing by the insured.[2] The order prohibits balance billing and establishes the payment amount for out-of-network providers: (1) the in-network rate for providers that otherwise contract with the insurer, and (2) 135 percent of the Medicare rate for providers that are completely out-of-network.

The Executive Order, which aligns with recommendations by the HPC to strengthen and expand out-of-network consumer protections and establish a reasonable maximum reimbursement for out-of-network providers,[3] could serve as a framework for enacting a more permanent, comprehensive Massachusetts solution following the COVID-19 pandemic.[4]

[1] See e.g., Ohio Department of Insurance, Bulletin 2020-05, COVID-19 Testing and Treatment: Out-of-Network Coverage (Mar. 20, 2020), https://iop-odi-content.s3.amazonaws.com/static/Legal/Bulletins/Documents/2020-05.pdf; and states with existing out-of-network billing laws have reinforced that they apply to COVID-19 services, see e.g., New York Department of Financial Services, Insurance Circular Letter No. 3 (2020) (March 3, 2020), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_03.

[2] Commonwealth of Massachusetts, Order Expanding Access to Inpatient Services, COVID-19 Order No. 25 (April 9, 2020), https://www.mass.gov/doc/april-9-2020-inpatient-services-and-billing/download.

[3] See, e.g., Health Policy Commission, 2019 Annual Cost Trends Report, available at https://www.mass.gov/doc/2019-health-care-cost-trends-report/download.

[4] Note that federal legislation, which is required to protect patients in self-insured health plans (which are regulated by the federal government), is still under debate. See, e.g., Jack Hoadley et al, "Update on Federal Surprise Billing Legislation: New Bills Contain Key Differences", The Commonwealth Fund (Feb. 20, 2020), https://www.commonwealthfund.org/blog/2020/update-surprise-billing-legislation-new-bills-contain-key-differences.

National Research on Out-of-Network Billing

- **Emergency, radiology, anesthesiology, and pathology (ERAP)** have been identified as specialties that are more prone to out-of-network billing[1] [2]
  - ERAP out-of-network services can occur when patients may not be able to choose care from an in-network provider (e.g., in emergency circumstances), or when they are unexpectedly treated by an out-of-network provider at an in-network facility
  - Median in-network prices for these procedures varied significantly by state[3]

- Using data from one of the largest national insurers, Cooper and Morton (2016) found that **22 percent of ED visits** nationally involved an out-of-network ED physician[4]

- In a follow-up study (2017) using the same data source, the authors found:[5]
  - **50 percent of hospitals** nationally have rates of out-of-network billing below **5 percent**
  - **15 percent** have a rate of out-of-network billing above **80 percent**
  - Rates of out-of-network billing are substantially higher at for-profit hospitals
  - Outsourcing emergency staffing is a lead contributor to out-of-network billing
    - 2/3 of hospitals nationally outsource ED staffing (for comparison, 1/3 of Massachusetts hospitals substantially outsource ED staffing)[6]

1 Cooper Z, Nguyen H, Shekita N, Morton FS. Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians. Health Affairs; 2020 Jan;39(1):24-32.

2 Duffy EL, Alder L, Ginsburg PB, Trish E. Prevalence And Characteristics Of Surprise Out-Of-Network Bills From Professionals In Ambulatory Surgery Centers. Health Affairs; 2020 Apr 15:101377hlthaff201901138

3 Health Care Cost Institute. Comparing Commercial and Medicare Rates for Select Anesthesia, Emergency Room, and Radiology Services by State, 2020 Jul 23.

4 Cooper Z, Morton FS. Out-of-Network Emergency Physician Bills - An Unwelcome Surprise. New England Journal of Medicine; 2016; 375:1915-1918

5 Cooper Z, Morton FS, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. National Bureau of Economic Research; 2017 Jul 20.

6 Registration of Provider Organizations, hospitals fall into this category if they report that an outside provider group provides “complete or substantial staffing” of their ED

National Research on Out-of-Network Billing, Continued

- The prevalence of out-of-billing has also been analyzed in **settings outside of the ED**:
  - Garmon and Chartock found that **20 percent of hospital admissions** that originated in the ED in 2014 were likely to lead to a "surprise bill"[1]
  - Using national data from one large commercial payer, Chhabra and Dimick (2020) found that **21 percent of elective surgical episodes** with in-network surgeons and facilities resulted in a potential "balance bill," with an average balance of $2011[2]

- Research generally suggests that potential balance amount on surprise bills is increasing over time:
  - For example, an out-of-network analysis focusing on ambulatory surgical centers found that the **average balance per episode increased by 81 percent,** from $819 in 2014 to $1,483 in 2017[3]

- In addition to professional services, ambulance transports are another area prone to out-of-network billing:
  - A recent study using 2013-2017 data from a national insurer reported that **71 percent of all ambulance rides** involved potential surprise bills[4]
  - Median potential surprise bills were $450 for ground transportation, and $21,698 for air transportation[4]

1 Garmon C, Chartock B. One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills. Health Affairs; 2017 Jan 1;36(1):177-181.

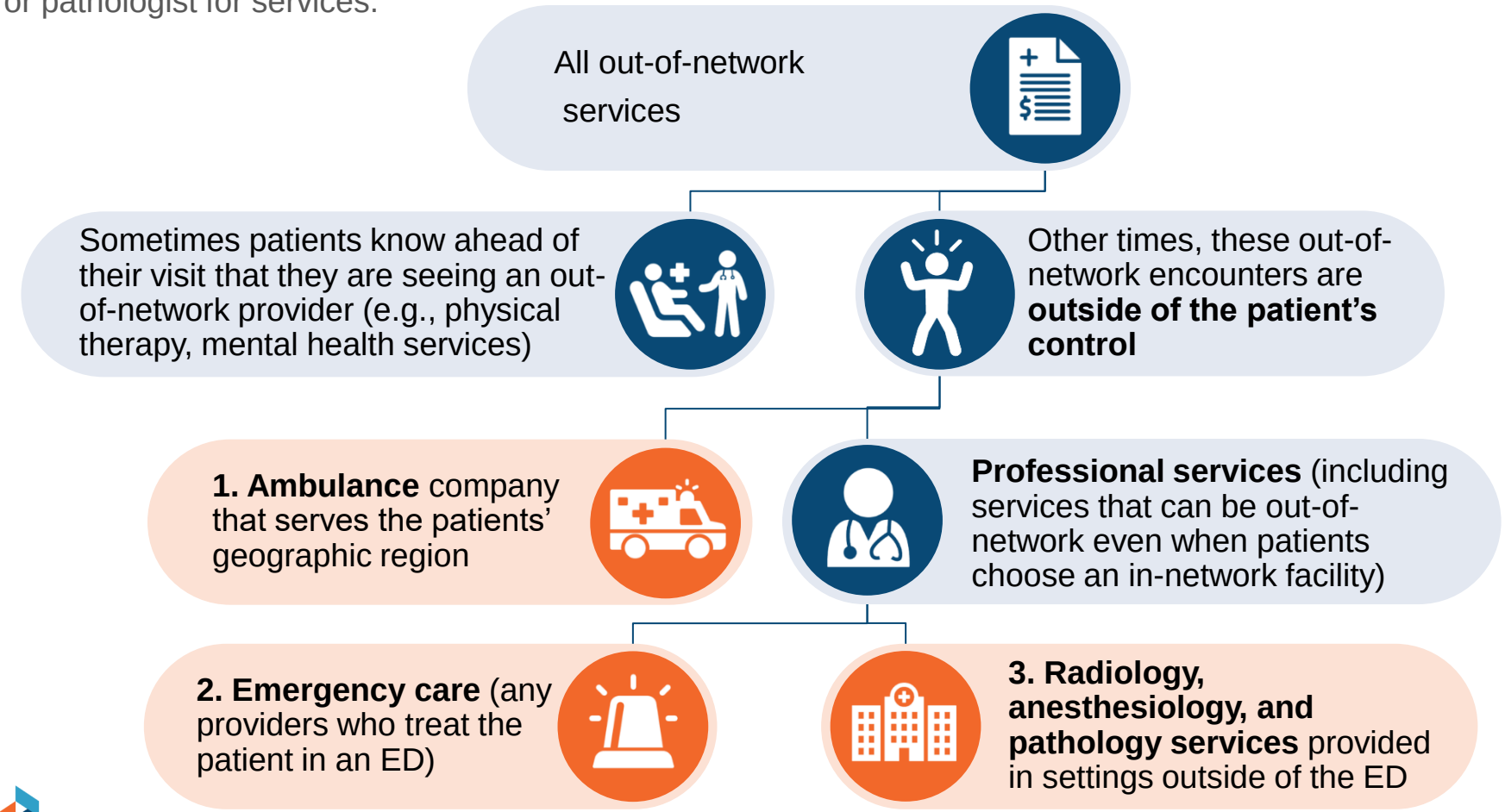
2 Chhabra KR, Sheetz KH, Nuliyalu U, Dekhne MS, Ryan AM, Dimick JB. Out-of-Network Bills for Privately Insured Patients Undergoing Elective Surgery With in network Primary Surgeons and Facilities. JAMA; 2020;323(6):538–547.

