MASSACHUSETTS
HEALTH POLICY COMMISSION

# Out-of-network Billing in Massachusetts

**November 1, 2017**

# Executive Summary and Key Findings

## Goal of the study

- Building off past HPC reports[1], this study analyzes a sample of commercial health insurance claims to better understand the characteristics of out-of-network billing in Massachusetts.
- This analysis is intended to inform the discussion of policies to address out-of-network billing in order to protect consumers, improve market functioning, enhance the viability of limited network products, and reduce costs.

## Key findings

- The HPC examined 70,000 distinct out-of-network claims in two of the largest commercial payer networks in 2014, representing over 30,000 members.
- Across a range of identical services, the average spending on out-of-network claims far exceeded the average spending on in-network claims
- In almost 2/3 of the cases, the insurer paid the full charge amount of an out-of-network claim; in other cases, the patient may have been liable for partial or full payment
- Ambulance and ERAP providers (emergency, radiology, anesthesiology, or pathology) accounted for over 90% of out-of-network claims
- Average out-of-network payment rates for common ambulance services exceeded in-network rates by 22% to more than 200%
- For non-emergency ambulance transportation services, average out-of-network payment rates exceeded $1,100, compared to an in-network average payment rate of approximately $340
- Average out-of-network payment rates for common ED visits were around 70% higher than in-network rates

1 HPC 2016 Annual Cost Trends Report; HPC 2015 Annual Cost Trends Report; HPC 2015 Policy Brief on Out-of-Network Billing

# Background on Out-of-Network Billing

- 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
  - But, often, it is outside of the patients' control, e.g.
    - a third party firm staffing an **Emergency Department** (ED) at an in-network hospital; or
    - an **out-of-network physician** participating in a surgery without the patient's knowledge; or
    - an **ambulance company** serving a geographic region.
- With no 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.

# Out-of-Network Billing Implications for Payers, Consumers, and Overall Market Functioning

- When payers pay higher rates to out-of-network providers:
  - Those costs are passed along through **higher premiums**; and
  - The costs of out-of-network payments may **diminish or even surpass any savings** the payer may be able to achieve through **limited network products**.
- If a payer does not pay the full amount charged by an out-of-network provider, the patient can be "**balance billed**" and expected to pay the difference, sometimes totaling thousands of dollars.
  - This can occur even where the patient did not knowingly choose to see an out-of-network provider (e.g. through a "surprise bill").

Because of the cost of out-of-network billing, some payers seek to bring as many providers in-network as possible, even at higher negotiated rates.

Looking at *frequency* of out-of-network billing, particularly for the largest/broadest payer networks, therefore understates the impact of out-of-network billing on total health care spending.

# National Research and Data on Out-of-Network Billing

- Using data from one of the largest national insurers, Cooper and Morton (2016) found that **22%** of ED visits nationally involved an out-of-network ED physician[1]

- In a follow-up study (2017) using data from the same payer they found[2]
  - **50%** of hospitals nationally have rates of out-of-network billing below **5%**; **15%** have a rate of out-of-network billing above **80%**
  - 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[3])

1 Cooper Z, Morton FS. Out-of-Network Emergency Physician Bills—An Unwelcome Surprise. Health Affairs; 2016 Nov 17.

2 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.

3 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

# HPC Study of Out-of-Network Claims

- Out-of-network billing was identified by the HPC as an area of policy interest in the 2015 and 2016 Annual Cost Trends reports. Building off of past analyses, the HPC sought to better understand the characteristics of out-of-network billing in Massachusetts using the all-payer claims database (APCD).

- We used 2014 claims from **two** large MA commercial payers that together represent **over 50%** of the Massachusetts commercial market
  - We identified out-of-network claims by using the 'in network' designation submitted by these payers
  - Claims are from MA residents under 65 who received care in Massachusetts
  - Professional claims only (excludes facility claims)

- Sample is limited to sites of service that could have involved multiple providers or resulted in a surprise out-of-network bill:
  - Emergency department
  - Ambulance
  - Hospital inpatient
  - Hospital outpatient
  - Ambulatory surgical centers
  - Urgent care

All acute care hospitals in Massachusetts are in both payers' networks.

