Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations

Pursuant to Section 71 of Chapter 260 of the Acts of 2020

Developed in consultation with the Health Policy Commission, the Center for Health Information and Analysis, and the Division of Insurance

September 8, 2021

Executive Summary

- **Section 71 of Chapter 260 of the Acts of 2021** directs the Secretary of the Executive Office of Health and Human Services ("EOHHS"), in consultation with the Health Policy Commission ("HPC"), the Center for Health Information and Analysis ("CHIA"), and the Division of Insurance ("DOI"), to develop a report and make recommendations on establishing a noncontracted, out-of-network commercial payment rate for both emergency and non-emergency health care services in the Commonwealth.
- Pursuant to this directive, **this report provides recommendation to enact legislation establishing an out-of-network default rate for the fully insured market,** complementing the federal legislation and consistent with both:
  - the proposal included in the Governor's 2019 health care bill which established a default payment rate for certain out-of-network services, and
  - an emergency order issued during the pandemic which established an out-of-network default rate for COVID-19 related emergency and inpatient services.
- The recommendation **is consistent with the federal framework and recognizes the federal action on this issue** which notably provides express deference to state laws that establish a payment rate or process to do so
- The recommendation to set the default reimbursement at the in-network median contracted rate **is consistent with the benchmarks contemplated in the federal law and will achieve the following:**
  - Provide a targeted solution for the fully insured market that will mitigate against cost increases, promote payer-provider contracting
  - Decrease administrative burden and cost intensive processes
  - Provide predictability, simplicity and transparency for the system.
  - Most importantly, it completes the goal of taking the consumer out of the middle of a dispute between a health care provider and insurer.

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Introduction

Out-of-network billing, or "surprise billing," is a long-standing priority policy area in Massachusetts, and recent state and federal actions are designed to protect consumers and address the impact of out-of-network billing.

Research shows that **out-of-network billing is an issue that impacts consumers and impacts total health care spending in Massachusetts**, although quantifying the exact prevalence is difficult due to inherent data challenges. Prior federal and state laws provided limited protections for patients in certain circumstances.[1] However, prior to 2020, such laws did not provide comprehensive protections for all patients in emergency and non-emergency situations, nor did they adequately address the significant implications for the health care market associated with out-of-network billing issues.

During the novel coronavirus pandemic ("COVID-19"), the federal and Baker-Polito Administrations recognized the potential financial exposure for patients from out-of-network billing issues related to COVID-19 and prohibited providers from balance billing patients.[2] The Governor's April 2020 order included balance billing protections and established a default reimbursement rate for out-of-network services related to COVID-19. This approach was consistent with the proposal included in the Governor's 2019 health care bill which established a default payment rate for certain out-of-network services as a percentage of Medicare.

Two significant out-of-network billing laws were recently enacted:

1. Congress passed a long-awaited law addressing out-of-network billing, **the federal *No Surprises Act*,** which President Trump signed into law on December 27, 2020.
2. On January 1, 2021, Governor Baker signed *An act promoting a resilient health care system that puts patients first,* **Chapter 260 of the Acts of 2020;** the law strengthened out-of-network billing protections in the Commonwealth and directed EOHHS to produce this report.

[1] See, e.g., Health Policy Commission, Out-of-Network Billing Policy Brief (2016), https://www.mass.gov/files/documents/2016/07/xu/2015-ctr-out-of-network.pdf. [2] HHS.Gov, *CARES Act Provider Relief Fund: General Information*, https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/general-information/index.html (last visited Jul. 22, 2021), Commonwealth of Massachusetts, Order Expanding Access to Inpatient Services, COVID-19 Order No. 25 (Apr. 9, 2020), https://www.mass.gov/doc/april-9-2020-inpatient-services-and-billing/download; see also Health Policy Commission, Out-of-Network Billing in Massachusetts Chartpack (2020), https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download.

Section 71 of Chapter 260 of the Acts of 2020

Section 71 of Chapter 260 of the Acts of 2020[1] directs the Secretary of the Executive Office of Health and Human Services ("EOHHS"), in consultation with the Health Policy Commission ("HPC"), the Center for Health Information and Analysis ("CHIA"), and the Division of Insurance ("DOI"), to develop a report and make recommendations on establishing a noncontracted, out-of-network commercial payment rate for both emergency and non-emergency health care services in the Commonwealth.

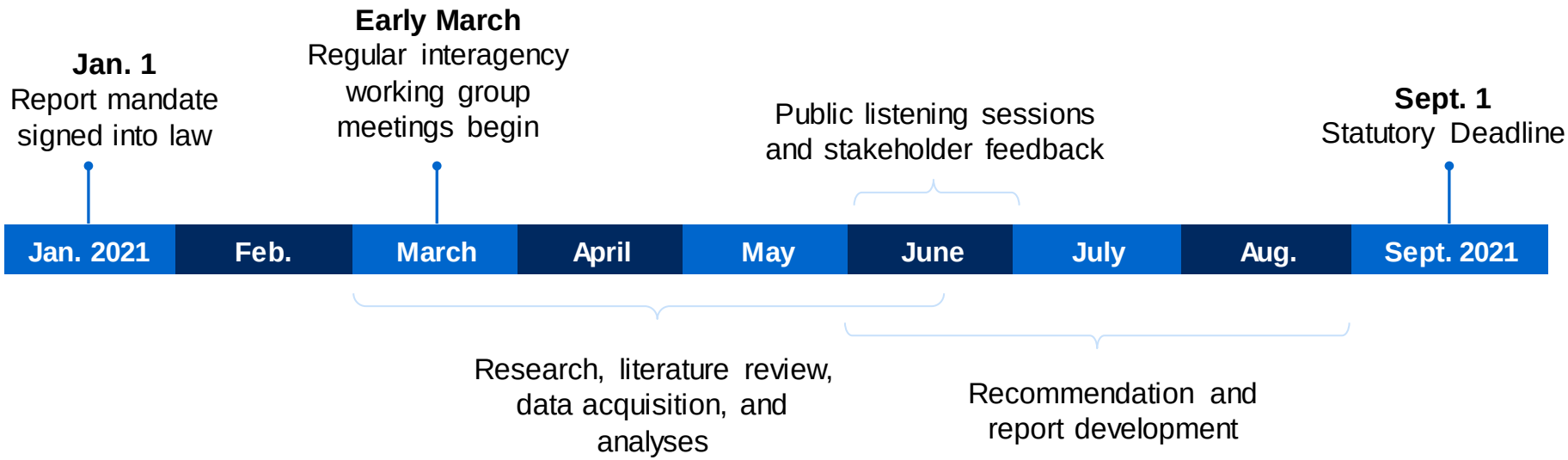
The report must include certain analyses, including but not limited to:

- Examination of the rates paid over the previous three years for public and private in-network and out-of-network health care services and the impact of the rates on the efficiency, accessibility and cost of the health care delivery system in the Commonwealth;
- The advisability of establishing noncontracted, out-of-network commercial payment rates for emergency and non-emergency health care services that represent the median or mean of commercial contracted rates, a percentage of the median or mean of commercial contracted rates or a percentage of Medicare rates;
- An assessment of potential noncontracted out-of-network commercial payment rates for emergency and non-emergency health care services and the impact of such rates on a variety of factors (e.g., provider network participation, insurance premiums and out-of-pocket costs, growth of total health care expenditures); and
- A review of best practices in other states.

[1] https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260

Overview of Timeline and Process

Led by EOHHS, the interagency working group undertook a thorough process that included literature review, data acquisition and analysis. The working group also held two public listening sessions, to facilitate stakeholder engagement. This report presents information and analyses that informed the recommendations herein.



Background on Out-of-Network Billing

Background on Out-of-Network Billing

Out-of-network billing issues, which derive from patients receiving unintentional out-of-network care, have significant implications for consumer protection as well as the functioning of the health care market overall.

While patients may intentionally seek care from a provider that is not in their commercial insurer's network, issues can arise when a patient *unintentionally* receives care from an out-of-network provider. This typically occurs in two scenarios: (1) emergencies; and (2) treatment by an out-of-network provider at an in-network facility. In these cases, a patient may receive a "balance bill" (whereby the patient must pay the out-of-network provider directly for the balance of the provider's charge not covered by the insurer) or a "surprise bill" (a bill received by a patient after receiving unintentional out-of-network care at an in-network facility). Such bills can be significant. 37% of Massachusetts residents reported having an unexpected medical bill in 2019, and although not all meet the definition of out-of-network surprise bills, residents who had unexpected bills were **three times as likely** as those who did not to have problems paying medical bills and to have family medical debt.[1]

In addition to the financial impact for patients, out-of-network billing has implications for overall 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 or other contract negotiations.

For additional background on out-of-network billing, including national research findings, see the HPC's Policy Brief on Out-of-Network Billing (2016) and the HPC's Out-of-Network Billing Chartpack (2020).

[1] Center for Health Information and Analysis, An Inside Look: Unexpected Medical Bills Are a Challenge for Many, Findings from the Massachusetts Health Insurance Survey (2021), *available at* https://www.chiamass.gov/assets/docs/r/pubs/2021/Inside-Look-Unexpected-Medical-Bills-.pdf.

Background on Out-of-Network Billing in Massachusetts

Out-of-Network Billing in Massachusetts

HPC research has established that out-of-network billing is a significant problem in Massachusetts as well as nationally, and many key indicators of out-of-network billing have worsened in recent years.

In 2020, the HPC published a chartpack on Out-of-Network Billing in Massachusetts, building off of HPC's previous analysis published in 2017. Using the most recent commercial claims data available (2017) from the Massachusetts APCD, the chartpack examined: (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.

HPC's analyses in both instances focused on the following settings where patients could not choose an in-network provider: (1) ambulances; (2) emergency care; and (3) radiology, anesthesiology, and pathology services provided in settings outside of the emergency department (providers in (1), (2) and (3) are collectively known as "ERAP" providers).

Key Takeaways from HPC analyses:

- In 2017, among 657,140 commercially-insured members, the HPC identified **68,342** out-of-network claims for **30,332** Massachusetts residents within the above scenarios (1)-(3)
- In 91% of cases, the provider's charge was not paid in full; thus, patients may have been "balance billed"
- The amounts insurers did pay were usually above in-network contracted rates, which are *already* likely inflated due to additional negotiating leverage afforded by threats of going out-of-network
- The above trends generally worsened from 2015 to 2017

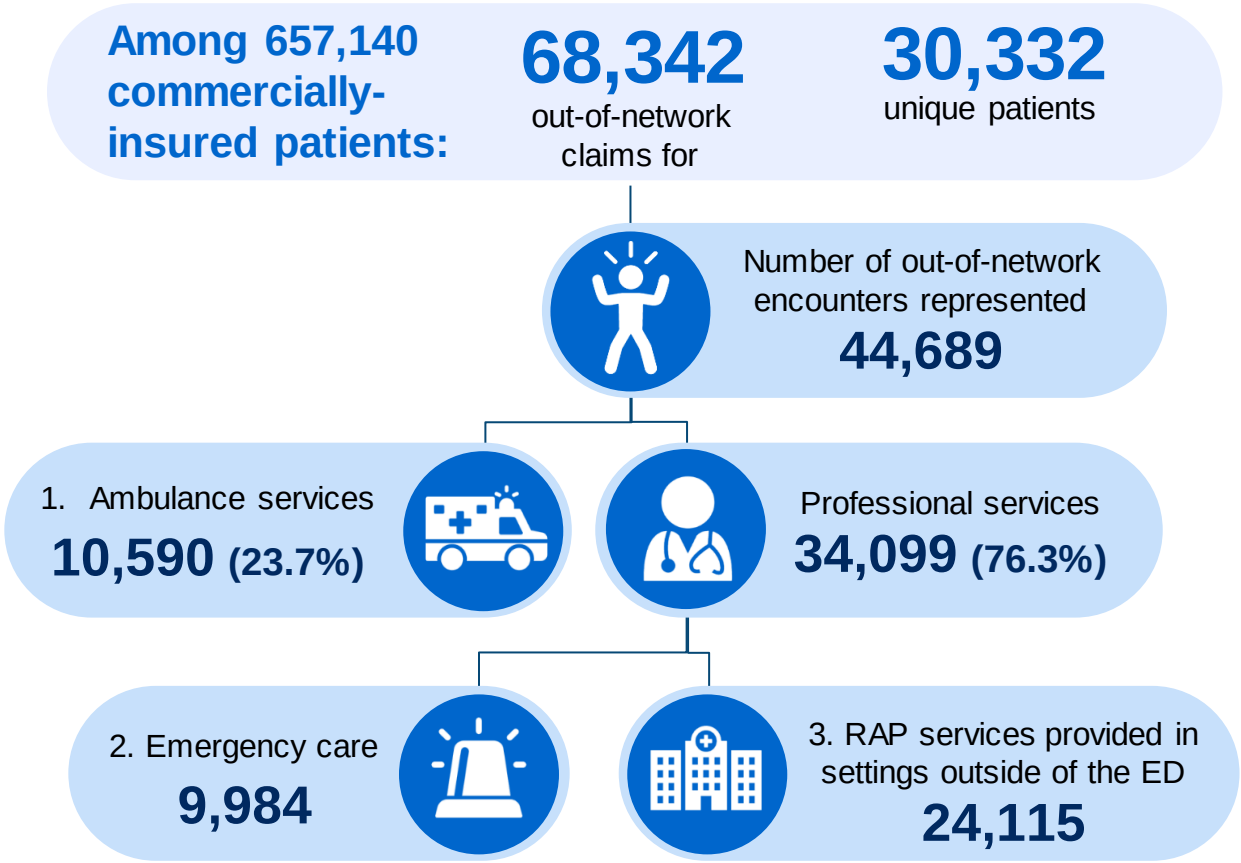
Select findings from the HPC's chartpack are shown on the following slides.

Precisely quantifying the prevalence of out-of-network billing in Massachusetts is challenging, in part because of data limitations. These publications made use of indicators on claims provided by two Massachusetts insurers for whether the payment was to an in-network or out of network provider.

Most unintentional out-of-network claims in MA were from radiology, pathology, and anesthesiology services provided outside of emergency settings.

HPC Out-of-Network Billing Chartpack

Out-of-network claims in Massachusetts, 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.

