An Analysis of Reasonable and Customary Out-of-Network Reimbursement Rates

for Medical/Surgical Services in the New York State Health Insurance Program

OFFICE OF THE NEW YORK STATE COMPTROLLER

Thomas P. DiNapoli, State Comptroller

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Executive Summary

The New York State Health Insurance Program (NYSHIP), administered by the State Department of Civil Service (Civil Service), is one of the nation's largest public sector health insurance programs. NYSHIP covers over 1.2 million active and retired State, local government, and school district employees, and their dependents. The Empire Plan is the primary health benefits plan for NYSHIP, covering 1.1 million of the NYSHIP members. The Empire Plan provides its members with four types of health insurance coverage: medical/surgical, hospital, prescription drugs, and mental health and substance abuse services.

Civil Service contracts with UnitedHealthcare (United) to administer the medical/surgical portion of the Empire Plan. Medical/surgical benefits cover a range of services including, but not limited to: office visits, diagnostic testing, outpatient surgery, physical therapy, chiropractic services, home care services, and durable medical equipment. United processes and pays claims submitted by health care providers on behalf of Empire Plan members.

United contracts with a large network of participating (in-network) providers who deliver medical/surgical services to Empire Plan members at rates established by United. Empire Plan members may also choose to receive services from non-participating (out-of-network) providers. United bases payment for most services provided by out-of-network providers either on the MultiPlan, Inc. rate or the reasonable and customary (R&C) rate. MultiPlan, Inc. is the provider network leased by United to supplement its own network. If the out-of-network provider does not receive the MultiPlan rate, United will reimburse the provider at the R&C rate. The R&C rate is generally based on provider charges for the same or similar service in the same or similar geographic region.

United's reimbursement rates for out-of-network services are generally higher—often significantly higher—than United's in-network reimbursement rates. Consequently, services provided by out-of-network providers are more costly to the State. During the five years 2012 to 2016, United paid $1.7 billion for out-of-network services. United's payments, based on the R&C rate, totaled approximately $902 million for 4,003,040 services. By comparison, United's payments based on the MultiPlan rate totaled approximately $832 million for 8,681,167 services. During the five year period, United's payments based on the in-network rate totaled about $6.5 billion for 226,128,077 services. To illustrate, the average reimbursement for a routine office visit in 2016 was $29 for in-network, $72 for MultiPlan, and $147 for R&C.

Despite efforts to control out-of-network costs, United's R&C-based payments increased steadily from 2012 to 2016—from $160 million to $202 million—an increase of 26 percent. Significant disparities were also found in the R&C rates across the State. For example, the rate for a certain spinal procedure in the Brentwood/Coram/Riverhead region was $38,000, over 225 times higher than the $167 rate for the same procedure in the Amherst/Niagara Falls region. Large disparities in R&C rates were also found in neighboring regions. For example, the rate for a different spinal procedure in the Far Rockaway/Hempstead region was $90,000, double the rate for the same procedure in both neighboring regions of Great Neck/Port Washington ($43,755) and Flushing/Jamaica ($45,000). There was no evidence that these increases and disparities stemmed from a predictable source (e.g., an increase in claims or medical care cost-of-living). As a result, there do not appear to be any readily identifiable factors to explain these differences other than the provider-driven nature of R&C rates, which, as stated, are based on provider charges for services.

Auditors determined significant cost savings are achievable if alternative reimbursement methodologies are considered for services that are paid based on R&C rates. If changes were adopted, the estimated potential recurring annual cost savings are $17 million to $146 million under various other reimbursement methodologies.

While Civil Service is responsible for administering the Empire Plan, the Council on Employee Health Insurance (Council) supervises the administration of changes to the Empire Plan and provides policy direction to the health insurance plans administered by the State. The Council consists of the President of the Civil Service Commission, the Director of the State Division of the Budget, and the Director of the Governor's Office of Employee Relations. The Empire Plan's benefit design, and any changes to it, are the result of collective bargaining. The Council develops ideas to be used in the collective bargaining process, which includes negotiating the out-of-network reimbursement rates.

Key Recommendation

The Council and key stakeholders should work together to determine if better reimbursement methodologies and plan design options exist for R&C out-of-network services other than one option that is based on provider-driven charges. The new methodologies and plan options should consider the cost effectiveness of reimbursement rates, thereby benefiting Empire Plan members and the State's taxpayers by lowering the Empire Plan's health care premiums, while continuing to provide the same level of medical services to all Empire Plan members.

Background

The New York State Health Insurance Program (NYSHIP) was established in 1957 under New York State Civil Service Law. Outside of the federal government, NYSHIP is one of the nation's largest public sector health insurance programs, covering over 1.2 million active and retired State, participating local government, and school district employees, and their dependents. The New York State Department of Civil Service (Civil Service) is the State agency responsible for administering NYSHIP. Members of NYSHIP have the opportunity to select from various plans for coverage. The Empire Plan is by far the most popular health benefit plan, covering 1.1 million people, or 89 percent of NYSHIP's members. The remaining 11 percent of NYSHIP's members are covered through various HMOs (health maintenance organizations).

The Empire Plan provides its members with four types of health care coverage: medical/surgical, hospital, prescription drug, and mental health and substance abuse. Medical/surgical benefits cover a range of services including, but not limited to: office visits, outpatient surgery, diagnostic testing, physical therapy, chiropractic services, home care services, and durable medical equipment. Civil Service contracts with UnitedHealthcare (United) to process and pay medical and surgical claims submitted by health care providers on behalf of Empire Plan members. United contracts with a large network of providers who deliver medical services to Empire Plan members. These participating (in-network) providers agree to be reimbursed at rates established by United. United pays in-network providers directly, based on claims they submit for services they provide to members. Members pay a nominal copayment to the in-network provider.

Empire Plan members may also choose to receive medical/surgical services from non-participating (out-of-network) providers. If members receive services from an out-of-network provider, they are required to pay deductibles and coinsurance to the provider. Additionally, United bases payment for most services provided by out-of-network providers either on the reimbursement rate of MultiPlan, Inc. (MultiPlan) or on a reasonable and customary (R&C) rate. MultiPlan is a nationwide provider network, which United contracts with to supplement its own network. The MultiPlan rate is a negotiated rate with out-of-network providers. MultiPlan also provides a fee negotiation service. If the out-of-network provider does not receive the MultiPlan rate, United will reimburse the provider at the R&C rate for the service. Both the MultiPlan and R&C rates are generally higher—often significantly higher—than United's in-network reimbursement rates. Consequently, services provided by out-of-network providers are more costly to the State. During the five years 2012 to 2016, United paid $1.7 billion for out-of-network services based on either the R&C or MultiPlan reimbursement rate: $902 million for R&C (for about four million services) and $832 million for MultiPlan (for about 8.7 million services), see Figure 2.

The Empire Plan defines the R&C rate as the lowest of: the provider's actual charge for the service, the provider's usual charge for the same or similar service,

or the usual charge of other providers for the same or similar service in the same or similar geographic area. The provider's charge is the full price for services or supplies furnished before insurance has been factored in. Providers supply this information on their claims to United. To determine the usual charge of other providers for the same or similar service in the same or similar geographic area, United obtains 'charge benchmark' data from FAIR Health, Inc.[1] United uses the 90th percentile of this charge data to determine the R&C rate for each service, as explained below.

FAIR Health creates the charge benchmarks as follows. FAIR Health collects provider charge data reported on health care claims, which are supplied by various health care insurance companies. FAIR Health groups the claim data by "geozips," which are geographic areas defined by ZIP code information. FAIR Health has defined 31 different geozip groups in New York State. FAIR Health then uses two methodologies to create their charge benchmarks: actual and derived.

- Actual: If a geozip has a sufficient number of actual charges for a procedure, those actual charge amounts are organized from lowest to highest and assigned to percentiles. A percentile is a position in a distribution of values below which a specified percentage of the values fall. For example, in a distribution of 100 data points, the 90th percentile is the value in the 90th position in the lowest-to-highest array of values. Thus, 90 percent of the values are equal to or lower than the 90th percentile value and 10 percent are equal to or higher than the 90th percentile value.
- Derived: If the number of actual charges for a procedure in a geozip is insufficient, the charge benchmarks are derived using the actual charges for all procedures in a group of related procedure codes within the geozip. Certain steps are taken to "normalize" those charge amounts, and the results are organized from lowest to highest and assigned to percentiles.

In creating the charge benchmarks, FAIR Health employs a statistical outlier methodology to exclude extremely low and extremely high values that might distort the distribution of data. United uses the 90th percentile of the charge benchmarks (the charge that is greater than or equal to 90 percent of the charges for that procedure and region) to establish R&C reimbursement rates for services provided by out-of-network providers. FAIR Health refreshes the charge benchmarks every six months.

1 The methodologies FAIR Health uses to create the benchmarks are described at their website: https://www.fairhealth.org/methodologies. Research for this report is based in part upon healthcare charge benchmark data compiled and maintained by FAIR Health, Inc. The Office of the New York State Comptroller is solely responsible for the research and conclusions reflected in this report. FAIR Health is not responsible for the conduct of the research or for any of the opinions expressed in this report. FAIR Health benchmarks are not fee schedules, and do not constitute stated or implied "reasonable and customary" charges or allowed amounts. When FAIR Health licenses benchmark data to payors, any reliance upon, interpretation of, or use of the benchmarks to establish fee schedules or set rates is in the payors' sole discretion.

