

Usual and Customary Survey
Revised January 2017



Texas Department of Insurance

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January 2017 Revisions

This report supersedes a report previously published by the Texas Department of Insurance in September 2016. Following publication of the report, TDI learned that some of the FAIR Health baseline data the department obtained pertaining to average amounts for medical procedures billed by health providers was incorrect on the FAIR Health Consumer website. This report corrects this data and notes instances where the data was revised. The changes only affected certain baseline amounts for FAIR Health.

The revised data appears on the following pages: 17, 19, 20, 21, 34, 39, 41, 44, and 45.

Executive Summary

A Preferred Provider Organization (PPO) is a type of health insurance plan that contracts with doctors and hospitals to create a network of preferred providers that can provide care to enrollees at a discounted cost. A preferred provider agrees to accept the contracted rate as full payment and an enrollee is only responsible for the in-network cost sharing, such as deductibles, coinsurance, and co-payments. A preferred provider may not bill an enrollee for charges above the contracted rate (for covered services).

PPO plans also provide benefits for certain services obtained from nonpreferred providers, providers who have no contractual agreement with the plan. The amount of reimbursement and cost sharing for these “out-of-network” services is based on the particular policy’s schedule of benefits and are generally reimbursed at a lower rate (“allowed amount”) and higher enrollee cost share than for in-network services. If a nonpreferred provider’s billed charge is higher than the allowed amount, the nonpreferred provider may bill the enrollee for the difference, a concept known as “balance billing.”

There are certain circumstances where a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances requiring emergency care; when no preferred provider is reasonably available within the designated service area for which the policy was issued; and when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider (28 TAC §3.3708(a)). In these circumstances where an enrollee has no opportunity to select a preferred provider, no opportunity to shop or negotiate the fee for the services received, and no contract between the parties exists, there must be a way to determine the fair value, and a fair distribution of the costs, for the services without unjust enrichment of the patient, the provider, or the insurer.

Texas Insurance Code (TIC), §1301.005(b) and §1301.155(b) require that claims in these circumstances be paid at the same level of reimbursement as for a preferred provider and TIC, §1301.005(a) also requires an insurer make out-of-network (basic level) benefits “reasonably available” to all insureds. Based on these requirements, Title 28 of the Texas Administrative Code (28 TAC) was amended in 2013 to require an insurer to pay these claims, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan. The reimbursement methodology used by insurers to determine the “usual and customary charge” in these circumstances is the subject of this survey.

Legal Overview

Under 28 TAC §3.3708(b), when services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of the section, the insurer must:

- (1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;
- (2) pay the claim at the preferred benefit coinsurance level; and

- (3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount, toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.

Under §3.3708(c), reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

- (1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects the market rates, including geographic differences in costs;
- (2) if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;
- (3) is updated no less than once per year;
- (4) does not use data that is more than three years old; and
- (5) is consistent with nationally recognized and generally accepted bundling edits and logic.

Survey Purpose and Overview

The Texas Department of Insurance (TDI) conducted a survey to assess the practices of the Texas health insurance industry pertaining to payment to nonpreferred providers in preferred provider benefit (PPO) plans. By rule, insurers are generally required to reimburse nonpreferred providers in specified circumstances at least at the "usual and customary charge" for services. It is also required by rule (28 TAC §3.3708(c)) that insurers use industry and market standards in determining the customary billed charges for services provided. However, providers and insurers do not always agree on what the appropriate reimbursement amount should be for a service. Further complicating the determination of usual and customary charges are factors such as inflated billing and geographic cost differences.

To get a clearer picture of how insurers reimburse nonpreferred providers, TDI sent a survey to insurers with historical annual health premiums of more than \$1 million. See Appendix A for the survey questions. The agency received submissions from 25 insurers making up about 90 percent of the total comprehensive health market.

Part of the survey addressed practices and methodologies used by insurers to determine reimbursement to nonpreferred providers. This section allowed respondents to answer questions with narrative answers. Since insurers were able to respond to questions in their own words, the analysis of these responses required TDI to categorize answers for presentation in this report. In most cases, answers were straightforward.

Another part of the survey asked for reimbursement data on six specific medical procedure codes in five urban ZIP codes. Responses from insurers were graphed alongside benchmark cost amounts for comparison. Any recent methodology changes by insurers might not be reflected in the historical

reimbursement data shown on the graph for that insurer. Additionally, not all insurers provided data for every possible element.

The survey results summarized in this report are intended to give a brief view of market practices and methodologies for reimbursing service providers at usual and customary charges.

Summary of Findings

The following general findings are based on survey responses submitted to TDI by insurers:

- The vast majority of insurers use a third-party data source in determining the amount of claims payment.
- Most insurers do not use Medicare in determining the amount of claims payment.
- Insurers that use Medicare as the basis for paying claims pay far less than those that do not.
- For calculating the amount of claims payment, all responding insurers use data that is regularly updated.
- Although not required by law, most insurers report holding enrollees harmless in balance billing situations.

Disparate Payments for Medical Procedures

The methods that insurers reported using to determine reimbursement amounts varied, but generally fell into a few categories. Some reported that they rely on FAIR Health exclusively or primarily, some reported that they use federal Medicare reimbursement data exclusively or primarily, and others reported a different method or a combination of methods, usually involving some kind of price negotiation. Summaries of these responses are detailed in questions 1, 2, and 3.

Since FAIR Health and Medicare both offer reimbursement schedules with specific dollar amounts, TDI analyzed the reimbursement amounts for these two reimbursement methods. TDI compared average reimbursement amounts for insurers that reported using FAIR Health primarily with those that reported using Medicare primarily.

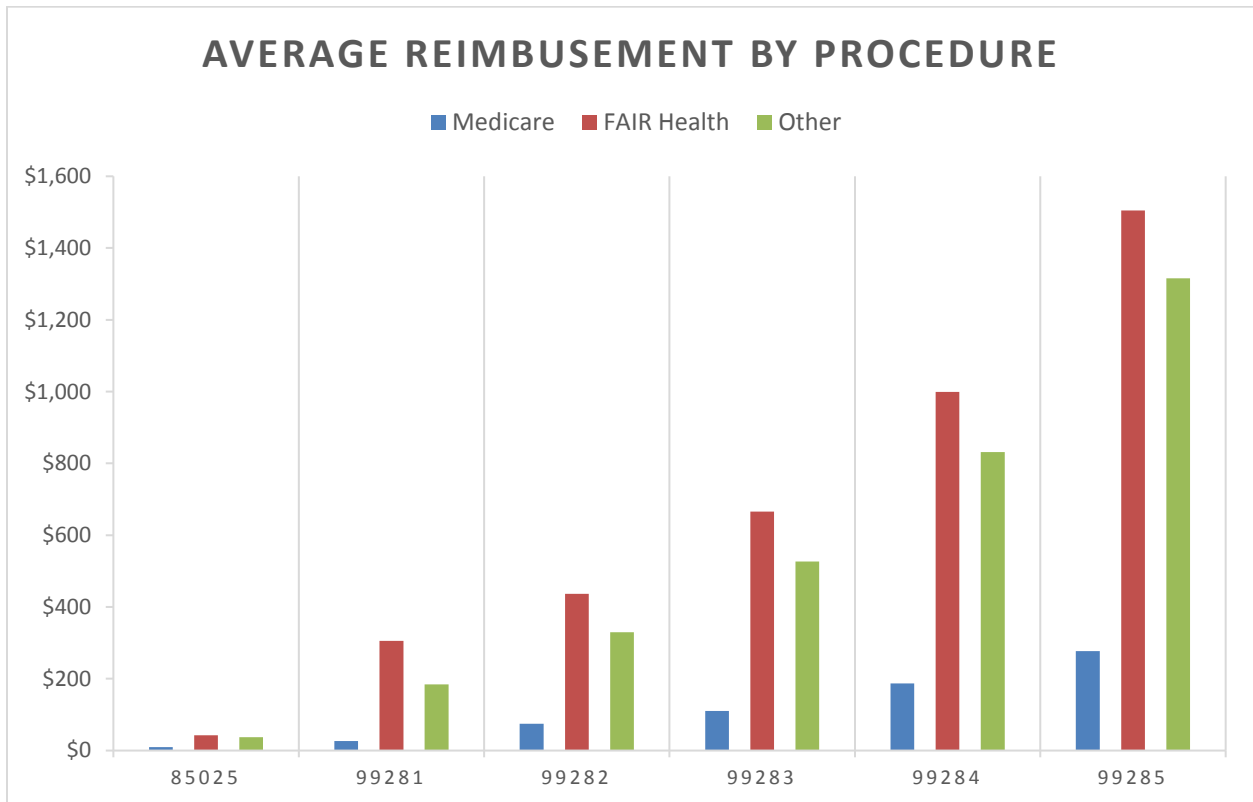
TDI looked at reimbursement data provided by insurers for six medical procedure codes in five urban locations in Texas. The Current Procedural Terminology (CPT) codes in Figure 1 correspond to the following procedures:

- 85025 - Complete blood count (CBC)
- 99281 - Emergency department visit – limited/minor
- 99282 - Emergency department visit – low to moderate severity
- 99283 - Emergency department visit – moderate severity
- 99284 - Emergency department visit – high severity and urgent evaluation
- 99285 - Emergency department visit – high severity and threat

Figure 1 shows aggregated payment amounts by insurers to providers in five ZIP codes in Texas corresponding to El Paso, Houston, Austin, Brownsville, and Dallas/Fort Worth. Figure 1 demonstrates a

marked difference between payments to providers that are made by insurers that primarily use FAIR Health and those that primarily use Medicare. Payments by insurers using another method fell in-between, but closer to the amounts reported by those using FAIR Health. As expected, greater payment variation is found in emergency department visits than in standardized lab tests such as a CBC.

Figure 1



Regional Differences in Reimbursement

TDI also analyzed the data for regional differences in payment. To do this, reimbursement data for a group of medical procedures was aggregated for the five urban ZIP codes used in the survey, separating those insurers that primarily used FAIR Health from those that primarily used Medicare. Insurers that reported using another method or a combination of methods were excluded from the analysis. Figure 2 shows how reimbursement amounts for those primarily using Medicare compare to the amounts for those primarily using FAIR Health. In other words, the figure shows how much of the amount paid by insurers using Medicare is of the amount paid by insurers using FAIR Health:

$$\frac{\text{Amounts for Insurers Using Medicare}}{\text{Amounts for Insurers Using FAIR Health}}$$

Since the underlying data for Figure 2 is the same as was used in Figure 1, the trend of reimbursement amounts for insurers using FAIR Health being higher than amounts of those using Medicare is still apparent in Figure 2. However, Figure 2 also shows that there is some variability in reimbursement by region.

Figure 2

	79936 El Paso	77084 Houston	78745 Austin	78521 Brownsville	75052 Dallas/Fort Worth
Reimbursement for insurers using Medicare as a percentage of those using FAIR Health	13.2%	19.4%	22.5%	15.0%	19.5%

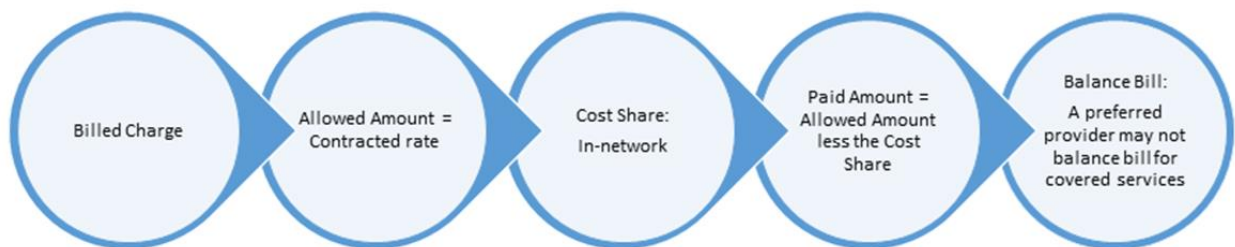
Example: In ZIP code 79936 (El Paso), insurers that use Medicare to determine reimbursement pay only 13.2 percent of the amount that insurers that use FAIR Health to determine reimbursement do for the same medical procedure.

