MASSACHUSETTS
HEALTH POLICY COMMISSION

ISSUE 14: AUGUST 14, 2019

HPC DATAPOINTS

The Price is Right? Variation in Potential Out-of-Network Provider Payment Benchmarks

Massachusetts claims data from FAIR Health, Inc., a national, independent, non-profit organization

INTRODUCTION

Out-of-network or "surprise" billing remains a priority policy issue for the Health Policy Commission (HPC) and for state and federal policymakers. As described in the HPC's Policy Brief on Out-of-Network Billing and research presentation, "surprise billing" scenarios typically occur either in emergency situations or when a patient receives care from an out-of-network provider at an in-network facility.

In recent years, efforts to address out-of-network billing have intensified around the United States. While there is an emerging consensus on protecting the patient from such bills, legislative proposals vary significantly on how to determine fair and reasonable payment to the out-of-network provider.[1]

State and federal legislative solutions utilize two primary approaches for determining out-of-network provider payment: (1) setting default reimbursement rates and (2) instituting a dispute resolution process. Payment benchmarks can be used in both approaches, either to establish the default payment rates or as reference points in independent dispute resolution processes. Benchmarks are typically based on provider charges (i.e., list prices), negotiated "allowed amounts" for in-network providers, and/or Medicare rates.

This DataPoints issue presents Massachusetts data from FAIR Health, Inc. on several specific services often involved in "surprise billing" scenarios and shows how payments would vary under different out-of-network payment benchmarks.[2]

This is a printable version of DataPoints. The online version features interactive graphics that show additional information, and is available on the HPC's website at mass.gov/service-details/hpc-datapoints-series.

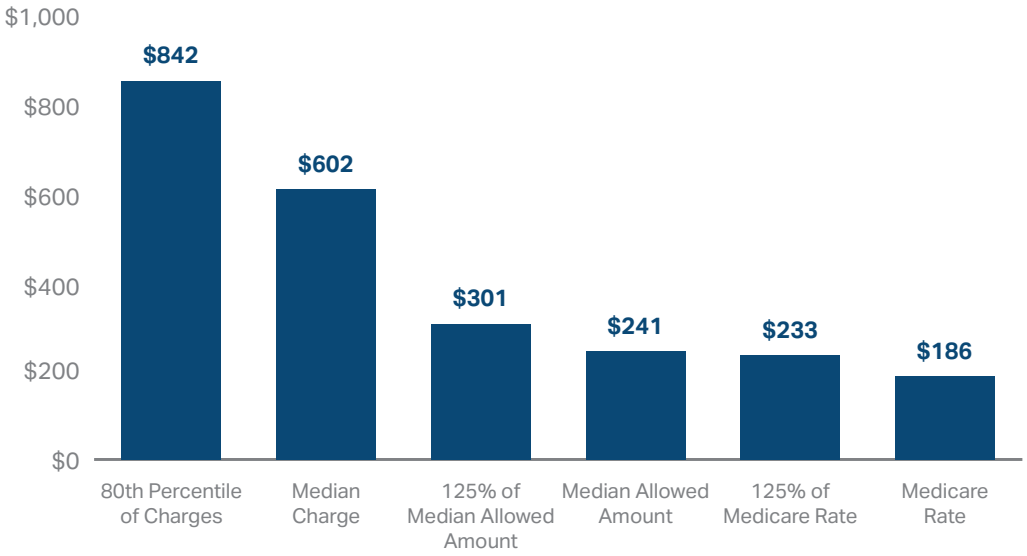
WIDE VARIATION IN POTENTIAL OUT-OF-NETWORK PROVIDER PAYMENT BENCHMARKS

The following data visualizations illustrate the range of payments associated with various benchmarks for specific procedure codes. The procedures were chosen because they are more likely than others to occur in "surprise billing" scenarios. Common providers in such scenarios are emergency, radiology, anesthesiology, and pathology ("ERAP") providers who are not employed by but contract with hospitals.[3] ERAP providers typically have less incentive to join insurer networks because given their role in health care delivery, they are often less dependent on the increased patient volume that being in-network can bring. The accompanying Tableau graphics present Massachusetts data on six payment benchmarks used in other states or proposed legislative solutions for six ERAP procedure codes.[4]