To illustrate how percentiles are determined, if FAIR Health received 10 charges by 10 health care providers for a colonoscopy procedure for a particular geozip, such as the following hypothetical charges: $500; $600; $700; $800; $900; $1,000; $1,100; $1,200; $1,300; and $1,400, these charges would be organized from lowest to highest to determine percentiles (see Figure 1).

Figure 1 – FAIR Health Benchmark Methodology: Hypothetical Example

Procedure	Percentile							
	50th	60th	70th	75th	80th	85th	90th	95th
Colonoscopy	$900*	$1,000	$1,100	$1,150	$1,200	$1,250*	$1,300	$1,350*

*50th Percentile = $900; 85th Percentile = ($1,200 + $1,300)/2; 95th Percentile = ($1,300 + $1,400)/2

In establishing the R&C rate and determining the lowest of either a provider's actual or usual charge or the usual charge of other providers for the same/similar service in the same/similar geographic area, United would identify the $1,300 (at the 90th percentile) as the amount for the usual charge of other providers for colonoscopies in this particular geozip. If $1,300 is lower than the provider's actual charge on the claim (or is lower than the provider's usual charge for the service), United would reimburse the provider based on the $1,300.

This examination focused on the R&C reimbursement rates used for the payment of medical/surgical services furnished by out-of-network providers to Empire Plan members in order to assess the costs of using provider-driven R&C rates compared to alternate methods for reimbursing out-of-network services.

While Civil Service is responsible for administering the Empire Plan, the Council on Employee Health Insurance (Council) supervises the administration of changes to the Empire Plan and provides policy direction to the health insurance plans administered by the State. The Council consists of the President of the Civil Service Commission, the Director of the State Division of the Budget, and the Director of the Governor's Office of Employee Relations. The Empire Plan's benefit design, and any changes to it, are the result of collective bargaining. The Council develops ideas that can be used in the collective bargaining process, which includes negotiating the out-of-network reimbursement rates.

Escalating R&C Payments

New York State's Out-of-Network Reimbursement Rate Workgroup (OON Workgroup), which was created in March 2016 per Part H of Chapter 60 of the Laws of 2014, is charged with reviewing the current out-of-network reimbursement rates used by health insurers licensed under the State Insurance Law, and making recommendations regarding an alternative rate methodology for

such rates. In January 2017, the OON Workgroup reported that out-of-network providers usually bill (i.e., charge) higher amounts than health plans actually reimburse.[2] In fact, health plans have reported that out-of-network providers' charges are increasing at a higher rate than those of in-network providers and hospitals, and out-of-network providers are becoming "more aggressive" in their pricing.

United's R&C-based reimbursement rates for out-of-network services are generally higher—and often significantly higher—than United's in-network rates and the MultiPlan rates. Figure 2 compares United's payments for medical services based on in-network, MultiPlan, and R&C rates over a five-year period.

Figure 2 – Comparison of United's Payments for Empire Plan Medical/Surgical Services, 2012–16

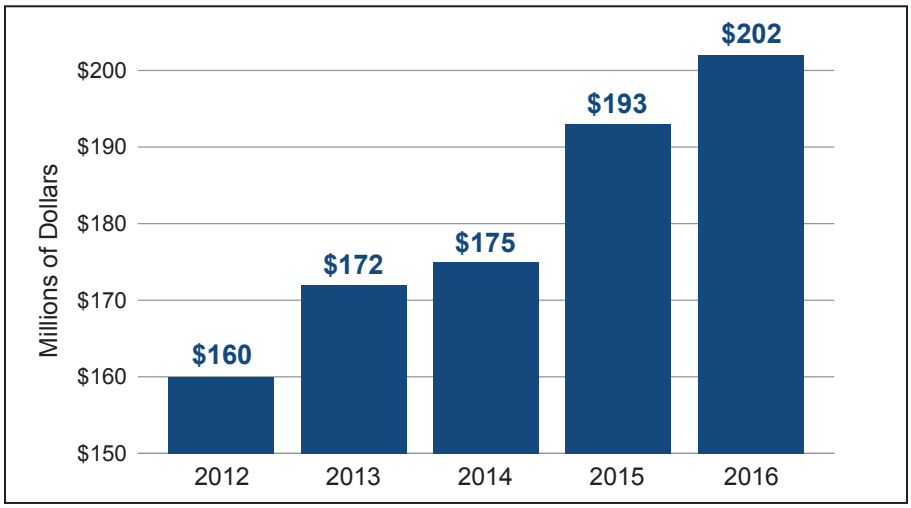
	Total Cost	Number of Services	Average Cost Per Service
In-Network	$6.5 billion	226,128,077	$29
MultiPlan	$832 million	8,681,167	$96
R&C	$902 million	4,003,040	$225

Also, R&C costs have risen significantly despite Council efforts to reduce out-of-network costs. R&C payments rose steadily from 2012 to 2016, from $160 million to $202 million, an increase of 26 percent (see Figure 3). Auditors determined this increase did not reflect any surge in the number of R&C medical services, as these decreased by 12 percent, declining from 782,975 units of service in 2012 to 688,860 in 2016. The increase in payments also did not reflect an increase in the number of Empire Plan members, which remained steady from 2012 to 2016, or in the number of members who used out-of-network services that were paid based on R&C rates, which decreased by 36 percent (from 69,570 members in 2012 to 44,413 members in 2016). While the R&C cost increases could be due in part to cost-of-living increases, the medical care cost-of-living index for the Northeast region of the United States increased only by 13 percent over the same five-year period, and therefore likely did not account for the full increase.[3]

2 Out-of-Network Reimbursement Rate Workgroup. *Report of the Out-of-Network Reimbursement Rate Workgroup*. January 26, 2017. Retrieved from the Department of Financial Services.

3 Auditors also analyzed changes in the services paid from 2012 to 2016 to determine whether this could account for the 26 percent increase in R&C costs. It was determined that the majority of service codes paid in 2012 and 2016 were the same. Specifically, 74 percent of the service codes paid in 2016 were also paid in 2012. These codes accounted for 93 percent of R&C payments in 2012 and 94 percent of R&C payments in 2016. Therefore, the mix of procedures remained largely stable from 2012 to 2016.

Figure 3 – Medical/Surgical R&C Payments, 2012–16



Auditors also analyzed the average cost per service and average cost per member for R&C payments and noted an increase in both from 2012 to 2016. Average R&C cost per service increased from $204 in 2012 to $293 in 2016, an increase of 43 percent (see Figure 4). Similarly, the average R&C cost per member (for members that utilized R&C out-of-network services) increased from $147 in 2012 to $186 in 2016, an increase of 26 percent (see Figure 5). As mentioned previously, while the 13 percent medical care cost-of-living increase may have accounted for some of these increases, it did not account for the full increase in cost per service or cost per member. For example, applying the medical care cost-of-living increase would have increased the average R&C cost per service to $230 (instead of $293, a difference of $63) and the average R&C cost per member would have increased to $166 (instead of $186, a difference of $20).

Figure 4 – Average Cost Per Service for R&C Payments, 2012 & 2016

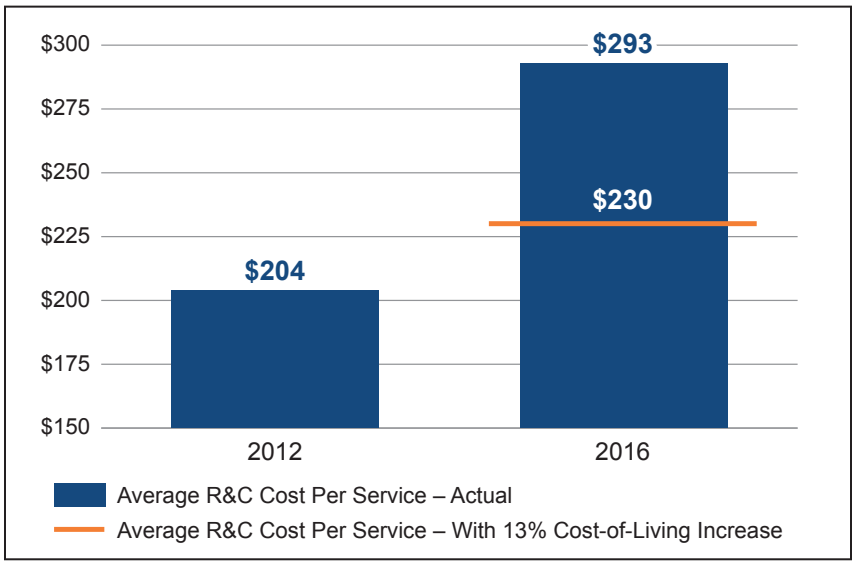
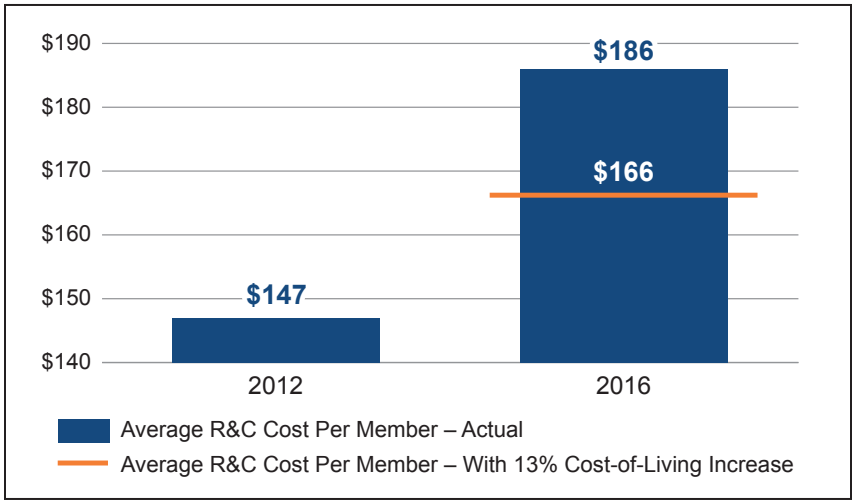