Background

Billing typically depends on where services are rendered. For billing purposes, service categories include: (1) in-network services; (2) services at an in-network facility using non-network physicians; (3) out-of-network non-emergency services; and (4) out-of-network services rendered due to an emergency or unavailability of in-network services. These service categories, and their corresponding billing scenarios, are outlined below. Scenario 4 is the subject of this survey.

PPO Claims and Balance Billing Scenarios

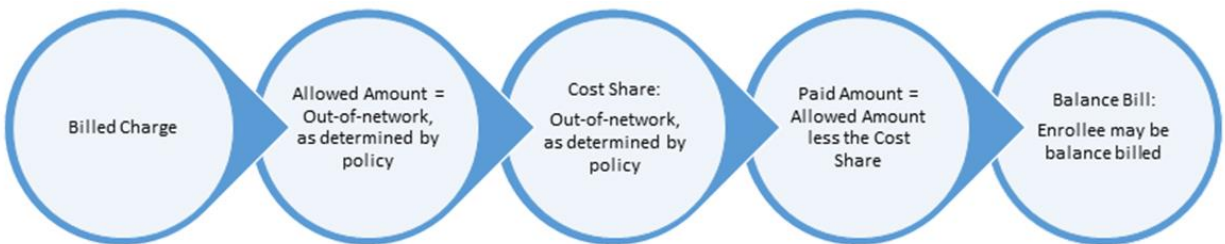
1) Services obtained from a preferred/contracting/in-network provider.



2) Services obtained at a preferred/contracting/in-network facility from a nonpreferred/non-contracting/out-of-network facility-based physician (radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon).

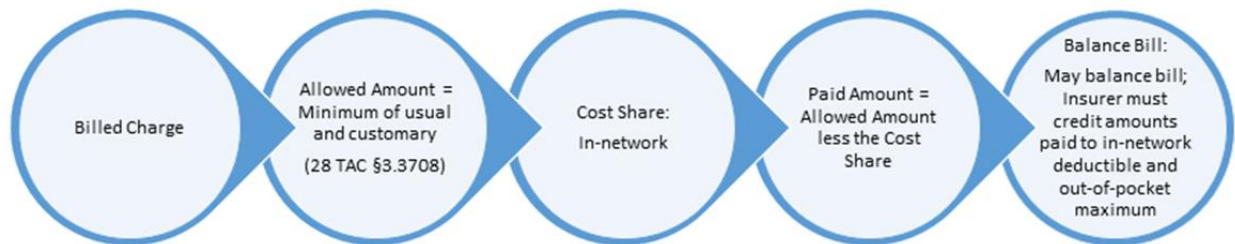


3) Voluntary, non-emergency, services obtained from a nonpreferred/non-contracting/out-of-network provider.



4) When a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:

- a. requiring emergency care;
- b. when no preferred provider is reasonably available within the designated service area for which the policy was issued; and
- c. when a nonpreferred provider’s services were pre-approved or preauthorized.



Timeline

The following is a list of significant events in the history of usual and customary reimbursement. Events specific to Texas are shown in bold.

- 1965 – Social Security Act of 1965 establishes Medicare and bases reimbursement on “reasonable, customary, and prevailing” charges leading to widespread adoption of usual and customary base reimbursement by private insurers.
- 1973 – The private Prevailing Healthcare Charges System (PHCS) is launched, providing a database of billed charges.
- **1986 – 28 TAC, Chapter 3, Subchapter X adopts rules pertaining to Preferred Provider Benefit**

Plans.

- 1992 – Medicare replaces usual and customary with the Resource-Based Relative Value Scale (RBRVS) ending the connection between Medicare reimbursement and usual and customary charges.
- **1997 – Texas SB 383 (75(R)) authorizes and regulates Preferred Provider Benefit Plans by statute.**
- 1998 – Ingenix acquires PHCS and the Medical Data Resource Database (MDR) and becomes the predominant provider of medical claims data (a subsidiary of United Healthcare) to insurers.
- **2007 – Texas SB 1731 (80(R)) requires new “balance billing” disclosures.**
- 2008 – Class action lawsuits prompt New York Attorney General’s investigation of Ingenix for understating usual and customary charges, resulting in a settlement and leading to the creation of FAIR Health.
- **2008 – TDI fines Blue Cross Blue Shield of Texas and orders restitution for unreasonably low out-of-network payments.**
- **2009 – Texas HB 2256 (81(R)) introduces mandatory mediation for certain balance bills by facility-based physicians over \$1,000.**
- 2009 – Ingenix disbanded, FAIR Health, a non-profit database, established.
- 2009 – Present - Insurers move to alternative reimbursement methodologies including a percentage of Medicare RBRVS, often with lower rates than the previous Ingenix system.
- **2011 – Texas HB 1772 (82(R)) authorizes Exclusive Provider Benefit Plans.**
- **2013 – TDI amends 28 TAC §3.3708(b) to clarify certain claims must be paid, at a minimum, at the usual and customary charge.**
- 2014 – New York passes the “Emergency Medical Services and Surprise Bills” law. This legislation impacts billing and reimbursement for some out-of-network health care services, requires new disclosures from providers regarding their plan participation status, and adds new rules for health plans regarding networks and reimbursement for out-of-network services.
- **2015 – Texas SB 481 (84(R)) lowers the threshold for mandatory mediation of certain balance bills to \$500.**
- **2016 – Multiple freestanding emergency rooms file complaints with TDI relating to underpayment for out-of-network emergency services.**

Overview of Common Reimbursement Methodologies

Medicare-Based

Medicare-based reimbursement calculates the allowed amount as a multiple of the Medicare Allowable Rate and usually applies typical Medicare bundling and edits. The level of reimbursement may vary widely across insurers using Medicare-based reimbursement depending on the multiple chosen (typically between 95 percent and 400 percent of the Medicare Allowable rate). Medicare reimbursement methodologies may also vary the multiple by type of procedure and type of facility. Often additional methodologies are used for services not typically covered by Medicare. Until 1992, Medicare physician fee schedules were based on “reasonable, customary, and prevailing” charges. Since 1992, Medicare fees have been determined using a resource-based relative value scale combined with a geographical adjustment and a conversion factor, which is administratively determined and not based on billed charges. A sufficiently high multiple of Medicare may equal or exceed the usual and

customary rate, but Medicare itself is not based on billed charges or usual and customary data. The data are publically available, geographically adjusted, and updated annually.

FAIR Health-Based

FAIR Health-based methodologies rely on the claims database maintained by FAIR Health, Inc., a non-profit, independent, source of claims information (see the glossary in Appendix B for additional information on FAIR Health, Inc.). Two factors, “percentiles” and “percentages,” which may vary greatly across insurers, play a role in determining the actual allowed amount of a FAIR Health-based methodology. The percentile denotes, on a scale of one to 100, the percentage of range of charges that is at or below that amount. The 80th percentile of FAIR Health would mean 80 percent of the charges for a given procedure are at or below that cost. Depending on how much variation there is among billed charges there may be very little difference between the percentiles. For example, if all billed charges in the database for a given procedure were equal, there would be no difference between the 80th, 50th, and 25th percentiles. An insurer may base its allowed amount on a percentage of a given percentile, such as 100 percent of the 80th percentile. Typical percentiles used by insurers are the 80th and the 50th percentile. FAIR Health physician reimbursement data are available to the public on a limited basis. The data are geographically adjusted, updated every six months, and based on non-discounted billed charges.

Other Claims Databases

In addition to FAIR Health, there are many vendors providing claims data to insurers. These vendors’ data are generally proprietary and not publically available. How the data is aggregated, validated, and updated varies by vendor and may also be proprietary. Ingenix, formerly one of the largest providers of claims data, was investigated by the New York Attorney General’s Office for using methodologies that understated customary charges. A settlement, without admitting wrongdoing, formed the basis for FAIR Health. Unlike FAIR Health, propriety vendor data are not generally publically available, and geographical adjustments and frequency of updates vary by vendor.

Federal ACA Requirement (45 CFR §147.138(b)(3))

Federal regulations define cost share and reimbursement as follows:

Cost Share - Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant, beneficiary, or enrollee for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant, beneficiary, or enrollee if the services were provided in-network.

Reimbursement - The lesser of the billed charge or the greater of:

- (A) the amount negotiated with in-network providers for the emergency service furnished;
- (B) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services; or
- (C) the amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service.

Negotiation

Negotiation between the insurer and the provider is often used in conjunction with other methods to reach agreement on reimbursement rates and reduce the incidence of balance billing. Negotiation is sometimes only initiated after an enrollee contacts the insurer regarding a balance bill. Enrollees that do not contact their insurer and either pay or ignore the balance bill may not benefit from negotiation.

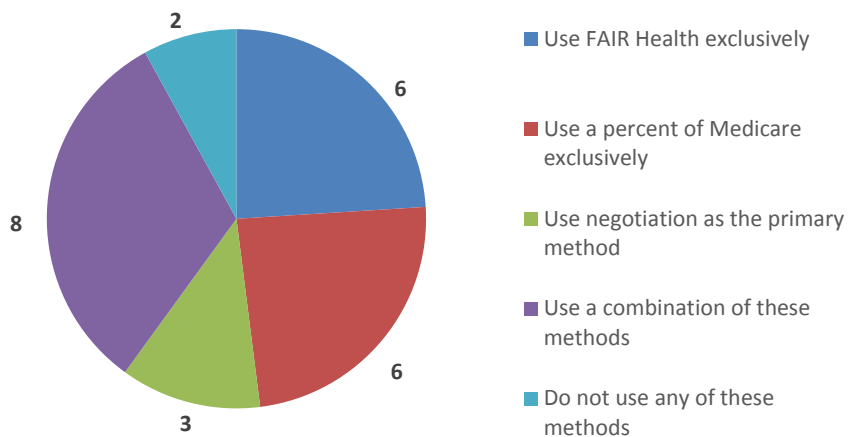
Summary of Responses

In some instances, responses to the survey questions are displayed in pie chart form. Some of the charts are based on the answers received from the 25 insurers that submitted responses. These charts display the responses for each insurer equally, despite some insurers doing more business than others. The other charts display the answers weighted by the total premium dollars received for comprehensive health coverage in 2015. For these charts, larger insurers with a greater market share will account for a larger portion of the pie chart than insurers with less total premiums.

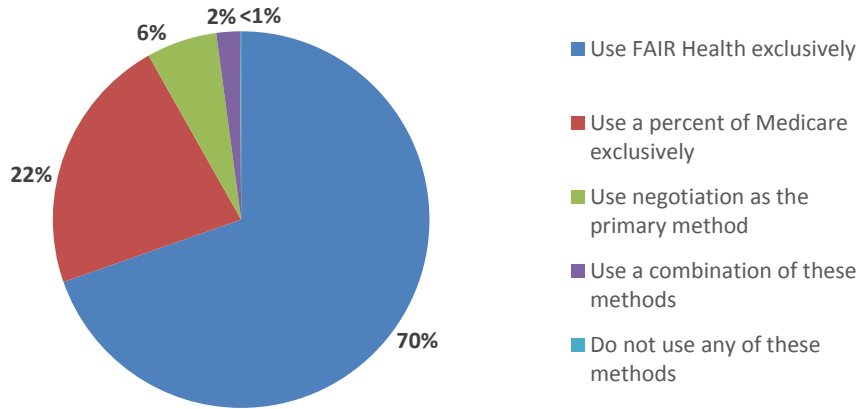
Survey Question 1

Provide a detailed description of the methodology you use to calculate reimbursements to nonpreferred providers for services in cases where a preferred provider is not reasonably available.

