OUT-OF-NETWORK BILLING IN MASSACHUSETTS: IMPLICATIONS FOR PATIENTS, PAYERS, AND MARKET DYNAMICS

ROSE KERBER, MPP, DAVID AUERBACH, PhD

MASSACHUSETTS HEALTH POLICY COMMISSION

INTRODUCTION

Out-of-network billing occurs when patients receive services from providers that do not have a negotiated rate with the patient's insurer. Sometimes patients see out-of-network providers knowingly for scheduled services, but in emergencies or in cases that involve interactions with multiple providers at an in-network facility, patients are often unaware that they have encountered an out-of-network provider. "Surprise billing" may be especially likely when patients come into contact with multiple providers, or with certain specialists that may render services to a patient without the patient's knowledge—such as anesthesiologists, pathologists, and radiologists. Previous research has found that emergency physicians frequently bill out-of-network as well.[1,2] Emergency departments are often staffed by physicians that contract separately from the hospital, which can lead to surprise billing scenarios involving out-of-network emergency care delivered at a hospital that is in a patient's network.[3]

Without a negotiated rate, payment to providers is typically based on a price that providers set for their services. Payers may pay some or all of these charges, but they typically pay a higher rate for these out-of-network services than they would pay in-network. Balance billing occurs when patients are charged for the portion of an out-of-network bill that their insurance doesn't cover.

OBJECTIVES

The HPC sought to understand the impact of out-of-network billing on Massachusetts patients, insurers, and overall market function by using claims data for two of the largest commercial insurers in Massachusetts, representing 51% of the commercially insured population. In particular, the HPC was interested in differential payment rates for in and out-of-network claims for identical procedures and the implications for payers as well as patients. Previous studies have used data on national insurers, which have a relatively small presence in Massachusetts. This body of research enhances our understanding of out-of-network billing for a majority of commercially insured members in Massachusetts.

STUDY DESIGN

Using 2014 data from the Massachusetts all-payer claims database (APCD) for two of Massachusetts largest commercial insurers, we studied claims from settings where out-of-network claims could come as a surprise—emergency departments, ambulances, hospital inpatient and outpatient departments, ambulatory surgical centers and urgent care. We identified out-of-network claims using an 'in network' designation submitted by the payers. We limited our sample to professional claims to focus on provider billing practices. While balance bills cannot be observed directly in claims data, we estimated potential balance billing by observing the difference between charges and amounts paid toward out-of-network claims. To calculate potential balance billing on a claim, we subtracted the amount paid toward a claim by the insurer and/or by the patient in the form of deductible spending, copays or coinsurance. For a select set of procedures that were common both in and out-of-network, we compared per claim spending to estimate average differences between in and out-of-network payments for these services.

It is important to note that our estimates of out-of-network billing apply only to the portion of the Massachusetts commercial market covered by the two payers in our sample and are likely to be conservative for that reason. Payers with a smaller market share, including national payers—which make up a small share of the Massachusetts commercial market, are likely to have higher rates of out-of-network billing.[4]

1. Cooper Z, Morton FS. Out-of-network emergency-physician bills—an unwelcome surprise. N Engl J Med. 2016 Nov 17;375(20):1915-8.
2. Garmon C, Chartock B. One in five inpatient emergency department cases may lead to surprise bills. Health Affairs. 2016 Dec 14;36(1):177-81.
3. 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.
4. Cooper and Morton, 2016.

RESULTS

The HPC identified 70,107 out-of-network professional claims for services provided to 30,538 individuals. Ambulance claims accounted for about half of the out-of-network claims, with physician and other professional claims making up the rest. The vast majority of out-of-network physician claims (85%) were from "ERAP" providers (emergency, radiology, anesthesiology, or pathology). In total, claims from ambulances and "ERAP" providers accounted for over 90% of the out-of-network claims in our sample (Figure 1).

In almost 2/3 of the cases, the insurer paid the full charge amount of an out-of-network claim (Figure 2). In other cases, the patient may have been liable for partial or full payment of out-of-network charges. Patients who could have received a balance bill on an out-of-network claim would have owed an average of $355 in addition to any cost sharing they would typically owe under the terms of their health plan. In total, insurers spent $27 million on the out-of-network claims in our sample, with patient cost sharing of $1.7 million, and an additional $2.2 million that could have been balance billed to patients.

