FINAL REPORT

Data Sources for Establishing Payment Rates for Out-of-Network Emergency Room Services

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Background and Objectives

ACA Sec. 10101 established financial protections for patients using out-of-network emergency room services. The purpose of ACA Section 10101 is to ensure that health plans do not impose an unreasonable financial burden on enrollees who receive care from an out-of-network provider in an emergency.

ACA Sec. 10101 was preceded by two class action law suits filed against Aetna and United HealthCare filed in 2007 and 2000 respectively. Plaintiffs charged both insurers of using a faulty database developed by United Healthcare's subsidiary Ingenix that resulted in systematically underpaying claims for out-of-network providers. Plaintiffs further charged that the "usual, customary, and reasonable" rates determined by the insurers used unreliable and at times insufficient data. Aetna ultimately agreed to a $120 million settlement and United HealthCare entered into a $350 million settlement. United further agreed to commit $150 million of the settlement to develop FAIR Health, a new, more comprehensive and transparent database that would be accessible to the general public and used for determining out-of-network payment levels.

Interim Final Rule published June 28, 2013 elaborates on the rules for ACA Sec. 10101:
"The amount for the emergency service should be calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of network for the cost-sharing provisions".... Specifically, a plan or issuer satisfies the copayment and coinsurance limitations in the statute if it provides benefits for out-of-network emergency services in an amount equal to the greatest of three possible amounts— (1) The amount negotiated with in network providers for the emergency service furnished; (2) The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing provisions; or (3) The amount that would be paid under Medicare for the emergency service. Each of these three amounts is calculated excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee (http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf).

CMS has received comments, particularly from the American College of Emergency Physicians (ACEP), expressing concern that the Interim Final Rule does not provide necessary specificity for what constitutes the copayment and coinsurance limitations, particularly the means of calculating the usual, customary and reasonable charges. ACEP did provide CMS with documentation recent issuer policy changes that have resulted in marked decreases in reimbursement for such services. In responding to this concern, CMS was unable to identify a "gold standard" upon with to rely in evaluating this concern. ACEP has proposed that CMS adopt clarifying language, either in regulation or sub-regulatory guidance, as follows:

> Issuers should utilize a database of usual and customary charges which meets requirements which ensure the accuracy of the non-participating, commercially insured claims data used to calculate these usual and customary charges. These features include *transparency, currency, statistical validity, protections against conflict of interest, and certification by an independent auditor* (italics added by author). This database should be made available to the issuers, providers, and the public though an independent third-party organization.

The objective of this task was to conduct a market scan of potential databases for benchmarking allowed charges for out-of-network payment to emergency room physicians, and their comparative strengths or possible shortcomings, and to assess the merits of further specifying criteria for establishing such allowed charges. This report presents findings from this market scan of potential databases and key informant interviews.

Methods and Evaluation Criteria

NORC contacted numerous nationally recognized experts who have conducted studies of commercial health insurance, and asked each expert what databases were available on a national or regional basis to meet the requirements specified by CCIIO. Besides researchers, we also queried leading organizations who sold medical claims databases as to whom they viewed as their major competitors. In addition to reviewing information available on the organization's web sites, we conducted interviews with executives of the organizations. The major issues addressed in these interviews were:

1. Are you able and willing to identify the number of covered lives in each state?
2. Do you know the geographical spread within a state?
3. Can you identify if the service was in or out-of-network?
4. Are billed and allowed charges available in the database?
5. Are CPT or HCPCS codes used for services?
6. How recent are the data?
7. Would the vendor make the data available to CCIIO and other interested parties?
8. What would be the cost of acquiring or using the database?
9. Are the rates set objectively, and are they transparent, and verifiable by external audit?