Reimbursement Methodologies - 25 Responses



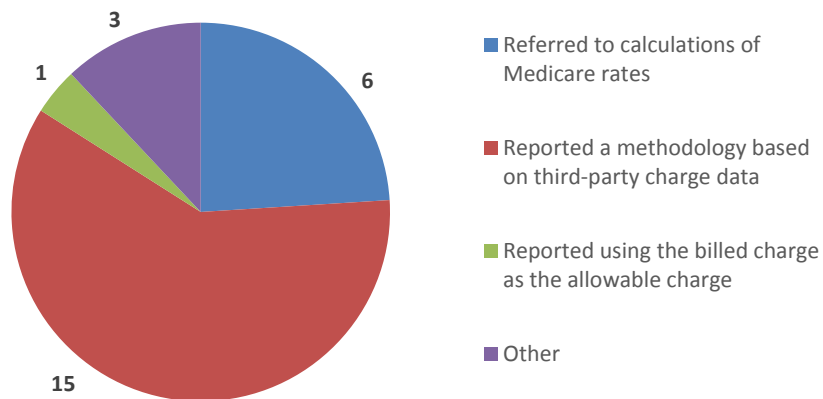
Reimbursement Methodologies - By Premium



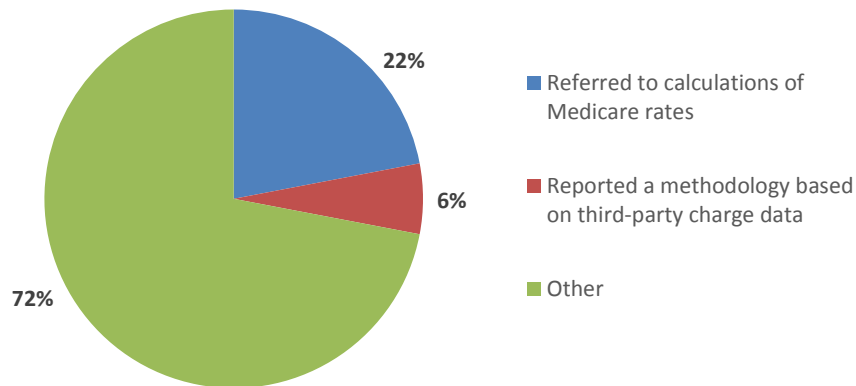
Survey Question 2(a)

If that methodology is based upon usual, reasonable, or customary charges, provide a detailed description of the generally accepted industry standards and practices for determining the customary billed charge for a service upon which the methodology is based. If you make a distinction between “customary charges” and “customary billed charges” please explain.

Industry Standards and Practices for Customary Billed Charges - 25 Responses



Industry Standards and Practices for Customary Billed Charges - By Premium



No insurers indicated making a distinction between “customary charges” and “customary billed charges.”

Survey Question 2(b)

If that methodology is based upon usual, reasonable, or customary charges, confirm that it is updated no less than once per year and that it does not use data that is more than three years old.

All insurers reported updating their data at least once per year.

Survey Questions 2(c) and 3(a)

If that methodology is based upon usual, reasonable, or customary charges provide a detailed explanation of how it accurately reflects market rates, including geographic differences in costs. If that methodology is based upon claims data, describe how it is based upon sufficient data to constitute a representative and statistically valid sample.

Most insurers reported using a methodology based on usual, reasonable, or customary charges. Of them, 30 percent used CMS-defined regions, and 70 percent used areas defined by FAIR Health to adjust for geographic differences. Larger insurers tended to use CMS-defined regions. For insurers that based their methodologies on claims data, 36 percent reported using FAIR Health data to constitute a representative sample. Larger insurers were more likely to use FAIR Health data.

Survey Questions 3(b) and 3(c)

If that methodology is based upon claims data, confirm that it is updated no less than once per year and that it does not use data that is more than three years old. Also, describe how it is consistent with nationally recognized and generally accepted bundling edits and logic.

No insurers reported updating their data less frequently than once per year. In addition, most insurers that used a methodology based on claims data used FAIR Health, another claims data source, or other accepted standards.

Survey Question 4

TDI asked insurers to supply average reimbursement amounts for certain emergency procedures by nonpreferred providers in specified urban ZIP codes. The department then benchmarked the results with FAIR Health to gauge how closely actual reimbursement was to rates in FAIR Health for the same region. FAIR Health does not include facility (e.g. hospital or ambulatory surgery center) charges in its estimates. In cases where an insurer had no data to report, the amount is listed as \$0.

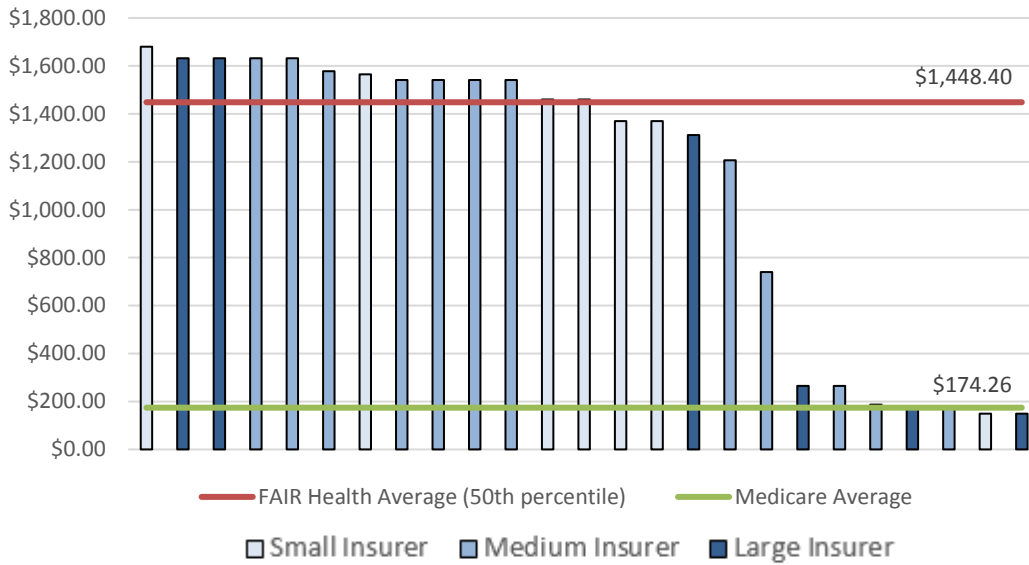
The following charts show the average amounts paid by the insurers, FAIR Health (50th percentile) averages, and regional Medicare averages for each CPT code. In addition, the first chart for each CPT code is color coded by the premium volume of each insurer where size is categorized as follows:

- small (less than \$10 million)
- medium (between \$10 million and \$100 million)
- large (greater than \$100 million)

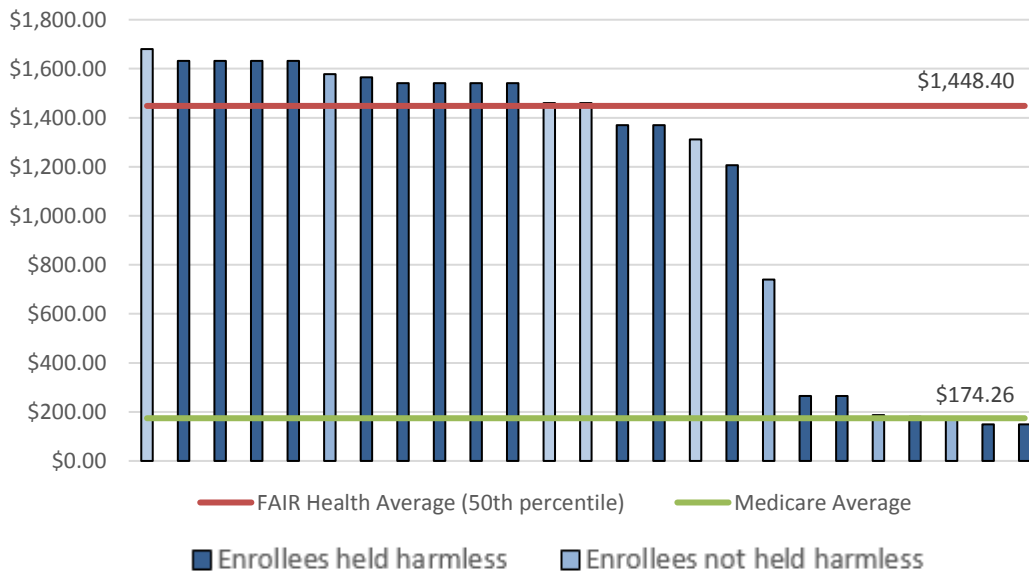
The second chart for each CPT code indicates whether enrollees are held harmless.

See Appendix C for charts displaying the insurer, FAIR Health (50th percentile), and Medicare amounts for each CPT code and ZIP code.

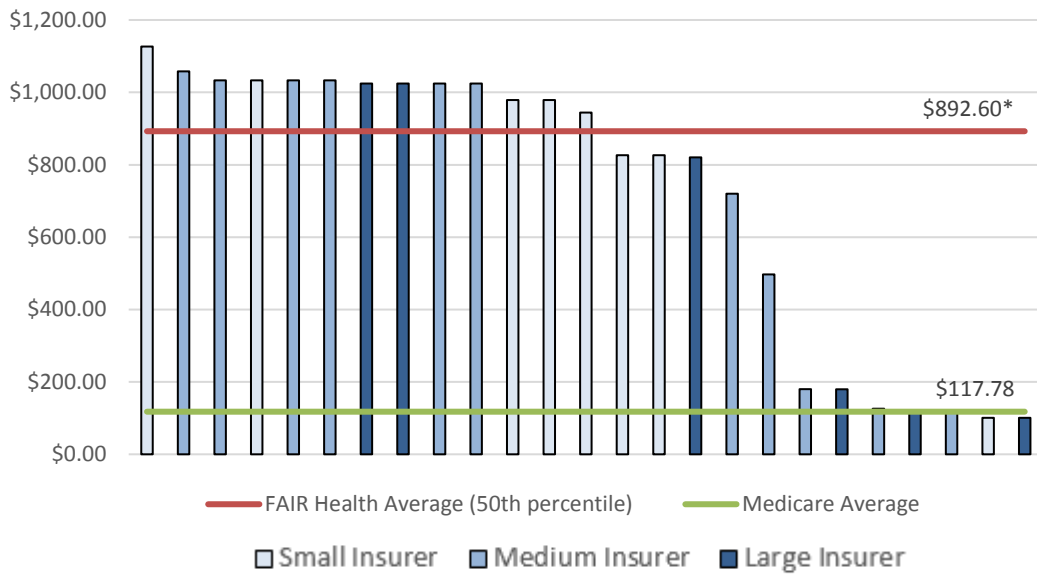
99285 - Emergency department visit - high severity and threat
Insurer averages across the five ZIP codes



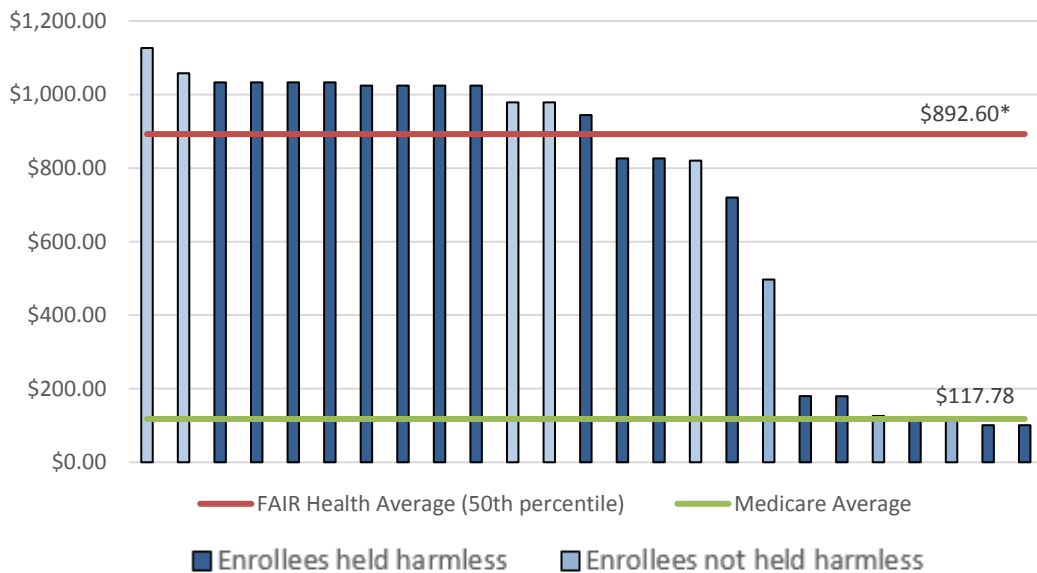
99285 - Emergency department visit - high severity and threat
Insurer averages across the five ZIP codes