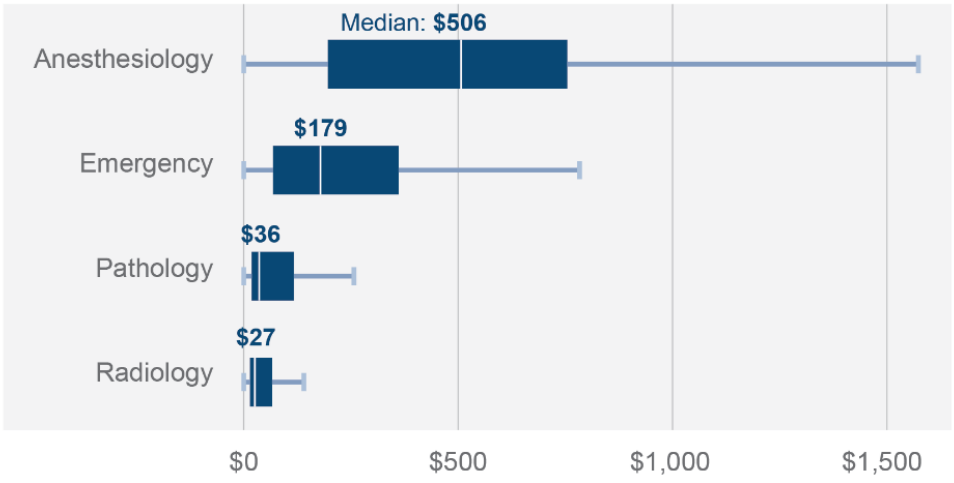
Notes: Only professional claims from an ambulance or from an emergency department or based on services performed by a radiologist, anesthesiologist, or pathologist (RAP) were included in this analysis. An encounter is created by grouping all services received by the same patient on the same day and same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

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

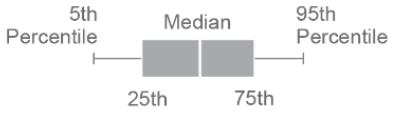
Of the 91.2% out-of-network professional claims with a potential for balance billing, the average potential balance bill was $167 per claim.

HPC Out-of-Network Billing Chartpack

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



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 average potential balance bill amount 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 bill amount 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

Key Out-of-Network Billing Updates in Massachusetts

Massachusetts Out-of-Network Billing Default Rate During COVID-19

The novel coronavirus ("COVID-19") pandemic prompted action at both the federal and state levels to limit the financial exposure of COVID-19 patients, and Massachusetts implemented a temporary default out-of-network provider payment rate for COVID-19 treatment to be set at 135% of Medicare.

The Baker-Polito Administration issued COVID-19 Order No. 25 (April 2020), which required the Group Insurance Commission ("GIC") and all carriers 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.[1] This order was consistent with the proposal included in the Governor's 2019 health care bill. Order No. 25 prohibited balance billing and established the reimbursement amount for out-of-network providers as follows:

1. For acute care hospital providers with whom carriers and the GIC contract, but not for the member's health plan, **the contracted rate** for such medically necessary emergency department and inpatient services, as applicable, including all professional, diagnostic, and laboratory services; and

2. For acute care hospital providers with whom carriers and the GIC do not contract, **135% of the Medicare rate** in the provider's geographic region for such medically necessary emergency department and inpatient services, as applicable, including all professional, diagnostic, and laboratory services, unless a carrier was directed otherwise by the Division of Insurance.

Order No. 25 was superseded and rescinded by COVID-19 Order No. 61 (January 2021).[2] Pursuant to COVID-19 Order No. 69 (May 2021), Order No. 61 remained in effect until the termination of the state of emergency on June 15, 2021.[3]

[1] 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. [2]https://www.mass.gov/doc/covid-19-order-61/download; [3]https://www.mass.gov/doc/covid-19-order-69/download

New Massachusetts Out-of-Network Billing Law

The state's recent health care law, signed by Governor Baker on January 1, 2021, strengthens the Commonwealth's out-of-network billing protections and charged EOHHS, in consultation with DOI, CHIA and HPC, with making a recommendation on the determination of out-of-network provider payments.

In recent years, there have been repeated calls to enhance the Commonwealth's out-of-network billing protections, including but not limited to in the HPC's Annual Cost Trends Reports and Out-of-Network Policy Brief, and the 2017 Special Commission on Provider Price Variation Report.

The Commonwealth's new law, *An act promoting a resilient health care system that puts patients first* (Chapter 260 of the Acts of 2020), which was **signed into law just days after the federal *No Surprises Act* was enacted**, comprehensively addresses the three components of out-of-network billing in Massachusetts:

1. **Reduce out-of-network billing scenarios:** Includes new disclosure and transparency requirements for providers and insurers in advance of non-emergency procedures
2. **Remove patients from the payment equation:** Prohibits out-of-network providers who fail to provide the required notifications from balance billing (subject to fines beginning in 2022)
3. **Required EOHHS report with recommendations:** Mandates EOHHS conduct analyses and make a recommendation on out-of-network provider payments, due to the legislature no later than September 1, 2021

Federal Law on Out-of-Network Billing, the No Surprises Act

Federal Law on Out-of-Network Billing

Beginning in 2022, pursuant to the No Surprises Act, surprise billing protections will take effect for millions of Americans, including consumers in Massachusetts for both members of fully-insured and self-insured health plans.

The *No Surprises Act* (part of H.R. 133 – Consolidated Appropriations Act 2021[1]) was signed into law on December 27, 2020. The law addresses the objectives of a comprehensive out-of-network billing solution for out-of-network emergencies and certain out-of-network care received at in-network facilities:

- **Reduce out-of-network billing scenarios:** New disclosure and transparency requirements for providers and insurers
- **Remove patients from the payment equation:** Prohibits balance billing and holds patients harmless at in-network cost-sharing levels
- **Establish reasonable and fair provider reimbursement:** Following a negotiation period, providers and insurers may utilize an independent dispute resolution process ("IDRP"), whereby the independent dispute resolution entity ("IDRE") chooses one of the parties' final offers (binding, "baseball style" arbitration). *See next slide for additional details on payment determination in the IDRP.*

The *No Surprises Act* applies to providers, facilities, and air ambulances (it establishes an advisory committee for ground ambulances, which are excluded), and **significantly, the law applies to both fully- and self-insured health plans**. A federal law is necessary to comprehensively address out-of-network billing because self-insured health plans are preempted from state insurance regulation under the federal Employee Retirement Income Security Act ("ERISA") preemption. As noted elsewhere in this report, state out-of-network billing laws typically only apply to fully-insured health plans. The *No Surprises Act* will apply to all plans in the commercial health insurance market in Massachusetts, including the 60.5% (2.74M) of members (2019) in self-insured plans.[2]

[1] https://www.congress.gov/bill/116th-congress/house-bill/133/text; [2] CHIA Annual Report (page 48), https://www.chiamass.gov/assets/2021-annual-report/2021-Annual-Report.pdf.

Considerations for Payment Determination in Federal Law's Independent Dispute Resolution Process ("IDRP")

IDR Entity must consider:

- ***Qualifying Payment Amount* ("QPA")** – defined as the **median contracted rate** for a given service in the same geographic region within the same insurance market across the insurer's health plans as of 1/31/19, indexed forward by the Consumer Price Index for All Urban Consumers
- Subject to prohibitions (below), information submitted on additional circumstances (e.g., acuity of patient or complexity of furnishing item/service, prior contracting history) or other information requested or provided

IDR Entity may not consider:

- Usual and customary OR billed charges
- Public payer reimbursement rates (e.g., Medicare, Medicaid)

Implementation of the *No Surprises Act*

Rulemaking by federal agencies is underway in advance of the *No Surprises Act* implementation date of January 1, 2022. The federal law defers to state law in certain circumstances, including the determination of out-of-network provider reimbursement.

The first in a series of key rules from federal agencies, including the Department of Health and Human Services ("HHS"), Department of Labor, and Department of the Treasury (together, the "Departments"), entitled *Requirements Related to Surprise Billing; Part I*[1], was published on July 13, 2021. Comments on the interim final rule ("IFR") may be submitted until September 7, 2021.

The IFR governs the key consumer protections in the *No Surprises Act*, including, but not limited to, patient cost-sharing requirements, notice and consent requirements, and a prohibition of balance billing. Additionally, the IFR provides further details on the methodology for calculating the QPA (generally defined as the median contracted rate). The **QPA is central to the law**, with respect to both patient cost-sharing and the determination of final payment in the IDRP.

Consistent with the statute, **the IFR provides deference to "specified state laws" with respect to patient cost-sharing and determination of out-of-network provider payment amount**. With respect to the latter, the IFR clarifies that the payment amount will be determined in this order: (1) an All-Payer Model Agreement, (2) specified state law, (3) a negotiated amount with the insurer, or (4) if one cannot be agreed to, an amount determined in the IDRP. The IFR also clarifies that deference to state law is given to state laws whether they provide a mathematical final payment amount or a process to determine one.

Further rulemaking by the Departments is anticipated in the coming months, including detailed information about the IDRP (e.g., guidance for arbitrators in considering the QPA in determining the final payment amount).[2]

[1] A comprehensive summary of the IFR is available at: https://www.healthaffairs.org/do/10.1377/hblog20210706.903518/full/; [2] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/06/24/equal-weighting-is-a-poor-framework-for-arbitration-decisions-under-the-no-surprises-act/

State Options for Consideration

This report reviews the actions that the Commonwealth may take regarding determination of noncontracted, out-of-network commercial payment rates for emergency and non-emergency health care services.

1. **Establish Massachusetts out-of-network payment rates**, which would govern reimbursement of out-of-network providers by fully-insured health plans (and self-insured plans, if given an option for self-insured plans to opt-in).

   Such payment rate may be determined by:

   - Setting a statutory **payment benchmark rate**

     or

   - Establishing an **independent dispute resolution process** to determine payment rates applicable on a case-by-case basis. To be based on Massachusetts's rules and regulations

2. **Take no action and allow the federal *No Surprises Act* to govern** the determination of out-of-network payment rates in Massachusetts beginning January 1, 2022. The federal law will apply to providers, facilities, air ambulances, and fully- and self-insured health plans. Resulting payment disputes between out-of-network providers and plans will be subject to the process prescribed in the federal law (i.e., initial payment, negotiation period, and IDRP if utilized).

State Laws on Out-of-Network Billing & Key Research Evaluating State Laws

Review of State Laws on Out-of-Network Billing

In recent years, states have increasingly enacted out-of-network billing laws, which typically apply only to fully-insured health plans and members thereof. While there is generally consensus about protecting patients, the laws take various approaches in addressing the controversial matter of fair and reasonable provider reimbursement.

Components of Comprehensive Out-of-Network Billing Laws

Notification and Disclosure Requirements

Holding the Patient Harmless

Out-of-Network Provider Payment Determination

Payment Standard / Benchmark

Reimbursement amount is set. Common benchmarks are (or are variations on) negotiated amounts, % of Medicare rates, and/or % of charges.

Independent Dispute Resolution Process ("IDRP")

Dispute resolution process established for payment disputes. Commonly binding, "final offer" arbitration.

Hybrid Approach

Combination of both approaches – i.e., reimbursement amount is set, but IDRP is available for remaining disputes

Taxonomy of State Approaches to Provider Payment Determination

Approach & *Example*	Summary of Provider Payment Determination	Notes
Benchmark ***Oregon (2018)***	▪ Median allowed amount paid to in-network providers, based on 2015 All-Payer All Claims database, adjusted annually ▪ Amount may be adjusted based on differences in allowed amounts in certain geographies	
IDRP ***New York (2015)***	▪ Billed amount, or plan attempts to negotiate ▪ If that fails, plan pays a "reasonable amount" ▪ Binding, final offer arbitration for disputes ▪ IDR entity must consider certain factors, including how amount compares to the usual, customary and reasonable ("UCR") amount	▪ UCR = 80th percentile of charges (in FAIR Health[1]) ▪ New Jersey has a similar process, with some differences
Hybrid ***Maine (2020)***	▪ Non-ambulance services, greater of: (1) carrier's median network rate; or (2) median network rate paid by all carriers in APCD ▪ For emergency services: binding, final offer arbitration available; arbitrator must consider factors, including median in-network rate in APCD	▪ Includes ambulance payment provision (but sunsets 10/2021) ▪ Self-insured plans can opt into the protections for emergency services

Additional examples are available in the Appendix.

[1] https://www.fairhealth.org/.

Key Research on the Impact of State Laws: California

Independent research evaluating the impact of California's law suggests overall that California's payment benchmark (greater of the average contracted rate or 125% of Medicare) protected patients, reduced spending, and maintained or increased patient access.

- Stakeholder interviews conducted post-implementation of AB72[1] **(Duffy 2019[2])** revealed that the law is protecting patients, and the out-of-network payment standard affects negotiation dynamics between hospital-based physicians and payers. Interviewees reported that the leverage shifted in favor of payers, which are incentivized to lower or cancel contracts above their local average contracted rate. Stakeholders also said that although AB72 applies to out-of-network providers, there is an additional effect on in-network hospital-based physicians with historical contracted rates above the new payment standard.

- Data from regulators at the **California Department of Managed Health Care** was featured in a 2019 brief by **Health Access California**[3], which concluded that patients are being protected from surprise bills, nearly all physicians are accepting the average contracted rate as payment in full (i.e., not utilizing the IDRP to seek higher payment), and insurers have broadened their networks.

- **Adler et al (2019)**[4] evaluated the impact of California's law on network breadth, cost of care, and other market dynamics. Their research analyzing the share of specialty services provided in- and out-of-network pre- and post-implementation showed a "modest shift" towards in-network for studied specialties, compared to emergency medicine (which was unaffected by California's 2017 surprise billing law, AB72).

[1] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB72; [2] https://www.ajmc.com/view/influence-of-outofnetwork-payment-standards-on-insurer-provider-bargaining-californias-experience; [3] https://health-access.org/wp-content/uploads/2019/09/ha-factsheet-AB72report-final.pdf ; [4] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/. In the Brookings publication, Adler et al addressed the perspectives of the California Medical Association and America's Health Insurance Plans on the impact of AB72.

Key Research on the Impact of State Laws: New Jersey and New York

The significant reliance on provider charges in New York's and New Jersey's arbitration systems results in higher awards to providers and higher health care spending relative to systems not reliant on charges.

Even though the number of out-of-network bills would likely be reduced under any of the approaches,[1] reliance on provider charges, whether as a reference point in arbitration or a component of a payment benchmark, can result in perverse incentives that may be harmful to the market.[2]

A 2021 study **(Chartock et al)** of **New Jersey's arbitration system**, which relies heavily on charges, showed:

- Awards are very generous to providers. For example, the median decision in the period studied was 5.7 times the median in-network rate and 8.5 times the Medicare rate.
- The policy affects more than just the relatively few cases in arbitration. A system that relies on charges in consistently awarding high payments to providers can substantially increase premiums because the expectation of generous awards increases the value of the provider's out-of-network option, which providers (particularly ERAP providers, who can generally anticipate volume regardless of network status) can leverage to extract higher in-network payment rates.