# Important Context and Caveats

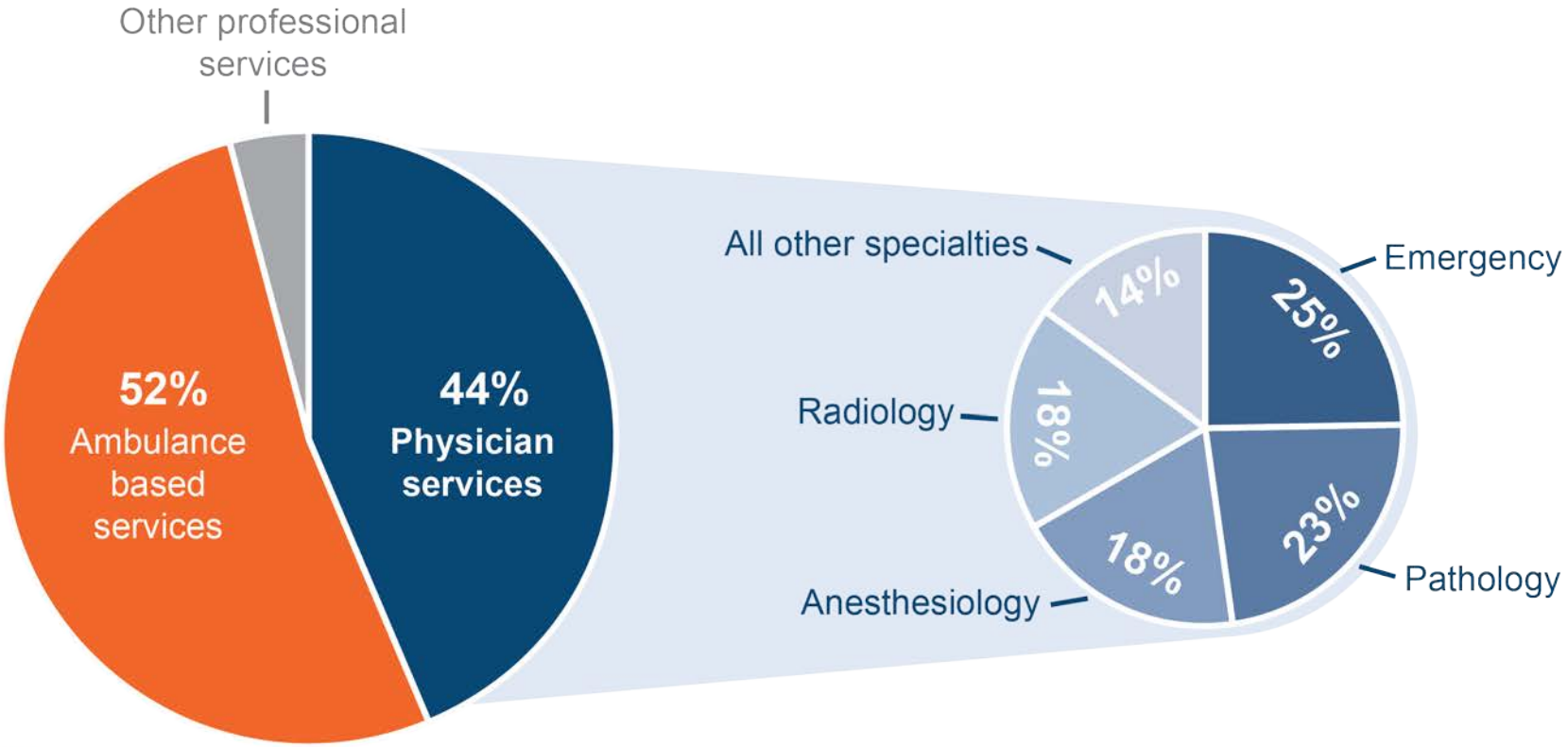
- Our estimates apply only to the portion of the Massachusetts commercial market covered by the two payers in our sample
- Estimates about the frequency and scale of out-of-network billing based on these two payers **are likely to be conservative**:
  - These are two of the largest payers in Massachusetts with the broadest networks
  - The broader a payer's network, the less likely it is that its members will encounter out-of-network providers
  - Insurers that are dominant in a particular market have more leverage to bring local providers into their networks.
  - Even between the two payers in this sample, the one with the larger market share has a lower rate of out-of-network billing
  - Estimates of out-of-network billing for payers with a national presence are much higher[1]