**99284 - Emergency department visit - High severity and urgent evaluation
Insurer averages across the five ZIP codes**

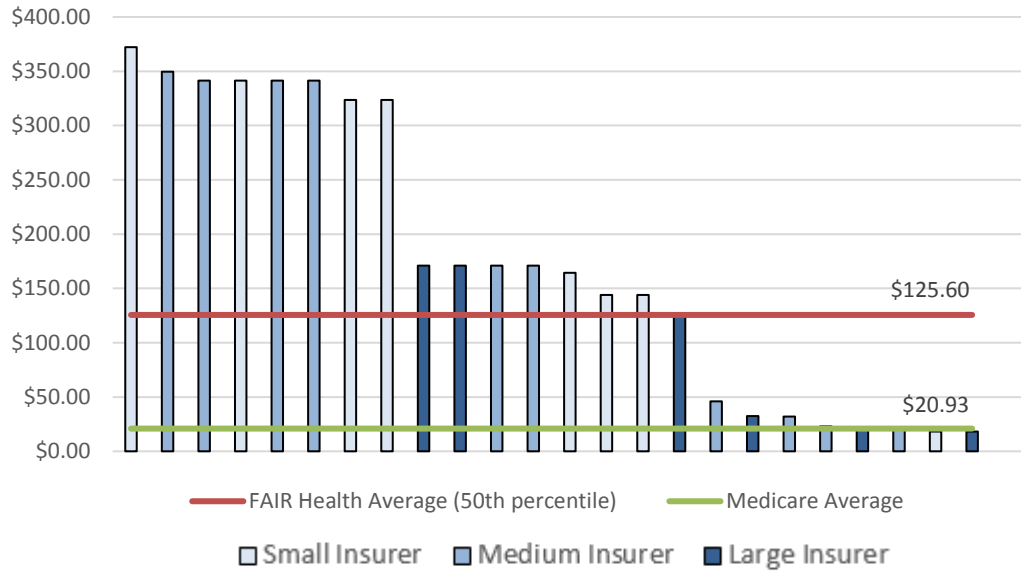


**99284 - Emergency department visit - High severity and urgent evaluation
Insurer averages across the five ZIP codes**

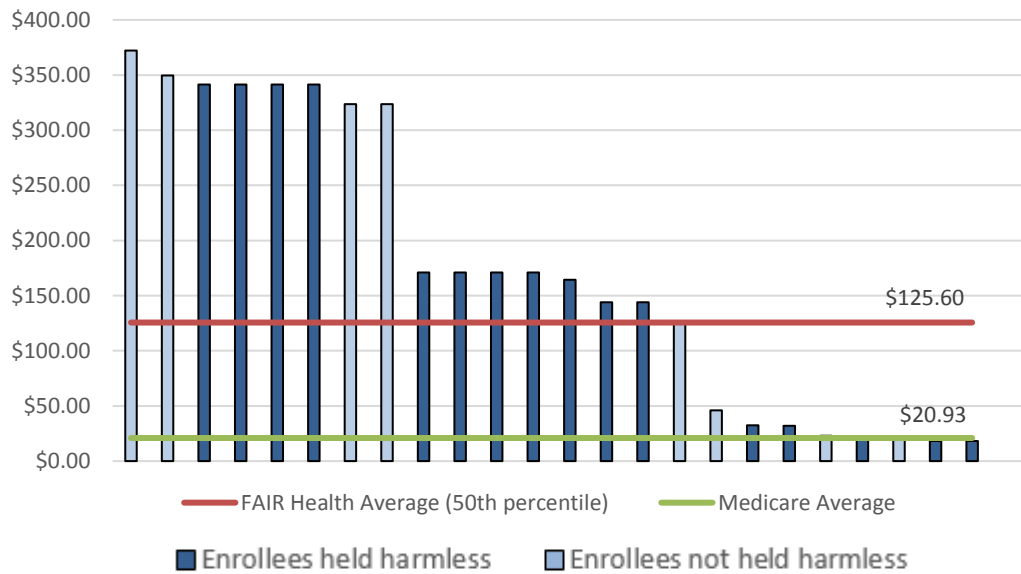


*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

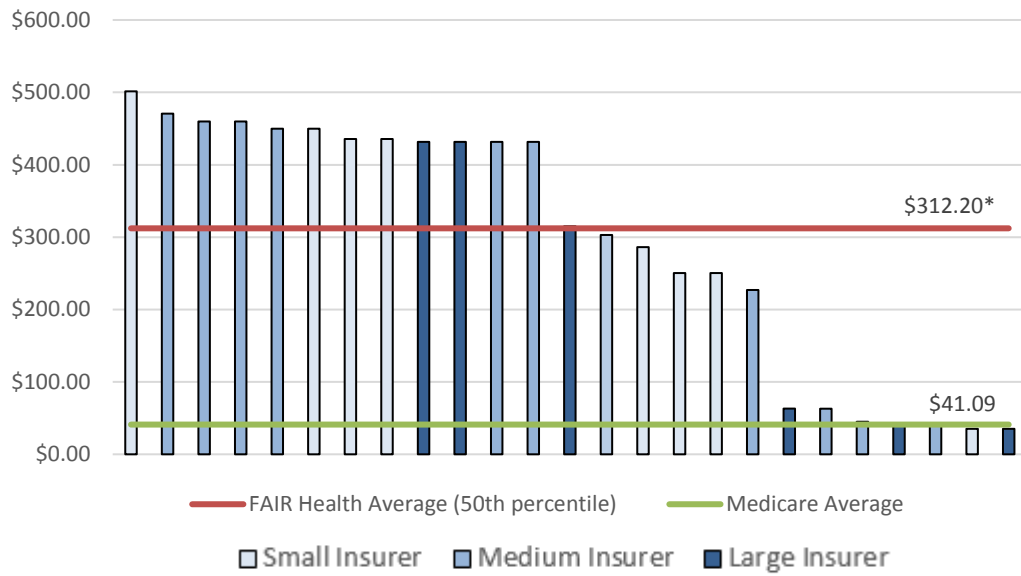
99281 - Emergency department visit - limited/minor
Insurer averages across the five ZIP codes



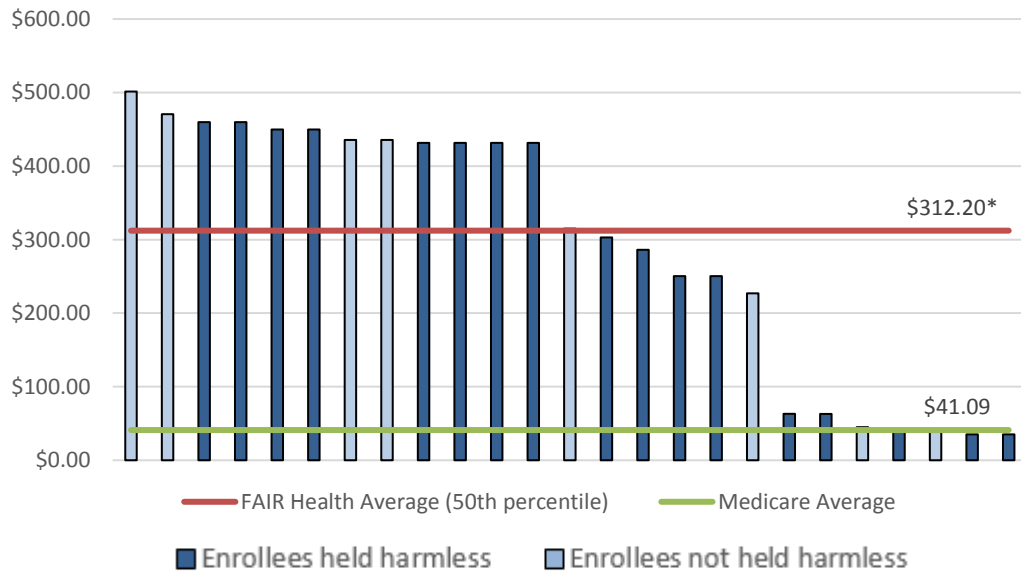
99281 - Emergency department visit - limited/minor
Insurer averages across the five ZIP codes



99282 - Emergency department visit - Low to moderate severity
Insurer averages across the five ZIP codes

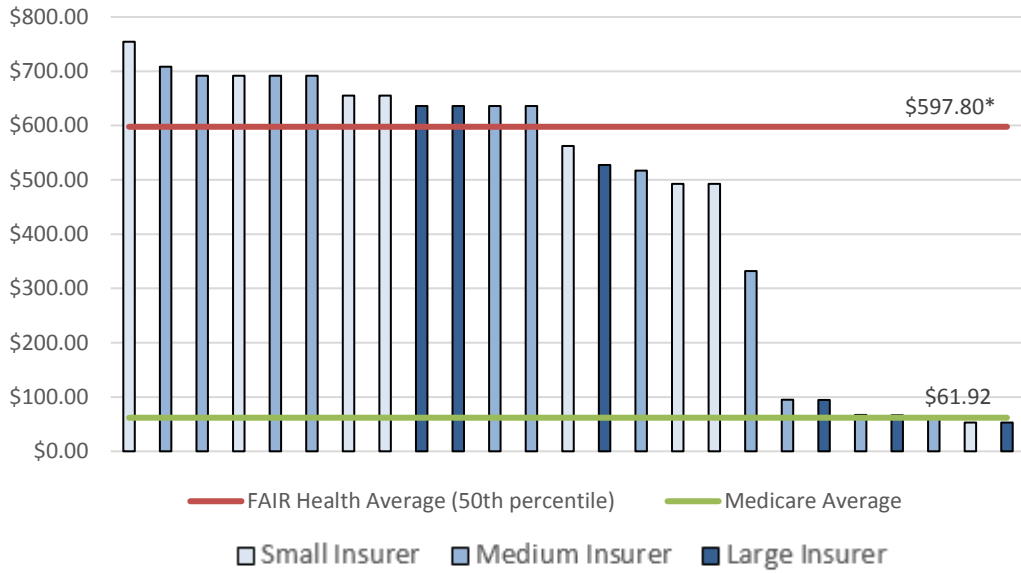


99282 - Emergency department visit - Low to moderate severity
Insurer averages across the five ZIP codes