Figure 5 – Average Cost Per Member for R&C Payments, 2012 & 2016



According to United officials, there is adequate access to in-network providers across the State and across all provider specialty areas. Nevertheless, out-of-network utilization was widespread across many different provider specialties. For 2012 to 2016, R&C payments were made for 255 different specialty areas, with general surgery, orthopedic surgery, plastic surgery, neurological surgery, obstetrics and gynecology, anesthesiology, podiatry, acupuncture, and internal medicine receiving the largest payments.

As of January 2017, the Empire Plan had 1,087,168 members, 970,744 of whom (89 percent) resided in New York State. Not all members use out-of-network services: from 2012–2016, only 5 percent of Empire Plan members used out-of-network services that were reimbursed based on R&C rates.

R&C Rate Increases Over Time

Auditors analyzed United's R&C-based claim payments and identified the top 141 service codes with the highest aggregate payments. They requested the R&C reimbursement rates for each of the 141 service codes from United and analyzed these rates for the 31 geozip groups in New York State. United paid $553 million based on the R&C rate for these 141 service codes, accounting for 61 percent of United's total R&C-based payments from 2012 to 2016. The analysis included a range of service codes, including highly utilized ones to less common codes with high dollar values. For example, the analysis included an anesthesia service code with 341,476 units of service, an office visit code with 139,016 units of service, and a spinal procedure code with 1,005 units of service.

Auditors found that R&C rates increased from 2012 to 2016 for the majority of the 141 highest-cost service codes. Many of the rate increases were substantial. Across the 31 geozip groups, the greatest rate increases for an individual service code ranged from 218 percent for a cardiac catheter to treat abnormal rhythm (Buffalo) to 2,948 percent for a carotid artery catheter placement (Far Rockaway/ Hempstead).

Furthermore, the rates for a majority of service codes—82 percent—at least doubled over the five-year period reviewed in one or more geozip groups. Figure 6 presents a few examples of service codes with rate increases that more than doubled. Figure 6 also illustrates how these R&C rate increases compared to the national payer, Medicare, and its rate increases.

Figure 6 – Service Codes with Large Rate Increases, 2012–16

Procedure	Geozip Group	R&C Rate			Medicare Rate		
		Jan – June 2012	Jul – Dec 2016	Percent Increase	2012	2016	Percent Increase
Skin Graft Procedure	Brentwood/Coram/ Riverhead	$5,950	$53,000	791%	$1,775	$1,887	6%
Hernia Repair Surgery	Far Rockaway/ Hempstead	$5,500	$49,000	791%	$1,795	$2,014	12%
Spinal Procedure A	Brentwood/Coram/ Riverhead	$7,000	$60,216	760%	$460	$545	19%
Ear, Eye, Nose, Lip Surgery	Hicksville	$2,500	$14,000	460%	$652	$621	-5%
Spinal Procedure B	Staten Island	$1,600	$8,275	417%	$459	$529	15%
Acupuncture Service	Rochester/Brighton	$29	$150	417%	N/A	N/A	N/A
Back Surgery	Staten Island	$3,400	$17,300	409%	$1,138	$1,290	13%
Wound Repair Procedure	Astoria/Brooklyn	$1,000	$5,000	400%	$260	$279	7%

As illustrated in Figure 6, the R&C rates for these procedures at the start of the comparison period were significantly higher than the Medicare rates for the same procedures, and also increased more dramatically than the corresponding Medicare rates. For example, in Brentwood/Coram/Riverhead, the R&C rate for the skin graft procedure increased by 791 percent (from $5,950 to $53,000), and the Medicare rate increased by only 6 percent (from $1,775 to $1,887).

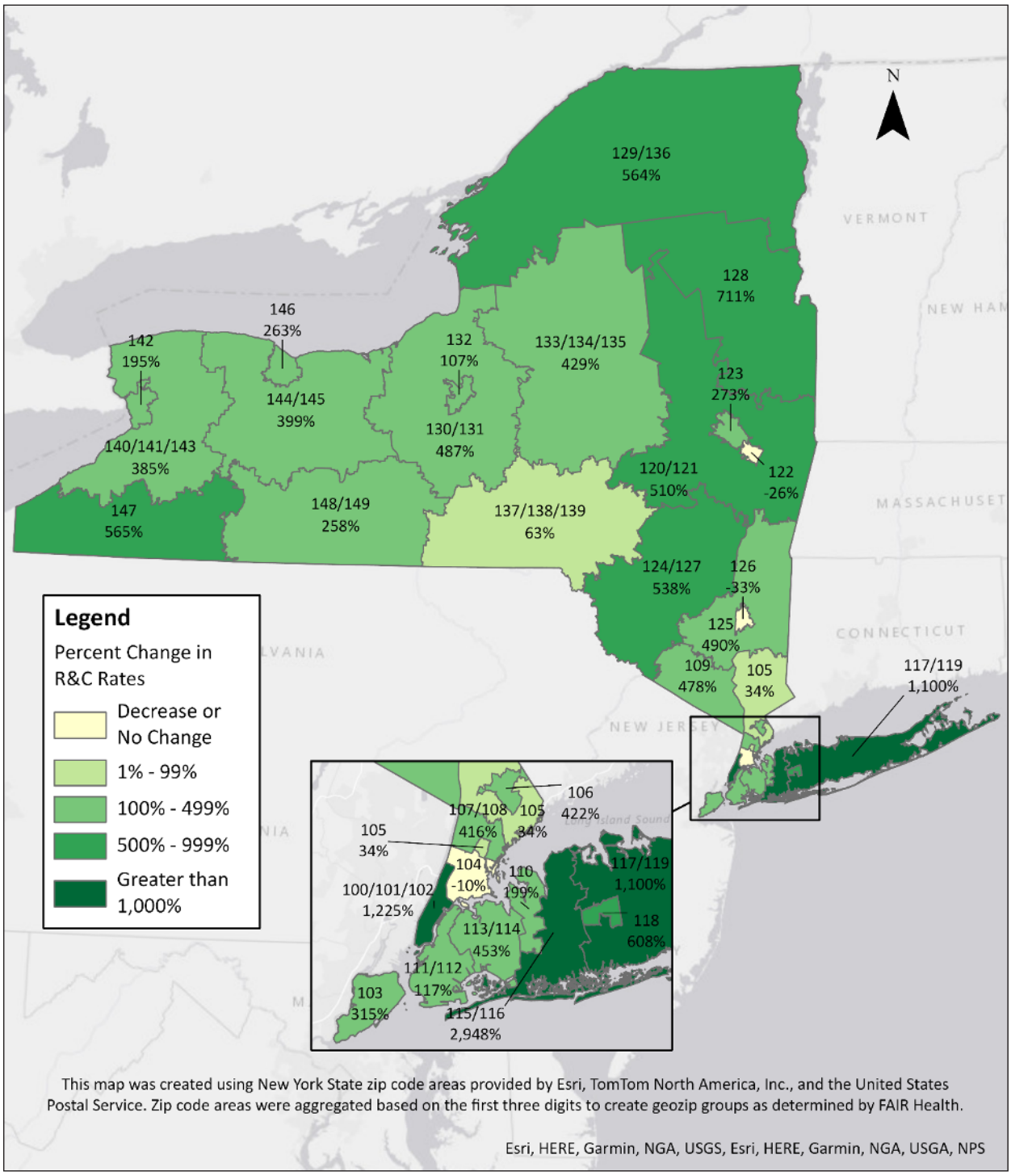
The extent of rate increases is best illustrated by a carotid artery catheterization procedure that was first introduced in 2013. In 2013, the R&C rates for this procedure in each geozip group were created using FAIR Health's derived benchmark methodology. However, by 2016, some geozip groups had enough provider charge data and R&C rates were created based on FAIR Health's actual benchmark methodology. The derived methodology is based on provider charges for related procedures; however, auditors observed large differences between rates based on the derived methodology and rates based on the actual methodology. For instance, sharp increases in R&C rates were identified for the carotid artery catheterization procedure from 2013 to 2016, as follows.