[1] https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/200131report.html [2] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.00217;

Key Research on the Impact of State Laws: New Jersey and New York, Cont'd

In evaluating **New York's law**, researchers in a 2020 study **(Cooper et al)** found that the law reduced OON billing incidence by 88% and lowered in-network ED payments by 15% (relative to what they were projected to have been absent the law).[1]

The New York State Department of Financial Services published a report providing data on awards made through the IDR process and extrapolated Cooper's result to estimate that the law saved consumers over $400 million over nearly four years, "realized in part through a reduction in costs associated with emergency services and an increased incentive for network participation."[2]

However, other researchers **(Adler 2019)** evaluating the same data on New York's arbitration process, where the IDR entity must consider 80th percentile of charges, suggested that the law raised spending because [3]:

- Decisions have averaged 8% higher than the 80th percentile of charges.
- Even decisions where the plan's final offer was selected, the offer averaged only 11% below the 80th percentile of charges – well above in-network rates or typical out-of-network payments.
- These results likely increase ERAP leverage in commercial negotiations, either causing providers to leave networks to obtain out-of-network payment, extract higher in-network payment, or both, which ultimately increases premiums.

A 2021 study **(La Forgia et al)** found that state laws curbing out-of-network billing had an impact on unit prices overall for both in-network and out-of-network anesthesiologists. For example, in New York, California, and Florida, the unit price paid to in-network anesthesiologists decreased by 7%, 11%, and 3%, respectively, after the introduction of surprise billing legislation.[4]

[1] https://zackcooper.com/sites/default/files/2020-09/OON%20JPE.pdf; [2] https://www.dfs.ny.gov/system/files/documents/2019/09/dfs_oon_idr.pdf; [3] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/10/24/experience-with-new-yorks-arbitration-process-for-surprise-out-of-network-bills/; [4] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2782816

Analyses Pursuant to Section 71 of Chapter 260 of the Acts of 2020

Analyses Pursuant to Section 71 of Chapter 260 of the Acts of 2020

Pursuant to the statutory charge, EOHHS, in consultation with the HPC, CHIA, and the DOI, conducted new analyses, reviewed key considerations and assessed the impact of potential out-of-network default rates.

1. **Data Analyses**
   - APCD v8.0 (2018)
   - FAIR Health, Inc. (2018-2020)
2. **Key Considerations and Advisability of Options for Establishing an Out-Of- Network Default Rate**
3. **Assessment of Impact of Potential Out-Of-Network Default Rates**

Analyses Pursuant to Section 71 of Chapter 260 of the Acts of 2020:

(1) Data Analyses

Analyses of Massachusetts Data on Out-of-Network Billing

The HPC conducted further analyses on Massachusetts data on out-of-network billing using the most recent data available from two distinct sources: (1) 2018 data from the Massachusetts All-Payer Claims Database ("APCD") and (2) 2019 and 2020 benchmark data from FAIR Health, Inc.'s private insurance claims database.

In support of the statutory charge, the HPC updated previous work (see slides 11-13 and an HPC DataPoints issue, as described on slide 41) to assess whether prior findings remained consistent using more recent data and whether there were other identifiable trends over time among key indicators.

Description of data sources:

- **APCD:** The APCD contains indicators of whether claims were billed out-of-network, as well as further detail allowing HPC analysts to identify key unintentional surprise billing scenarios. The APCD also contains actual insurer-paid amounts on each claim. Data in the APCD sample analyzed covers 1.8 million Massachusetts residents across five payers in 2018.
- **FAIR Health, Inc. custom payment benchmark data:** The FAIR Health, Inc. claims-based data on payments utilizes an imputation method to estimate insurer-paid amounts (i.e., "imputed allowed amounts"). The FAIR Health data includes a larger portion of Massachusetts commercial claims and contains more recent data (2019-2020) than the APCD.

Taken together, the APCD and FAIR Health analyses presented in this report provide a comprehensive update to prior research and confirm that overall takeaways have not changed in recent years.

Additional information on methodology is available in the Appendix.

Analysis of Massachusetts APCD Data on Out-of-Network Billing

The HPC updated analyses on in-network and out-of-network rates and provider payment variation for common ERAP procedures, which showed on average, out-of-network payments remain considerably higher than in-network payments.

The HPC analyzed in-network and out-of-network payment rates and provider payment variation for common ERAP procedures (i.e., procedures that are commonly involved with potential surprise bills). The HPC used the most recent data available from CHIA's APCD (v8.0 for 2018). Data are presented in the following slides, and details on methodology are available in the Appendix.

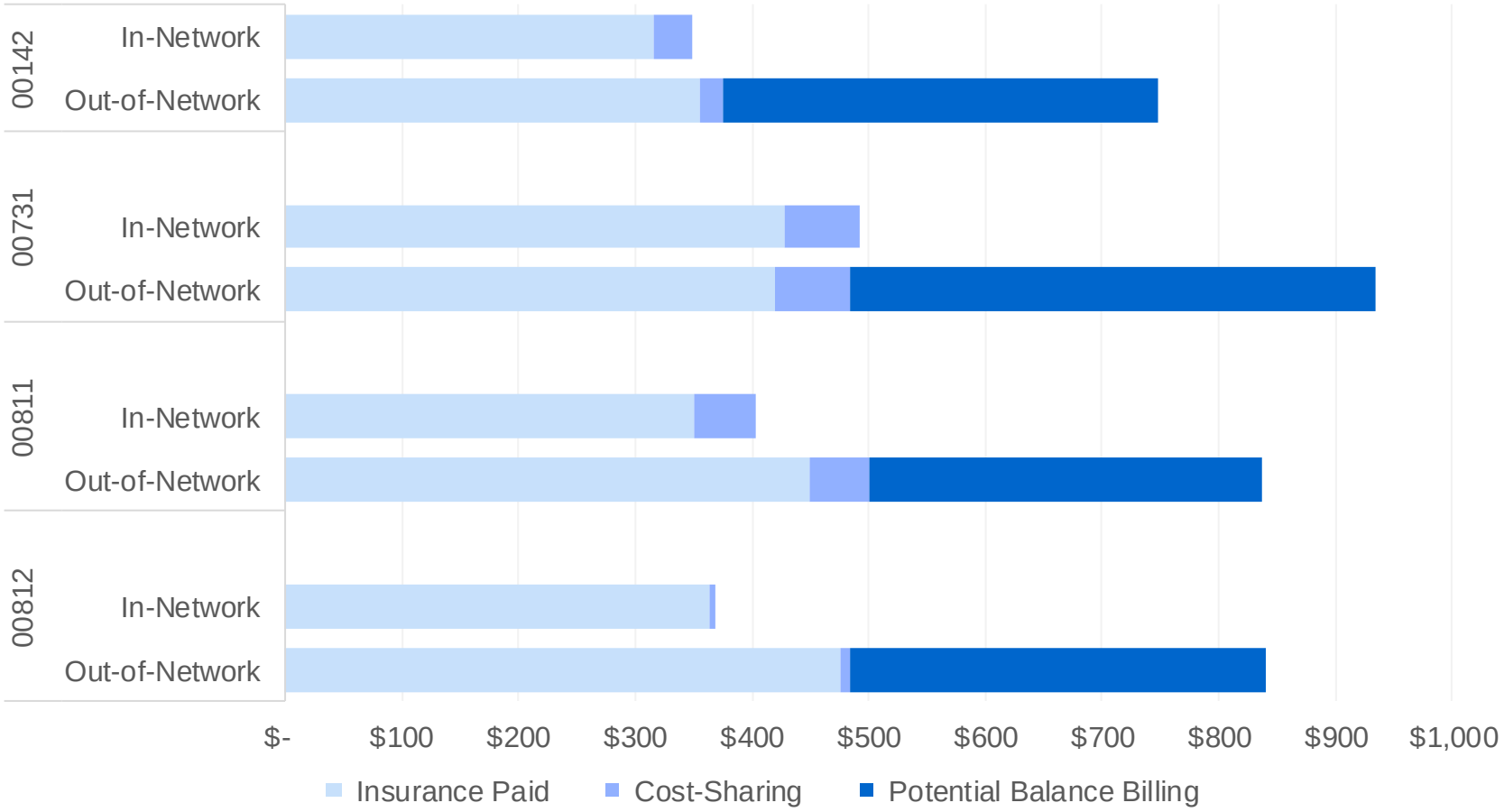
Summary of key takeaways from APCD (v8.0) analysis:

- In general, out-of-network services result in higher average insurer payments, as well as potential balance billing that is far higher than cost-sharing for in-network services.
- The distribution of payments for in-network ERAP claims showed very high provider payment variation. Because these distributions were often skewed towards higher payments, the resulting mean was higher than the median.

In-Network Spending Compared to Out-of-Network Spending and Charges for Top Out-of-Network Anesthesia Procedures, 2018

2018 APCD

Average payments for in-network and out-of-network anesthesia procedures, 2018

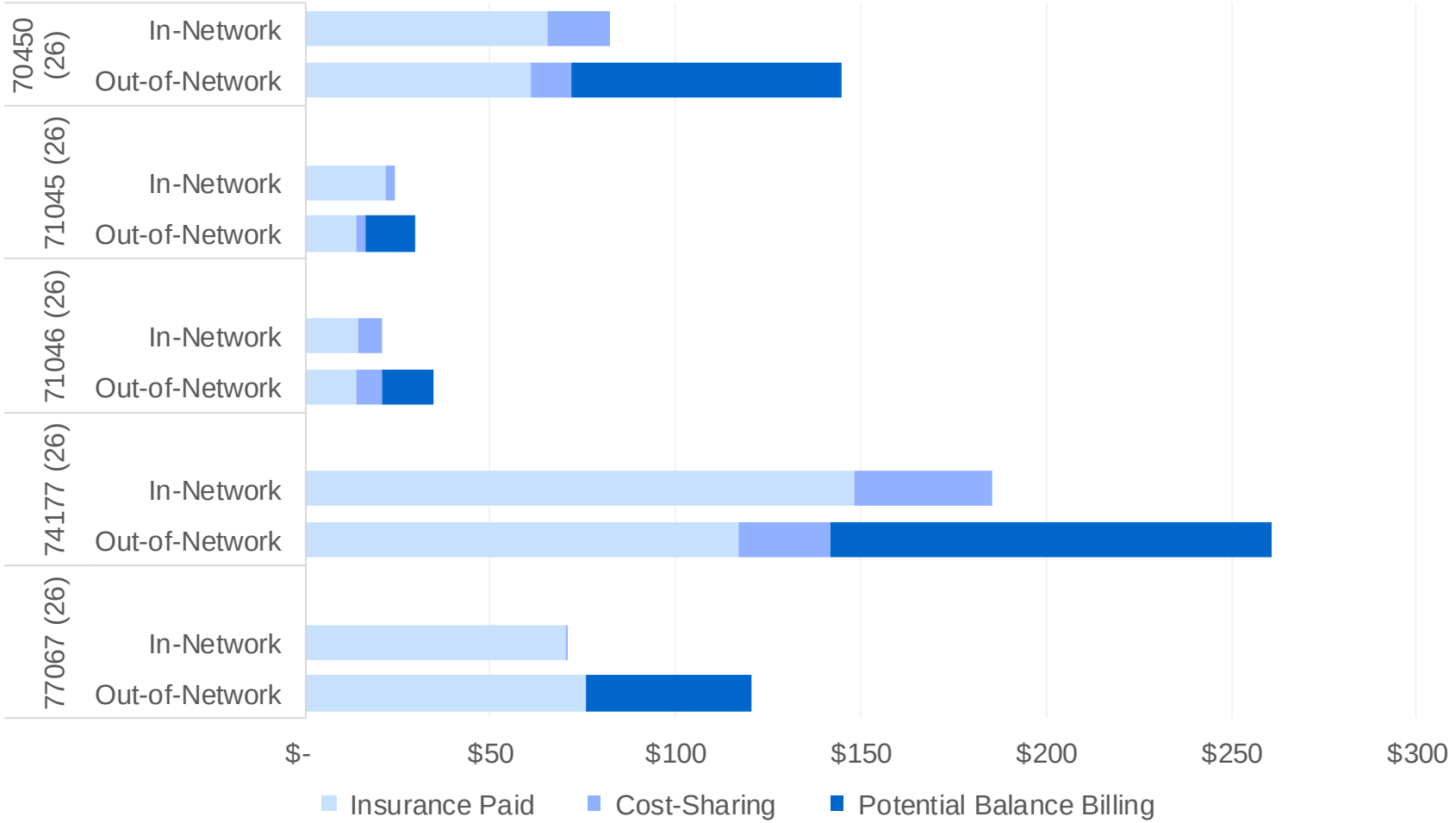


Notes: The following procedures are included: Anesthesia Eye Lens Surgery (00142), Anesthesia Upper GI Endoscopy (00731), Anesthesia Lower Intestine Endoscopic Procedures (00811), Anesthesia Lower Intestine Endoscopic for Screening Colonoscopy (00812).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Spending Compared to Out-of-Network Spending and Charges for Top Out-of-Network Radiology Procedures, 2018