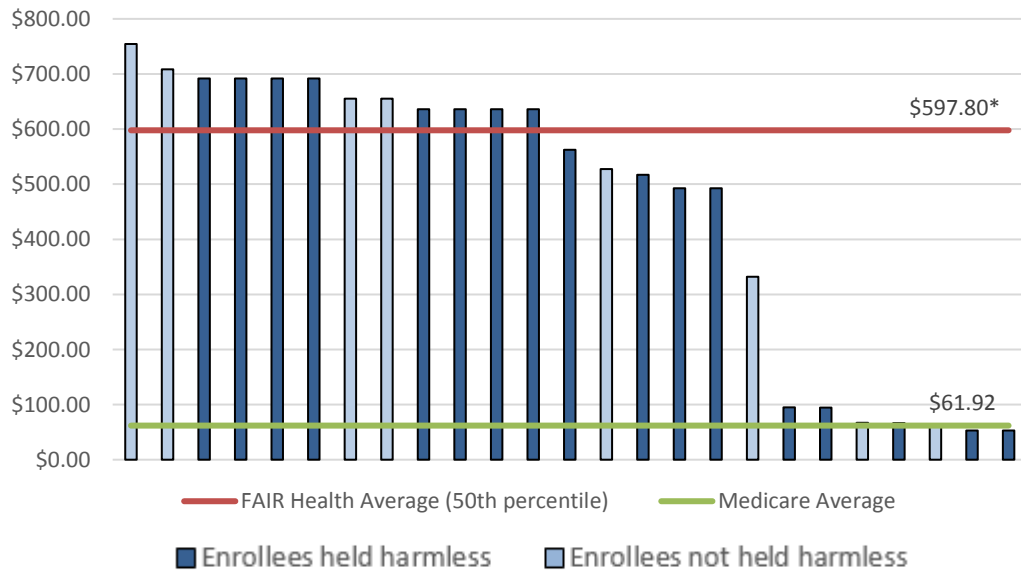


*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

**99283 - Emergency department visit - Moderate severity
Insurer averages across the five ZIP codes**

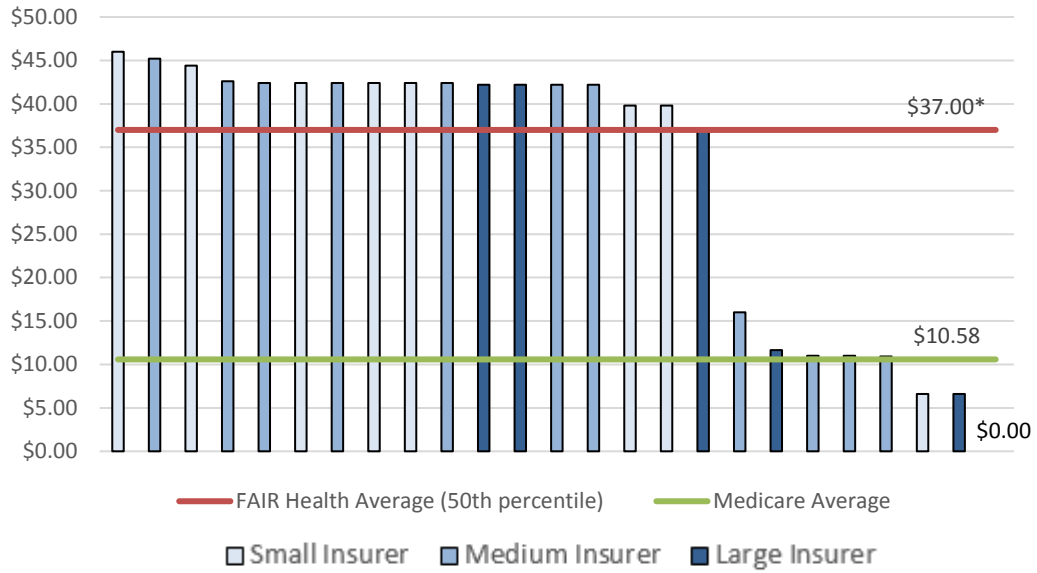


**99283 - Emergency department visit - Moderate severity
Insurer averages across the five ZIP codes**

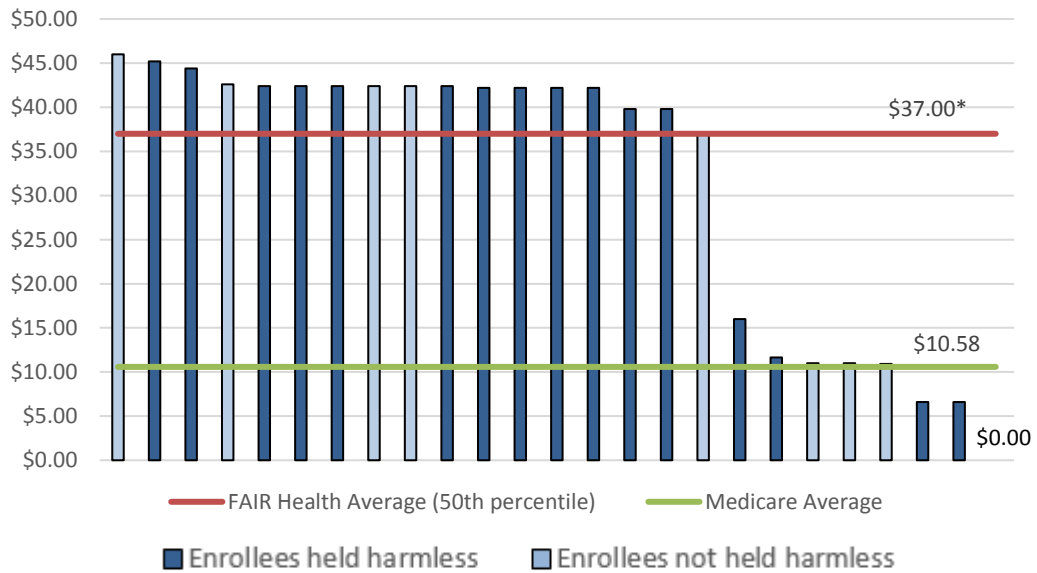


*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

85025 - Complete blood count
Insurer averages across the five ZIP codes



85025 - Complete blood count
Insurer averages across the five ZIP codes



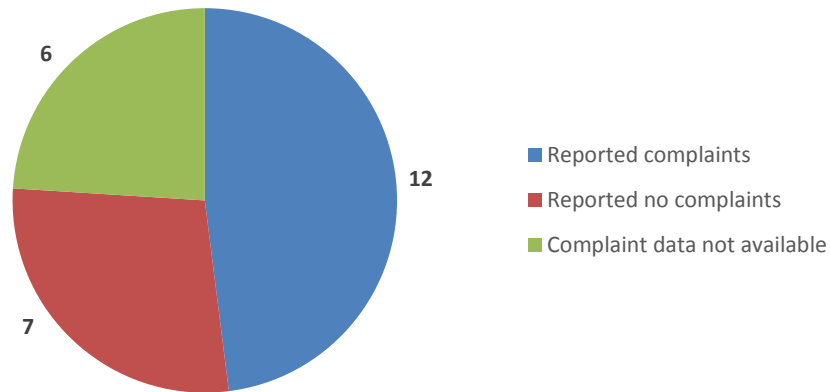
*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

Survey Question 5

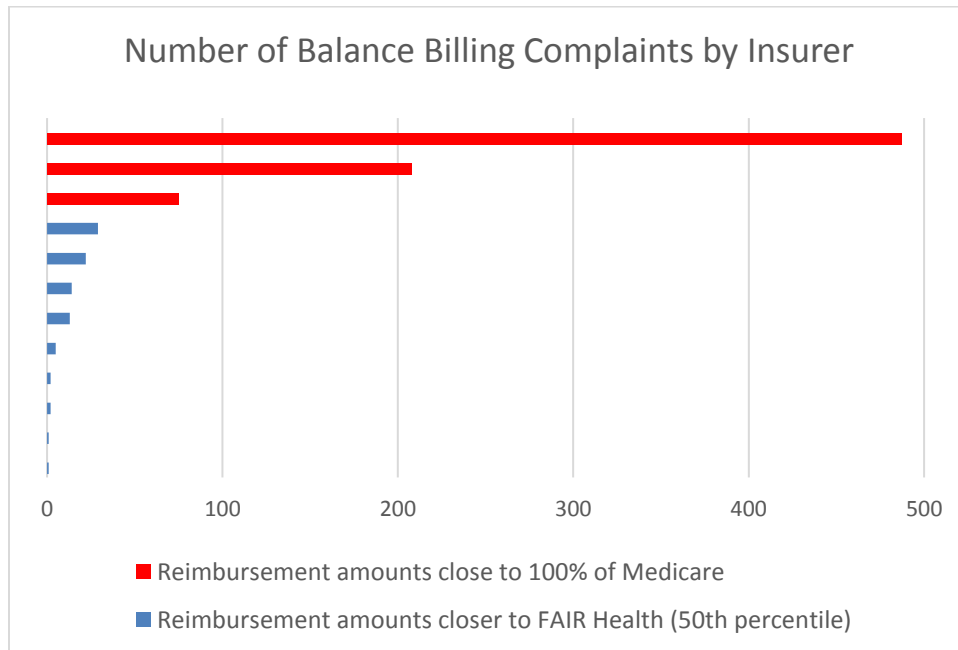
For calendar year 2015, summarize any information you have regarding your enrollees being balance billed by out-of-network providers in emergency or inadequate network situations, including the number of complaints from enrollees who were balance billed.

Forty-eight percent of the insurers reported complaints about balance billing. Larger insurers were more likely to report such complaints.

Balanced Billing Complaints - 25 Responses



Of the 12 insurers that reported complaints, a breakdown of the number of complaints is given below.



Survey Question 6

In the event that you find that an enrollee is balance billed by an out-of-network provider in emergency or inadequate network situations, describe your procedures for resolving the issue. For example, do you contact the provider and negotiate an amount other than what is billed? Do you ensure that the enrollee is held harmless?

Fifty-six percent of the insurers reported that they negotiate with providers to resolve balance billing issues; larger insurers were less likely to report doing so. Sixty-eight percent of the insurers reported holding their enrollees harmless; larger insurers were less likely to report doing so.

Survey Question 7

For the calendar year 2015, provide the number of cases in which your enrollees have requested mediation under 28 TAC Subchapter PP.

Twenty percent of the insurers reported having at least one case in which an enrollee requested mediation. The number of reported cases ranged from 1 to over 400. Larger insurers were more likely to report mediation cases.

The following table shows the minimum, maximum, median, and average insurer payment amounts for each ZIP code and CPT code included in the survey.

		99285	99284	99281	99282	99283	85025
El Paso 79936	Min	\$148.00	\$100.00	\$18.00	\$35.00	\$53.00	\$0.00
	Max	\$1,982.00	\$1,329.00	\$439.00	\$606.00	\$890.00	\$48.00
	Med	\$1,858.00	\$1,246.00	\$85.00	\$536.00	\$835.00	\$36.00
	Avg	\$1,342.17	\$881.48	\$191.98	\$372.07	\$577.73	\$28.45
Houston 77084	Min	\$146.00	\$99.00	\$18.00	\$34.00	\$52.00	\$0.00
	Max	\$1,803.00	\$1,209.00	\$400.00	\$538.00	\$809.00	\$48.00
	Med	\$1,257.00	\$831.00	\$177.50	\$303.00	\$557.00	\$41.00
	Avg	\$1,031.72	\$639.41	\$164.63	\$264.76	\$415.85	\$31.15
Austin 78745	Min	\$150.00	\$101.00	\$18.00	\$35.00	\$53.00	\$0.00
	Max	\$1,283.00	\$824.00	\$272.00	\$367.00	\$552.00	\$47.00
	Med	\$1,114.00	\$697.00	\$162.50	\$266.00	\$398.00	\$42.00
	Avg	\$880.40	\$576.49	\$146.13	\$223.11	\$348.71	\$31.51
Brownsville 78521	Min	\$155.00	\$105.00	\$19.00	\$37.00	\$55.00	\$0.00
	Max	\$1,859.00	\$1,247.00	\$412.00	\$555.00	\$835.00	\$61.00
	Med	\$1,710.00	\$1,041.00	\$230.50	\$315.00	\$620.00	\$51.00
	Avg	\$1,250.05	\$814.56	\$214.11	\$320.19	\$503.45	\$36.75
Dallas/Fort Worth 75052	Min	\$147.00	\$99.00	\$18.00	\$33.00	\$52.00	\$0.00
	Max	\$1,528.00	\$1,024.00	\$338.00	\$456.00	\$686.00	\$48.00
	Med	\$1,430.00	\$900.00	\$120.00	\$303.00	\$544.00	\$41.00
	Avg	\$1,055.75	\$674.23	\$160.00	\$288.51	\$453.93	\$30.55

Conclusion

According to information provided to TDI, the majority of insurers surveyed use a third-party data source to determine how much to reimburse nonpreferred providers for services. While most insurers use a data source such as FAIR Health, some use Medicare to help determine how much to pay. Insurers using third-party data sources also reported utilizing the geographic aspects of the data to determine how much to pay in the regions where claims are incurred. Insurers using Medicare as the basis for determining reimbursement generally pay a lesser amount than those using claims data sources such as FAIR Health. Many insurers reported negotiating with providers to settle on the amount to pay. For most insurers, the practice is to hold enrollees harmless of balance billing obligations.