As Figure 7 demonstrates, most locations across New York State had rate increases of over 100 percent for this service. The largest rate hikes occurred in:

- Far Rockaway/Hempstead (geozips 115/116), with a dramatic increase of 2,948 percent (from $1,050 in 2013 to $32,000 in 2016);
- Manhattan (geozips 100/101/102) with an increase of 1,225 percent (from $1,645 in 2013 to $21,800 in 2016); and
- Brentwood/Coram/Riverhead (geozips 117/119) with an increase of 1,100 percent (from $875 in 2013 to $10,500 in 2016).

In contrast, while the R&C rate increased by 2,948 percent in Far Rockaway/Hempstead (from $1,050 to $32,000), the Medicare rate in the same region only increased by 10 percent (from $2,052 to $2,253).

Figure 7– Percent Change in R&C Rates for Carotid Artery Catheterization, 2013 to 2016[4]



4 Portions of the maps contained in this report include the intellectual property of Esri and its licensors and are used under license. Copyright © 1987-2020 Esri and its licensors. All rights reserved.

R&C Rate Disparities Statewide

For the five-year period from 2012 to 2016, there were large disparities in R&C rates across the State. For 90 percent of the service codes analyzed, significant disparities were found between downstate and upstate regions, with downstate (geozip 105 [Mount Vernon/Ossining/Peekskill], geozip 109 [Rockland County/New City], and all geozips south of geozips 105 and 109) usually having the highest rates for service codes and upstate (geozip 124/127 [Kingston/Monticello], geozip 125 [Newburgh/Rhinebeck], geozip 126 [Poughkeepsie], and all geozips north of these geozips) usually having the lowest. The degree of disparity was itself significant: the highest rate was as much as 228 times greater than the lowest rate. In fact, for almost half of the service codes analyzed, the highest rate was 10 times greater than the lowest rate.

Figure 8 illustrates regional disparities for selected procedures.

Figure 8 - Regional Disparities in R&C Rates

Procedure	Time Period	Region 1	R&C Rate	Region 2	R&C Rate
Neck Procedure	Jan–June 2016	Brentwood, Coram, Riverhead	$60,216	Amherst, Niagara Falls	$634
Spinal Procedure 1	July–Dec 2016	Flushing, Jamaica	$90,000	Cohoes, Troy	$3,712
Spinal Procedure 2	Jan–June 2015	White Plains	$70,000	Albany	$921
Spinal Procedure 3	July–Dec 2016	Far Rockaway, Hempstead	$62,100	Canandaigua, Penn Yan	$1,837
Spinal Procedure 4	July–Dec 2016	Brentwood, Coram, Riverhead	$38,000	Amherst, Niagara Falls	$167
Office Visit 1	Jan–June 2015	Great Neck, Port Washington	$736	Jamestown, Olean	$248
Office Visit 2	July–Dec 2016	Bronx	$675	Glenfield, Rome, Utica	$230

The extent of these disparities is best illustrated using examples from the service codes analyzed. Figure 9 presents rates in different regions of the State for a spinal procedure in 2016. As demonstrated, there are generally extremely large differences in rates between upstate and downstate regions, ranging from a low of $3,802 in Amherst/Niagara Falls (geozips 140/141/143) to a high of $90,000 in Hicksville (geozip 118) and Far Rockaway/Hempstead (geozips 115/116)—a rate 24 times greater than in Amherst/Niagara Falls. Other downstate regions also had high rates, including: Brentwood/Coram/Riverhead (geozips 117/119) $87,500; White Plains (geozip 106) $66,525; Mount Vernon/Ossining/Peekskill (geozip 105) $63,525; New Rochelle/Yonkers (geozips 107/108) $57,990; Manhattan (geozips 100/101/102) $50,000; Flushing/Jamaica (geozips 113/114) $45,000; and Great Neck/Port Washington (geozip 110) $43,755. With the exception of Glens Falls/Newcomb (geozip 128), which had a relatively high rate of $35,686, all other rates statewide fell at or below $12,375.

For this same spinal procedure, the statewide difference was far less significant for both in-network and Medicare rates. Average in-network rates ranged from a low of $255 in Great Neck/Port Washington (geozip 110) to a high of $2,337 in Auburn/Liverpool (geozip 130/131), only nine times greater than the lowest rate. Even less significant was the statewide difference in Medicare rates, with a high of $2,314 downstate, only 1.4 times greater than the lowest rate of $1,687 in most locations upstate.

Figure 10 shows R&C rates for a brain surgery procedure in 2016, demonstrating significant rate disparities between upstate and downstate regions, with the largest rates occurring downstate: Far Rockaway/Hempstead (geozips 115/116) $45,000; White Plains (geozip 106) $32,152; Manhattan (geozips 100/101/102) $8,066; and Flushing/Jamaica (geozips 113/114) $5,430. Elsewhere in the State, rates ranged from $2,500 to a low of $550 for Binghamton/Vestal/ Oneonta (geozips 137/138/139), a rate 82 times less than that for Far Rockaway/ Hempstead.

There was also far less statewide disparity among the in-network and Medicare rates for this procedure. The lowest average in-network rate was $65 (Great Neck/Port Washington, geozip 110), while the highest rate was $422 (Manhattan, geozips 100/101/102)—only six times higher than the lowest in-network rate. The highest Medicare rate of $332 (in many downstate regions) was only 1.4 times greater than the lowest Medicare rate of $233 (in many upstate regions).

Figure 9 – R&C Rates for a Spinal Procedure, 2016[4]