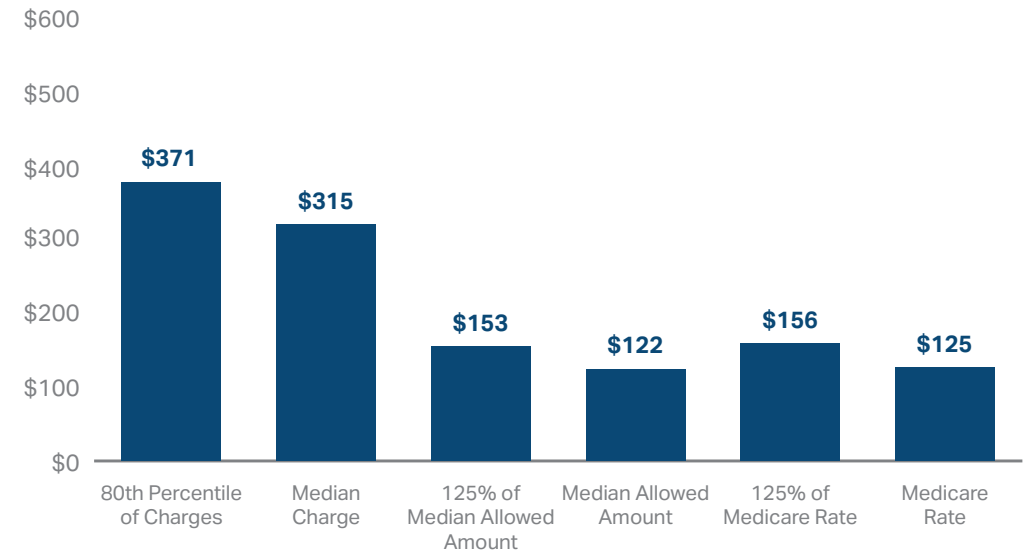
The first graphic below illustrates how the payment benchmark levels vary for a high severity emergency department visit in Massachusetts (CPT 99285). In this case, paying the out-of-network provider at the level of 80th percentile of charges would result in a payment of $842, **3.5 times higher** than the median allowed amount of $241. Alternatively, setting the benchmark at 125% of the Medicare rate would result in a payment of $233, just below the median allowed amount.[5]

For simple repair of superficial wounds of the face, ears, eyelids, nose, lips (CPT 12011), which often occurs in the emergency department, an out-of-network bill paid at the level of 80th percentile of charges would result in a payment of $371, **3 times higher** than the median allowed amount of $122 or the Medicare rate of $125.[6]

Varying payment benchmarks for emergency department visits with high severity and threatening function (CPT code 99285), Massachusetts, 2018-2019

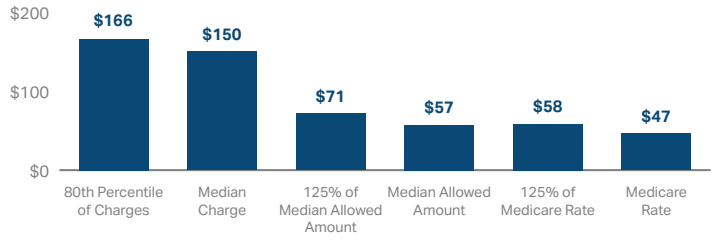


Varying payment benchmarks for simple repair of the face, ears, eyelids, nose, lips, mucuous membrates 2.5 cm or less (CPT code 12011), Massachusetts, 2018-2019

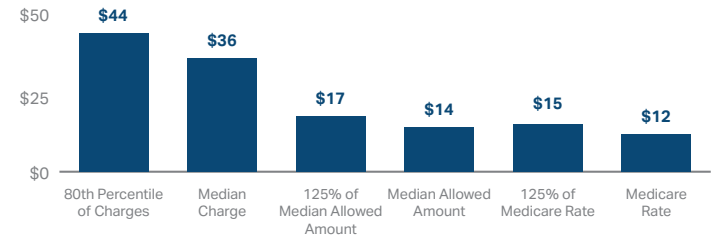


The following graphics explore four additional services typically provided in hospitals by radiologists, anesthesiologists, and pathologists, who are often not in insurer networks as described above.[7] For imaging procedures, although the actual scan or x-ray procedure may be in-network for a patient, if the radiologist interpreting the scan is out-of-network, the patient may still receive an out-of-network bill. As in the above examples, payments based on charge benchmarks are **typically two to three times higher** than those based on negotiated allowed amounts or Medicare rates.