HPC

1 The four largest national payers made up 24% of the MA commercial market in March 2017 (CHIA Enrollment Trends, 2017)

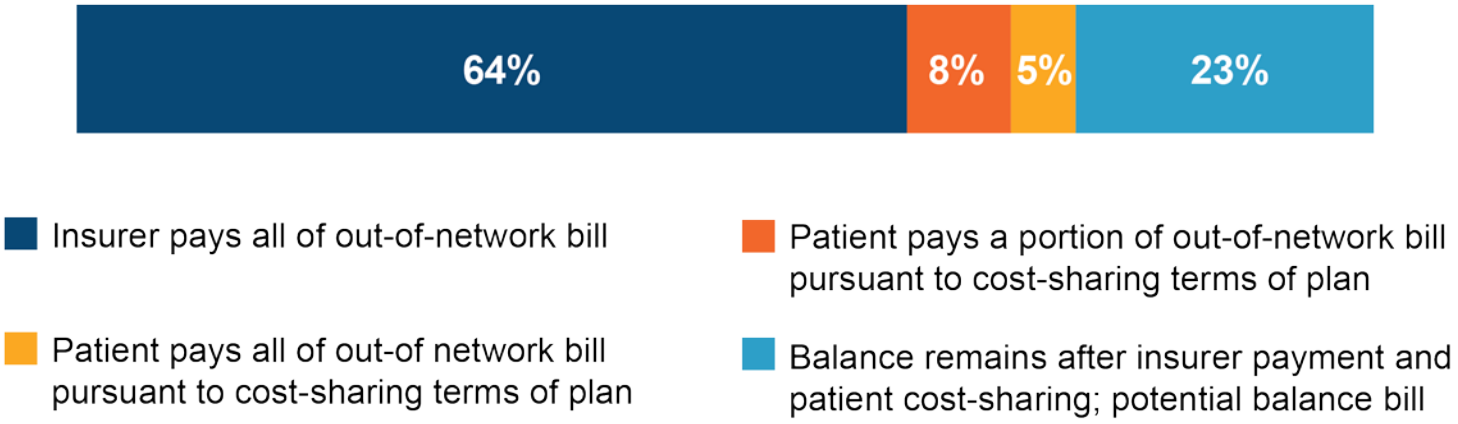
# By service/provider type, ambulance and ERAP providers account for 90% of out-of-network claims

- The HPC identified **70,107** out-of-network professional claims for services provided to **30,538** individuals
- Claims for ambulance-based services are the largest share of out-of-network claims for professional services
- Out of all out-of-network physician service claims, **85%** were for emergency, radiology, anesthesiology, or pathology (ERAP) providers