3 Duffy EL, Alder L, Ginsburg PB, Trish E. Prevalence And Characteristics Of Surprise Out-Of-Network Bills From Professionals In Ambulatory Surgery Centers. Health Affairs; 2020 Apr 15:101377hlthaff201901138

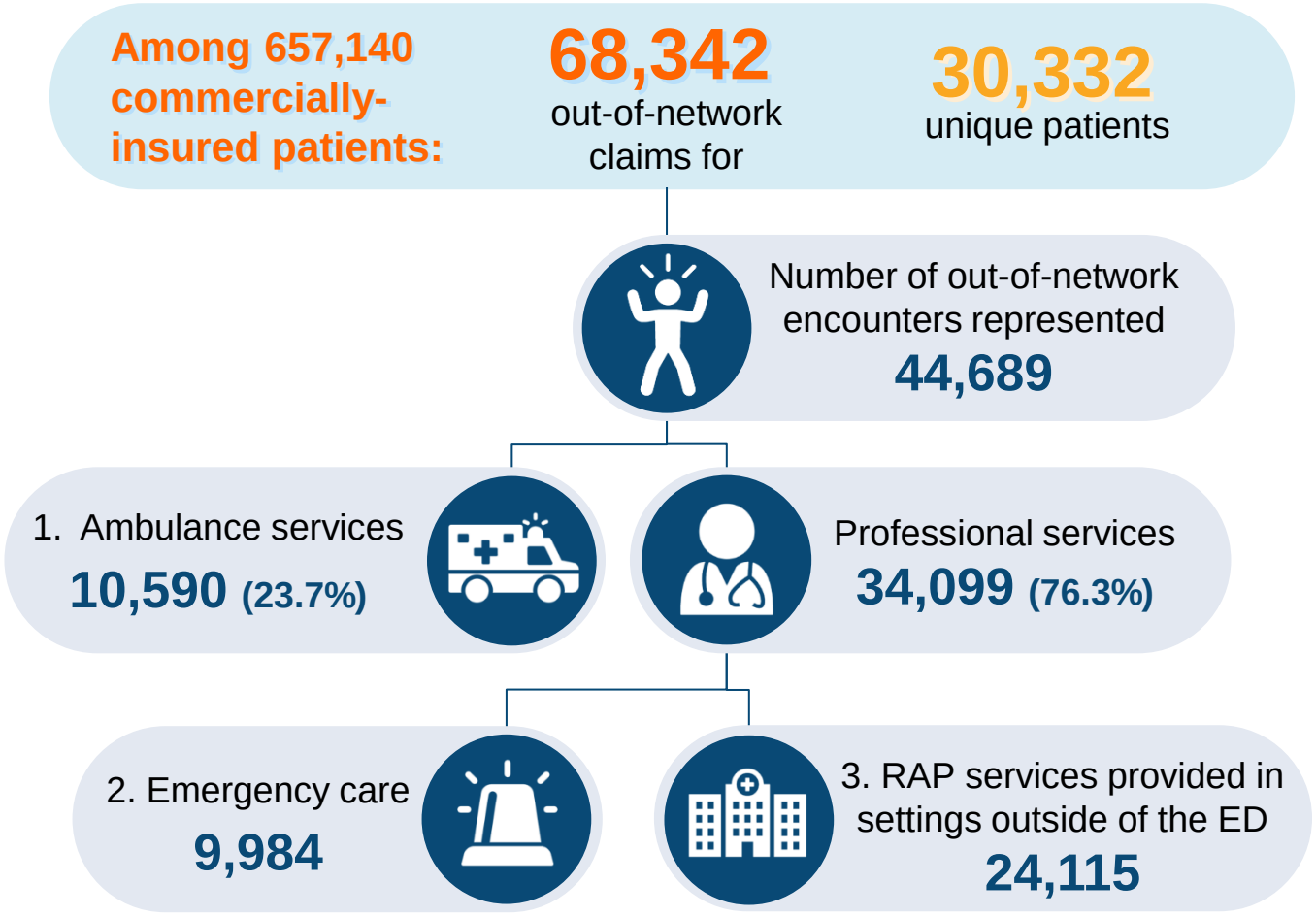
4 Chhabra KR, McGuire K, Sheetz KH, Scott JW, Nuliyalu U, Ryan AM. Most Patients Undergoing Ground And Air Ambulance Transportation Receive Sizable Out-Of-Network Bills. Health Affairs; 2020 Apr 15:101377hlthaff201901484.

Out-of-Network Billing Scenarios and Terminology

The analyses presented in this chartpack focus on the out-of-network services received where patients could not choose an in-network provider (those with orange circles below). Within this chartpack "out-of-network billing" refers to instances of "surprise billing" – unexpected bills from an out-of-network provider after an emergency or when the patient seeks care at an in-network facility but is billed by a radiologist, anesthesiologist, or pathologist for services.



Out-of-Network Claims in Massachusetts At-a-Glance, 2017



In 2017, among 657,140 commercially-insured members included in this analysis, the HPC identified 68,342 out-of-network claim lines (hereinafter referred to as claims). These represent 30,332 unique Massachusetts residents during 44,689 encounters in which patients most likely received care from out-of-network providers that they were not able to directly choose either because it was an emergency or because the out-of-network service was not the primary reason for the encounter.