Organizations and Attitudes towards Transparency

NORC ultimately interviewed five organizations with either national or state-based medical claims databases. These five organizations were:

1. FAIR Health
2. Truven
3. Health Care Cost Institute
4. All-Payers Claims Database Council at the University of New Hampshire
5. Towers-Watson Human Resource Consulting

It became clear in the interviews that commercial organizations who sold databases had concerns with providing data to outside organizations, including CCIIO, in a transparent manner. These organizations are dependent on contributing insurers (and large self-insured employers) to build their database. Insurers compete by obtaining discounts from providers of care and don't want to reveal these discounts to their competitors. Thus, insurers are very uncomfortable making available data on billed and allowed charges, but particularly allowed charges. Insurers are most comfortable when the data are pooled with many competitors. Insurers are least comfortable providing claims data in rural states where one Blue Cross Blue Shield plan may hold 80 percent of the market. FAIR Health, in contrast, is a non-profit organization, whose mission is to bring transparency to health care and health insurance costs. Consequently, Fair Health was enthusiastic about providing data to CCIIO about the cost of emergency room services.

The subsequent section addresses each of the nine research questions for each of the five claims databases.

FAIR Health

The mission of FAIR Health is to provide transparency to the health care and health insurance marketplaces. FAIR Health grew out of lawsuit with United HealthCare and Aetna where plaintiffs claimed that insurers were misrepresenting usual and customary charges for services. The Attorney General's Office in New York reached agreement with insurers in settling the case.

Insurers were to create a fair, independent, and transparent database for use in determining out-of-network payments to providers.

Sixty insurers and employers donate medical claims to FAIR Health. FAIR Health has medical claims for approximately 150 million covered lives, 16 billion medical procedures, and these figures are growing. Claims include dental claims but not prescription drug claims. The database consists of claims for the most recent 12 months available.

FAIR Health has an advisory board of university professors and other statisticians.

Are you able and willing to identify the number of covered lives in each state?

FAIR Health has data on the number of covered lives and will provide this information upon request.

Do you know the geographical spread within a state?

FAIR Health has divided the nation into 491 geo-ZIP codes, based on the first three digits of the ZIP code.

Can you identify if the service was in or out-of-network?

Approximately 53 percent of claims include a field as to whether the claim is in-or-out-of-network.

Are billed and allowed charges available in the database?

About one-third of claims have both billed and allowed charges in the database. There is no requirement that both fields be included in the submission of data to FAIR Health. The remaining claims have either allowed charges or billed charges. Insurers were sensitive to providing both allowed and billed charges because the two fields allow one to calculate discounts. FAIR Health has an algorithm to calculate allowed charges when the data are missing.

Are CPT or HCPCS codes used for services?

CPT codes are used for medical and surgical services, and HCPCS codes are used for anesthesia. There are also American Dental Association (ADA) codes for emergency dental services.

How recent are data?

The most recent month of data available is February 2014. Thus the current database is from March 2013 to February 2014.

Would the vendor make the data available to CCIIO and other interested parties?

FAIR Health would make the data available. The format would be a tool to query the data base. The user could specify the geographic area, CPT code, date and obtain data on the distribution of allowed and billed charges.

What would be the cost of acquiring or using the database?

For emergency only services, the estimated cost for the data is $120,000. For the complete medical, surgical and dental databases, the cost would be $150-175,000.

Are the rates set objectively, and are they transparent, and verifiable by external audit?

Through the use of a software tool, persons who purchasers FAIR Health may examine the distribution of customary allowed charges and billed charges in the relevant geographic area. FAIR Health has been subject to audits. It views the transparency of the data and the methods used to calculate customary charges as a central aspect of FAIR Health's mission.

Additional Analysis

At the request of CCIIO, we asked Fair Health to conduct a hypothetical task. For CPT code 99285 for an urban area, Arlington Virginia, and a rural area, Lexington, Virginia, we asked what counties would constitute the geographic area. We also asked the sample sizes for these two areas. For Arlington, the reference counties are Arlington, Fairfax, and the city of Alexandria. For Lexington the reference counties are 26 rural counties and independent cities in Virginia. The sample size for CPT 99285 was 7,003 for Arlington and 3,040 for Lexington.

NORC was impressed by the transparency, speed of response, and sample sizes for this validating task.

Truven Health Analytics

Truven is a for-profit enterprise that sells services to healthcare researchers and providers, including hospitals, government agencies, employers, health plans, clinicians, and pharmaceutical and medical device companies. It is currently owned by Veritas Capital who purchased the company from Thomson/Reuters in 2012. Its medical claims database known as MarketScan is widely used in health services research.