2018 APCD

Average payments for in-network and out-of-network radiology procedures, 2018

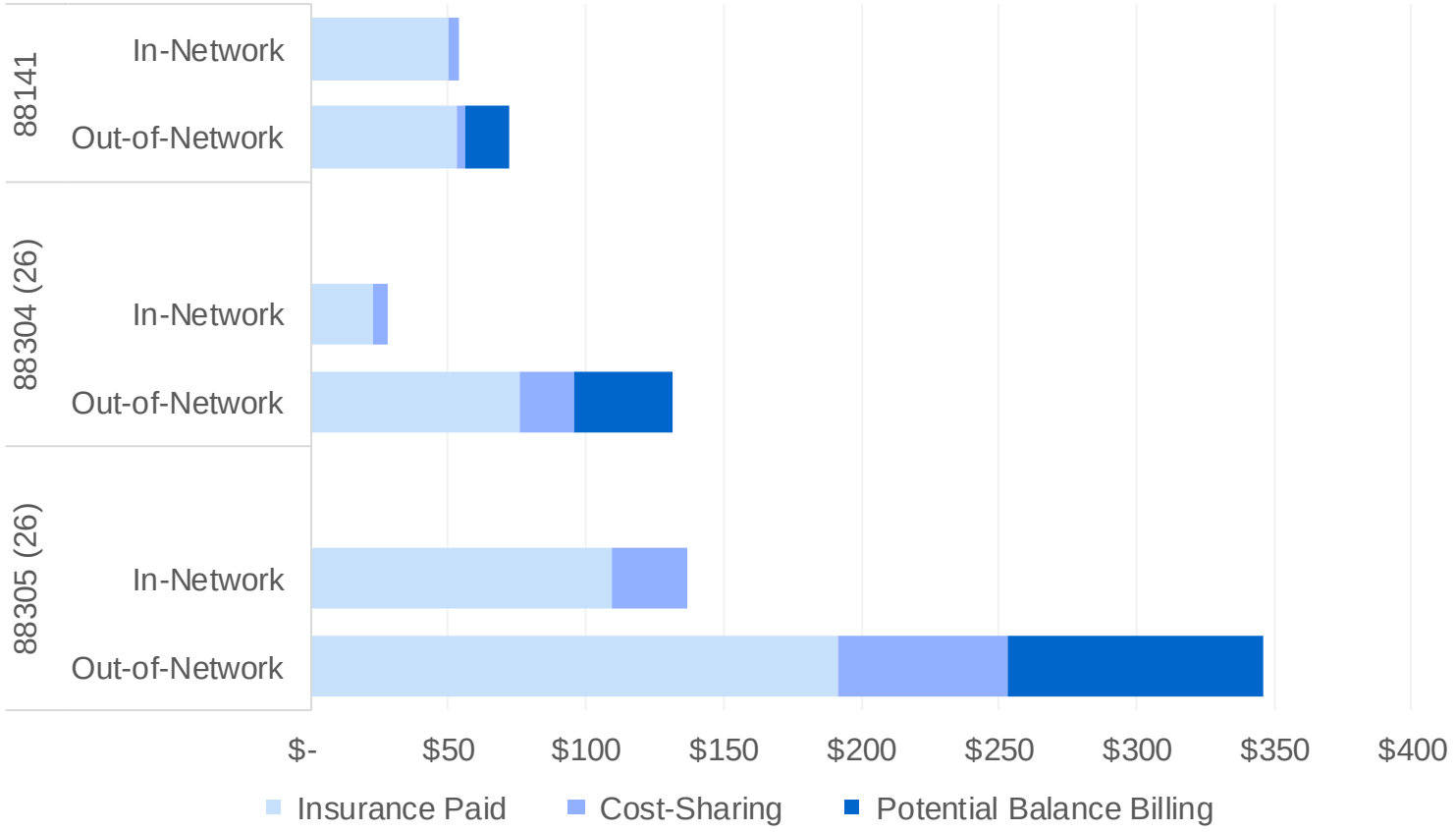


Notes: The following imaging procedures are included with the modifier "26" indicating interpretation only (not the technical component): CT of Head/Brain Without Contrast Material (70450), Radiologic Exam Chest Single View (71045), Radiologic Exam Chest 2 Views (71046), CT of Abdomen & Pelvis with Contrast Material (74177), Screening Mammography Bilateral 2-View Breast Including Computer Aided Detection (77067).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Spending Compared to Out-of-Network Spending and Charges for Top Out-of-Network Pathology Procedures, 2018

2018 APCD

Average payments for in-network and out-of-network pathology procedures, 2018

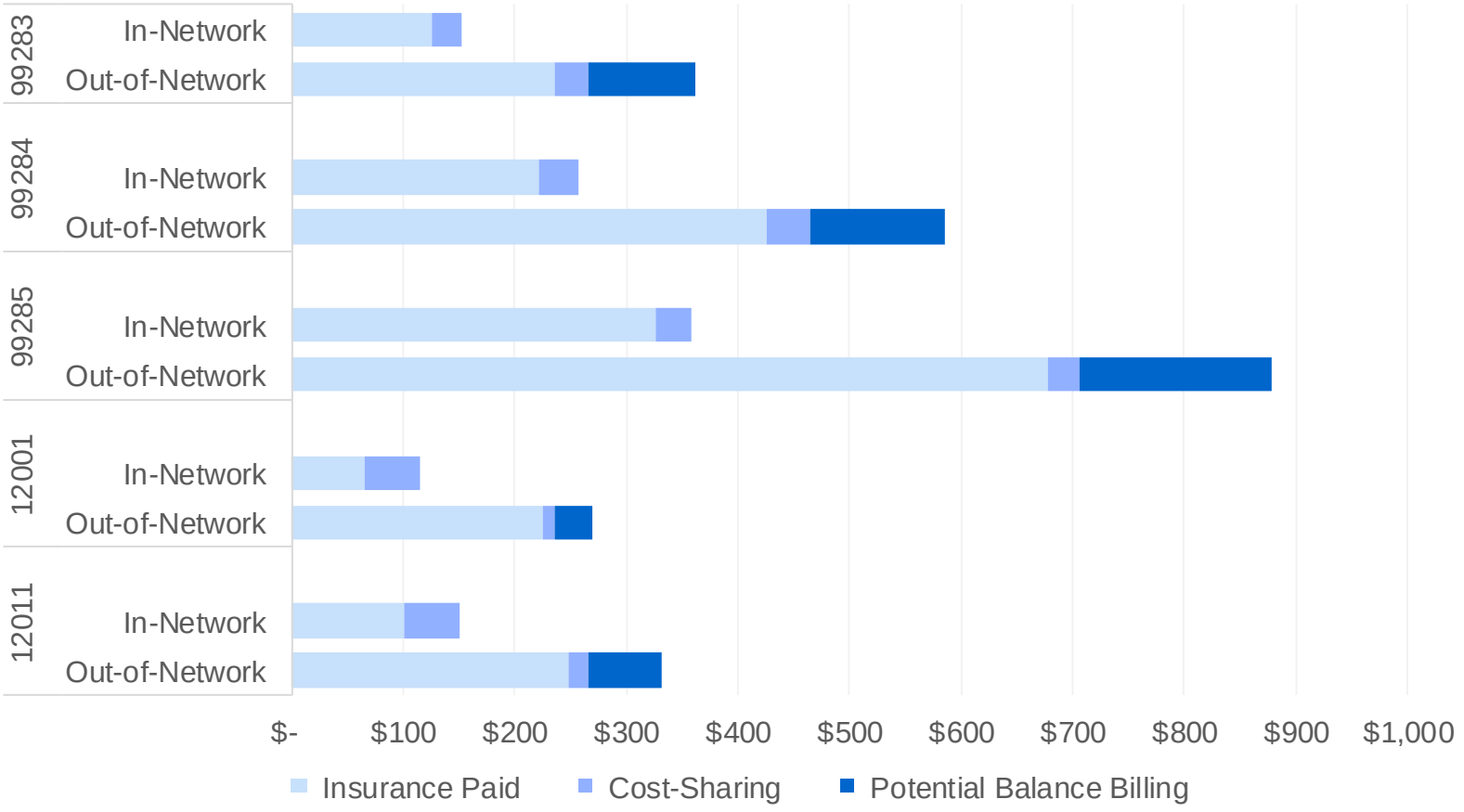


Notes: The following procedures are included: Cytopathology Cervical/Vaginal Requiring Interpretation by a Physician (88141); Level III Surgical Pathology Gross & Microscopic Exam (88304); Level IV Surgical Pathology Gross & Microscopic Exam (88305). 88304 and 88305 are restricted to claim lines with a modifier "26" indicating interpretation (not the technical component).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Spending Compared to Out-of-Network Spending and Charges for Top Out-of-Network Emergency Procedures, 2018

2018 APCD

Average payments for in-network and out-of-network emergency procedures, 2018

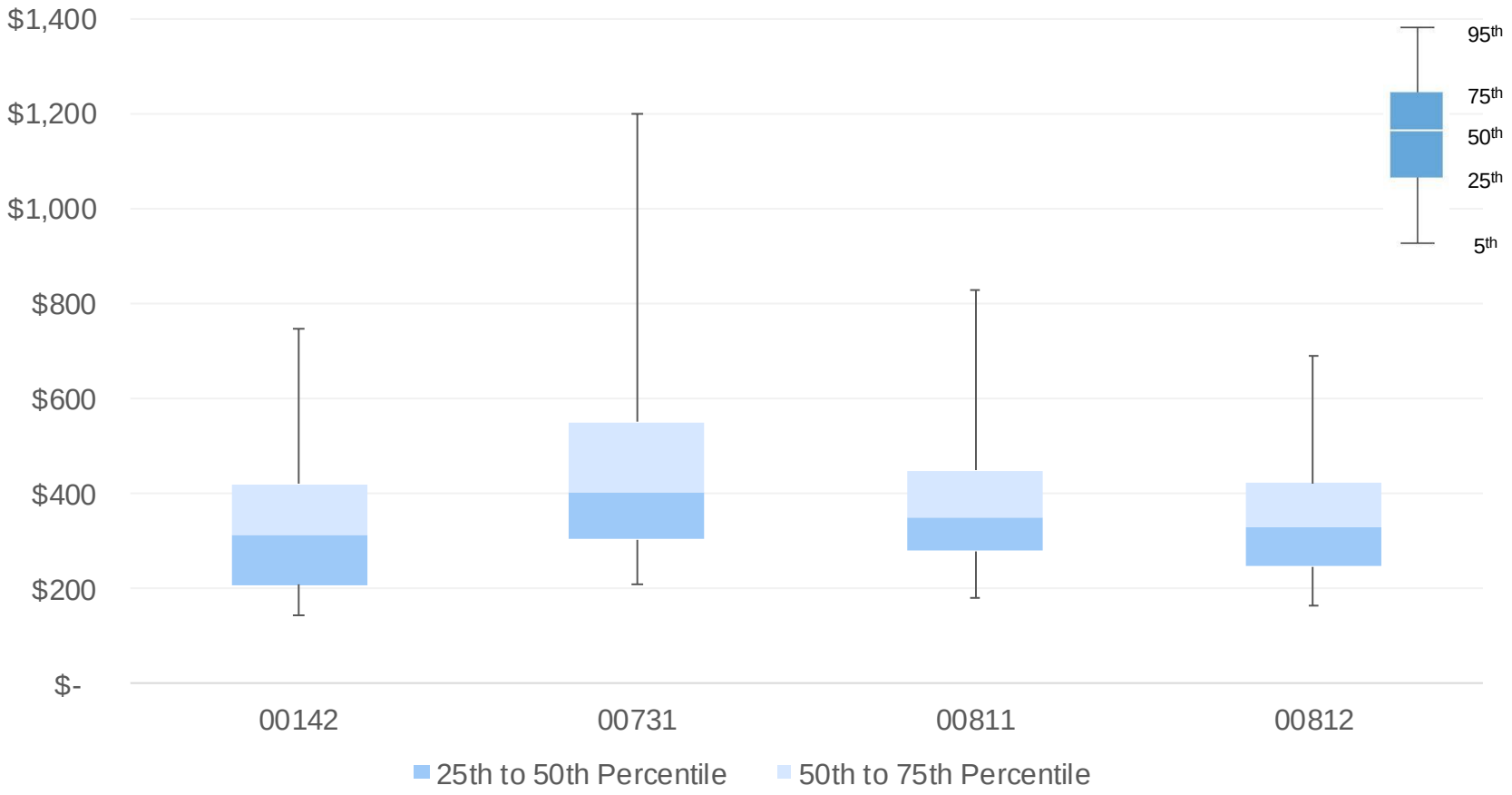


Notes: The following procedures are included: Simple Repair of Scalp/Neck/Axillae/Genital/Trunk/Extremities 2.5CM< (12001), Simple Repair of Face/Ears/Eyelids/Nose/Lips/Mucous Membranes 2.5CM< (12011); Emergency Department Visit Moderate to High Severity (99283-99285).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Payment Variation for Common Anesthesia Procedures

2018 APCD

5th Percentile to 95Th percentile payment amounts for in-network anesthesia procedures, 2018

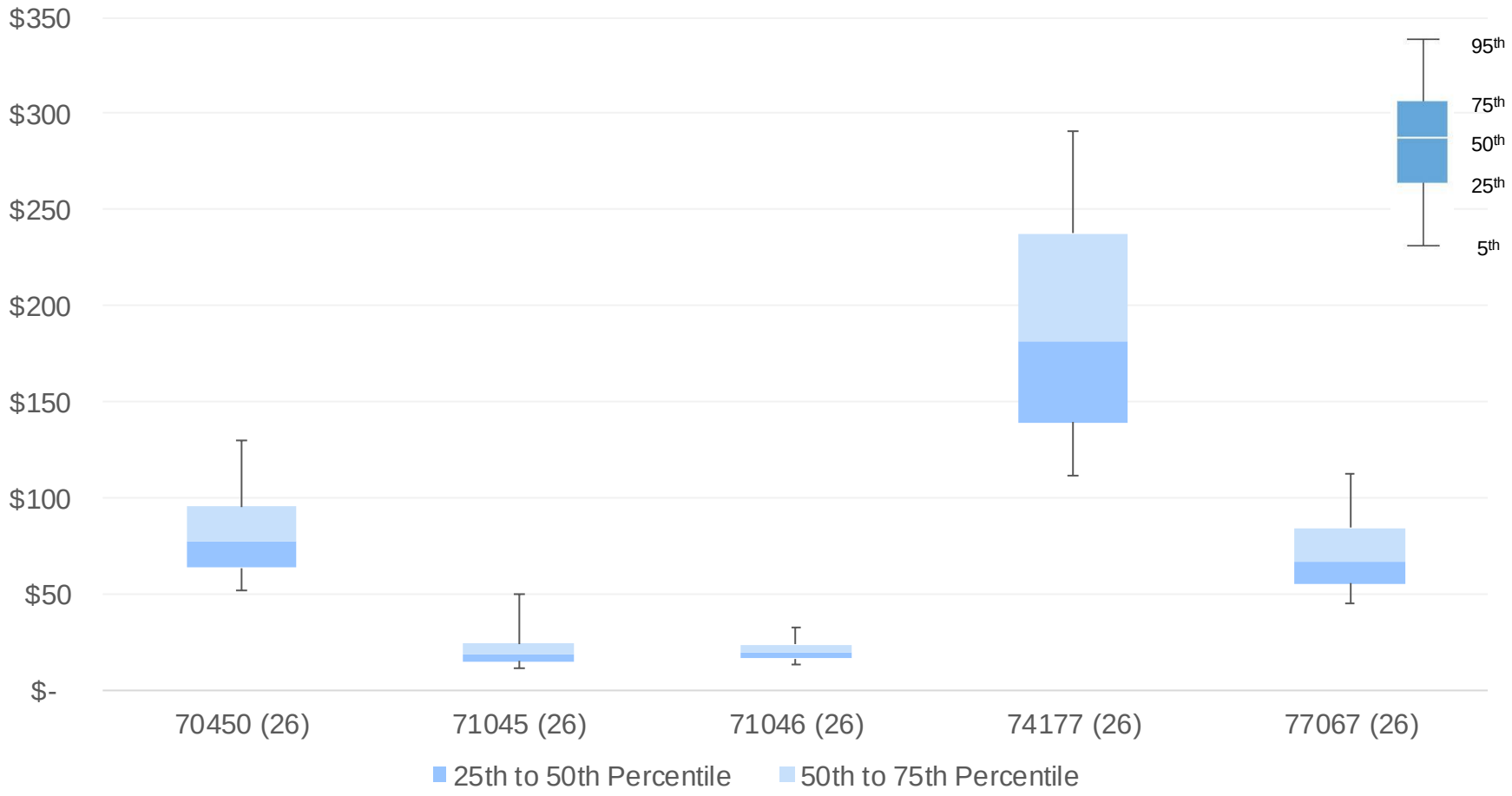


Notes: The following procedures are included: Anesthesia Eye Lens Surgery (00142), Anesthesia Upper GI Endoscopy (00731), Anesthesia Lower Intestine Endoscopic Procedures (00811), Anesthesia Lower Intestine Endoscopic for Screening Colonoscopy (00812)
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Payment Variation for Common Radiology Procedures