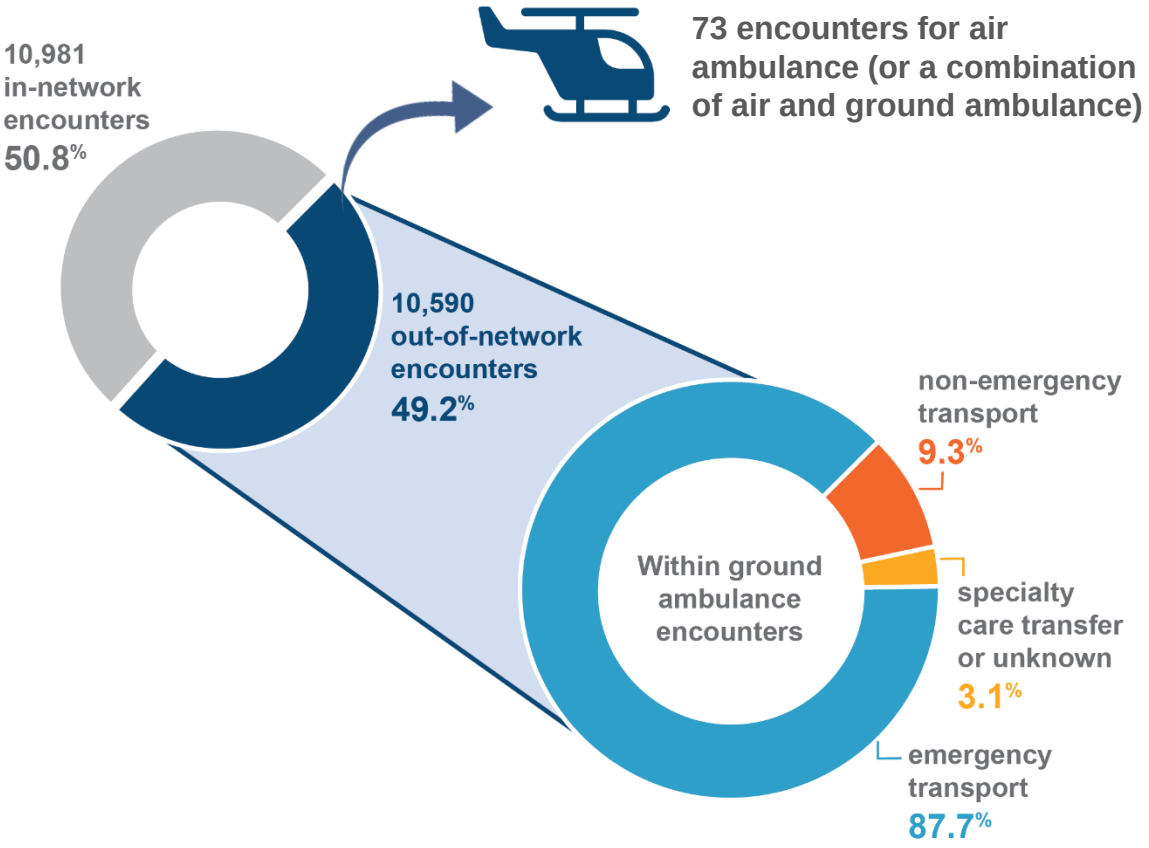
Among these encounters,10,590 (23.7 percent) were attributed to ambulance-based services, and 34,099 (76.3 percent) were attributed to professional services.

Notes: Only professional claims from an ambulance or from an emergency department or based on services performed by a radiologist, anesthesiologist, or pathologist (RAP) were included in this analysis. An encounter is created by grouping all services received by the same patient on the same day and same site of service. An out-of-network encounter refers to an encounter that results in at least one out-of-network claim line. See slide 25 for more details on methodology.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Out-of-Network Claims for Ambulance-Based Services, 2017

Ambulance



The HPC identified 21,503 ambulance encounters; nearly half (10,590) resulted in at least one one-of-network claim.

Ambulance transports can be broadly categorized as emergency or non-emergency. The latter refers to transportation services due to the patient's condition requiring stretcher transport (e.g., transportation to/from dialysis treatment).

The majority of out-of-network ambulance encounters were ground emergency transport. Compared to emergency ground transports, 59 percent of which were out-of-network, only 19 percent of ground non-emergency transports were out-of-network.

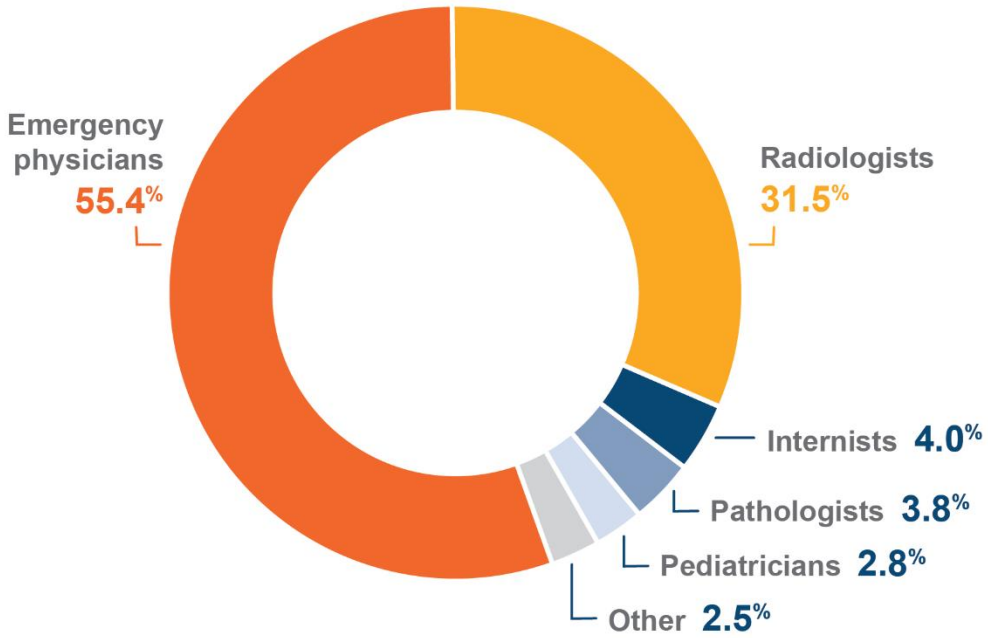
The HPC also identified 73 out-of-network encounters involving air ambulances.

Note: Ambulance claims were identified using a combination of site of service codes and CMS' Healthcare Common Procedure Coding System (HCPCS) codes. Each ambulance encounter includes charges for activation (e.g., advance life support or basic life support), mileage, and any other supplies or services provided (e.g., IV therapy).

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Emergency Department (ED) Out-of-Network Claims by Provider Specialty, 2017

Emergency care



The HPC identified 9,984 out-of-network encounters at the emergency department (ED), accounting for 29.3 percent of all out-of-network encounters as a result of professional services.

Among ED out-of-network encounters, the most common provider specialties involved were emergency medicine (55.4 percent of claims) and radiology (31.5 percent).