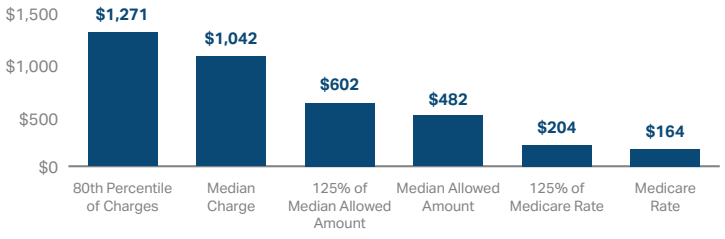
Varying payment benchmarks for the reading of CT head/brain without contrast material (CPT code 70450, modifier 26), Massachusetts, 2018-2019



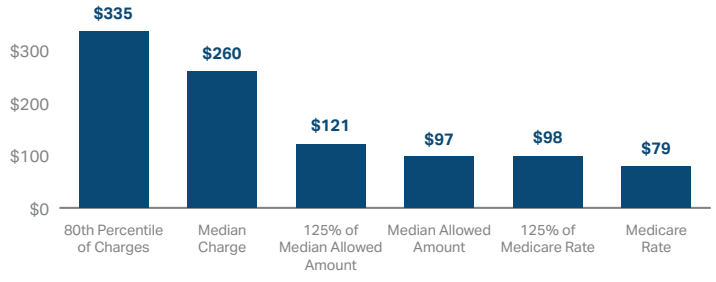
Varying payment benchmarks for the reading of radiologic exam chest–2 views (CPT code 71046, modifier 26), Massachusetts, 2018-2019



Varying payment benchmarks for anesthesia for lower intestinal endoscopic procedures (CPT code 00812), Massachusetts, 2018-2019



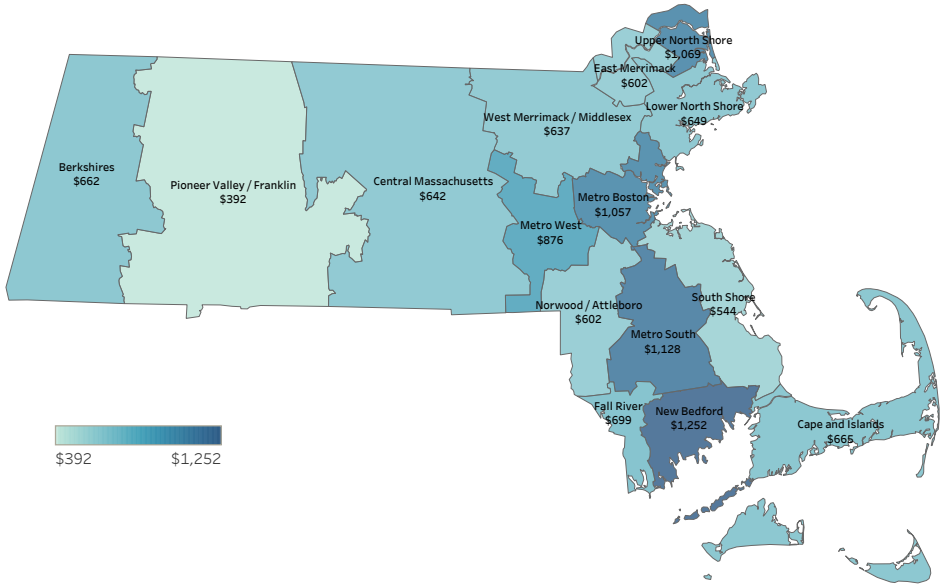
Varying payment benchmarks for level IV surgical pathology, gross and microscopic examination (CPT code 88305), Massachusetts, 2018-2019