# How are out-of-network claims paid?

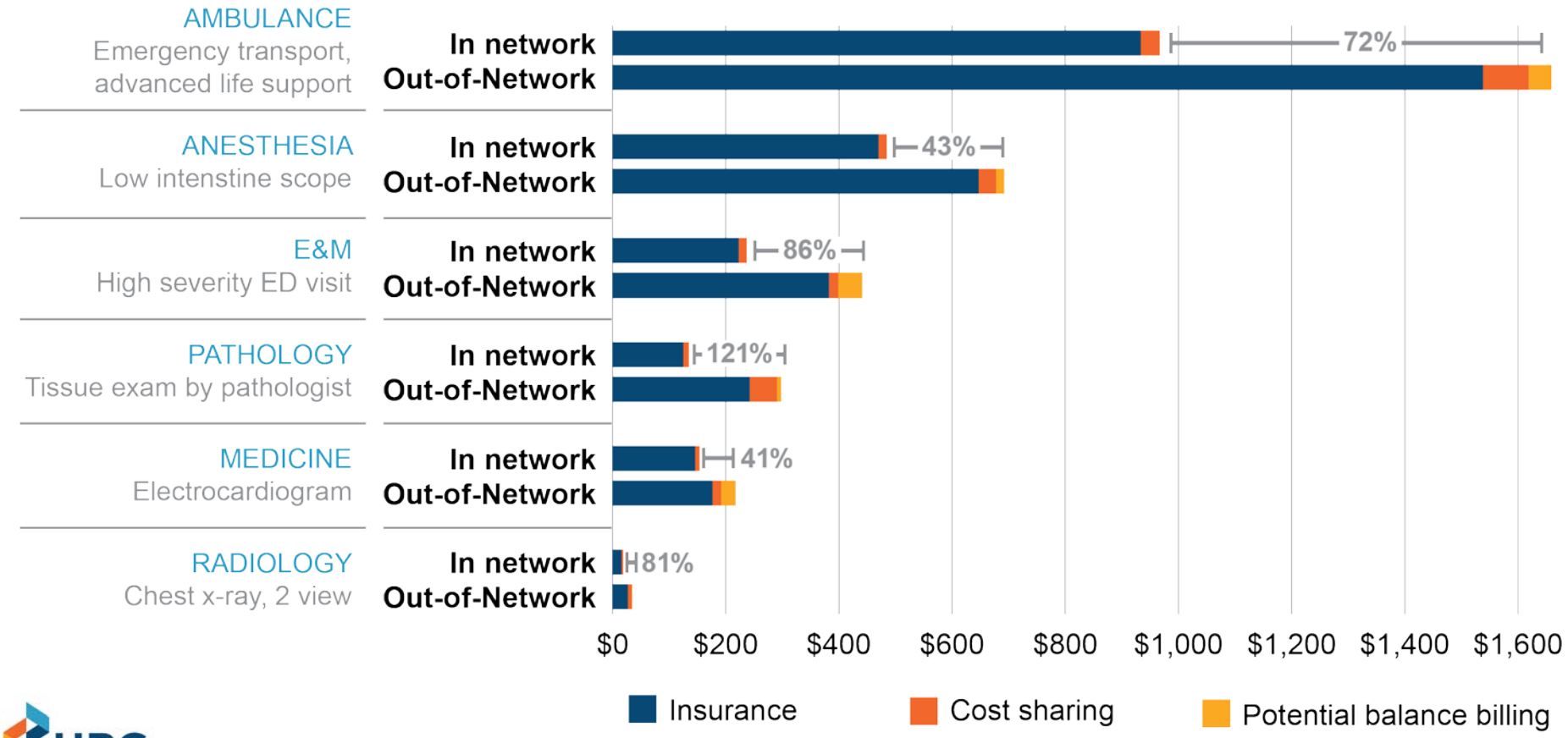
- In almost **2/3** of cases, the insurer paid the full charge amount on an out-of-network claim
- Nearly **1/4** of network claims in this sample may have resulted in a balance bill
  - **9,668** Massachusetts residents in this sample could have received balance bills
  - Average potential balance bill per member with any outstanding balance: **$355**