FIGURE 1: By service/provider type, ambulance and ERAP providers account for 90% of out-of-network claims

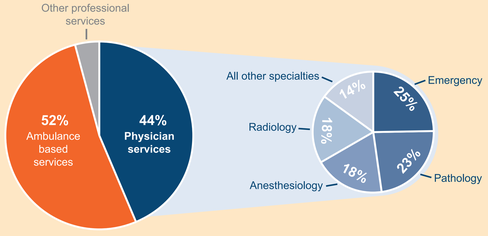
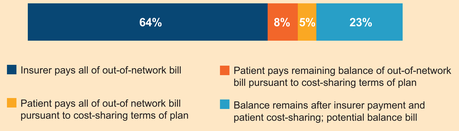


FIGURE 2: Who pays for out-of-network services?



The HPC found that in addition to balance billing that patients may incur from out-of-network providers, commercial insurers often pay out-of-network providers much higher rates than network providers for the same services. We observed substantial differences in spending between in and out-of-network claims for common identical services across a range of procedure categories (Figure 3). On average, electrocardiograms were 41% more costly when performed by an out-of-network physician, while tissue exams from out-of-network pathologists cost more than twice as much as in-network tissue exams. These figures include potential balance billing, but in all cases the amount paid by the insurer accounts for most of the difference in spending between in and out-of-network claims.

Even without balance billing, average out-of-network payment rates for common ED visits were much higher than in-network rates (Figure 4). On average, insurers paid $143 for a moderate severity ED visit (99283) with an in-network provider, and $248 for a moderate severity ED visit with an out-of-network provider—a difference of 73%.

FIGURE 3: Across a range of services, the average spending on out-of-network claims far exceeds the average spending on in-network claims

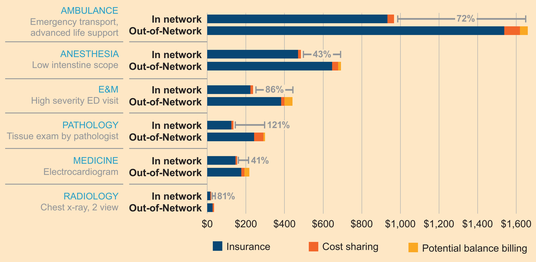
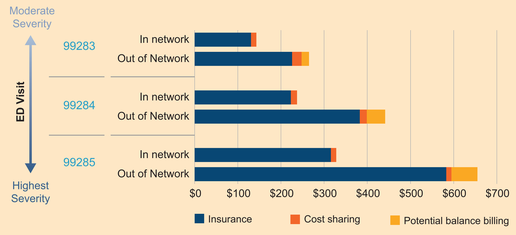


FIGURE 4: Out-of-network payment rates for common ED visit types exceed in-network rates by 68% to 81%, on average



CONCLUSIONS

This research contributes to an understanding of the market dynamics involved in out-of-network billing. We see that even for payers with broad networks in Massachusetts, out-of-network billing leads to higher spending, even when consumers are shielded directly from out-of-network charges. For the majority of out-of-network claims in Massachusetts, payers paid the full charge amount billed by the out-of-network provider. While this method prevents balance billing, it contributes to higher overall spending. When insurers pay higher rates for out-of-network claims than for in-network claims, they may seek to recoup losses by raising premiums on their members. Certain providers with particular leverage can opt out of network participation entirely and still expect reimbursement that they may bill patients for if insurance does not cover the provider's charges. Prior research has established, and this research confirms, that ambulance companies, emergency physicians, radiologists, anesthesiologists and pathologists are especially likely to opt out of network participation.

IMPLICATIONS

State policies that seek to protect consumers from balance billing without setting clear terms of reimbursement for out-of-network providers will not be sufficient to reduce spending associated with out-of-network billing. Complementary federal policies may be needed to protect members of self-funded plans which are federally regulated and may not be affected by changes in state policy. Many states have enacted policies to address out-of-network billing, with varying degrees of success. States like New Jersey and Alaska that have focused on patient protection without sufficient limitations on reimbursement have experienced dramatic spending increases, while states like New York and California that have adopted more comprehensive policies have had more success in controlling costs while protecting patients from balance billing.

CONTACT

Rose Kerber
Senior Research Associate
Research and Cost Trends
Massachusetts Health Policy Commission
rose.kerber@mass.gov

David Auerbach
Director
Research and Cost Trends
Massachusetts Health Policy Commission
david.auerbach@mass.gov

www.mass.gov/hpc