The insurers using a payment system based on a standard third-party data source pay claims at a similar rate. Insurers using Medicare as a determinant for reimbursement pay at a markedly lower rate than industry peers. Disagreements between insurers and nonpreferred providers over payments for services most likely occur with insurers paying at the lowest rates.

APPENDIX A: Survey Questions

Insurers were asked to submit information in response to the following:

- (1) Provide a detailed description of the methodology you use to calculate reimbursements to nonpreferred providers for services in cases where a preferred provider is not reasonably available. If you use different methodologies for different services or different product types (i.e. group versus individual), you should provide responsive information for each methodology.
- (2) If that methodology is based upon usual, reasonable, or customary charges:
 - (a) Provide a detailed description of the generally accepted industry standards and practices for determining the customary billed charge for a service upon which the methodology is based. If you make a distinction between “customary charges” and “customary billed charges” please explain.
 - (b) Confirm that it is updated no less than once per year and that it does not use data that is more than three years old.
 - (c) Provide a detailed explanation of how it accurately reflects market rates, including geographic differences in costs.
- (3) If that methodology is based upon claims data:
 - (a) Describe how it is based upon sufficient data to constitute a representative and statistically valid sample.
 - (b) Confirm that it is updated no less than once per year and that it does not use data that is more than three years old.
 - (c) Describe how it is consistent with nationally recognized and generally accepted bundling edits and logic.
- (4) For the following CPT codes and ZIP codes, provide the reimbursement amounts that your methodology would result in when calculating reimbursement to nonpreferred providers for services in cases where a preferred provider is not reasonably available.
 - CPT Codes
 - 85025 – Complete blood cell count
 - 99281 – Emergency department visit – limited/minor
 - 99282 – Emergency department visit – limited/minor
 - 99283 – Emergency department visit – moderate severity
 - 99284 – Emergency department visit – high severity and urgent evaluation
 - 99285 – Emergency department visit – high severity and threat
 - ZIP codes
 - 75052 – Dallas / Fort Worth
 - 77084 – Houston
 - 78521 – Brownsville
 - 78745 – Austin
 - 79936 – El Paso

- (5) For calendar year 2015, summarize any information you have regarding your enrollees being balance billed by out-of-network providers in emergency or inadequate network situations, including the number of complaints from enrollees who were balance billed.
- (6) In the event that you find that an enrollee is balance billed by an out-of-network provider in emergency or inadequate network situations, describe your procedures for resolving the issue. For example, do you contact the provider and negotiate an amount other than what is billed? Do you ensure that the enrollee is held harmless?
- (7) For the calendar year 2015, provide the number of cases in which your enrollees have requested mediation under 28 TAC Subchapter PP.

APPENDIX B: Glossary of Common Terms

Allowed/Allowable amount - The maximum dollar amount that an insurer will consider reimbursing for a covered service or procedure. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any co-insurance or deductible. The allowed amount for claims from preferred providers is the contracted rate, and the allowed amount for non-preferred provider claims is determined by other methods and may be considerably lower. The allowed amount for a claim is generally always the lesser of the billed charge or the calculated allowed amount.

Balance billing - The practice of charging an enrollee in a health benefit plan that uses a provider network to recover from the enrollee the balance of a non-network health care provider's fee for service received by the enrollee from the health care provider that is not fully reimbursed by the enrollee's health benefit plan.

Bundling edits and logic - Bundling occurs when a procedure or service with a unique CPT® or Healthcare Common Procedure Coding System (HCPCS) code is included as part of a “more extensive” procedure or service provided at the same time. The allowed amount of the claim, after bundling edits are applied, will be based on the more extensive code and the included codes will be denied if billed separately. One source of nationally recognized and generally accepted bundling edits is the National Correct Coding Initiative Policy Manual for Medicare Services. 28 TAC §3.3708(c) requires usual, reasonable or customary based methodologies to be consistent with nationally recognized and generally accepted bundling edits and logic.

CPT® or Current Procedural Terminology® - CPT® is a registered trademark of the American Medical Association (AMA). CPT codes are numbers assigned to services and procedures performed for patients by medical practitioners. The codes are part of a uniform system maintained by the AMA and used by medical providers, facilities, and insurers. Each code number is unique and refers to a written description of a specific medical service or procedure. CPT codes are often used on medical bills to identify the charge for each service and procedure billed by a provider.

Exclusive Provider Organization (EPO) - A type of health insurance plan where services are covered only if an enrollee uses a preferred provider. Out-of-network care is only covered in an emergency, or if an enrollee can't access the care needed in-network. EPO plans are similar to HMO plans, but EPOs are offered by insurance companies, which are regulated differently than HMOs. EPO's are authorized and governed by TIC, Chapter 1301 and 28 TAC, Chapter 3, Subchapter X, Division 2.

Emergency health care services - Services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- (1) placing the person's health in serious jeopardy;
- (2) serious impairment to bodily functions;

- (3) serious dysfunction of a bodily organ or part;
- (4) serious disfigurement; or
- (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

FAIR Health - FAIR Health, Inc. is a non-profit entity established in October 2009 as part of the settlement of an investigation by the New York Attorney General into certain health insurance industry reimbursement practices which had been based on data compiled and controlled by a major insurer. FAIR Health was formed to create a conflict-free, trusted, and transparent source of data to support the adjudication of healthcare claims and to promote sound decision-making by all participants in the healthcare industry. FAIR Health reimbursement rates are developed from a comprehensive database comprising:

- data from more than 60 contributors, covering over 150 million individuals;
- more than 19 billion billed medical and dental procedures;
- non-discounted fees-for-service as reported on claims submitted by providers to insurers and administrators;
- data from 2002 to the present; and
- 493 “geoziips” (codes that are defined by the first 3 digits of ZIP codes) covering all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

Health Maintenance Organization (HMO) - A type of health benefit plan that usually limits coverage to care from preferred providers - the doctors who work for or contract with the HMO. Out-of-network care is only covered in an emergency, or if an enrollee can't access the care needed in-network. In an HMO plan, each enrollee's care is managed by a primary care provider, and a referral is required in order to see a specialist. HMO plans are similar to EPO plans, but HMOs are regulated differently than insurance companies. HMO's are authorized and governed by TIC, Chapters 843 and 1271 and 28 TAC, Chapter 11.

Ingenix - Formerly the predominant provider of medical claims data and a subsidiary of UnitedHealthcare Group. Formed by the acquisition of the Prevailing Healthcare Charges System database and the Medical Data Resource Database, Ingenix was the subject of multiple class actions suits and an investigation by the New York Attorney General's Office for its methodology for calculating usual and customary charges with respect to claims payments. The demise of Ingenix in 2009 led to the establishment of FAIR Health and the move by many insurers to Medicare-based pricing.

In-Network - Refers to services received from preferred providers, who have a business relationship with an enrollee's health plan, which means they have agreed to the plan's allowed amount and will not balance bill the enrollee. Services received in-network are covered according to the plan's in-network cost-sharing provisions.

Preferred provider - A provider that contracts with an insurer. A group of preferred providers makes up an insurer's network. Insurers negotiate lower medical rates with their network and an enrollee receives these discounts when visiting preferred providers.

Preferred Provider Organization (PPO) - A type of health insurance plan that contracts with doctors and hospitals to create a network of preferred providers that can provide care to enrollees at a discounted cost. PPOs will cover some out-of-network costs, but enrollees will pay more and may be balance billed. PPO's are authorized and governed by TIC, Chapter 1301 and 28 TAC, Chapter 3, Subchapter X, Division 1.

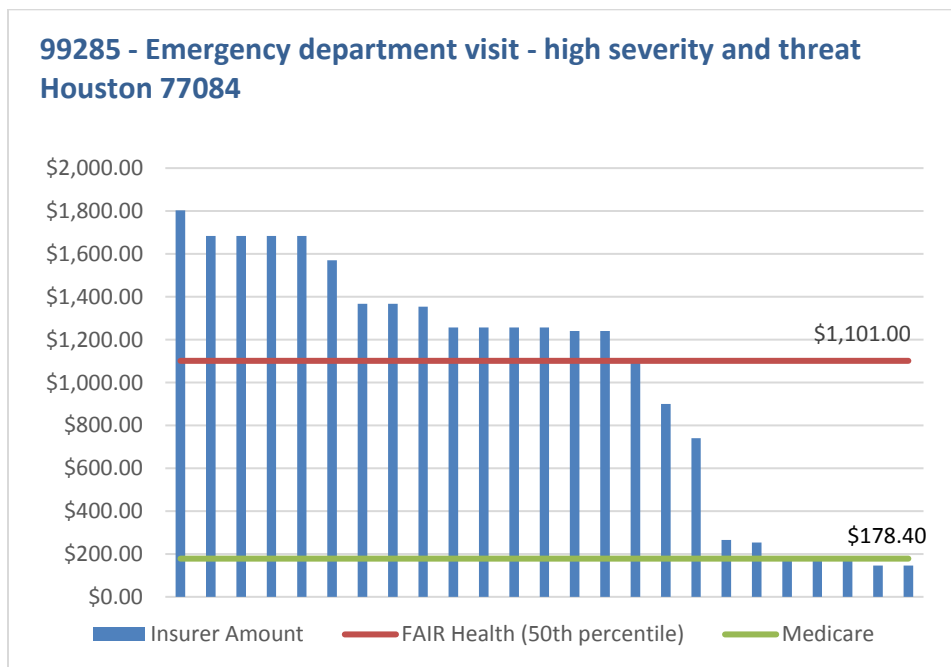
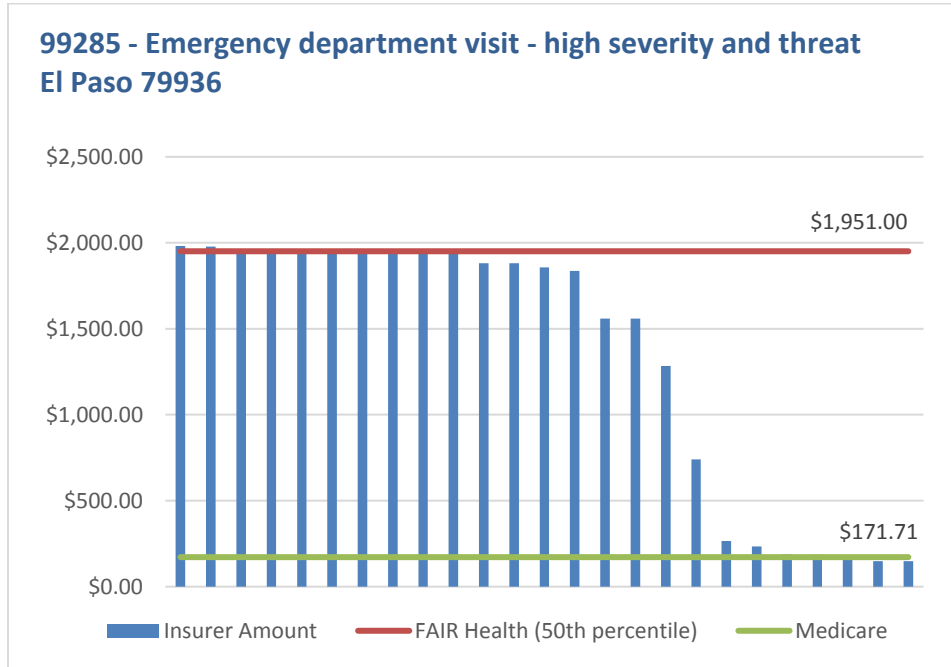
Usual and Customary (U&C)/Usual, Customary, and Reasonable (UCR) Charges - Not defined by statute. Generally defined as:

- Usual: A charge is considered "usual" if it is a physician's usual charge for a procedure.
- Customary: A charge is considered "customary" if it is within a range of fees that most physicians in the area charge for a given procedure (often measured at a specific percentile of all charges submitted for a given procedure in that community).
- Reasonable: A charge is considered "reasonable" if it is usual and customary, or if it is justified because of special circumstances.