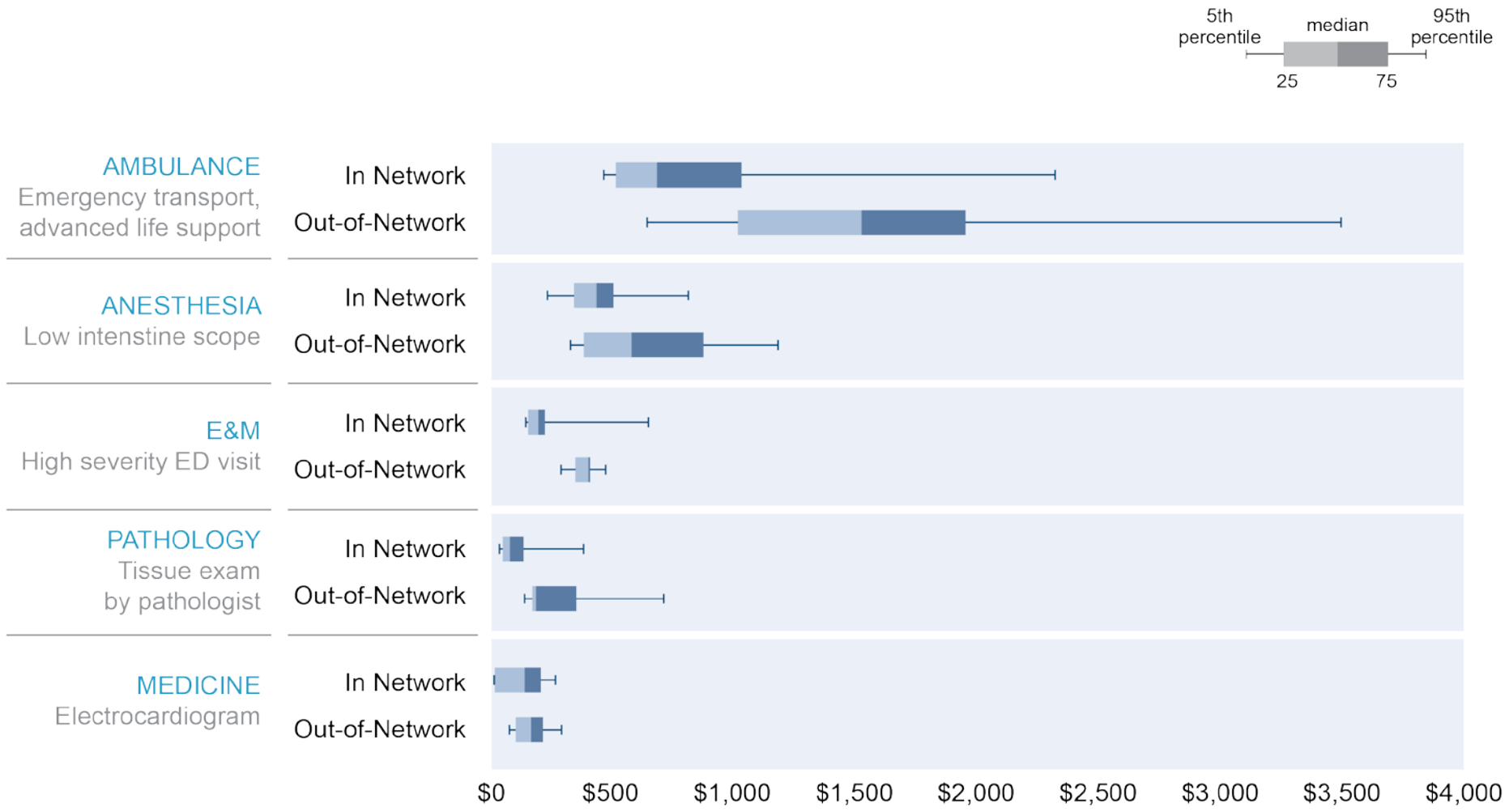

**Potential balance bill**: An out-of-network claim where the combined amount paid by the insurer and the member (through deductible, copay, and coinsurance) is less than the charge amount on the claim

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

- Combined spending on out-of-network professional claims for both payers in the sample totaled **$28.7 million** in 2014.
  - **$27.0 million** paid by insurers
  - **$2.2 million** that might have been balance billed to patients



# For the same services, the range of spending on out-of-network claims is often larger than for in-network claims



# Out-of-network payment rates for common ambulance services exceed in-network rates by 22% to more than 200%, on average

Ambulance ground mileage
- In network: **$214**
- Out-of-network: **$261**

22%

47% of all ambulance claims

Emergency transport with advanced life support
- In network: **$967**
- Out-of-network: **$1619**