2018 APCD

5th Percentile to 95th percentile payment amounts for in-network radiology procedures, 2018

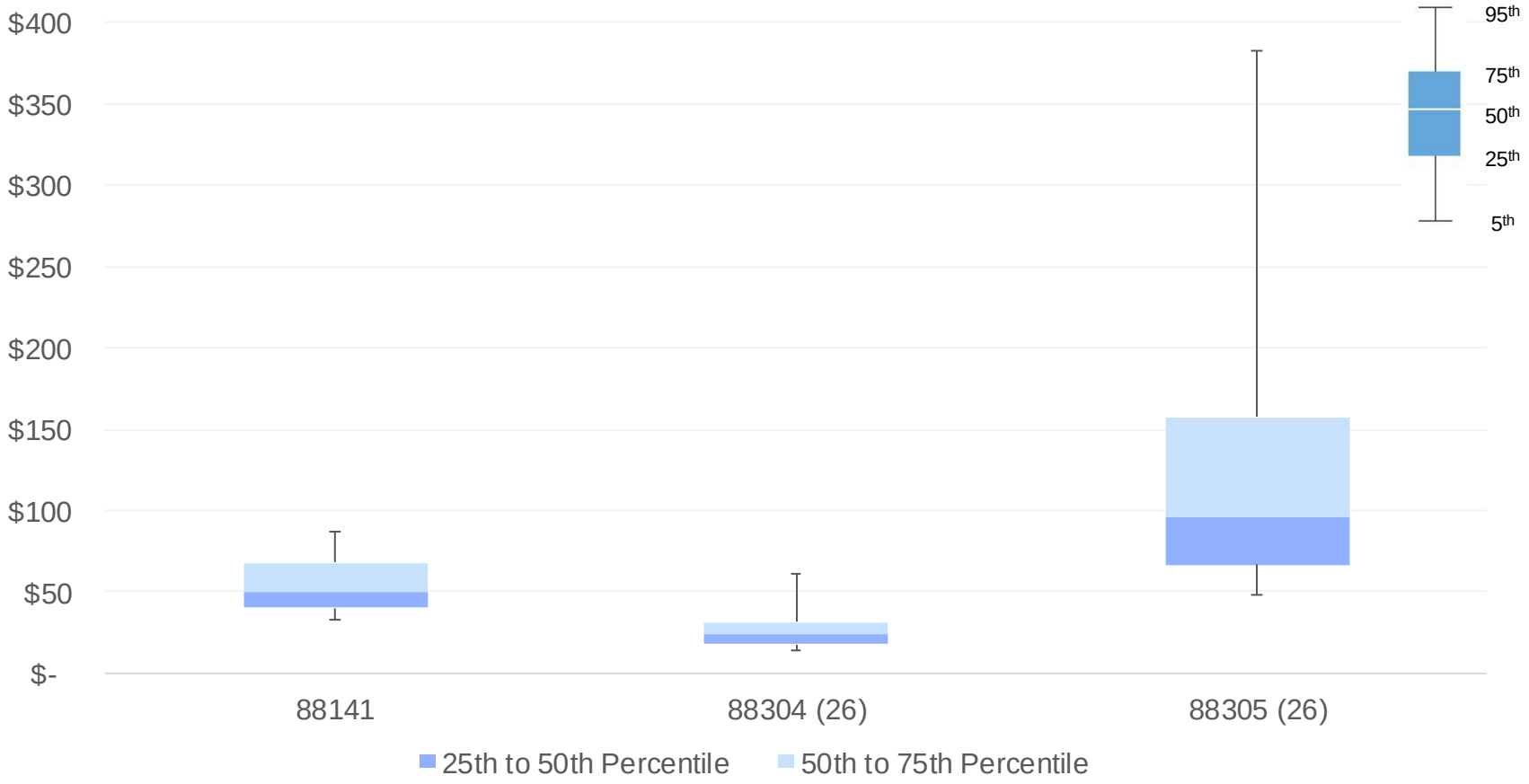


Notes: The following imaging procedures are included with the modifier "26" indicating interpretation only (not the technical component): CT of Head/Brain Without Contrast Material (70450), Radiologic Exam Chest Single View (71045), Radiologic Exam Chest 2 Views (71046), CT of Abdomen & Pelvis with Contrast Material (74177), Screening Mammography Bilateral 2-View Breast Including Computer Aided Detection (77067).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Payment Variation for Common Pathology Procedures

2018 APCD

5th Percentile to 95th percentile payment amounts for in-network pathology procedures, 2018

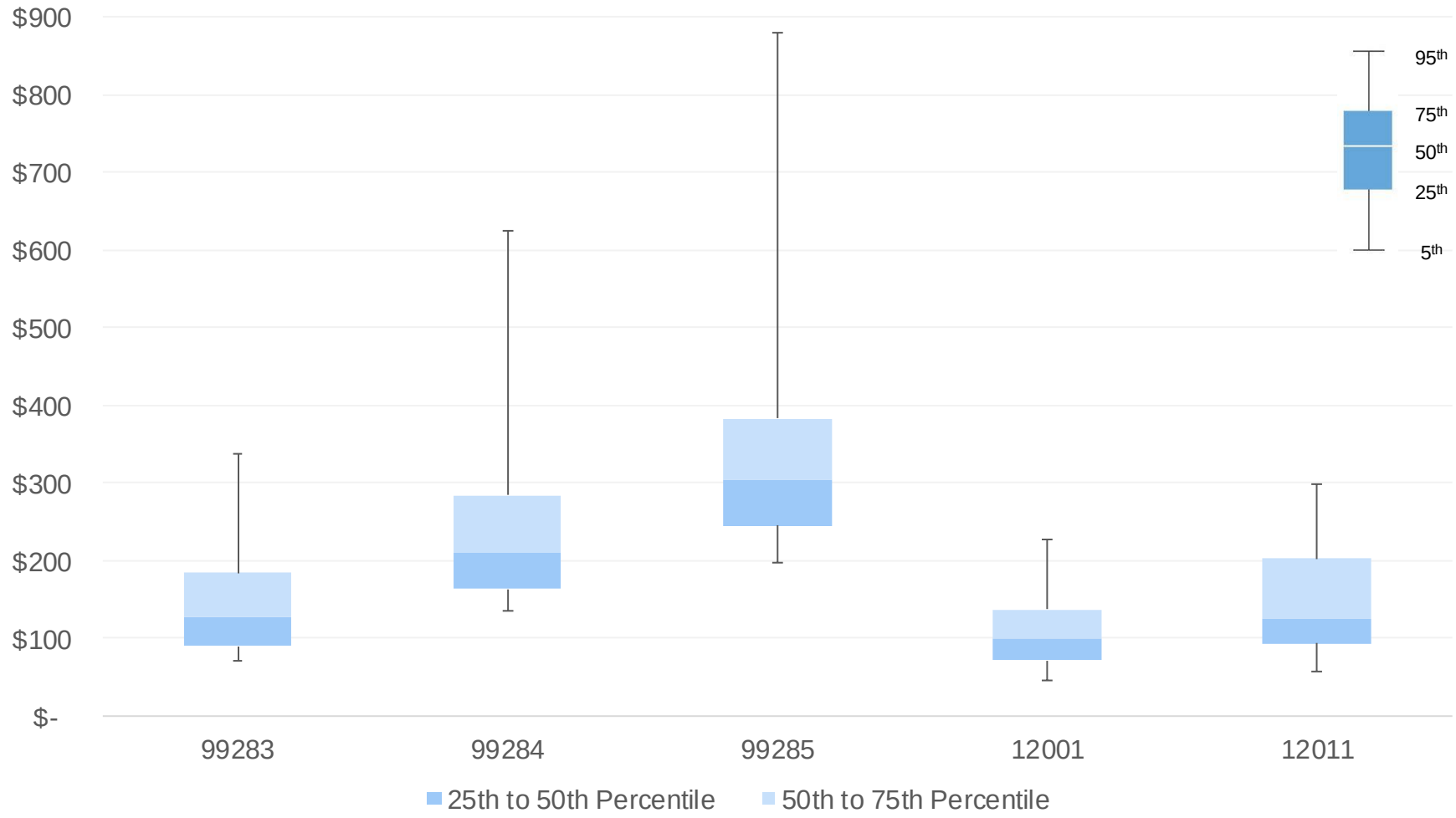


Notes: The following procedures are included: Cytopathology Cervical/Vaginal Requiring Interpretation by a Physician (88141); Level III Surgical Pathology Gross & Microscopic Exam (88304); Level IV Surgical Pathology Gross & Microscopic Exam (88305). 88304 and 88305 are restricted to claim lines with a modifier "26" indicating interpretation (not the technical component).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

In-Network Payment Variation for Common Emergency Procedures

2018 APCD

5th Percentile to 95th percentile payment amounts for in-network emergency procedures, 2018



Notes: : The following procedures are included: Simple Repair of Scalp/Neck/Axillae/Genital/Trunk/Extremities 2.5CM< (12001), Simple Repair of Face/Ears/Eyelids/Nose/Lips/Mucous Membranes 2.5CM< (12011); Emergency Department Visit Moderate to High Severity (99283 -99285).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v8.0 for 2018

Recent Data on Potential Payment Benchmarks

The HPC obtained recent Massachusetts claims data on potential provider payment benchmarks. The data suggest in-network payments are generally above and growing relative to a benchmark based on 135% of Medicare.

A payment benchmark establishes the default reimbursement rate that governs payment to out-of-network providers for services rendered in identified circumstances. Payment benchmarks are commonly based on known payment amounts, such as in-network (i.e., negotiated) rates, Medicare rates, and/or charges.

To further investigate Massachusetts payment trends and the implications of potential benchmarks, the HPC obtained updated Massachusetts benchmark data from FAIR Health, Inc.[1] Each benchmark is based on claims data from a 12-month period during 2019-2020, the most recent benchmark data available at the time of the study. The following slides present data on benchmark charges, imputed allowed amounts, and Medicare rates for common ERAP procedures, showing benchmarks used or contemplated in legislative solutions around the U.S. See the Appendix for details on source and methodology.

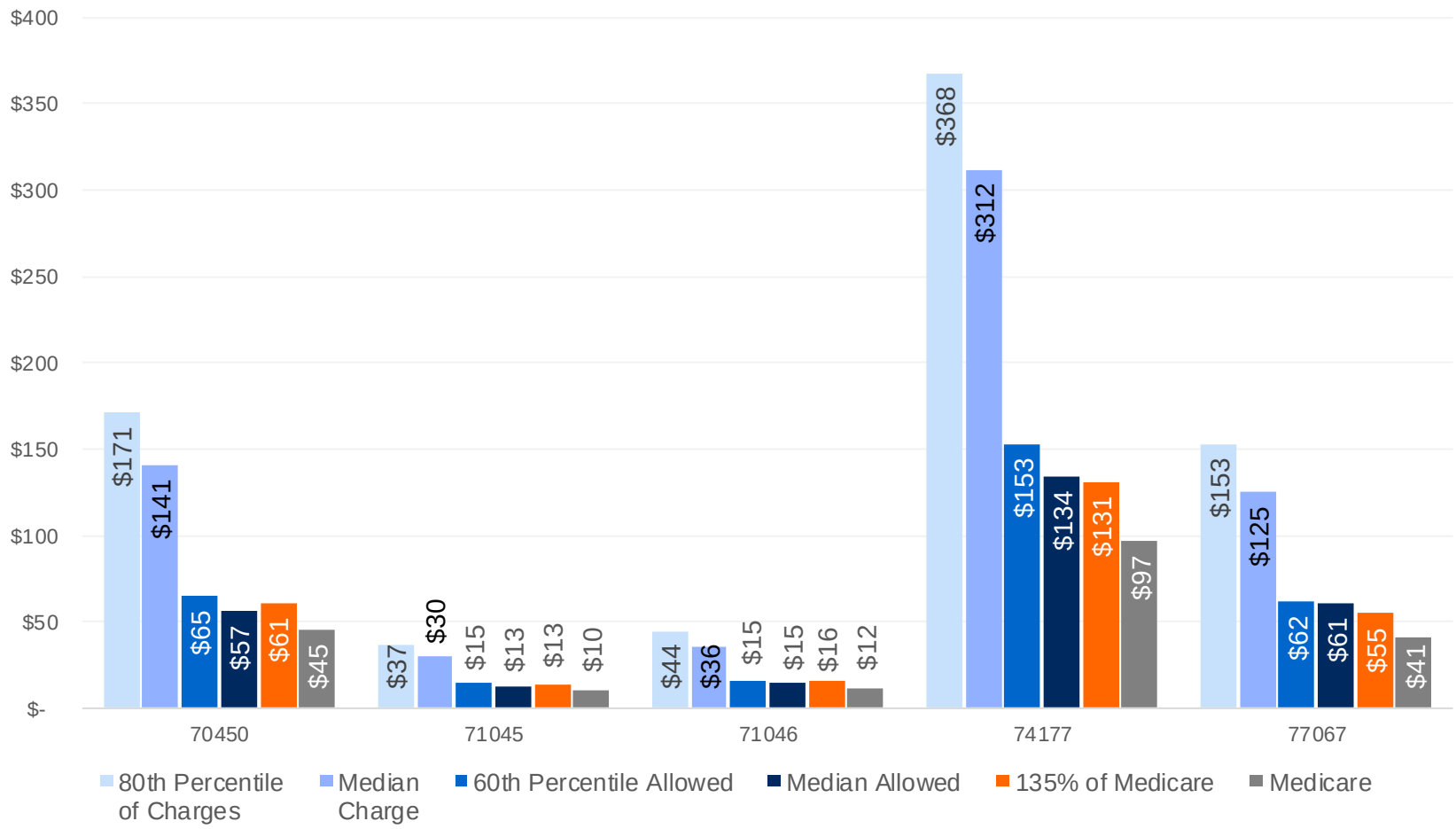
Summary of key takeaways:

- Overall, the 2019-2020 data are consistent with the earlier data (2018-2019) published by the HPC that showed wide variation in potential provider payment benchmarks.
- For the updated data (2019-2020): (1) the 80th percentile of charges range from 149% to 523% more than the median imputed allowed amount; and (2) median imputed allowed amounts compared to 135% of Medicare rate for the metro Boston area varied, ranging from -25% to 128%
- Compared to the earlier timeframe (2018-2019), median (imputed) allowed amounts grew slightly relative to Medicare rates

[1] FAIR Health, Inc. is a national, independent, non-profit organization whose mission is to increase transparency around health care costs and health insurance information. FAIR Health has been designated as the official benchmarking database in some states with out-of-network billing laws (e.g., New York, Connecticut).