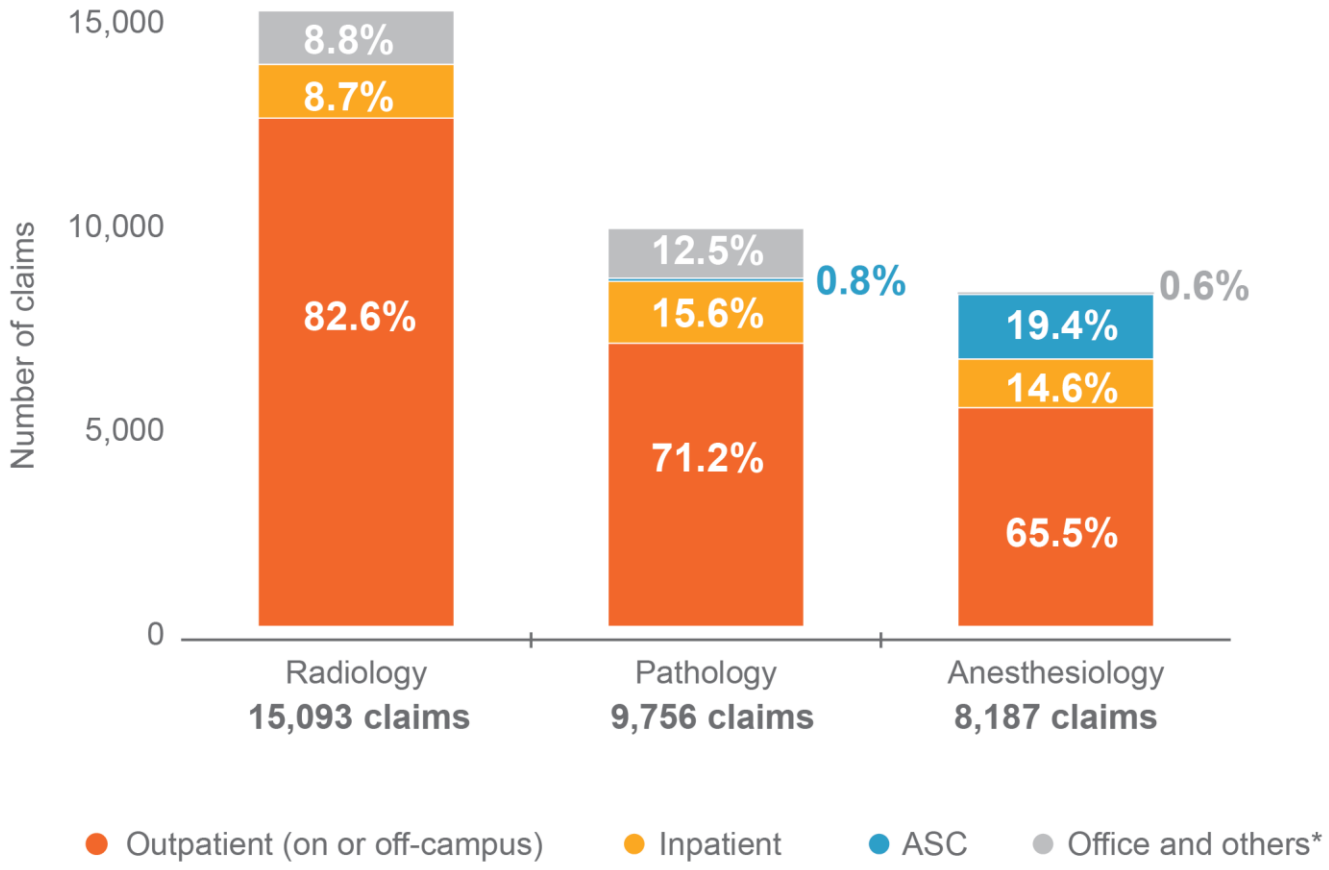
Other specialties include internal medicine (4.0 percent), pathology (3.8 percent), pediatrics (2.8 percent).

Notes: An out-of-network encounter refers to an encounter that results in at least one out-of-network claim line. Setting was analyzed at the encounter level, and provider specialty was analyzed at the claim line level.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Out-of-Network Claims by Non-ED Sites of Service and Provider Specialty, 2017

RAP providers



Out-of-network encounters often occur even when a patient chooses an in-network facility ahead of a visit or procedure. These out-of-network services are most often provided by a specialist who is not the primary reason for the visit (e.g., a pathologist examining a sample after a biopsy).

Outside of the ED and among provider specialties prone to out-of-network billing, radiology had the most out-of-network claims in 2017 (15,093), followed by pathology (9,756), and anesthesiology (8,187).

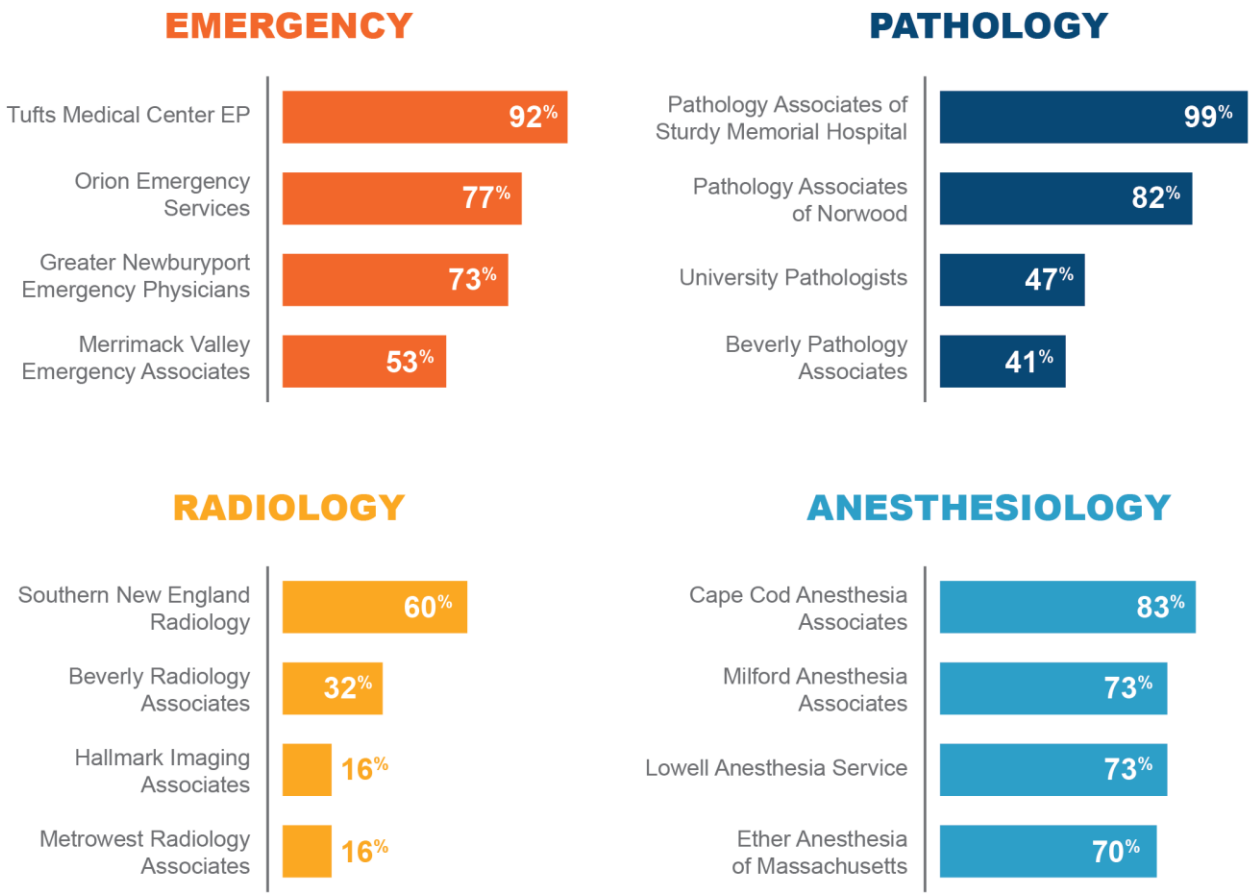
In all three specialty areas, hospital outpatient department was the setting where most out-of-network encounters occurred, accounting for 82.6 percent of non-ED out-of-network radiology claims, 71.2 percent for pathology, and 65.5 percent for anesthesiology.

Notes: Other refers to lab settings for pathology and radiology. Percentages are of non-ED out-of-network claim lines performed by specialty physicians that are more prone to out-of-network billing (radiology, pathology, anesthesiology).

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

Percentage of Claims that were Out-of-Network among ERAP Provider Organizations with the Highest Volume of Out-of-Network Claims, 2017

Professional services



Published literature suggests that staff outsourcing is a leading contributor to out-of-network billing.[1] In recent years, clinical outsourcing generally appears to have increased nationally.[2 3]

The HPC identified the clinical organizations that billed the highest volume of out-of-network claims in 2017 in the four specialty areas identified as prone to "surprise billing."

There are several reasons emergency departments and other facilities may outsource their care including lack of sufficient volume for certain services within a facility, employment/contracting concerns, and lack of professionals within the geographic area. Some of these independent specialty groups may have a business model where they do not contract with any insurers.

1 Cooper Z, Morton FS, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. National Bureau of Economic Research; 2017 Jul 20.