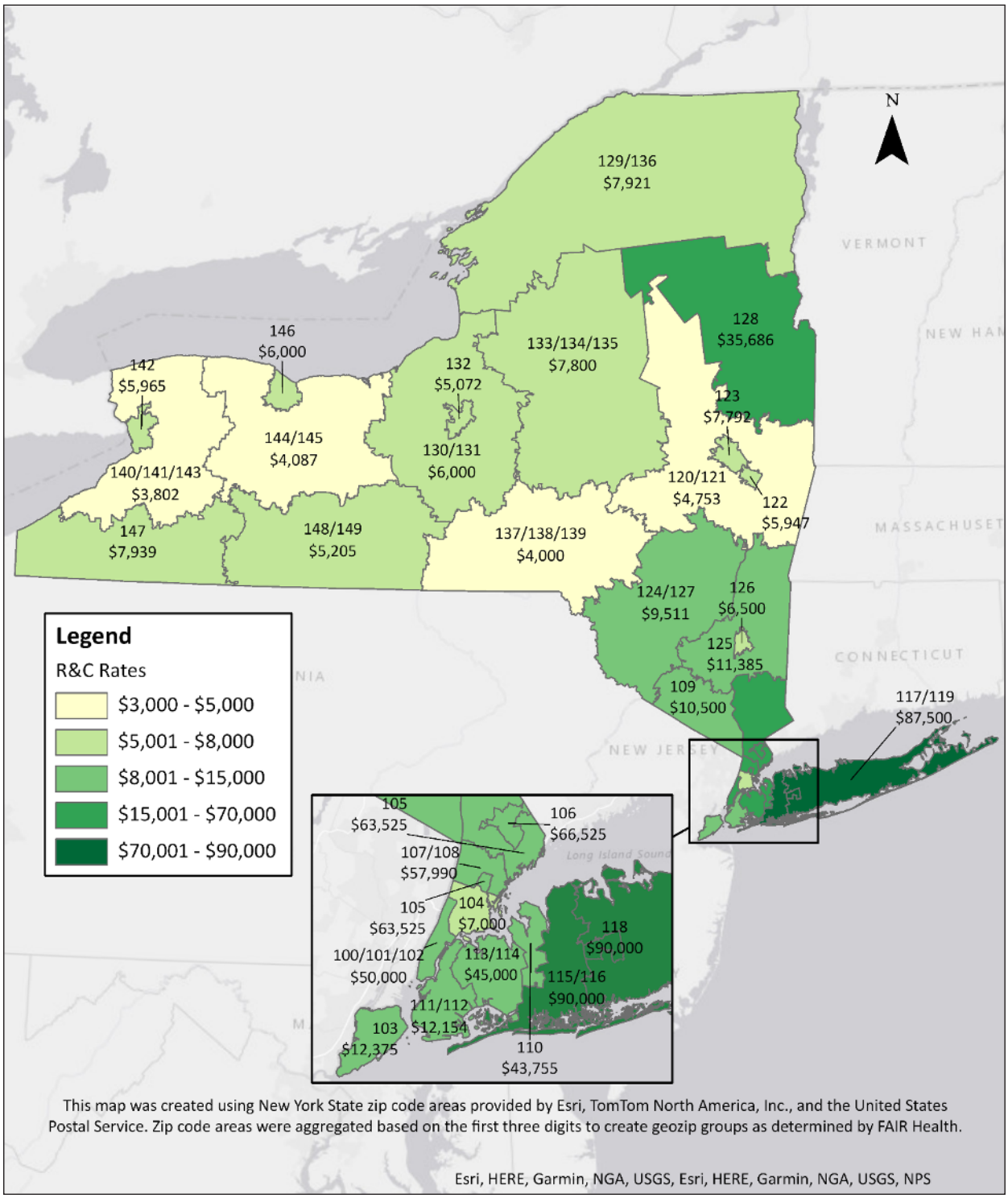
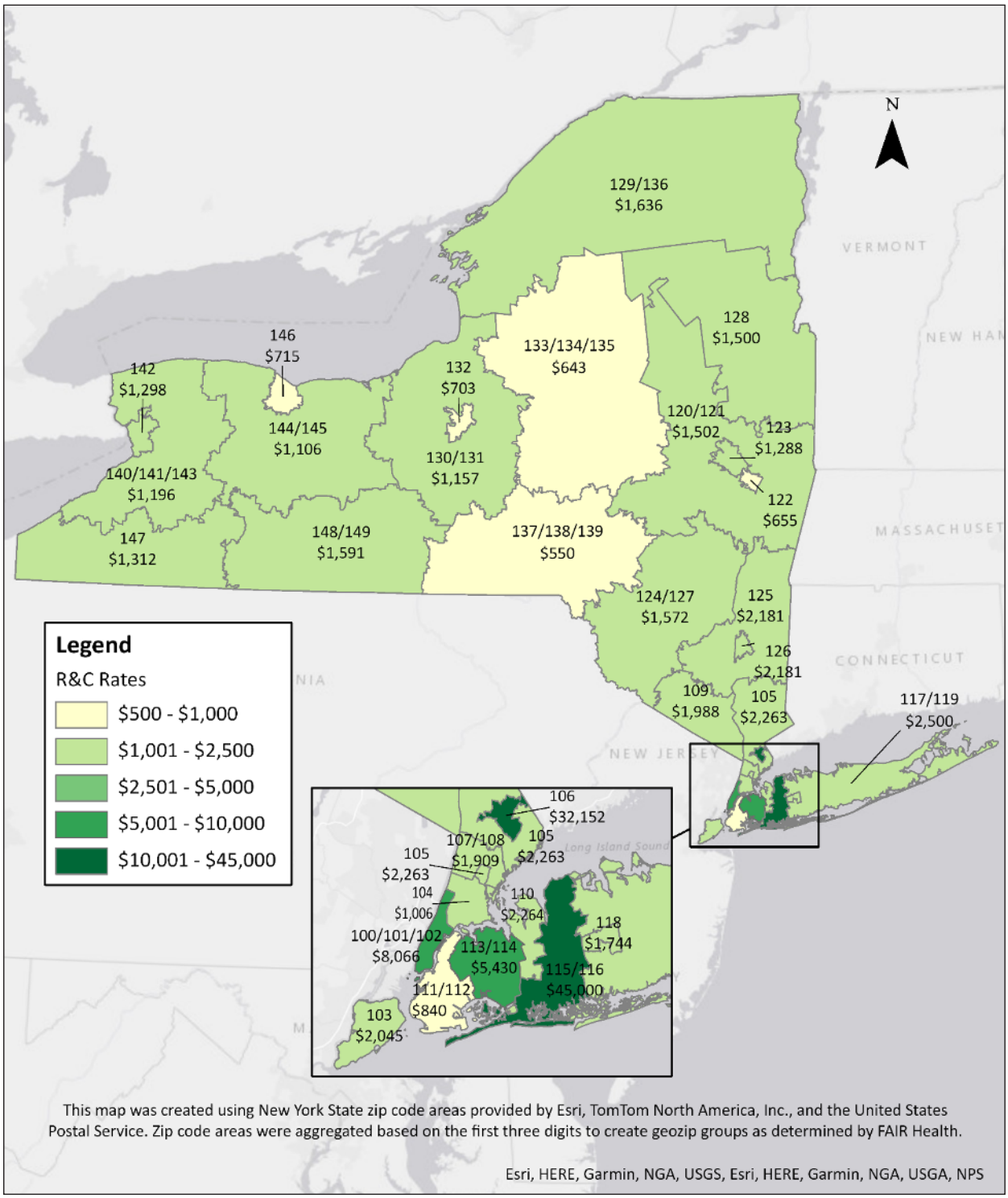


Figure 10 – R&C Rates for a Brain Surgery Procedure, 2016[4]



R&C Rate Disparities Among Adjacent Geozip Groups

By comparing R&C rates across regions, auditors identified questionable patterns of disparity that raise questions about the provider-driven nature of R&C rates. The R&C rates are provider-driven in that the rates are determined from actual provider charges in a geozip. As such, there is the potential for providers in a particular region, knowing that the R&C rate is based on a percentile derived from that region's provider billings (i.e., charges), to bill higher than necessary for a service, thereby driving up the R&C rate for that service in that region.

Auditors found substantial rate differences for some service codes among neighboring regions. As illustrated by Figure 9, spinal procedure rates in Flushing/Jamaica (geozips 113/114) of $45,000 and Great Neck/Port Washington (geozip 110) of $43,755 were roughly half the rate in adjacent Far Rockaway/Hempstead (geozips 115/116) of $90,000. The rate difference for this procedure is even more pronounced in neighboring areas:

- $63,525 in Mount Vernon/Ossining/Peekskill (geozip 105) versus $10,500 in Rockland County/New City (geozip 109);
- $50,000 in Manhattan (geozips 100/101/102) versus $7,000 in the Bronx (geozip 104);
- $45,000 in Flushing/Jamaica (geozips 113/114) versus $12,154 in Astoria/Brooklyn (geozips 111/112); and
- $35,686 in Glens Falls/Newcomb (geozip 128) versus $7,921 in Keeseville/Watertown (geozips 129/136), $7,800 in Glenfield/Rome/Utica (geozips 133/134/135), and $4,753 in Cohoes/Troy (geozips 120/121).

FIgure 10, showing rates for a brain surgery procedure, demonstrates a similar pattern:

- $45,000 in Far Rockaway/Hempstead (geozips 115/116) compared with less than $3,000 in the neighboring locations of Great Neck/Port Washington (geozip 110), Brentwood/Coram/Riverhead (geozips 117/119), and Hicksville (geozip 118); and
- $32,152 in White Plains (geozip 106) compared with $1,909 in New Rochelle/Yonkers (geozips 107/108) and $2,263 in Mount Vernon/Ossining/Peekskill (geozip 105).

With the exception of Far Rockaway/Hempstead and White Plains, the rates elsewhere across the State were lower, ranging from $8,066 to $550. However, even among these lower rates, auditors still found rather large disparities. For example, the rate for Manhattan (geozips 100/101/102) was $8,066, compared with $840 in Astoria/Brooklyn (geozips 111/112) and $1,006 in the Bronx (geozip 104). In fact, all 31 geozip groups in New York State had at least some service code rates that were at least double the rate in an adjacent region. The Far Rockaway/Hempstead region (geozips 115/116) had rates for 73 of 141 service codes that were at least double the corresponding rates in three neighboring regions: Great Neck/Port Washington (geozip 110), Flushing/Jamaica (geozips 113/114), and Brentwood/Coram/Riverhead (geozips 117/119).

The analysis of rate differences among neighboring geozip groups for each year also revealed extreme disparities for certain procedures, as shown in Figure 11.

Figure 11 – Large Rate Disparities Among Neighboring Geozip Groups by Year

Geozip Group	R&C		Medicare	
	Rate*	Percent Difference	Rate	Percent Difference
2012 – Spinal Procedure A				
Far Rockaway/Hempstead	**$16,100**		$197	
Great Neck/Port Washington	$1,750	820%	$197	0%
Flushing/Jamaica	$2,500	544%	$197	0%
Brentwood/Coram/Riverhead	$10,000	61%	$195	1%
Hicksville	$13,000	24%	$195	1%
2013 – Spinal Procedure B				
White Plains	**$60,500**		$2,021	
Mount Vernon/Ossining/Peekskill	$7,531	703%	$2,021	0%
2014 – Application of Spinal Prosthetic Device				
Manhattan	**$15,000**		$487	
Astoria/Brooklyn	$1,287	1,066%	$512	-5%
Bronx	$4,000	275%	$511	-5%
2015 – Needle Localization Procedure				
Mount Vernon/Ossining/Peekskill	**$4,500**		$111	
Newburgh/Rhinebeck	$250	1,700%	$99	12%
Bronx	$255	1,665%	$111	0%
Rockland County/New City	$300	1,403%	$111	0%
New Rochelle/Yonkers	$325	1,285%	$111	0%
White Plains	$480	838%	$111	0%
2016 – Carotid Artery Catheterization				
Manhattan	**$21,800**		$2,166	
Bronx	$1,257	1,634%	$2,253	-4%
Astoria/Brooklyn	$2,504	771%	$2,253	-4%

*The rate is an average of the two six-month periods (January–June and July–December) for the geozip.