Varying Payment Benchmarks for Radiology Procedures, 2019-2020

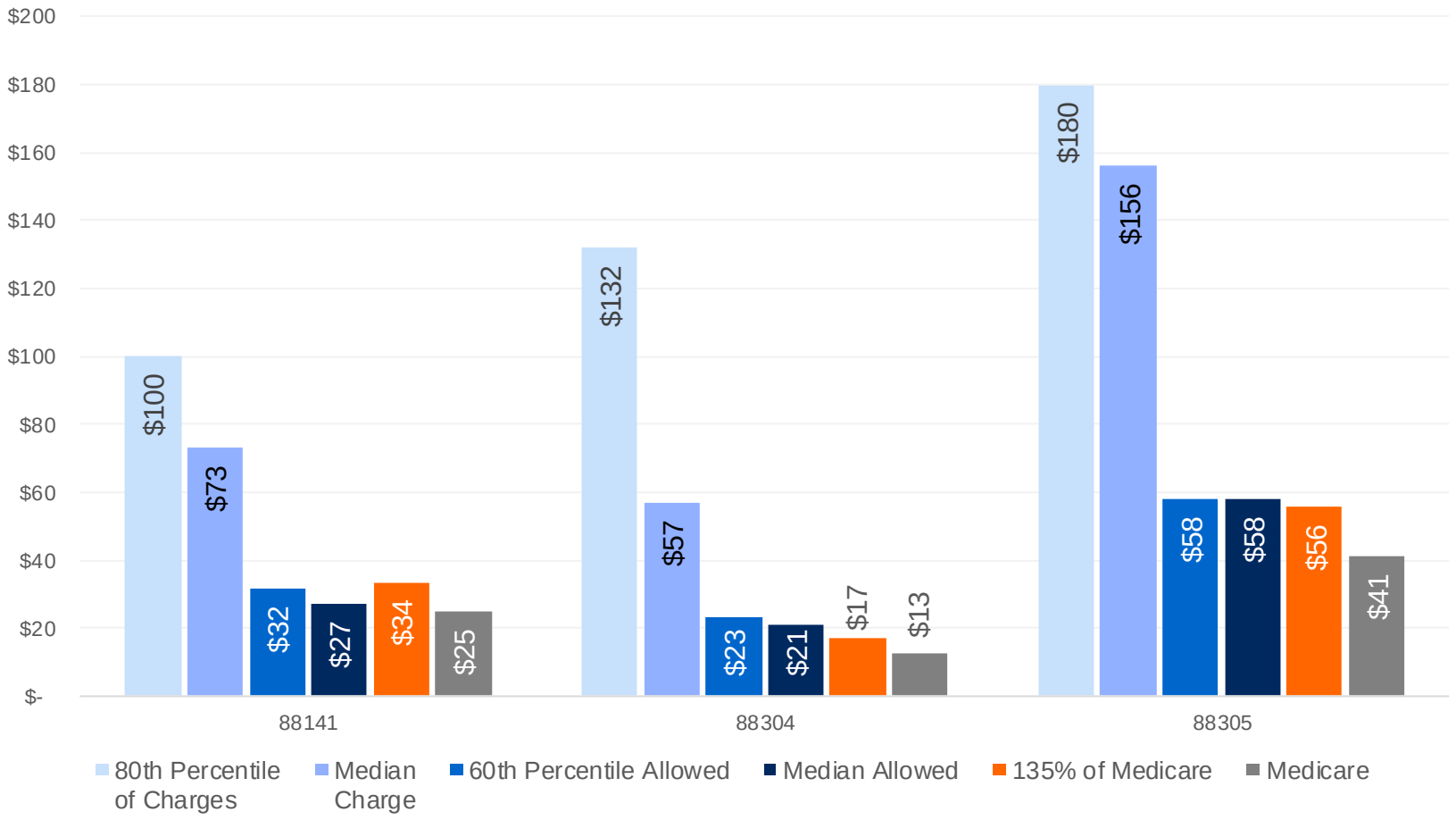
FAIR Health, Inc.



Notes: The following imaging procedures are included with the modifier "26" indicating interpretation only (not the technical component): CT of Head/Brain Without Contrast Material (70450), Radiologic Exam Chest Single View (71045), Radiologic Exam Chest 2 Views (71046), CT of Abdomen & Pelvis with Contrast Material (74177), Screening Mammography Bilateral 2-View Breast Including Computer Aided Detection (77067). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Varying Payment Benchmarks for Pathology Procedures, 2019-2020

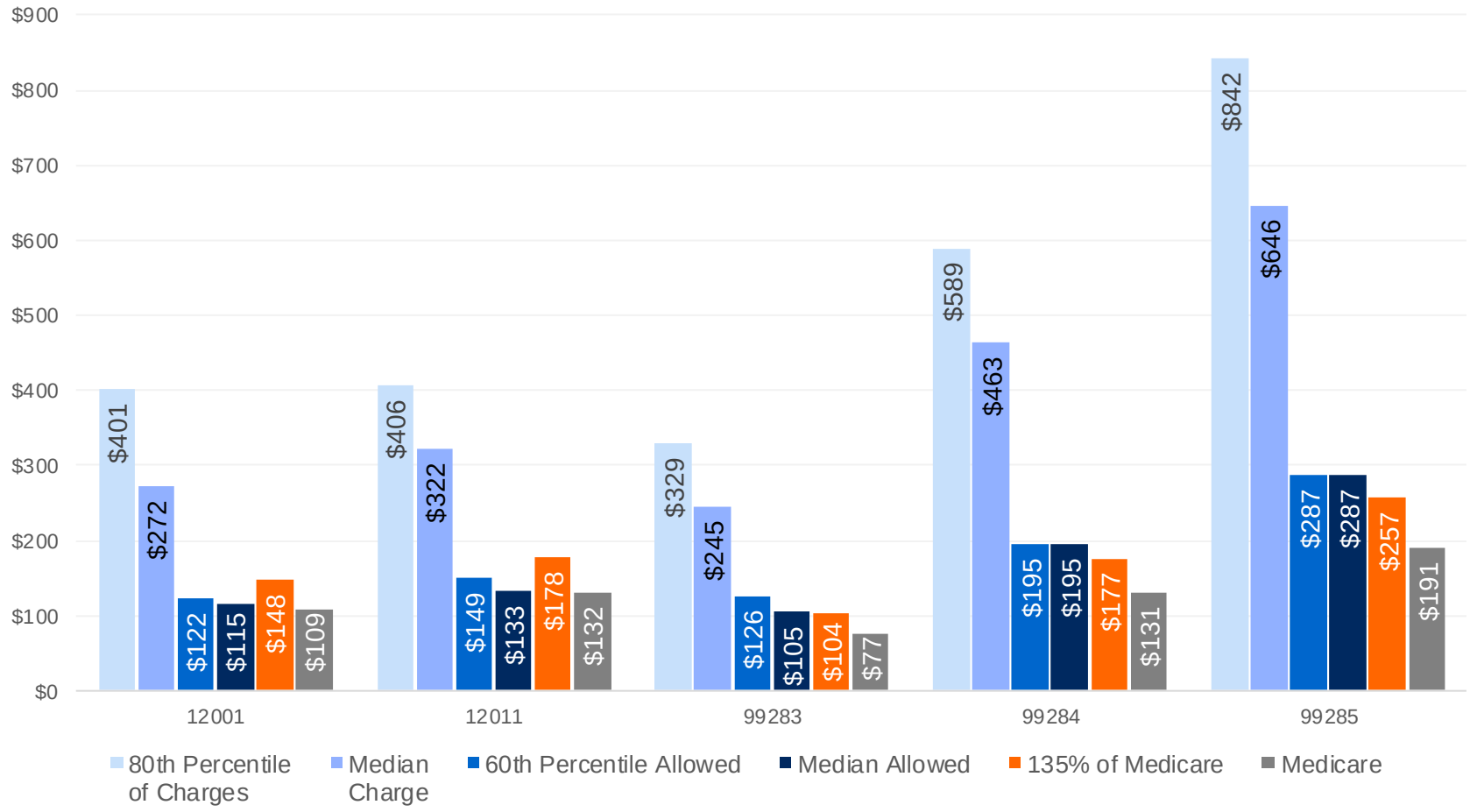
FAIR Health, Inc.



Notes: The following procedures are included: Cytopathology Cervical/Vaginal Requiring Interpretation by a Physician (88141); Level III Surgical Pathology Gross & Microscopic Exam (88304); Level IV Surgical Pathology Gross & Microscopic Exam (88305). 88304 and 88305 are restricted to claim lines with a modifier "26" indicating interpretation (not the technical component). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Varying Payment Benchmarks for Emergency Procedures, 2019-2020

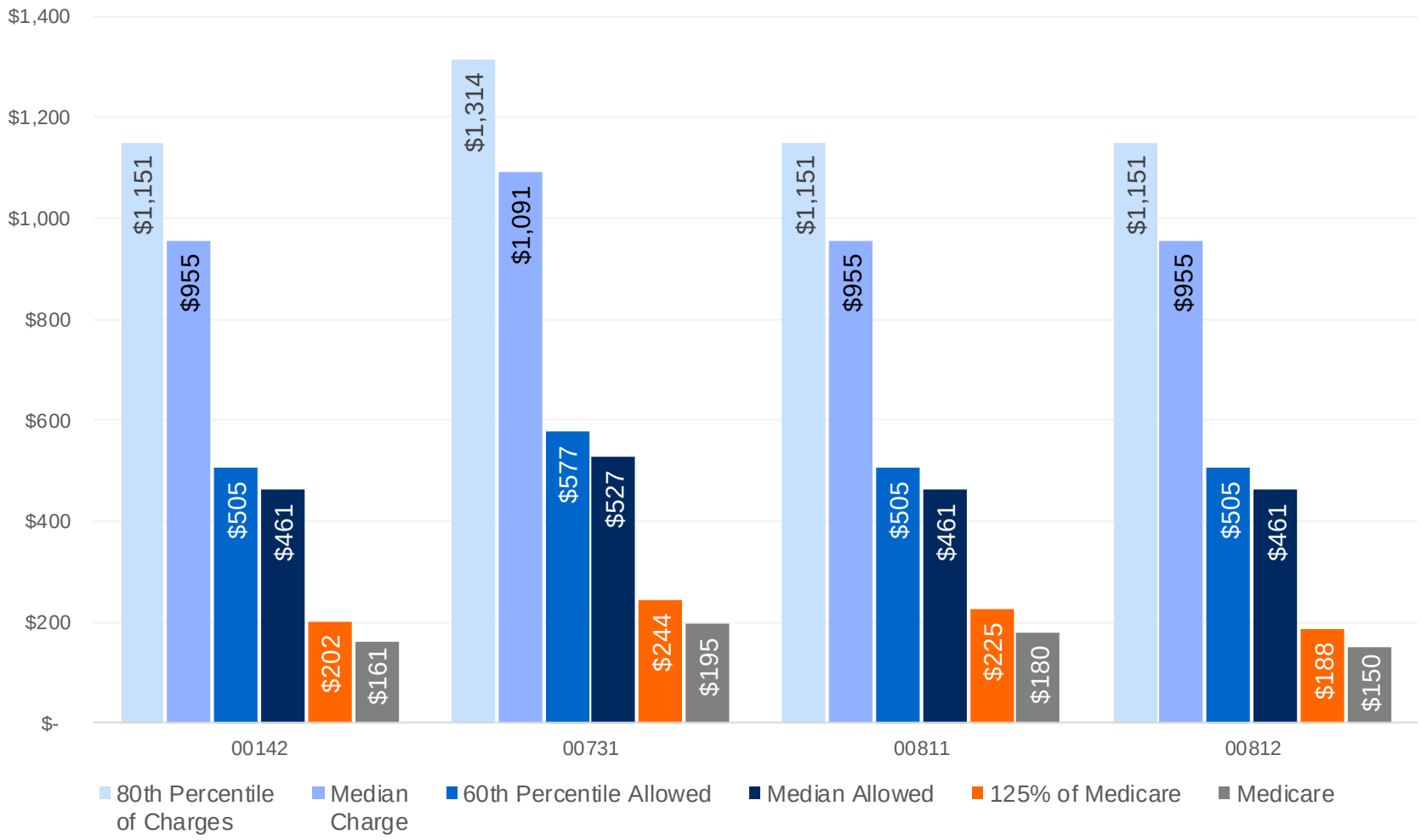
FAIR Health, Inc.