Three hundred large self-insured employers and 25 insurers donate their data to Truven. Marketscan now covers more than 40 million covered lives each year. Truven has medical claims from every state.

Are you able and willing to identify the number of covered lives in each state?

Truven has the capacity to do so but does not want to share this information currently as it views this information as proprietary.

Do you know the geographical spread within a state?

MarketScan data includes fields for the ZIP code of the beneficiary and the provider. Truven would not want to provide such data currently.

Can you identify if the service was in or out-of-network?

Carol Forhan, the representative of Truven, was not certain if this data were available.

Are billed and allowed charges available in the database?

Only allowed charges are available to outside parties who buy the data. Internally, both billed and allowed charges are available.

Are CPT or HCPCS codes used for services?

CPT and HCPCS codes are available.

How recent are data?

2012 data are now available, and 2013 data will be available in December 2014.

Would the vendor make the data available to CCIIO and other interested parties?

Truven would be most comfortable with the customer requesting data runs. It is possible to purchase a de-identified data base, but the geographic coverage is in question. In some states where one carrier dominates, Truven will use regional data to determine "allowed charges."

What would be the cost of acquiring or using the database?

CMS has a contract with Truven to use MarketScan data, but the contract is a project-by-project one. The marginal cost for an additional study is likely to be modest. My best estimate is it would cost less than $100,000.

Are the rates set objectively, and are they transparent, and verifiable by external audit?

Truven would be uncomfortable with an audit, particularly in small states where the Blue Cross/Blue Shield plan dominates the market. They are highly sensitive to disclosing any information that would reveal the discounts that an insurer has obtained.

Health Care Cost Institute (HCCI)

HCCI is a non-partisan, non-profit organization with an overarching objective –"to provide complete, accurate, unbiased information about health care utilization and costs to better understand the US health care system." Founded in 2011, HCCI seeks to answer questions about spending and utilization through an analysis of a large national medical claims database.

Four large insurers donate data to HCCI – United Health Care, Humana, Aetna, and Kaiser Permanente. The database has 50 million covered lives from every state in the nation. HCCI recently signed contracts with ten organizations to mine the HCCI data and address specific research agendas. MEDPAC and CBO are the only government organizations among the ten organizations.

In conversations with HCCI President David Newmark, he was clear that HCCI was not interested in leasing HCCI data to CCIIO. He stated that he lacked the manpower to provide data runs, and that providing information on allowed charges is not within the mission of HCCI. Newmark sees this mission operationally as building the database and analytical structure to better understand factors behind rising health care costs – not to provide data so insurers can set "allowed charges."

Are you able and willing to identify the number of covered lives in each state?

It is unlikely that HCCI would be willing to provide state-by-state totals.

Do you know the geographical spread within a state?

One data field is the ZIP code of patients, so it is possible to examine the geographic spread within a state. HCCI gave the impression they were not interested in providing such information.

Can you identify if the service was in or out-of-network?

HCCI is not able to identify in and out-of-network services.

Are billed and allowed charges available in the database?

Billed and allowed charges are available. HCCI is unlikely to provide such data.

Are CPT or HCPCS codes used for services?

These codes are used in the dataset.

How recent are data?

The last year available is 2012. Data are available back to 2007.

Would the vendor make the data available to CCIIO and other interested parties?

HCCI was explicit that CCIIO could not purchase the data, and that HCCI lacked the manpower to conduct data runs.

What would be the cost of acquiring or using the database?

HCCI declines to make the data available to CCIIO.

Are the rates set objectively, and are they transparent, and verifiable by external audit?

HCCI is not inclined to make the data available, and hence, would not be willing to make data available for audits.

All-Payers Claims Database Council at the University of New Hampshire

Five states have operational all-payer claims data bases (APCD) and 11 more are in the implementation phase. "Operational" states are those with formal procedures for organizations and individuals to obtain the databases. The other eleven states are working on the regulations for making data available to interested parties. The five operational states are Vermont, Maine, New Hampshire, Massachusetts and Colorado. The eleven "implementing" states are: NY, RI, Conn., Va., WV, (Utah revising), Kan., Oregon, Minn., and Tenn.