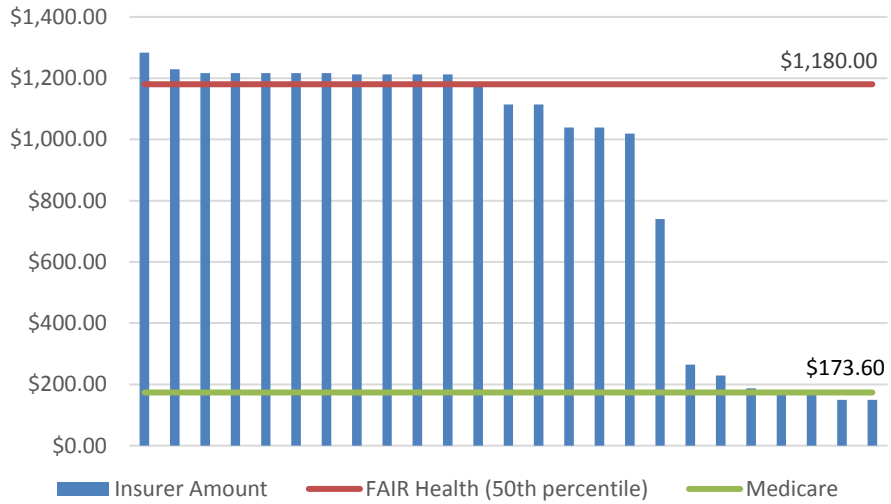
28 TAC, §3.3708(c)(1) requires a methodology based on usual and customary charges to be based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.

APPENDIX C: Survey Question 4 Data

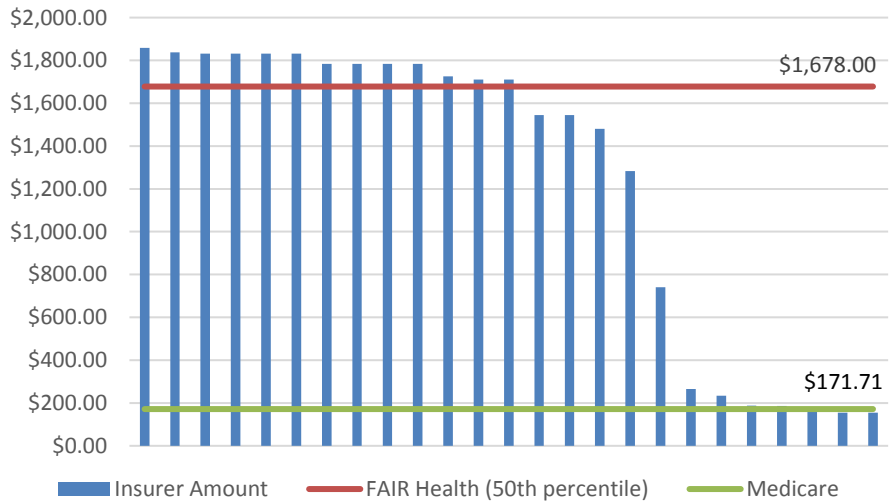
The following charts display the insurer, FAIR Health (50th percentile), and Medicare amounts for each CPT code and ZIP code.



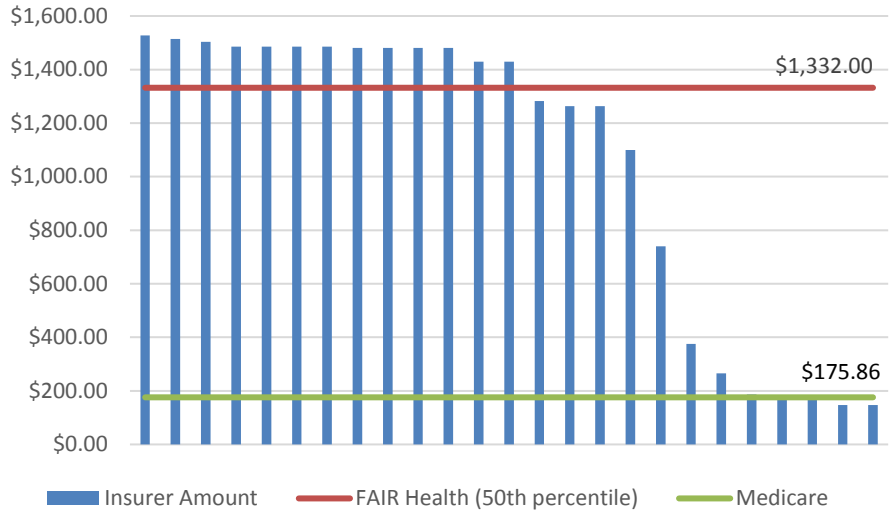
**99285 - Emergency department visit - high severity and threat
Austin 78745**



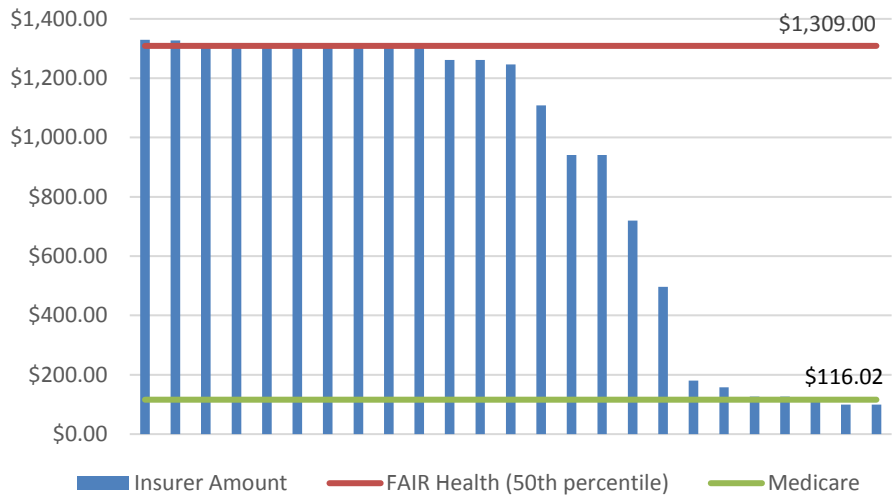
**99285 - Emergency department visit - high severity and threat
Brownsville 78521**



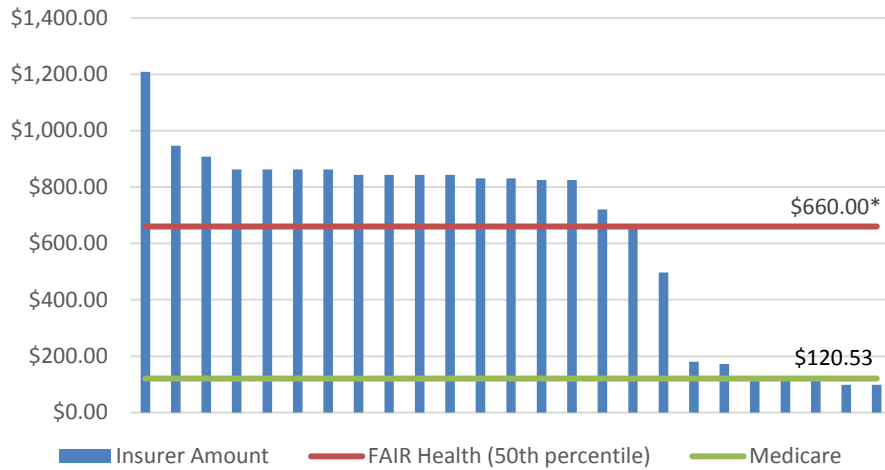
**99285 - Emergency department visit - high severity and threat
Dallas/Fort Worth 75052**



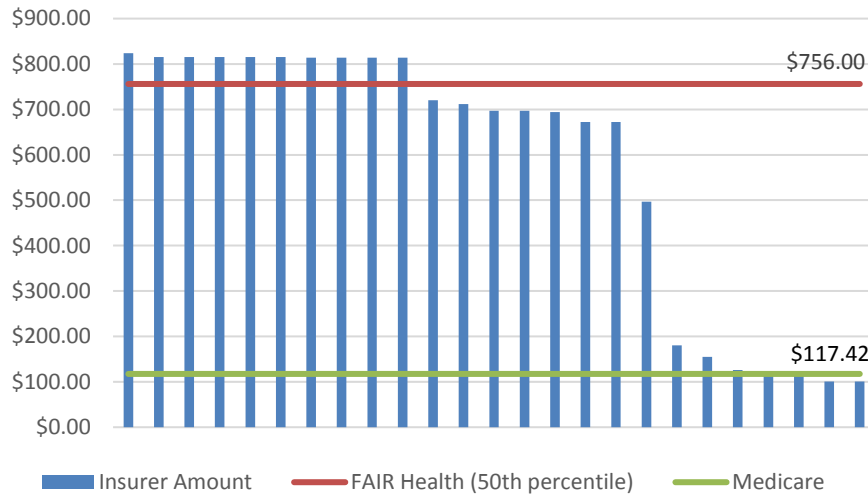
**99284 - Emergency department visit - high severity and urgent
evaluation
El Paso 79936**



**99284 - Emergency department visit - High severity and urgent evaluation
Houston 77084**

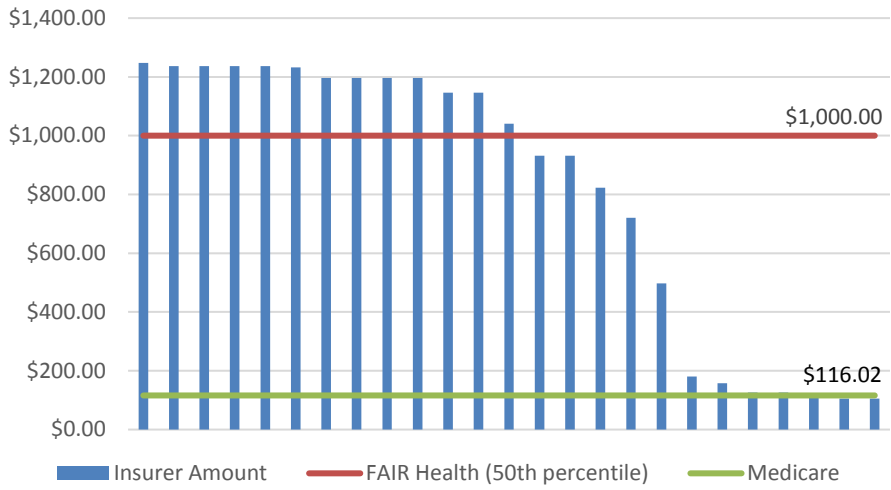


**99284 - Emergency department visit - high severity and urgent evaluation
Austin 78745**

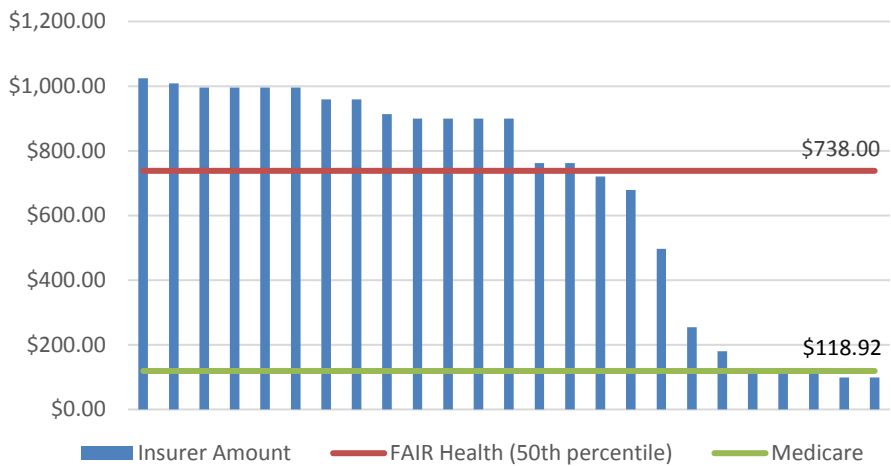


*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

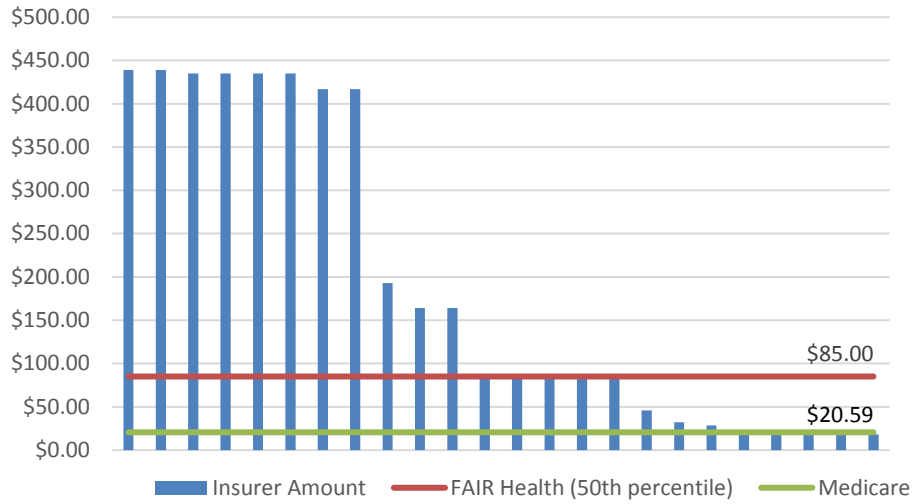
**99284 - Emergency department visit - high severity and urgent evaluation
Brownsville 78521**