For the procedures and locations in Figure 11, auditors also examined Medicare rates and found immaterial or no differences in the Medicare rates among neighboring regions. For example, for the needle localization procedure in 2015, the Medicare rate in Mount Vernon/Ossining/Peekskill was only 12 percent higher than in Newburgh/Rhinebeck. By contrast, the R&C rate for that procedure was 1,700 percent higher in the Mount Vernon region than in the Newburgh region. In another example, the R&C rate in 2016 for the carotid artery catheterization procedure in Manhattan was 1,634 percent higher than the Bronx rate and 771 percent higher than the Astoria/Brooklyn rate. By contrast, the Medicare rate in Manhattan was within 4 percent of the rates in both the Bronx and Astoria/Brooklyn regions.

R&C Rates Compared With Other Rates

Based on a comparative analysis of R&C, MultiPlan, in-network, and Medicare rates, auditors determined R&C rates are generally higher than the other three. In 2016, for instance, R&C rates were:

- 1.5 to 49 times higher than the average MultiPlan rate for 35 percent of the service codes in the analysis;
- 1.5 to 100 times higher than the average in-network rate for 99 percent of the service codes in the analysis; and
- 1.5 to 25 times higher than the average Medicare rate for the portion of service codes in the analysis (86 percent) for which there were Medicare rates.

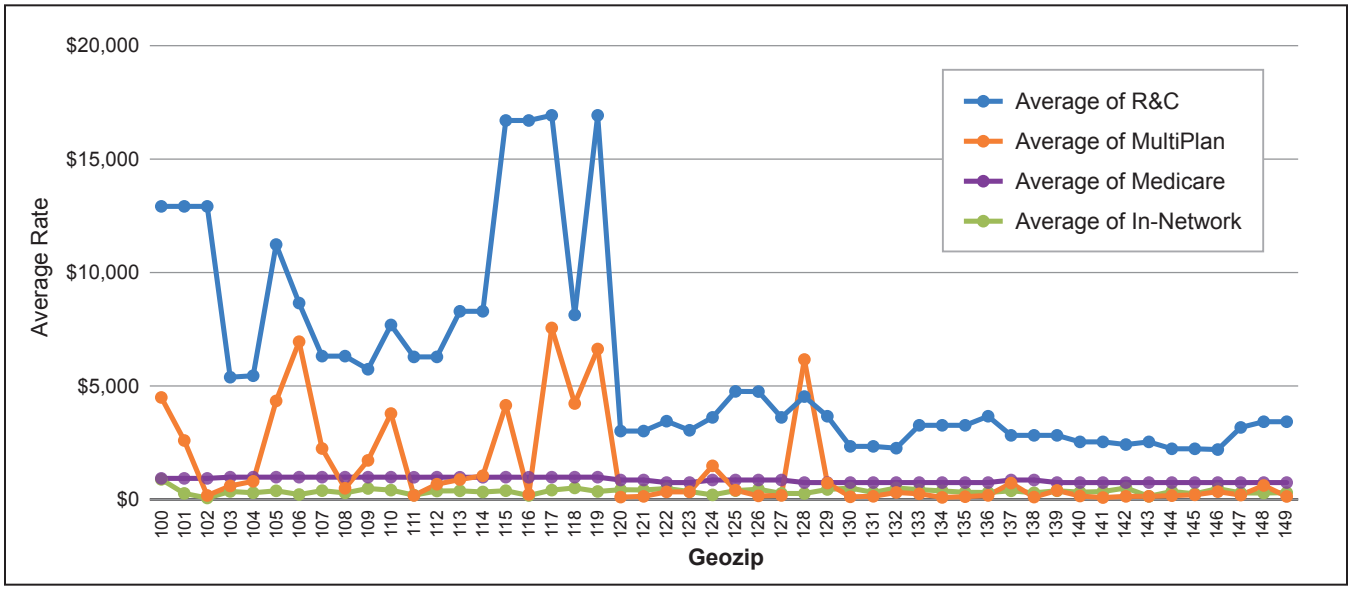
Furthermore, in 2016, average R&C rates were:

- Higher than average MultiPlan rates in all but one of the geozips;
- Higher than average in-network rates in all geozips; and
- Higher than average Medicare rates in all geozips.

Figure 12 illustrates the rate differences for each geozip statewide.

Figure 12 – Extent of Rate Differences by Geozip

Rate Comparisons by Geozip (July–Dec 2016)



The rate differences within some of the geozips are extremely large. Figure 13 illustrates rate comparisons in Brentwood/Coram/Riverhead, where the average R&C rate across all service codes in our analysis was $16,929—twice the MultiPlan average rate of $7,558; 41 times the average in-network rate of $409; and 17 times the Medicare rate of $980.

Figure 13 – Rate Comparisons for Brentwood/Coram/Riverhead

Average Rates (July–Dec 2016)

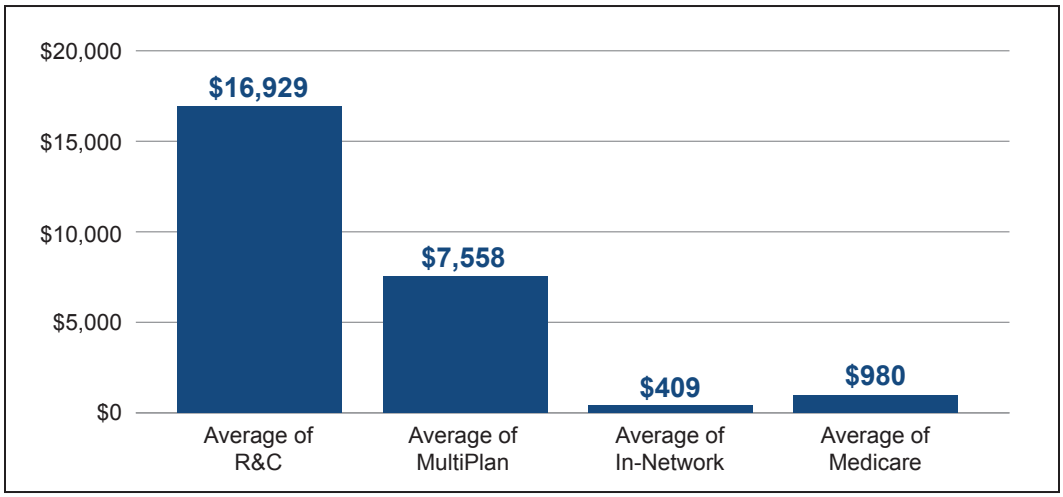
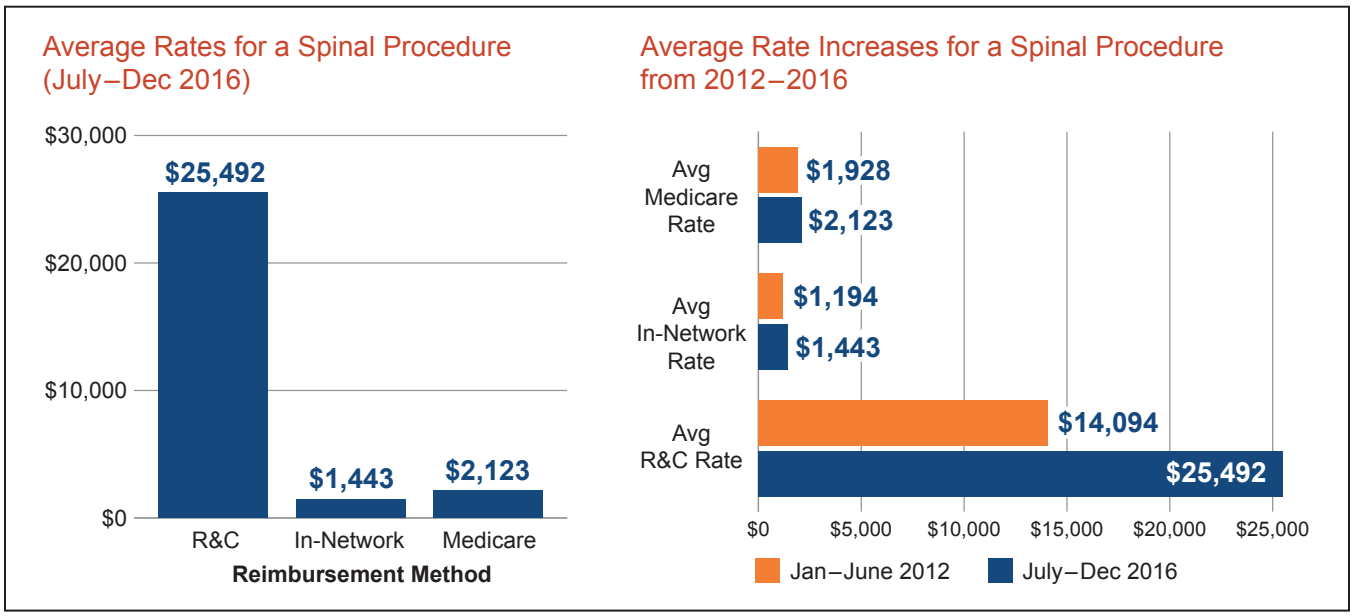


Figure 14 illustrates differences in the rates for a spinal procedure. For the period July–December 2016, the average R&C rate for this procedure across all State geozips was $25,492, compared with $1,443 for in-network, and $2,123 for Medicare. (Note: a comparable MultiPlan rate for this procedure was not available). It is also important to point out that the R&C rate increased at a far greater pace than both the in-network and Medicare rates from 2012 to 2016. For example, the average R&C rate increased from $14,094 in 2012 to $25,492 in 2016, an increase of $11,398 (81 percent). By contrast, the average in-network rate increased from $1,194 to $1,443, an increase of only $249 (21 percent); and the average Medicare rate increased from $1,928 in 2012 to $2,123 in 2016, an increase of $195 (10 percent).