With funding from the Robert Wood Johnson Foundation, the University of New Hampshire Database Council runs learning co-operative for the APCD states. The Council does not have direct access to the state databases. Organizations interested in obtaining state data must acquire the data from the individual states. Each state has different variables in their database, different timelines for building APCD databases, and different procedures for releasing data. Consequently, parties interested in using APCD must proceed on a state-by-state basis.

Subject to the caveat that data for each APCD is different, the databases usually include data from the small group, individual and fully-insured group markets. In some cases self-insured plans will submit data to the state. Medicare and Medicaid data are also usually included in APCDs. States with a formalized procurement system usually have a public use and limited use file, with the limited use file making more data fields available.

Are you able and willing to identify the number of covered lives in each state?

With the caveat that each state is different, users of APCD should be able to learn this through their code.

Do you know the geographical spread within a state?

States have the ZIP code of the beneficiary and provider on each medical claim. In some states, the provider's identification may be limited for physicians.

Can you identify if the service was in or out-of-network?

This varies from state-to-state.

Are billed and allowed charges available in the database?

This too varies from state-to-state.

Are CPT or HCPCS codes used for services?

All states use CPT codes.

How recent are data?

Colorado had 2012 medical claims data. 2011 is the last year of data for the other four operational states.

Would the vendor make the data available to CCIIO and other interested parties?

All states view making their data available as central to their mission for their APCD agency.

What would be the cost of acquiring or using the database?

A year of data will typically cost $6,000-$7,000.

Are the rates set objectively, and are they transparent, and verifiable by external audit?

Third parties can purchase the public use and limited use files. For data fields that are missing, such as in-network status, it may not be possible to audit.

Towers-Watson Human Resource Consulting

Towers-Watson is one of the five largest benefit consulting firms in the U.S. and worldwide with a large actuarial practice. Its market niche is large employers with more than 1,000 workers. Towers-Watson has a reputation with the possible exception of Milliman for investing more resources in data and analysis than its rivals. For these reasons NORC interviewed analysts at Towers-Watson about the claims data they use for work with clients, and the firm's willingness to make the data available to CCIIO.

Towers-Watson uses two databases for their client work. The first is the National Data Co-Op which includes 30 large employers. However, the respondents emphasized that most work with medical claims data is with MarketScan from Truven. MarketScan includes more covered lives and has greater geographic distribution.

Ultimately, Towers-Watson has little interest in serving as a data source for setting payment rates for out of network services. Like other commercial companies, there is the fear that clients may see Towers-Watson as compromising their proprietary data. This risk overshadows the limited revenue that could be earned from the use of a proprietary database.

Are you able and willing to identify the number of covered lives in each state?

That is likely, but Towers is highly unlikely to provide such information.

Do you know the geographical spread within a state?

Towers is highly unlikely to make such data available.

Are billed and allowed charges available in the database?

Towers-Watson has such data but is unlikely to make such data available.

Are CPT or HCPCS codes used for services?

Data uses CPT and HCPCs codes.

Would the vendor make the data available to CCIIO and other interested parties?

Towers-Watson is not interested in making their data available to CCIIO.

Are the rates set objectively, and are they transparent, and verifiable by external audit?

Towers-Watsons would reject any audit of their data.

Conclusion

This review of medical claims databases finds, with few exceptions, that there is a paucity of sources for validated, transparent charge and reimbursement data. Additionally, barring CMS' actually contracting with one of these services, CMS does not have immediate access to typical or benchmark allowable charges paid for OON emergency care (i.e. that the current system is fundamentally non-transparent).

The one organization that was most enthusiastic about making these data available in a transparent manner, that also best satisfies the evaluation criteria laid out earlier in this report, is also the organization that owns the most current, comprehensive, and transparent database – FAIR Health. When NORC requested information on rating areas and sample sizes for two Virginia counties, Fair Health provided this information within a few hours. Other organizations would likely regard such data as proprietary. In time APCDs will prove useful, particularly in small states, but only five states have procurement procedures currently.

For the immediate future, FAIR Health is the database best suited to help address CMS' concerns about establishing comprehensive and transparent out of network payment benchmarks.