2 Becker's Hospital Review. Outsourcing is Exploding in Healthcare — Will the Trend Last? Available from: https://www.beckershospitalreview.com/human-resources/outsourcing-is-exploding-in-healthcare-will-the-trend-last.html

3 Shinkman R. The outsourcing explosion: Hospitals turn to outside firms to provide more clinical services [Special Report]. Fierce Health. April 21, 2015. Available from: https://www.fiercehealthcare.com/finance/outsourcing-explosion-hospitals-turn-to-outside-firms-to-provide-more-clinical-services

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

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Potential Balance Bills for Out-of-Network Professional Service Claims, 2017

Professional services

Payment	Percent of out-of-network claims
Insurer paid out-of-network charge in full	7.4%
Patient paid out-of-network charge in full	0.8%
Out-of-network bill paid in full by insurer and patient	0.6%
Potential balance bill	91.2%[1]
Total	100%

Potential balance bill: an out-of-network claim where the combined amount paid by the insurer and the patient (through deductible, copay, and coinsurance) is less than the charge amount on the claim.

Balance billing occurs when a patient is billed for the difference between the insurer's payment and the provider's charges.

While it is unclear whether a patient did receive a balance bill based on claims data, the HPC found the potential for balance billing in more than 90 percent of out-of-network claims from professional services.

In 7.4 percent of cases, insurers paid the full charge, though that varied by insurer, ranging from one insurer paying 20.5 percent of out-of-network professional claims in full to less than 1 percent.

1 The results refer to the percent of claims with the "potential" for balance billing, as claims data do not reflect how often balance billing actually occurs on an out-of-network claim. In addition, for a subset of these claims, balance billing is not permitted. See slide 25 for more details.

Notes: Only professional claims in the emergency department setting or performed by a radiologist, anesthesiologist, or pathologist were included in this analysis. Ambulance-based services were excluded. Claims with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in the analysis of out-of-network payment.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

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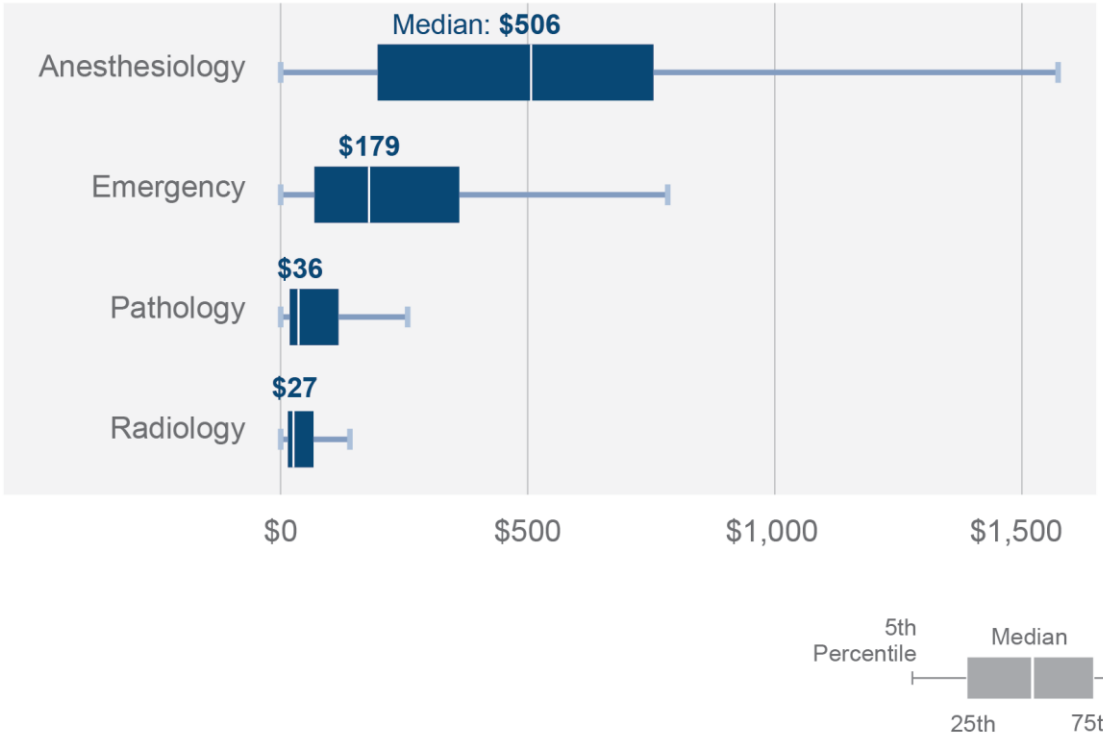
Distribution of Potential Balance on Out-of-Network Professional Claims that were Not Paid in Full, 2017

Professional services



Within the 91.2 percent of out-of-network professional claims with the potential for balance billing, the average balance potentially billed to patients was $167 per claim. However, the amount on individual claims varied widely, ranging from $5 at the 5th percentile to $749 at the 95th percentile.

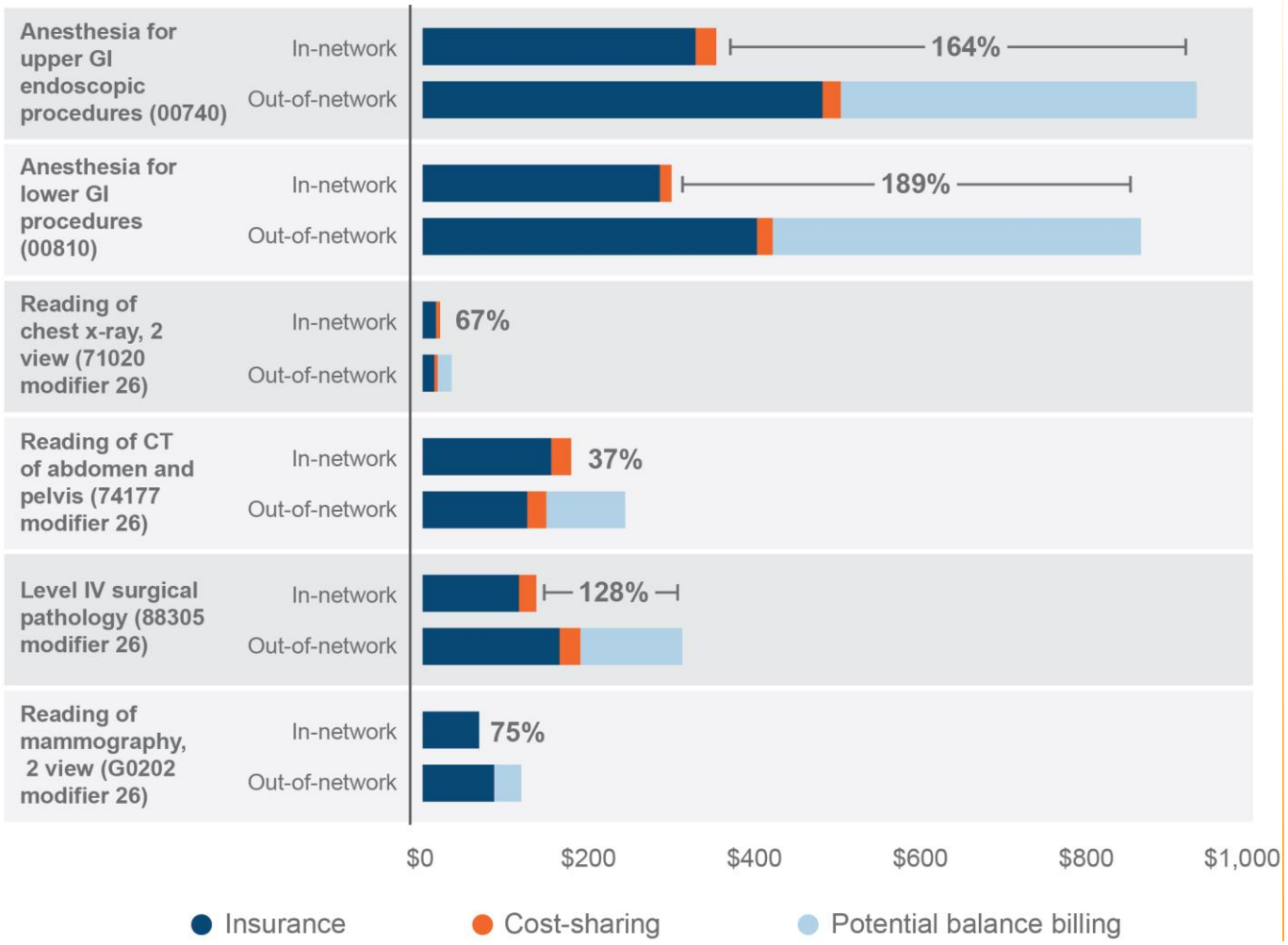
The amount of potential balance also varied significantly by specialty, with anesthesiology claims having the highest average potential balance ($588) and radiology claims having the lowest ($58). The average potential balance was $249 for emergency claims and $85 for pathology claims.