Figure 14 – Rate Comparisons for a Spinal Procedure



Considerations for Changing the Empire Plan's Use of R&C Rates

Auditors found no evidence that increases and disparities in R&C rates stemmed from a predictable source (e.g., an increase in claims or medical care cost-of-living). As a result, there does not appear to be any readily identifiable factors to explain these differences other than the provider-driven nature of R&C rates, which, as stated, are based on provider charges for services:

- The R&C out-of-network reimbursement methodology is based on provider-driven charges. The benchmark percentiles used to reimburse out-of-network R&C claims are created using actual provider charges in a geographic area.

As such, there is a risk that providers can bill higher than necessary (submit high charge amounts) to drive up the R&C rate.

- The Empire Plan reimburses at the higher 90th percentile of the charge benchmarks. Other plans within New York State and across other states reimburse using other methodologies and/or different percentiles. The 90th percentile rate is high and results in greater reimbursements than other methodologies used by other states and plans.

Because the R&C is based on provider-driven charges and R&C rates tend to be significantly higher than other rates, auditors estimate that New York State is paying more in out-of-network reimbursements than it would under various other reimbursement methodologies. Auditors calculated potential annual cost savings of $17 million to $146 million under various alternative reimbursement methodologies (discussed later in the section titled 'Potential Cost Savings').

According to Civil Service officials, the use of the 90th percentile is a long-established practice and any change must be negotiated through collective bargaining. This reimbursement methodology dates back to at least 1986 and has never been changed.

Council officials have acknowledged that the cost of out-of-network benefits is a concern, and reducing out-of-network reimbursement rates would realize cost savings for the Empire Plan. At the same time, they also expressed concern that reducing out-of-network reimbursement rates could expose Empire Plan members to increased balance bills from providers, whereby patients are responsible for paying the difference between United's reimbursement amount and an out-of-network provider's full charges. However, most members using out-of-network providers have sufficient access to in-network providers. Members who are concerned about liability for out-of-network providers' balance bills for amounts above United's reimbursement can choose to utilize in-network providers and thus avoid balance bills. In addition, prior State Comptroller audits have shown that out-of-network providers in New York State often waive patient balances above United's reimbursement.[5] This practice circumvents the financial incentives for enrollees to choose in-network providers over out-of-network providers.

Civil Service officials also noted some members live in areas of the country (for instance, retirees) with limited or no in-network provider access. While this may be the case, auditors determined that approximately 88 percent of the services that United paid based on the R&C rate from 2012 to 2016 occurred in New York State — where there is adequate access to in-network providers. California and Texas, two of the states with limited in-network access, experienced much

5 Office of the New York State Comptroller, Preventing Inappropriate and Excessive Costs in the New York State Health Insurance Program – A Summary of Audits Identifying Out-of-Network Providers Engaged in Routine Waiving, Report No. 2016-D-1, May 2018. https://osc.state.ny.us/audits/allaudits/093018/sga-2018-16d1.pdf

lower out-of-network utilization by members from 2012 to 2016. United's R&C-based payments for services rendered in California and Texas totaled about $15.3 million over this period. Given the relatively low out-of-network utilization in regions across the country with limited in-network access, it is likely that steps, such as having various plan design options, could be taken to protect members in these regions from large balance bills.

Alternative Out-of-Network Reimbursement Approaches

The Empire Plan reimburses out-of-network costs based on the 90th percentile of FAIR Health benchmark charge data. There are significant risks to basing R&C rates on provider-driven charges. For example, there is a risk that providers in a particular region may bill higher than necessary for a service, knowing that the R&C rate is based on a percentile derived from provider billings (charges) in that region, thereby driving up the R&C rate for that service in that region.

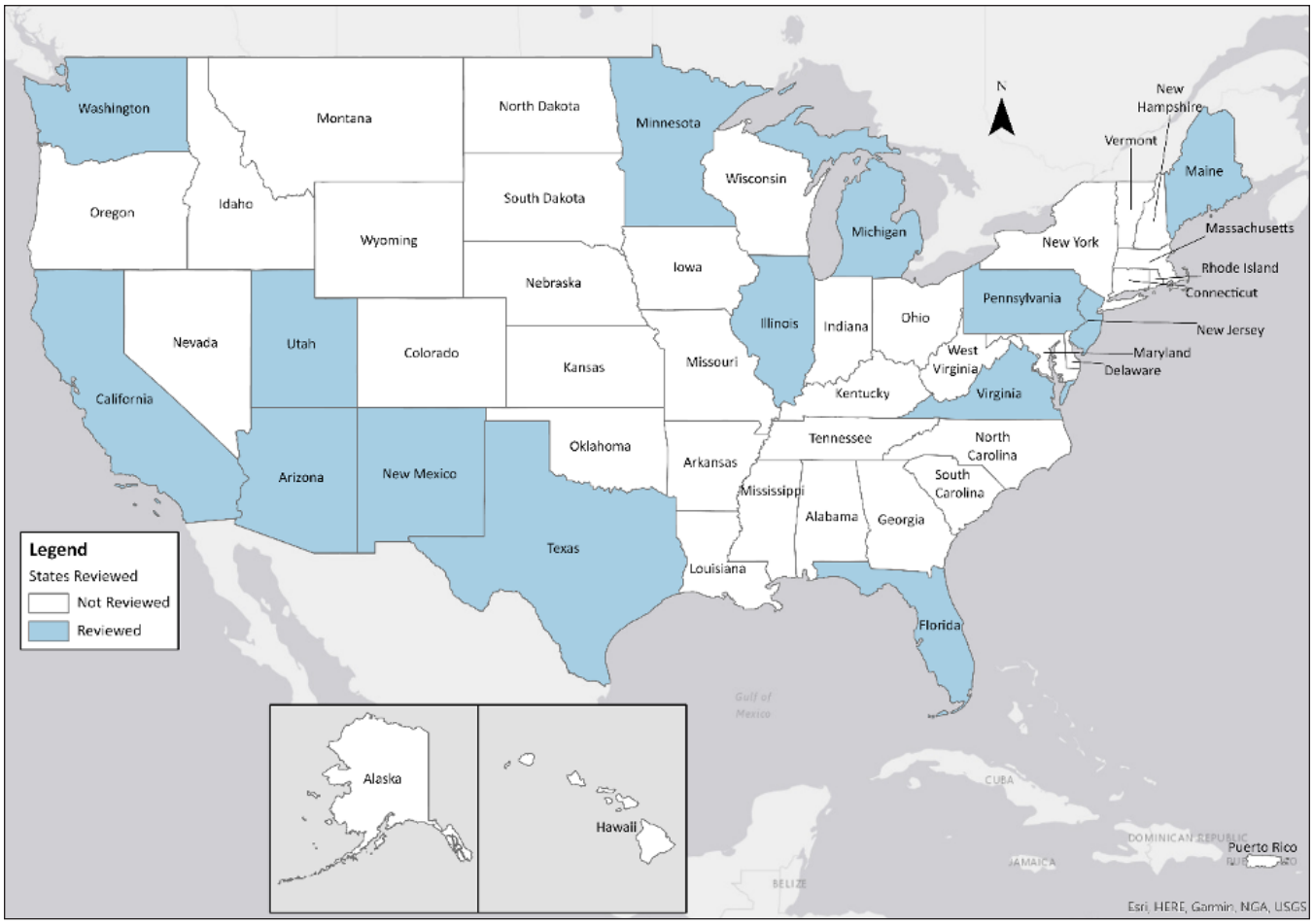
Council officials say they have proposed plan designs that do not use the 90th percentile benchmark for determining R&C rates, including use of the 70th and 80th percentiles of the FAIR Health benchmark charge data, and a percentage of the Medicare rates. However, given the challenges of implementing changes to the out-of-network reimbursement methodology, the Council has focused on incentivizing employees to use in-network providers by increasing members' out-of-network utilization costs (i.e., out-of-pocket deductibles and coinsurance) and expanding the availability of in-network providers. According to Civil Service officials, to increase the availability of in-network providers, Civil Service has partnered with United to recruit 10 additional provider groups into the Empire Plan network—representing 664 individual providers—for an annual estimated savings of approximately $21 million for the Empire Plan.

In 2014, the Insurance Law was amended to add Section 3241, which sets forth out-of-network coverage requirements and requires insurers and other entities subject to this section to offer *at least one option* for coverage for at least 80 percent of the "usual and customary cost" of each out-of-network health care service. Usual and customary cost is defined as the 80th percentile of all charges for a service and geographic area as reported by FAIR Health. Reimbursement at the 80th percentile of FAIR Health would be lower than reimbursement at the Empire Plan's 90th percentile, meaning that the Empire Plan's reimbursement is more generous than that required for insurers and other entities subject to Section 3241 of the Insurance Law. Additionally, the OON Workgroup, in their 2017 report, found that plans that reimburse out-of-network services using the Medicare rate reimburse significantly less than plans reimbursing at the 80th percentile of the FAIR Health benchmark charge data. The OON Workgroup also reviewed alternative rate methodologies for out-of-network coverage and discussed a hybrid approach, whereby the 80th percentile of the FAIR Health

benchmark charge data could be blended with in-network provider rates to arrive at a reimbursement rate that is between actual charges and a negotiated rate that an in-network provider would accept.