Notes: The following procedures are included: Simple Repair of Scalp/Neck/Axillae/Genital/Trunk/Extremities 2.5CM< (12001), Simple Repair of Face/Ears/Eyelids/Nose/Lips/Mucous Membranes 2.5CM< (12011); Emergency Department Visit Moderate to High Severity (99283-99285). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Varying Payment Benchmarks for Anesthesia Procedures, 2019-2020

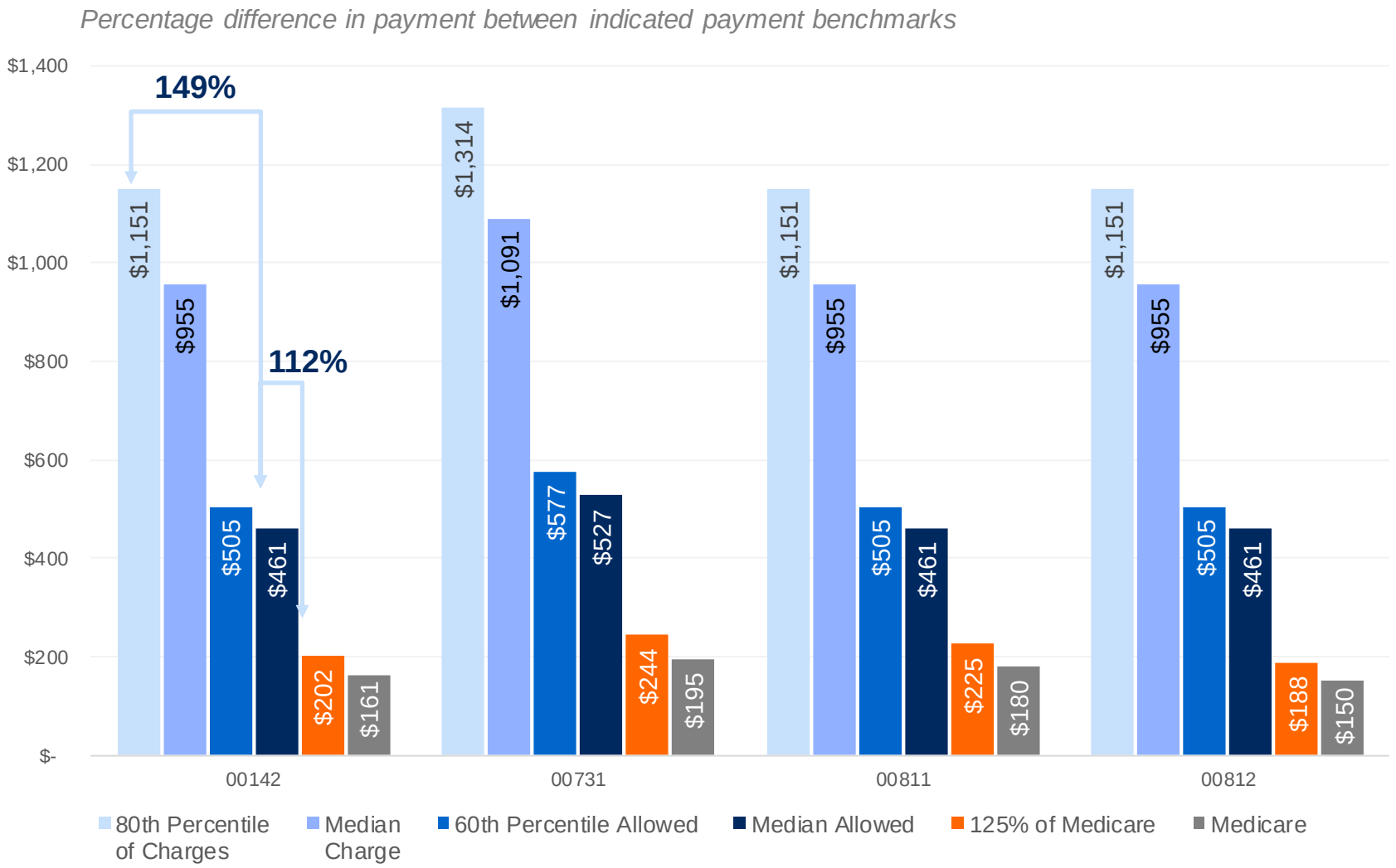
FAIR Health, Inc.



Notes: The following procedures are included: Anesthesia Eye Lens Surgery (00142), Anesthesia Upper GI Endoscopy (00731), Anesthesia Lower Intestine Endoscopic Procedures (00811), Anesthesia Lower Intestine Endoscopic for Screening Colonoscopy (00812). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Key Payment Benchmark Differentials

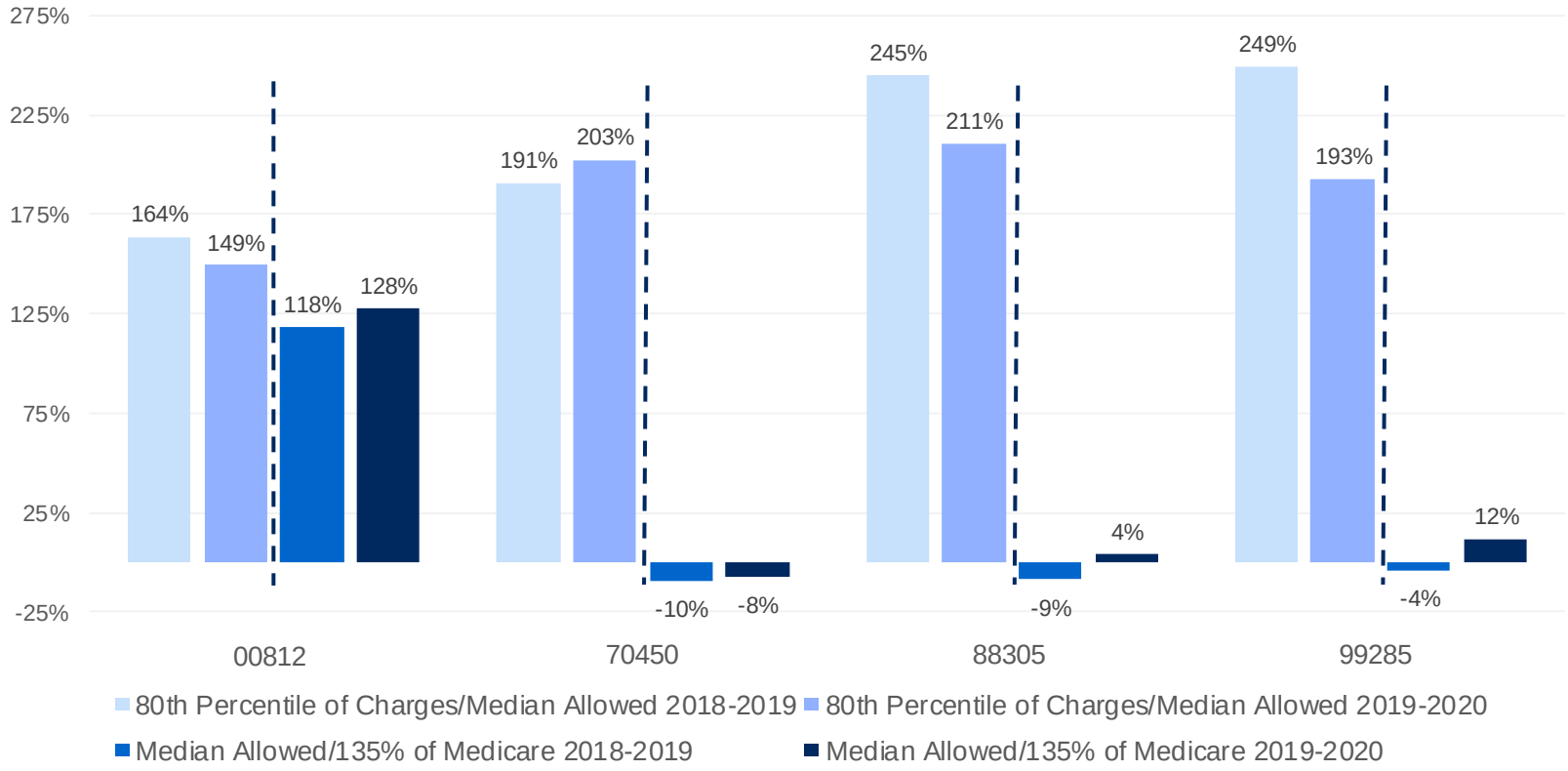
FAIR Health, Inc.



Notes: The following procedures are included: Anesthesia Eye Lens Surgery (00142), Anesthesia Upper GI Endoscopy (00731), Anesthesia Lower Intestine Endoscopic Procedures (00811), Anesthesia Lower Intestine Endoscopic for Screening Colonoscopy (00812). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Changes in Payment Differentials Over Time

FAIR Health, Inc.



For the four procedures analyzed (one from each ERAP specialty), the median allowed amount grew faster than 135% of Medicare. Growth in charges versus growth in median amounts did not have a consistent pattern.

Notes: The following procedure codes are shown: Anesthesia Lower Intestine Endoscopic for Screening Colonoscopy (00812); CT of Head/Brain Without Contrast Material (70450); Level IV Surgical Pathology Gross & Microscopic Exam (88305); Emergency Department Visit High Severity (99285). 70450 and 88305 are restricted to claim lines with a modifier "26" indicating interpretation (not the technical component). Medicare fee rate is the fee rate for metro-Boston.
Source: FAIR Health, Inc. 2018-2019 and 2019-2020 custom benchmark databases for HPC. See Appendix for complete information.

Analyses Pursuant to Section 71 of Chapter 260 of the Acts of 2020:

(2) Key Considerations and Advisability of Options for Establishing an Out-Of-Network Default Rate

Advisability of Establishing an IDRP to Determine Payment Rates

Given the forthcoming implementation of the No Surprises Act, it is not advisable to establish an IDRP in Massachusetts for determining out-of-network payment rates.

Compared to a payment benchmark, there is greater uncertainty associated with payment determination in a dispute resolution process. Such a process is more costly to administer and more time-consuming for parties, and the success of the process is contingent upon the details and guiderails (i.e., what the entity making the determination may or may not consider).

As previously noted, the federal *No Surprises Act* establishes a binding, "final offer" arbitration process that may be utilized for payment determination, following a period of negotiation by the parties. Given the implementation of the federal law in 2022, which will apply to (at least) the approximately 60% of the private commercial market in Massachusetts which is self-insured, ***it is not advisable to create a separate dispute resolution process for payment by fully-insured health plans*** (and self-insured plans, should there be an opportunity to opt-in under state law) that would operate in parallel to, but distinctly from, that established by federal law.

Not only would the Commonwealth have the burden of administering two processes (that could have different rules), but it would likely cause significant confusion for payers and providers.

Advisability of Establishing a State Payment Benchmark

There are multiple advantages of establishing a state payment benchmark, including predictability for the market and simplicity of administration.

Compared to a dispute resolution process to determine payment rates in individual circumstances, a state-established benchmark provides cost savings, simplicity, certainty and transparency for the market.

Cost Savings

If set appropriately, a payment benchmark, which limits the otherwise potentially very high out-of-network reimbursement rates, can result in overall cost savings to the health care system.

Simplicity

Administering an established payment benchmark is less costly and more straightforward to administer than establishing and managing a dispute resolution process.

Certainty

Compared to a dispute resolution process that results in a case-specific determination, a payment benchmark provides predictability and certainty for both payers and providers.

Transparency

Specifics of a payment benchmark calculation methodology can be drawn from the QPA calculation methodology in the federal law via a regulatory development process.

See generally, e.g., Hoadley & Lucia, Are Surprise Billing Payments Likely to Lead to Inflation in Health Spending?, The Commonwealth Fund (2021), https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending.

Considerations for Establishing a State Payment Benchmark

A state benchmark based on a median contracted rate balances the relevant interest of payers and providers, could be easily determined, and is consistent with the approach in the federal law.

Use of provider charges likely increases spending: Charges which providers are incentivized to increase, are typically much higher than negotiated rates, especially for ERAP providers. The 80th percentile of charges is significantly higher than the median (i.e., 50th percentile) allowed amount. Furthermore, research on New York and New Jersey laws found that the reliance on charges during the independent dispute resolution processes resulted in higher health care spending (slides 26-27).

Experts have raised the following points about setting the Payment Benchmark at an optimal level:[1,2]

- **If set *too high*:** An established benchmark set above current average contracted rates places upward pressure on negotiated rates, which will lead to higher health care spending. Above a certain level, such increases in negotiated rates can more than offset any reduction in payments to physicians currently billing out-of-network and undermine payer-provider contracting.
- **If set *using approximately contracted rates*:** Such a benchmark will reflect the likely inflated payments for emergency department and ancillary services but can also reduce health care spending, including by reduction of in-network rates. ERAP providers are currently paid more than they would earn absent the ability to routinely treat and bill patients out-of-network.
- **If set *too low*:** Such a benchmark could be potentially perceived as unfair, and a very low benchmark could theoretically cause temporary disruptions to provider supply.

See generally, e.g., https://www.commonwealthfund.org/blog/2021/are-surprise-billing-payments-likely-lead-inflation-health-spending ; [1] See, e.g., Duffy et al (RAND) 2020, https://www.rand.org/pubs/research_reports/RR4378.html; [2] https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf

Considerations for Establishing a State Payment Benchmark, Cont'd

Medicare vs. In-Network Rates:

- ***Medicare rates*** are straightforward, transparent, reasonable estimates of the cost of providing services. They are generally lower than negotiated commercial rates, but benchmarks can use a multiplier of Medicare. Medicare rates are not tied to market negotiations and can be affected by political and budgetary considerations.
- ***In-network rates*** are market-driven and can more accurately reflect relative costs of providing services. They represent actual payments to providers by a payer in a particular market and are readily ascertainable by payers based on contracting data or through analysis of claims databases, retrospectively. The recent Interim Final Rule to implement the *No Surprises Act* provides guidance on the methodology for calculating the QPA (defined as the median contracted rate). (See slides 19-20 for additional information.)
- Data show that median allowed amounts (i.e., in-network rates) are typically greater than Medicare rates.

Utilization of median or mean in-network rates:

- The ***mean*** (i.e., average) is generally higher than the median and is more sensitive to outliers. Due to high provider payment variation in MA, especially with more higher payment outliers than lower payment outliers, any benchmark based on a mean is likely to be higher and influenced by higher-priced providers.
- The ***median*** is generally a more robust metric, particularly if small numbers are involved (e.g., calculating a rate for a sub-specialty service). The median is also a key component of the federal *No Surprises Act,* as the QPA is defined as the median contracted rate.

Evaluation of the Calculation and Administration of Payment Rates & Advisability of Establishing a Process to Dispute Payment Rates

It is feasible for the Commonwealth to implement a payment benchmark for out-of-network provider reimbursement based on Massachusetts in-network rates, calculated by payers (consistent with federal law).

Pursuant to the interim final rule to implement the federal *No Surprises Act*, *Requirements Regarding Surprise Billing; Part I*, payers will be responsible for calculating the QPA, which is payer-specific. Accordingly, given the significant investment demanded of payers to undertake this effort, it is ***sensible to adhere to that approach, for reasons of administrative simplicity and certainty, for any Massachusetts-established payment benchmark***.

To further align with the federal calculation of QPA, and in order to incentivize payers to negotiate competitive rates and keep (or add) providers in-network, ***rates should be calculated on a payer-specific basis***, as opposed to calculating an all-payer rate (i.e., across all payers in the APCD). An all-payer rate would particularly harm the ability of payers who have negotiated affordable rates (such as Connector plans) to retain providers in network as an all-payer benchmark could be far higher than the in-network rates for these plans.