Notes: Only professional claims in the emergency department setting or performed by a radiologist, anesthesiologist, or pathologist were included in this analysis. Ambulance-based services were excluded. Claim lines with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in the analysis of out-of-network payment.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

In-Network Spending Compared to Out-of-Network Spending and Charges for Top Out-of-Network Procedures, 2017

Professional services



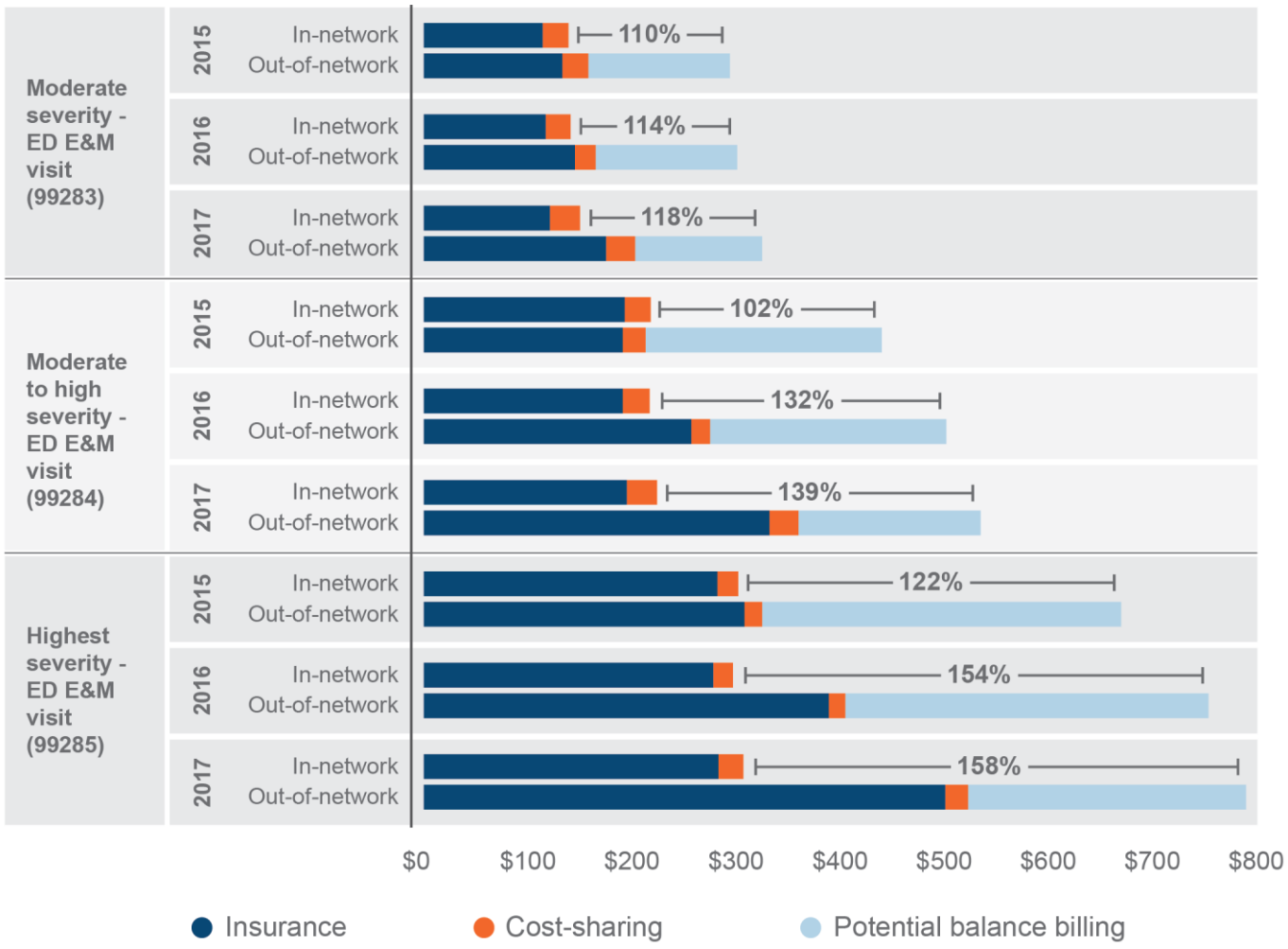
The HPC examined spending for a list of top out-of-network procedures and found that in the vast majority of cases, insurers paid more on average for the out-of-network claims than the in-network claims of the same procedure. Despite the insurers paying more on many of these claims, patients are still potentially left with a substantial amount due to higher charges on the out-of-network claims.

In particular, the average out-of-network spending on some anesthesia procedures appears more than double the average in-network spending on the same procedures.

Notes: Claim lines with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in analysis.
Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

In-Network Spending Compared to Out-of-Network Spending and Charges for Emergency Department E&M Procedures, 2015 -2017

Professional services



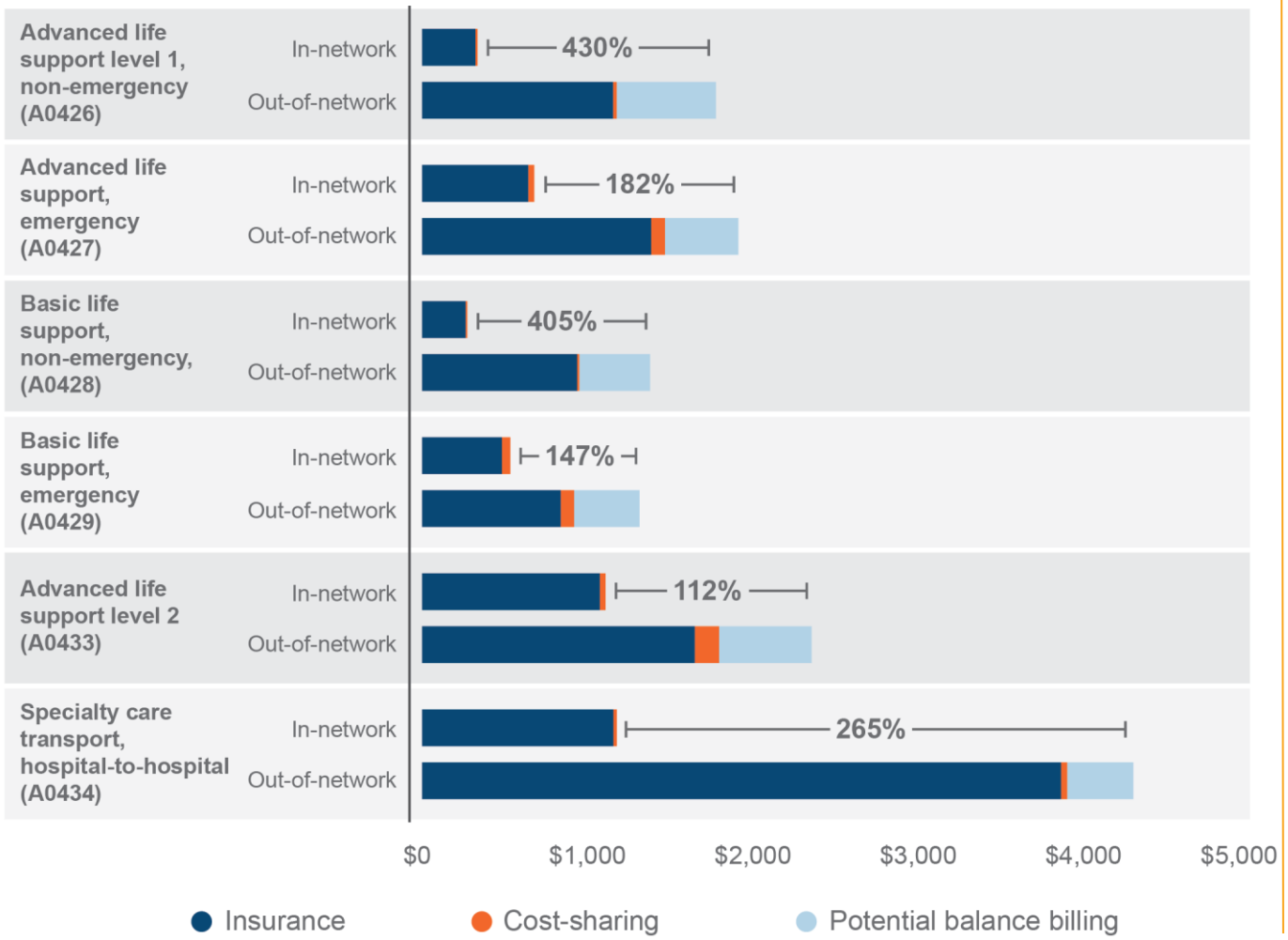
For some procedure codes, insurers have increased the amount paid on their out-of-network claims over time. However, in some cases charges have grown faster which results in leaving patients with even larger potential balance bills.