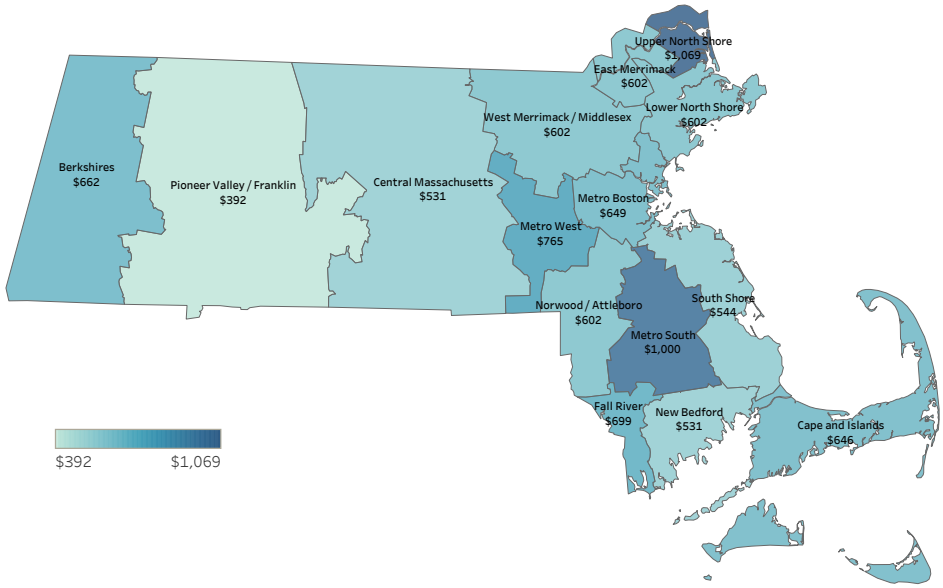
GEOGRAPHIC VARIATION IN POTENTIAL BENCHMARK PAYMENTS

Provider payments vary. For example, the map below shows the 80th percentile of charges and the median charges for one emergency procedure code for providers in the area. Because provider charges vary, a benchmark based on charges would vary accordingly.[8] The darker shades of blue indicate higher provider charges.

80th percentile of charges for emergency department visit with high severity and threatening function (CPT code 99285) by HPC region, 2018-2019



Median charge for emergency department visit with high severity and threatening function (CPT code 99285) by HPC region, 2018-2019



Notes

1. See also, e.g., Adler et al, State Approaches to Mitigating Surprise Out-of-Network Billing, USC-Brookings Schaeffer Initiative for Health Policy (2019), available at https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf.
2. 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).
3. For example, approximately one-third of Massachusetts hospitals substantially outsource emergency department staffing. HPC, Research Presentation on Out-of-Network Billing (Nov. 1, 2017), available at https://www.mass.gov/files/documents/2017/11/14/20171101%20-%20Commission%20Document%20-%20Presentation%20FINAL.pdf (slide 46).
4. All data in the visualizations, except for the Medicare rates, are from FAIR Health's charge and imputed allowed benchmarks. Benchmarks 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 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. With the exception of the regional data in the Geographic Variation section, all benchmark payment data in this DataPoints issue is presented at the level of statewide average.
5. Medicare rates established by the Centers for Medicare & Medicaid Services vary slightly by region. These data visualizations use the Medicare rates for the metropolitan Boston area (i.e., the highest available in Massachusetts). Medicare rates for the rest of the state range from $0.42 to $8.09 less than the metropolitan Boston area for the procedures presented in this DataPoints issue. For more information on Medicare rates, please see: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.
6. Procedure code 12011 can also be performed in an office setting.
7. See HPC research presentation in [3]. See also the USC-Brookings report in [1].
8. Benchmarks in legislative solutions are typically defined in a manner that accounts for the geography and specialty of the relevant out-of-network service.

The Massachusetts Health Policy Commission (HPC), established in 2012, is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and innovative health care system through its independent policy leadership and innovative investment programs.

HPC DataPoints is a series of online briefs that spotlight new research and data findings relevant to the HPC's mission to drive down the cost of health care. It showcases brief overviews and interactive graphics on relevant health policy topics. The analysis underlying these briefs is conducted by HPC staff. To view all HPC DataPoints, visit our website.