Payer-specific rates could be validated and enforced pursuant to an audit process, as in the federal law, or potentially by utilizing the APCD. These mechanisms could alleviate the need for a dispute resolution process to dispute the rates, although the legislature could consider a further process to verify rates.

Such method for determining out-of-network provider reimbursement should apply to both emergency and non-emergency health care services.

Analyses Pursuant to Section 71 of Chapter 260 of the Acts of 2020:

(3) Assessment of Impact of Potential Out-Of-Network Default Rates

Assessment of Impact of Potential Out-of-Network Payment Rates

Eliminating out-of-network billing would result in substantial reductions in commercial premiums, mainly by eliminating the leverage used by out-of-network providers to charge higher in-network rates.

Impact on total health care expenditures and insurance premiums / out-of-pocket costs:

- The Congressional Budget Office estimated that lower payments to some providers pursuant to the *No Surprises Act* would reduce premiums by 0.5-1% in most affected markets in most years[1], saving taxpayers $17 billion over ten years and saving consumers approximately twice that amount between reduced premiums and cost-sharing[2].
- Researchers have estimated that if ERAP physicians were paid at the same level orthopedic surgeons are paid for knee replacements (i.e., 164% of Medicare, on average), it would lower US health expenditures by $60 billion annually (i.e., lower private health spending by approximately 5%).[3] Others have found that reducing payment for ancillary and emergency services by 15% would reduce premiums by 1.6% ($12 billion across the national commercially insured), and reducing average payment to 150% of Medicare would reduce premiums by 5.1% ($38 billion nationally).[4]
- Researchers have also found that if ERAP physicians are not able to balance bill, health care spending for people with employer-sponsored insurance is estimated to fall by approximately $40 billion annually (3.4%).[5]

[1] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf; [2] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/; [3] https://onepercentsteps.com/wp-content/uploads/brief-oon-210208-1700.pdf; [4]https://www.ajmc.com/view/policies-to-address-surprise-billing-can-affect-health-insurance-premiums; [5]Cooper, Zack, et al. "Out-Of-Network Billing And Negotiated Payments For Hospital-Based Physicians:" Health Affairs 39.1 (2020): 24-32.

Assessment of Impact of Potential Out-of-Network Payment Rates, Cont'd

An out-of-network payment benchmark should incentivize providers to remain (or become) in-network providers. A state-established payment benchmark may attract self-insured health plans to take advantage of an opportunity to opt-in.

Provider price variation: The 2017 Special Commission on Provider Price Variation members reached consensus that establishing a default out-of-network payment rate is a critical part of a recommendation on provider price variation and urged the state to consider certain principles (e.g., the impact should result in cost savings to consumers and employers and have minimal additional administrative expense for providers and payers).[1] The report notes that establishing the rate is important for facilitating novel insurance product designs that can help address provider price variation, and the Commission stressed the importance of setting a rate at an appropriate level such that it will not entice providers to leave a network or make a health plan indifferent as to whether the provider is in- or out-of-network.

Utilization of payment rate by self-insured health plans: While the *No Surprises Act* applies to both fully- and self-insured health plans, the ability for self-insured plans to opt-in to the protections of applicable state out-of-network billing laws (which govern fully-insured health plans) remains relevant, as made clear by the interim final rule (Part I) published in July 2021. An appropriate benchmark rate may encourage self-insured plans to opt-in. Data show that a considerable number of self-insured health plans have opted in to state laws that provide for that opportunity: e.g., New Jersey (137)[2], Washington (230)[3], and Virginia (351)[4].

Provider financial stability and delivery of care to underserved communities: EOHHS did not review or identify evidence that setting an appropriate benchmark rate would negatively impact the financial stability of providers and health systems or the delivery of care by providers predominantly serving communities that experience health disparities as a result of race, ethnicity, or socioeconomic status. To the contrary, an appropriate benchmark could incentivize network participation, enhance patient access, and improve affordability.

[1] https://www.mass.gov/doc/special-commission-on-provider-price-variation-report/download;
[2].https://www.state.nj.us/dobi/division_insurance/oonarbitration/data/210131report.html; [3] https://www.insurance.wa.gov/self-funded-group-health-plans; [4] https://scc.virginia.gov/balancebilling

Public Listening Sessions and Stakeholder Comments

Summary of Stakeholder Feedback

Stakeholder perspectives on noncontracted, out-of-network commercial rates varied. In general, health plan representatives favor establishing a payment benchmark and provider representatives support the approach in the federal law (i.e., no benchmark).

EOHHS held two virtual public listening sessions in June 2021 for stakeholders and the public to provide testimony. A total of 15 written comments were submitted for the record.

Key takeaways from stakeholder feedback with respect to potential out-of-network payment rates are summarized here and on the following slide.

- **Health Plans:** Representatives from Blue Cross Blue Shield MA and the Massachusetts Association of Health Plans ("MAHP") **strongly recommend establishing a payment benchmark** (i.e., a default reimbursement rate), and specifically setting it at (or no higher than, as asserted by MAHP) 135% of Medicare, consistent with the rate established by the Baker-Polito Administration during the COVID-19 state of emergency.
- **Providers:** Representatives from the Massachusetts Health & Hospital Association, several groups representing ERAP providers, and some individual providers **strongly oppose establishing a payment benchmark**, advocating that the federal *No Surprises Act* should go into effect for all commercial health plans in Massachusetts (i.e., Massachusetts should not enact a payment benchmark for fully-insured health plans).

Summary of Stakeholder Feedback, Continued

Additional information on feedback received is summarized in the chart below.

Recommendation on Rates		Organization or Individual
Establish a Payment Benchmark	135% of Medicare	**Blue Cross Blue Shield MA**; **MA Association of Health Plans**
	Other Benchmark	**Atrius Health** (between Medicare and in-network rate); **Boston Children's Hospital** (benchmark using in-network rates, not Medicare, and follow federal law where provider is not contracted with the payer at all)
Do Not Establish a Payment Benchmark	Allow the federal *No Surprises Act* and IDR process to take effect in MA for all insurance plans	**Dr. Gary Chinman, Bretta Karp** (Berkshire Health System), **MA College of Emergency Physicians**, **MA Health & Hospital Association, MA Medical Society, MA Orthopaedic Association, MA Society of Anesthesiologists, MA Society of Pathologists, Amy Pfeffer** (Sturdy Memorial Hospital), **Physician Performance, LLC, Ruthann Rizzi, MD, Dr. Donald Smith** (raising concerns about a default rate for all out-of-network services)
Other	--	**Health Care for All / Health Law Advocates / MASSPIRG** (expressed some concerns regarding the federal arbitration process with respect to cost and transparency; support ensuring that a default rate (or process) results in cost savings to the system that lowers premiums)

Recommendations for Establishing an Out-Of-Network Default Rate

Recommendations

Based on the key findings throughout the report, EOHHS, in consultation with CHIA, DOI, and HPC, recommends that the Massachusetts legislature establish a default noncontracted, out-of-network commercial payment rate for emergency and non-emergency health care services, to be evaluated after a reasonable period.

Establishing a default reimbursement rate for unintentional out-of-network care will immediately address the longstanding, well-documented concerns of out-of-network billing costs in Massachusetts that impact patients and affect market dynamics. Capping maximum out-of-network reimbursement amounts, among the backdrop of the *No Surprises Act*, will buttress existing state laws on out-of-network billing, result in overall savings for the Commonwealth's health care system, and provide cost relief to patients and health insurance purchasers at large.

- The **median in-network rate** (as may be further defined in a regulatory process) is a reasonable approach that balances the important interests of payers and providers and is administratively feasible for the Commonwealth and relevant parties to implement. The choice of a median in-network rate, as calculated by payers, is consistent with the federal law's reliance on the QPA, which will become a nationwide standard beginning in 2022.
- The **Commonwealth should evaluate the impact of the rate**, including on overall costs, health care quality, patient access, and network breadth. The evaluation of the rate should also assess the impact of the federal law to the extent data is available (e.g., arbitration cases, awards, administrative costs).
- The legislature could also consider: (1) an opportunity for self-insured plans to opt in; (2) sunset of the rate, pending evaluation; and (3) clarifying and reinforcing state balance billing prohibitions.

Appendix

Statutory Crosswalk

Statutory Language	Key Slides
(i) an examination of the rates paid over the previous 3 years for public and private in-network and out-of-network health care services and the impact of the out-of-network payment rates on the efficiency, accessibility and cost of the health care delivery system in the commonwealth	32-48
(ii) the advisability of establishing a noncontracted, out-of-network commercial payment rate for emergency health care services and a noncontracted, out-of-network commercial payment rate for non-emergency health care services that represents the median or mean of commercial contracted rates, a percentage of the median or mean of commercial contracted rates or a percentage of Medicare rates	42-48, 51-54
(iii) an assessment of potential noncontracted, out-of-network commercial payment rates for emergency health care services and potential noncontracted, out-of-network commercial payment rates for non-emergency health care services and the impact of such rates on:	--
(A) patient access to health care services by geographic location	26-28, 57
(B) encouraging in-network participation by health care providers and incentivizing carriers to contract with health care providers	26-28, 57
(C) the financial stability of health care providers and systems, including, but not limited to, community hospitals	57
(D) the growth of total health care expenditures	56

Statutory Crosswalk, Continued

Statutory Language	Key Slides
(E) the delivery of care by health care providers predominately serving communities that experience health disparities as a result of race, ethnicity, or socioeconomic status	57
(F) insurance premiums and out-of-pocket costs	56
(G) provider price variation	38-41, 57
(H) the likelihood of utilization of the rate by self-insured health plans	57
(iv) an evaluation of the ease of transparency in calculating certain noncontracted, out-of-network commercial payment rates and the ease of administration by health care providers and carriers	51-54
(v) an analysis of the advisability of establishing a process for health care providers or carriers to dispute the accuracy or appropriateness of a noncontracted, out-of-network commercial payment rate	50, 54
(vi) best practices in other states	23-28; and Appendix

Data Methodology and Source Information: HPC Analyses

APCD

Center for Health Information and Analysis All-Payer Claims Database v8.0, 2018

- Claims from **three large Massachusetts commercial payers** that had an out-of-network indicator well-populated for the majority of their claims,
- Out-of-network claims were identified using the 'in-network' designation submitted by payers
- In-state, **professional claims** only (i.e., excluding facility claims, which were rarely out-of-network for the payers included in this analysis)
- Out-of-network claims were only included if they were considered "ERAP" claims. ERAP claims were identified either by site of service (i.e., any professional claim in an emergency department) or the service provider taxonomy code indicated that the professional services was provided by a radiologist, anesthesiologist or pathologist.

FAIR Health, Inc.

FAIR HEALTH 2019-2020 & 2018-2019 custom benchmark databases for HPC

- All FAIR Health, Inc. benchmark data are from FAIR Health, Inc. Medical, Allowed Medical, Anesthesia, and Allowed Anesthesia Benchmarks databases. These allowed amounts represent the estimated dollar amount for professional services only and do not reflect any facility fees. The charge benchmarks are based on actual non-discounted provider charges observed in the FAIR Health, Inc. claims data. In order to protect the proprietary nature of in-network rates, the allowed amounts are derived using an imputation methodology which starts with actual allowed amounts, then determines a region-wide average ratio of allowed amounts to charges (for the North East region), and applies that ratio to actual provider charges in Massachusetts. This produces benchmark values with a high correlation to the range of actual allowed amounts across commercial payers in Massachusetts, according to FAIR Health, Inc. All FAIR Health, Inc. benchmark data in this report is presented at the statewide level, or in the case of Medicare rates, Metro Boston.
- *Research presented in this report that incorporates FAIR Health, Inc. data is based upon healthcare claims data compiled and maintained by FAIR Health, Inc. The Massachusetts Health Policy Commission is solely responsible for the research and conclusions utilizing FAIR Health, Inc. data reflected in this report. FAIR Health, Inc. is not responsible for the conduct of the research or for any of the opinions expressed in this report. Data © 2019-2021, FAIR Health, Inc. Used by permission.*

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Additional Examples of State Approaches

Example & *Approach*	Summary of Provider Payment Determination	Notes
Connecticut ***(2016)*** ***Benchmark***	▪ Emergency services: greatest of three: (1) in-network rate; (2) usual and customary rate (UCR); or (3) Medicare rate. Can negotiate a greater amount. ▪ Non-emergency services: in-network rate, unless otherwise agreed	▪ UCR = 80th percentile of charges (in FAIR Health) ▪ Payment for emergency services modified by a COVID-19 Exec. Order
New Mexico ***(2020)*** ***Benchmark***	▪ 60th percentile of allowed amounts as reported in a 2017 benchmarking database ▪ Payment floor of 150% of Medicare	▪ FAIR Health selected as the benchmarking database
Texas ***(2020)*** ***IDRP***	▪ UCR or agreed upon rate ▪ Binding, final offer arbitration for OON *providers* ▪ Arbitrator must consider certain factors, including 50th percentile of allowed amounts and 80th percentile of charges	▪ Benchmark data from FAIR Health ▪ For OON *facilities*, a non-binding mediation process is available
Washington ***(2020)*** ***IDRP***	▪ "Commercially reasonable amount" ▪ Binding, final offer arbitration for disputes ▪ Arbitrator must consider certain factors, and may consider data from APCD	▪ Self-insured health plans can opt in

Note: the Commonwealth Fund maintains updated information on state approaches.

Additional Examples of State Approaches, Continued

Example & *Approach*	Summary of Provider Payment Determination	Notes
California (2017) Hybrid	▪ Non-emergency services: greater of 125% of Medicare or the average contracted rate ▪ Binding, final offer IDRP available for providers who want to contest the payment amount	▪ CA addressed OON emergencies in 2009 ▪ IDR organization may consider rates for same services in FAIR Health
Colorado (2020) Hybrid	▪ Multiple payment standards: e.g., for OON providers at in-network facilities, the greater of: (1) 110% carrier's median in-network rate or (2) 60th percentile of in-network rate from APCD ▪ Binding, final offer arbitration for rate disputes	▪ If claim is submitted after a certain time, only required to reimburse 125% of Medicare
Michigan (2020) Hybrid	▪ Greater of: (1) median amount for the carrier; or (2) 150% of Medicare ▪ Providers can request additional compensation for emergency services, and if denied by insurer, can file request for binding arbitration	▪ Additional compensation is an additional 25% of the payment standard
Ohio (2020) Hybrid	▪ Greatest of: (1) median rate; (2) usual method paid for OON services, such as UCR; and (3) Medicare ▪ Can instead attempt negotiation and request binding, final offer arbitration if fails (subject to criteria, e.g., billed amount exceeds $750)	▪ Attempts to include ground ambulances ▪ Rulemaking underway

Note: the Commonwealth Fund maintains updated information on state approaches.

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