For example, for a moderate severity ED evaluation and monitoring (E&M) visit, the in-network insurer paid amount increased 5 percent from $114 to $121 between 2015 and 2017, while the out-of-network insurer paid amount for the same procedure increased 32 percent from $133 to $175. Yet patients are still left an average potential balance of $122 per claim in 2017, as the out-of-network charge on this procedure grew 11 percent from $294 to $325.

1 Health Policy Commission. 2018 Annual Health Care Cost Trends Report. Mar. 2020. Available from: https://www.mass.gov/doc/2018-health-care-cost-trends-report/download
Notes: Claim lines with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in analysis.
Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

In-Network Spending Compared to Out-of-Network Spending and Charges for Ambulance Services, 2017

Ambulance



Similar to professional services, insurers paid more on average for out-of-network ambulance claims than in-network claims.

Primarily due to higher insurer payment, the average spending on out-of-network ambulance claims far exceeds the average spending on in-network claims.

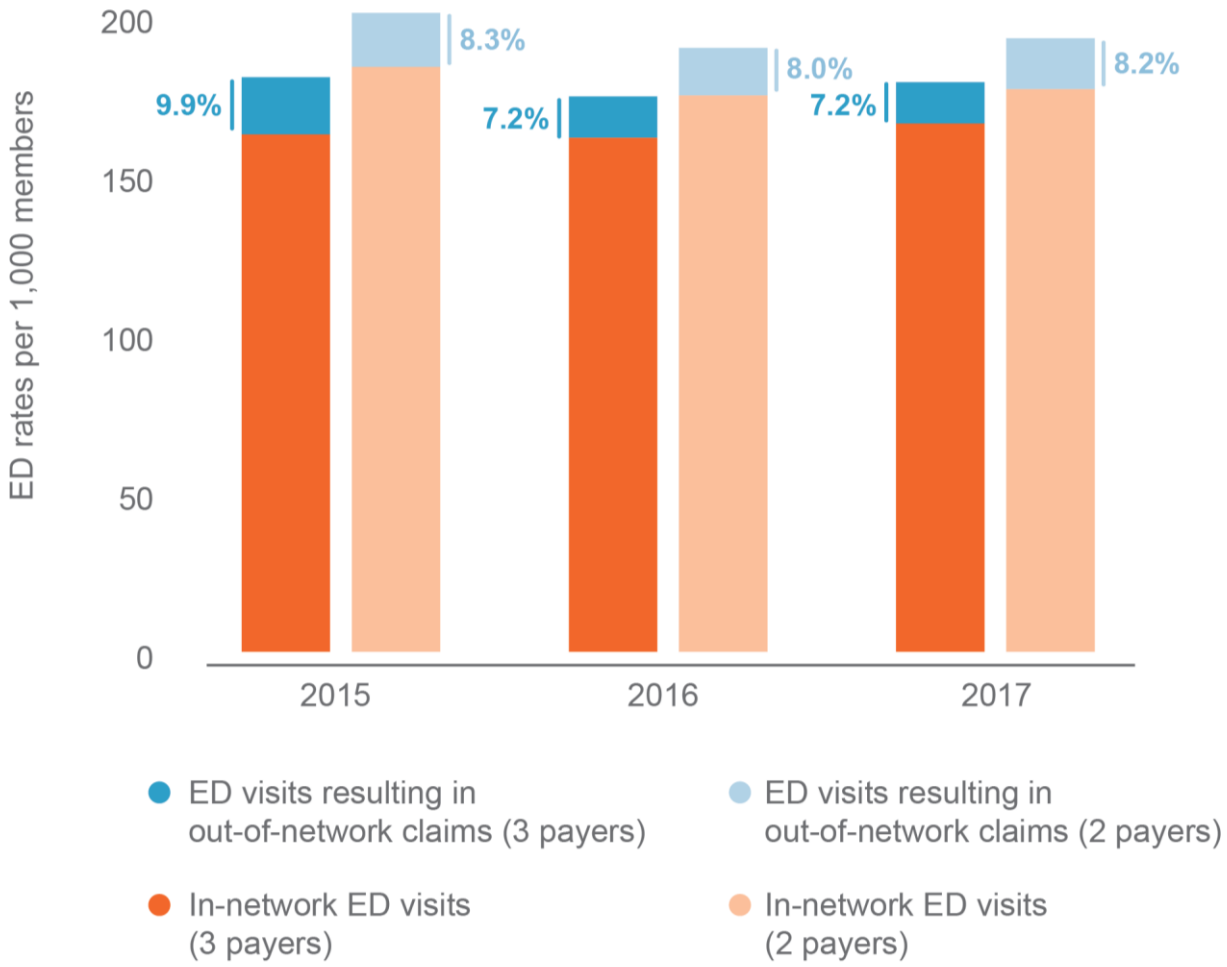
Patient balance billing protocol may vary significantly by ambulance company. Some ambulance services, particularly those funded by municipal budgets, have explicit policies to forgo the balance.

HPC

Notes: Claim lines with reliable fee-for-service paid amounts (e.g., not paid under a global budget, capitated encounter, or secondary payment) were included in analysis.
Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017

Share of ED Visits that Resulted in at Least One Out-of-Network Claim, by Year

ED visits



Among the three payers examined, 7.2 percent of ED visits in 2017 resulted in at least one out-of-network claim.

This rate of out-of-network ED claims signals a slight decline from 2015; however, these results were driven primarily by one payer which reported a sharp decline in the number of out-of-network ED visits. Excluding this payer from the analysis, the trend is relatively stable over time.

This rate of out-of-network ED claims is lower than the national rate found in Cooper and Morton.[1] However, due to differences in payers analyzed, these results may not be directly comparable.

1 Cooper Z, Morton FS. Out-of-Network Emergency Physician Bills—An Unwelcome Surprise. New England Journal of Medicine; 2016; 375:1915-1918 (Study analyzed data from from one national commercial insurer. National insurers may have smaller networks in any given state than the Massachusetts-based insurers used in HPC's study.)