Auditors reviewed the government employee health plans of 14 states and the federal government to determine what other methodologies are used to reimburse out-of-network services for employee health plans.

Figure 15 – Sample of State Employee Health Plans Reviewed[4]



One state reviewed generally only offered in-network services to its members (Minnesota), and only paid for out-of-network services if considered urgent or for emergency care, in which case the provider is paid as though the member was treated through an in-network provider. For the federal government and remaining 13 states that offered out-of-network coverage, auditors identified three commonly used reimbursement methodologies: Medicare rate based; in-network rate based; and rates based on provider charge data.

Five of the government plans had out-of-network reimbursement methodologies that based payment on the Medicare rate, such as: 85 percent of the Medicare rate and 300 percent of the Medicare rate. Three government plans had out-of-network reimbursement methodologies that based payment on the in-network rate, such as: the in-network rate less 25 percent and 60 percent of the in-network rate. Eight government plans had out-of-network reimbursement methodologies that based payment on provider charges, such as: the 70th percentile and 80th percentile of charge data. One of the eight plans based reimbursement on the 90th percentile; however, that plan required members to pay a higher coinsurance (either 30 or 40 percent, depending on the option selected) than the 20 percent required of Empire Plan members. In fact, 12 of the 14 states reviewed, plus the federal government, had health plans with a coinsurance greater than 20 percent, with most being 40 percent.

In January 2017, the OON Workgroup reported that, while some plans reimburse out-of-network services at the 80th percentile of FAIR Health benchmark charge data, the majority of consumers in the individual and small-group markets have out-of-network coverage that reimburses at a percentage of Medicare rather than a FAIR Health-based benchmark charge. The OON Workgroup also found that plans that reimburse at the 80th percentile of the FAIR Health benchmark charge data generally cost more in premiums than plans that reimburse based on the Medicare rate.

Premiums

In 2012, the combined State and employee premium for individual coverage was approximately $168 monthly, compared with approximately $188 in 2016, an overall increase of 12 percent. The premium for family coverage increased by 20 percent, from approximately $409 monthly in 2012 to approximately $490 in 2016.

The premiums that Empire Plan enrollees pay vary based on bargaining unit, employment grade, and choice of coverage (i.e., individual vs. family). Enrollees pay the same premium, regardless of whether they choose to use more costly out-of-network providers. Therefore, members who exclusively or primarily use in-network providers would, in effect, subsidize members who use higher-cost out-of-network providers more extensively. As of January 2017, the Empire Plan had 1,087,168 members, 970,744 of whom (89 percent) resided in New York State. Not all members utilize out-of-network services: from 2012–16, only 16 percent of Empire Plan members utilized out-of-network services reimbursed based on R&C or MultiPlan rates. Of these, fewer still—only 5 percent—were provided services paid based on R&C rates.

Health plans from two states in this analysis—Virginia and Arizona—require different premiums depending on whether they cover out-of-network services. Virginia offers a plan that only covers in-network services, and another option that

covers both in-network and out-of-network services. Similarly, Arizona also offers two plans, one covering only in-network services and another option covering both in-network and out-of-network. In Arizona, in 2016, the total employee and state premium for the combined in-network/out-of-network plan was higher than the premium for the in-network-only plan. For individual coverage, the employee share of the premium for the plan offering in-network and out-of-network coverage was $47.08 per pay period, and only $18.46 per pay period for the plan offering only in-network coverage.

Potential Cost Savings

To estimate potential cost savings resulting from the use of reimbursement methodologies other than the 90th percentile of the charge benchmarks, auditors analyzed United's claim payment data for 2016. Auditors identified 297 service codes with the highest aggregate R&C-based payments and based the cost-savings estimates on these service codes. Auditors limited their analysis to services from providers based in either New York or New Jersey (a bordering state that had the highest number of out-of-state R&C-based payments), which accounted for $153 million, or 76 percent, of United's R&C-based payments in 2016.

Auditors estimated potential savings at different benchmark percentiles of the FAIR Health benchmark charge data, different percentages of United's in-network rate, and different percentages of the Medicare rates. Auditors identified potential annual cost savings ranging from approximately $17 million to $146 million. As illustrated in Figures 16-18, estimated annual cost savings were most significant using a percentage of in-network and Medicare rates. Moving from the 90th percentile to the 80th percentile using FAIR Health benchmark charge data would result in approximately $25 million in cost savings, while paying as much as 300 percent of both the in-network and Medicare rates would result in approximately $105 million and $94 million in cost savings, respectively. If United paid out-of-network claims at the 70th percentile benchmark (consistent with the federal government's plan), the cost savings would be approximately $39 million. Paying out-of-network claims at 500 percent of the Medicare rate would result in $24 million more in cost savings than paying at the 70th percentile of the FAIR Health benchmark charge data. Auditors attribute the relatively low estimated savings based on alternative R&C percentiles to the provider-driven nature of the R&C rates.

Figure 16 – Estimated Cost Savings Based on Alternate FAIR Health Percentiles

FAIR Health Percentile	R&C Payment at 90th Percentile	Recalculated Payment Based on Alternate Methodology	Estimated Cost Savings
70th Percentile	$153,162,756	$113,954,414	$39,208,342
75th Percentile	$153,162,756	$120,605,826	$32,556,930
80th Percentile	$153,162,756	$128,065,711	$25,097,045
85th Percentile	$153,162,756	$136,052,732	$17,110,024

Figure 17 – Estimated Cost Savings Based on Alternate Percentages of In-Network Rates

Percent of In-Network Rate	R&C Payment at 90th Percentile*	Recalculated Payment Based on Alternate Methodology	Estimated Cost Savings
50% of In-Network Rate	$150,888,313	$4,500,174	$146,388,139
75% of In-Network Rate	$150,888,313	$8,637,284	$142,251,029
100% of In-Network Rate	$150,888,313	$12,774,393	$138,113,920
150% of In-Network Rate	$150,888,313	$21,048,613	$129,839,700
200% of In-Network Rate	$150,888,313	$29,322,833	$121,565,480
250% of In-Network Rate	$150,888,313	$37,597,053	$113,291,260
300% of In-Network Rate	$150,888,313	$45,871,273	$105,017,040

*Some payments were not recalculated because we could not determine an average in-network rate for that service code and geozip group; therefore, this amount differs from the amount in Figure 16.

Figure 18 – Estimated Cost Savings Based on Alternate Percentages of Medicare Rates

Percent of Medicare Rate	R&C Payment at 90th Percentile*	Recalculated Payment Based on Alternate Methodology	Estimated Cost Savings
100% of Medicare Rate	$136,975,282	$11,544,414	$125,430,868
110% of Medicare Rate	$136,975,282	$13,091,213	$123,884,069
140% of Medicare Rate	$136,975,282	$17,731,611	$119,243,671
150% of Medicare Rate	$136,975,282	$19,278,410	$117,696,872
200% of Medicare Rate	$136,975,282	$27,012,407	$109,962,875
250% of Medicare Rate	$136,975,282	$34,746,403	$102,228,879
300% of Medicare Rate	$136,975,282	$42,480,399	$94,494,883
350% of Medicare Rate	$136,975,282	$50,214,395	$86,760,887
400% of Medicare Rate	$136,975,282	$57,948,392	$79,026,890
450% of Medicare Rate	$136,975,282	$65,682,388	$71,292,894
500% of Medicare Rate	$136,975,282	$73,416,384	$63,558,898

*Some payments were not recalculated because those service codes did not have Medicare rates; therefore, this amount differs from the amount in Figure 16.

Recommendation

The Council and key stakeholders should work together to determine if better reimbursement methodologies and plan design options exist for R&C out-of-network services other than one option that is based on provider-driven charges. The new methodologies and plan options should consider the cost effectiveness of reimbursement rates, thereby benefiting Empire Plan members and the State's taxpayers by lowering the Empire Plan's health care premiums, while continuing to provide the same level of medical services to all Empire Plan members.

Contributors to This Report

Andrea Inman, Audit Director

David Fleming, Audit Manager

Paul Alois, Audit Manager

Laura Brown, Audit Supervisor

Devisha Gujjar, Examiner-in-Charge

Tracy Glover, Senior Examiner

Michael Schaffer, Senior Examiner

Constance Walker, Senior Examiner

Jonathan Julca, Mapping Analyst

Hilary Papineau, Mapping Analyst

Rachael Southworth, Mapping Analyst

Mary McCoy, Supervising Editor

Andrea Majot, Senior Editor

Contact

Office of the New York State Comptroller
110 State Street
Albany, New York 12236

(518) 474-4044

www.osc.state.ny.us

Prepared by the Division of State Government Accountability

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