67%

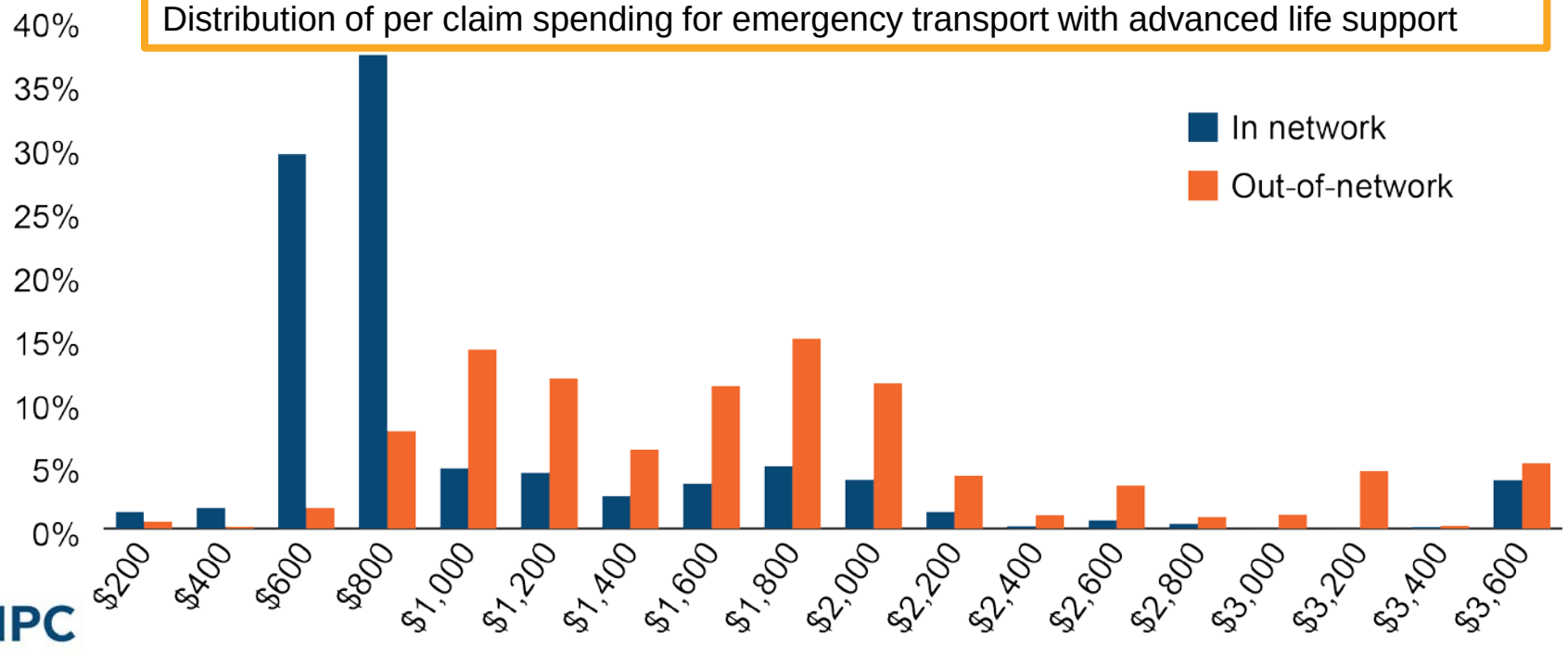
19% of all ambulance claims

Non-emergency transport with basic life support
- In network: **$338**
- Out-of-network: **$1107**

227%

9% of all ambulance claims

Distribution of per claim spending for emergency transport with advanced life support



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

ED visit moderate severity (99283)
- In network: **$143**
- Out-of-network: **$248**