Notes: Only professional claims in the emergency department were included in this analysis. ED visits that did not result in any facility claims were excluded.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2015- 2017

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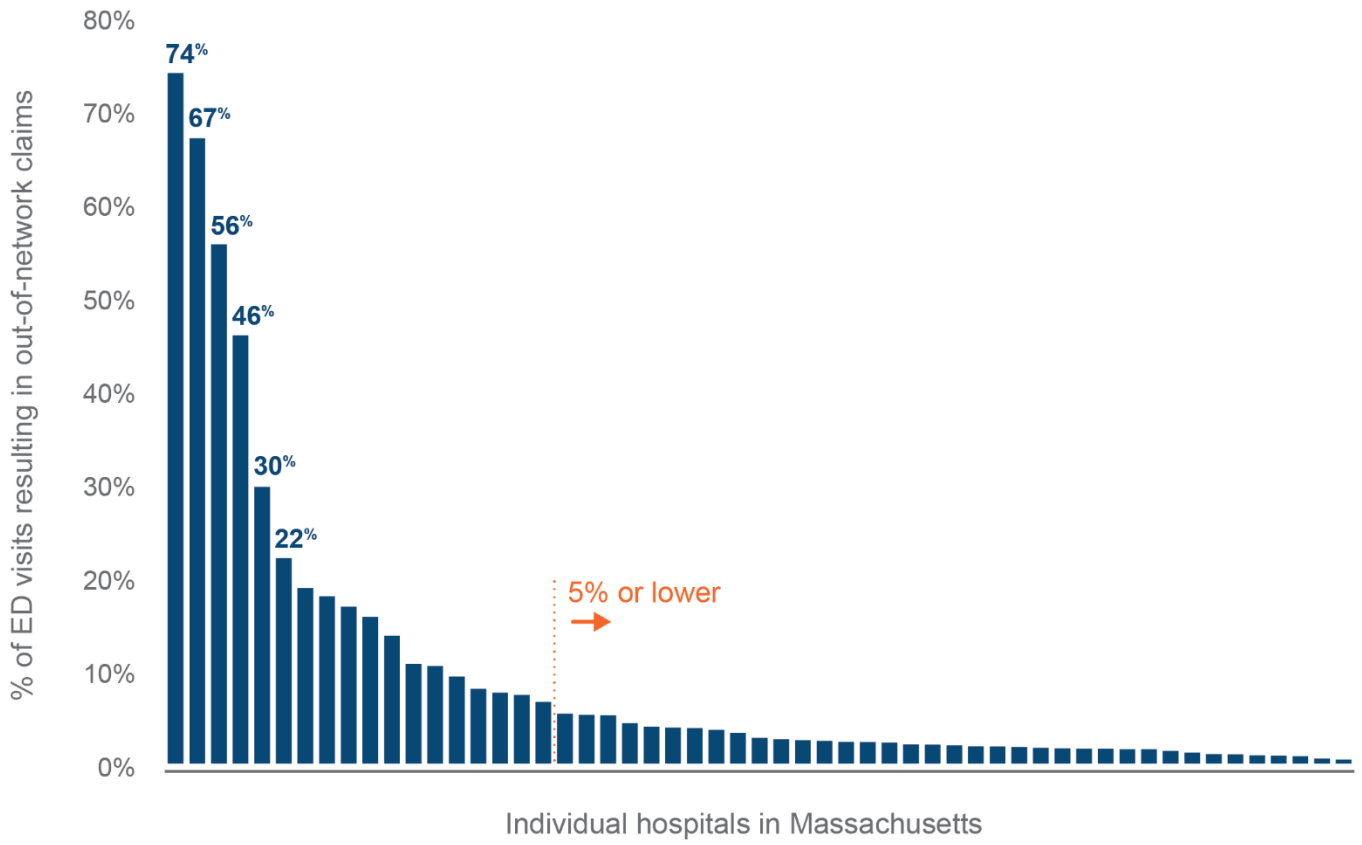
Percent Of ED Visits that Resulted in at Least One Out-of-Network Claim, 2015 – 2017, by Hospital

ED visits



The rate of ED out-of-network claims varied substantially by hospital.

In a three-year span (2015-2017), the percent of ED visits that resulted in at least one out-of-network claim ranged from 74 percent to less than 1 percent.

Among the 55 hospitals where ED out-of-network claims could be identified, 37 (67 percent) had an ED out-of-network billing rate of 5 percent or lower.

This is consistent with prior research findings that ED out-of-network claim rates are highly variable at the hospital level.[1] Emergency staff outsourcing may be one key contributor to out-of-network claims. In our analysis, four out of the top five hospitals reported complete or substantial outsourcing of their ED staff.[2]

1 Cooper Z, Morton FS, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. National Bureau of Economic Research; 2017 Jul 20.

2 Massachusetts Registration of Provider Organizations (MA-RPO) Program, 2015-2017.

Notes: Only professional claims in the emergency department were included in this analysis. ED visits that did not result in any facility claims were excluded. Hospitals with 11 or fewer out-of-network ED visits were excluded.

Data: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2015- 2017

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Conclusion

This analysis provides further insight on the prevalence of “surprise billing” in the Commonwealth. Surprise billing not only harms consumers faced with unexpected and high medical bills, but it also impacts market functioning, leading to higher spending and premiums. While it is not possible to determine if a patient received a balance bill in the encounters analyzed, the HPC observed the potential for balance billing in Massachusetts particularly for professional services, primarily from ERAP providers, and ambulance services; and the average spending on out-of-network claims far exceeded the average spending on in-network claims.

As compared to the HPC’s 2017 analysis of 2014 data, **many indicators of surprise billing in Massachusetts have gotten worse**, including the number of claims with a potential balance bill and amounts charged by out-of-network providers. In addition, while there is considerable variation among hospitals, **many continue to outsource certain specialty providers including ED doctors, anesthesiologists, pathologists, and radiologists**, as tracked by the HPC’s Registry of Provider Organizations, a practice associated with higher rates of out-of-network claims. Although there may be legitimate business reasons why this outsourcing occurs, one consequence may be more surprise bills for patients.

Federal and state policymakers have taken action in the COVID-19 pandemic to protect patients from financial exposure, including balance bills related to COVID-19 testing and treatment by out-of-network providers. In particular, action taken by the Baker-Polito Administration aligns with recent HPC recommendations and could serve as a framework for enacting a more comprehensive Massachusetts solution following the COVID-19 pandemic.

Methodology

Sources

- Center for Health Information and Analysis All-Payer Claims Database v7.0 2015 – 2017
  - Claims from **three large Massachusetts commercial payers** that had an out-of-network indicator well-populated for the majority of their claims: Tufts Health Plan, Neighborhood Health Plan, Anthem[1]
    - These plans represent **657,140 insured lives in the Commonwealth in 2017**
  - Out-of-network claims were identified using the 'in-network' designation submitted by payers
  - In-state claims
  - **Professional claims only** (excludes facility claims, which were rarely out-of-network for the payers included in this analysis)

Sites of service and specialty

- Ambulance
- Any provider type within an emergency department
- Radiology, anesthesiology, pathology (RAP) providers in non-emergency settings including:
  - Hospital inpatient
  - Hospital outpatient
  - Ambulatory surgical centers
  - Office
  - Labs

1 Approximately 25 percent of all out-of-network claim lines in this analysis were services provided to Anthem Unicare members (GIC indemnity plan). Balance billing is prohibited for those members pursuant to M.G.L. c. 32A, § 20.

About the Health Policy Commission

The Massachusetts Health Policy Commission, an independent state agency, strives to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs. The HPC's goal is better health and better care – at a lower cost – for all people across the Commonwealth.

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www.mass.gov/hpc
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