73%

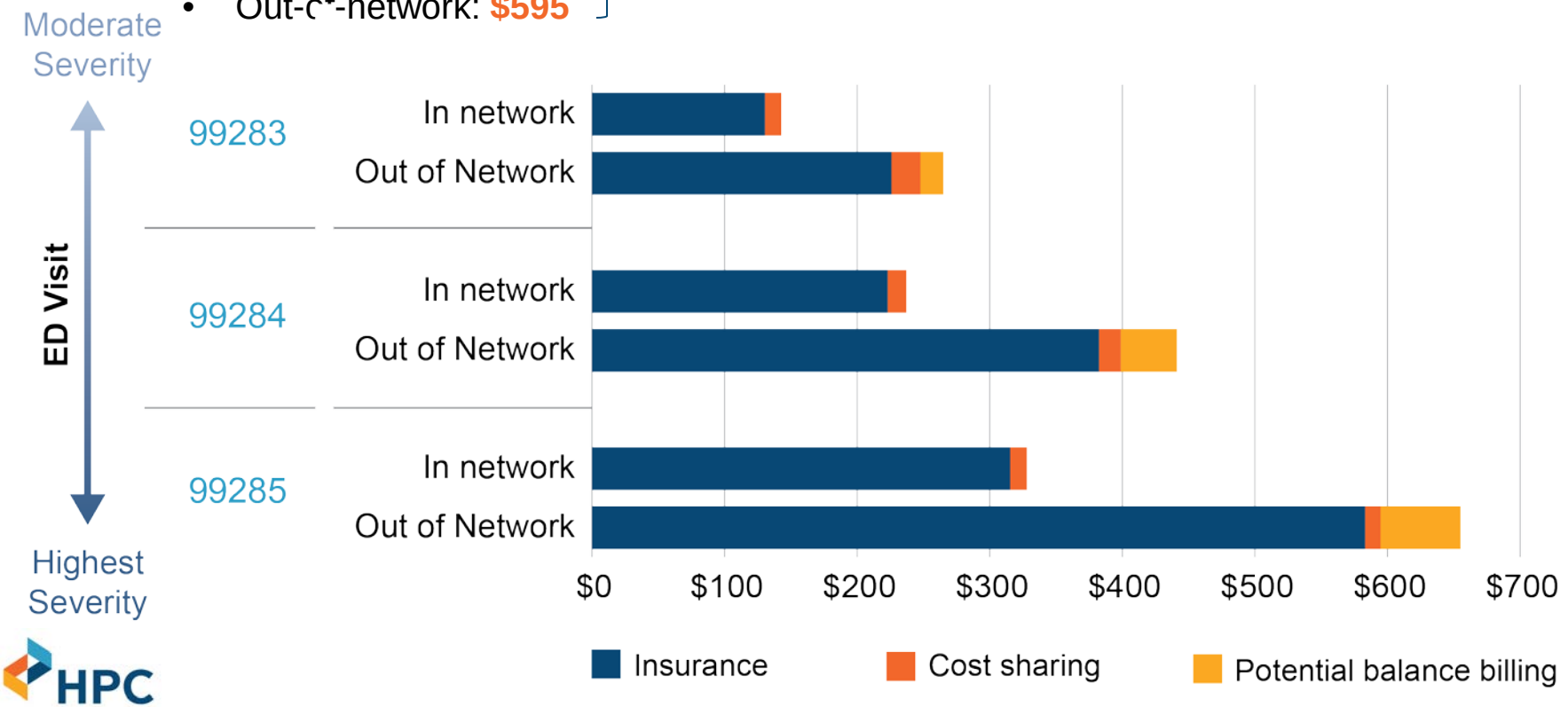
ED visit high severity (99284)
- In network: **$237**
- Out-of-network: **$399**

68%

ED visit highest severity (99285)
- In network: **$328**
- Out-of-network: **$595**

81%

These three E & M codes for moderate to very severe ED visits make up **46%** of in-network ED claims and **71%** of out-of-network ED claims



# State Policies to Address Out-of-Network Billing

- Some states have taken effective approaches to protecting patients from out-of-network emergency care and surprise billing
- A handful of states have banned balance billing and established guidelines for provider reimbursement (CA, NY, CT, FL, NJ)
- In addition, these states have introduced some novel policies to address out-of-network billing:
  - New York (2014) resolves payment disputes about out-of-network claims through a binding third party arbitration process
    - Cooper et al. found that the NY law lowered the incidence of out-of-network billing by **one third**
  - California (2016) allows patient cost-sharing to count toward patient's annual maximum out-of-pocket allowance and requires out-of-network providers to refund with interest any cost-sharing in excess of in-network rates
  - Connecticut (2015) requires surprise bills issued to a patient to be marked with "this is not a bill" and prohibits their referral to a collection agency if the patient doesn't pay
- Note that state policies that address out-of-network billing may not affect self-funded plans, which are federally regulated under ERISA (**60%** of the Massachusetts commercial market)