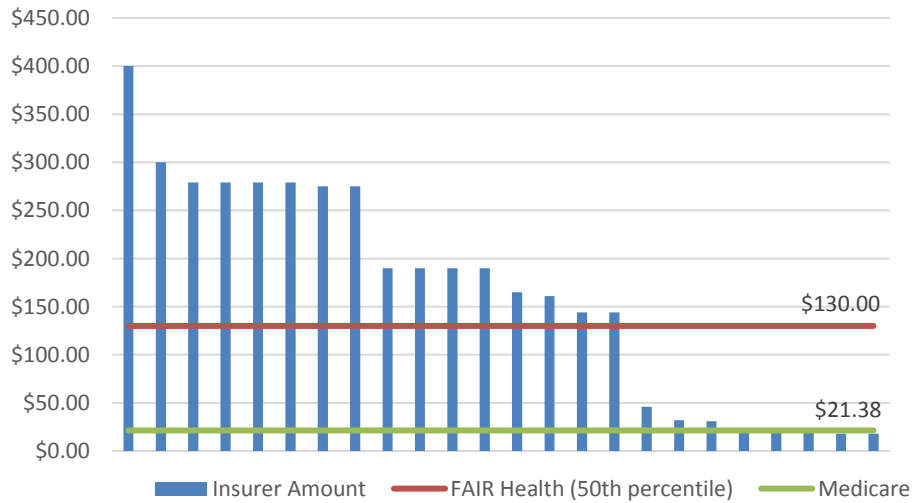
**99284 - Emergency department visit - high severity and urgent evaluation
Dallas/Fort Worth 75052**



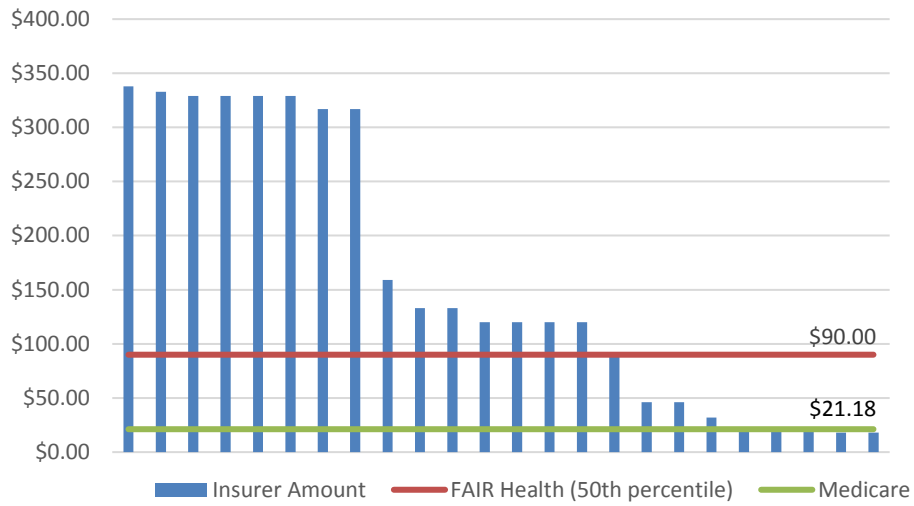
**99281 - Emergency department visit - limited/minor
El Paso 79936**



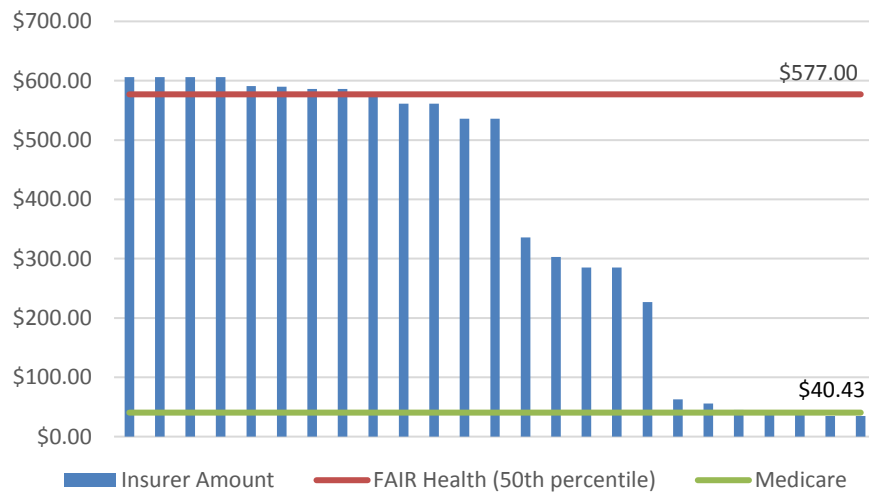
**99281 - Emergency department visit - limited/minor
Houston 77084**



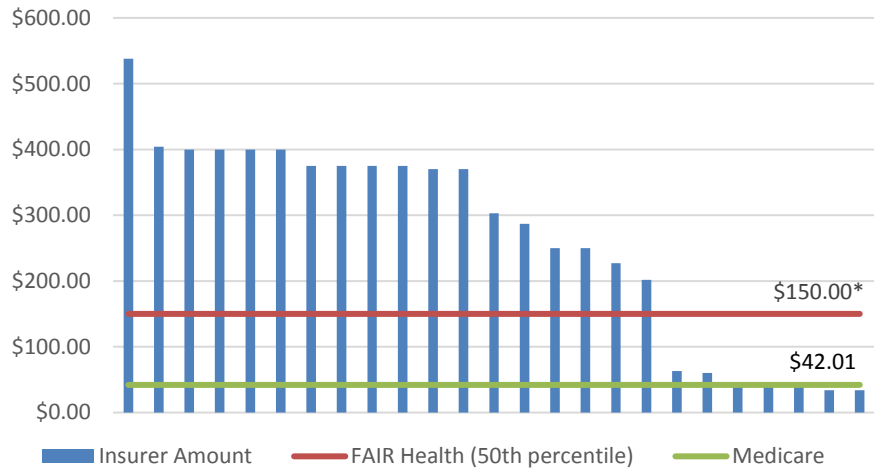
**99281 - Emergency department visit - limited/minor
Dallas/Fort Worth 75052**



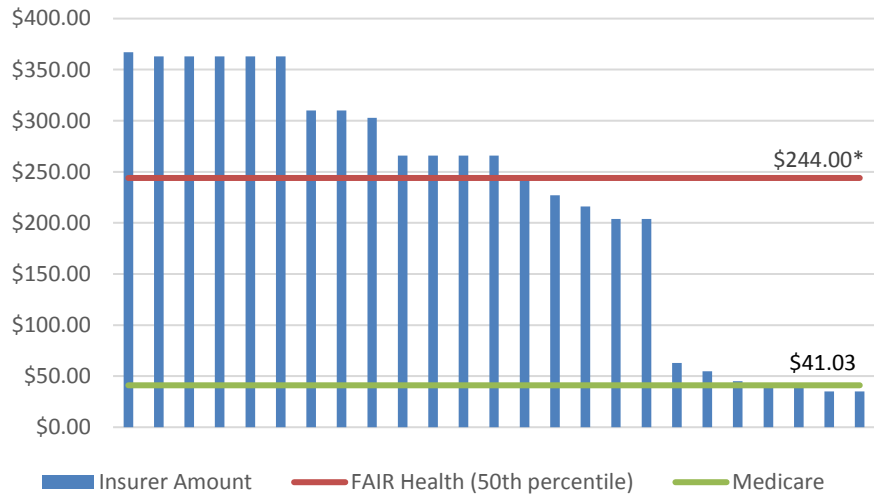
**99282 - Emergency department visit - low to moderate severity
El Paso 79936**



**99282 - Emergency department visit - Low to moderate severity
Houston 77084**

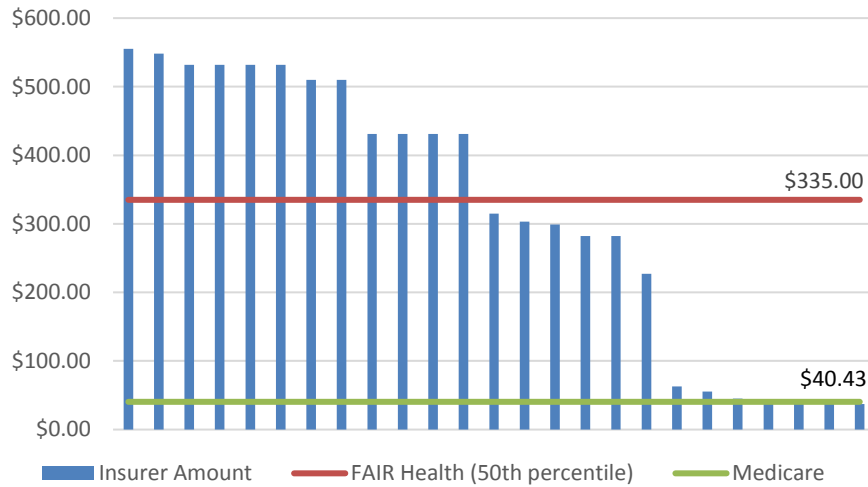


**99282 - Emergency department visit - Low to moderate severity
Austin 78745**

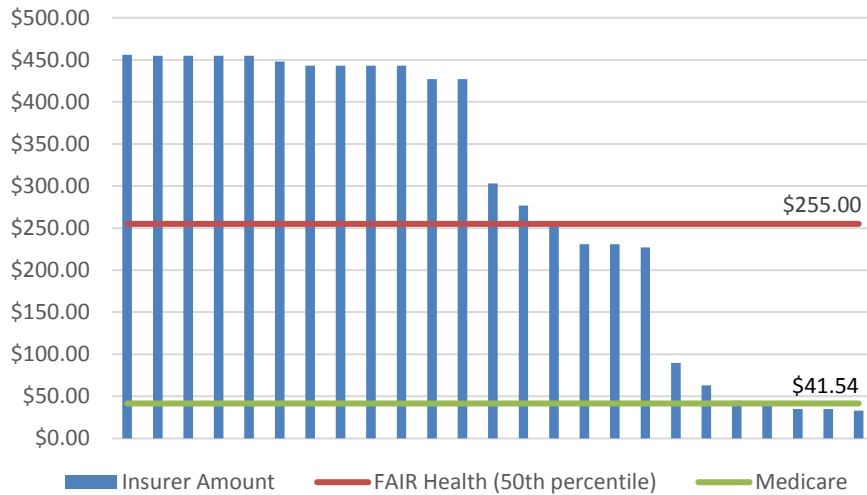


*The dollar amount originally published for the 50th percentile baseline of FAIR Health was incorrect. FAIR Health has since revised its data. This report shows the corrected amount.

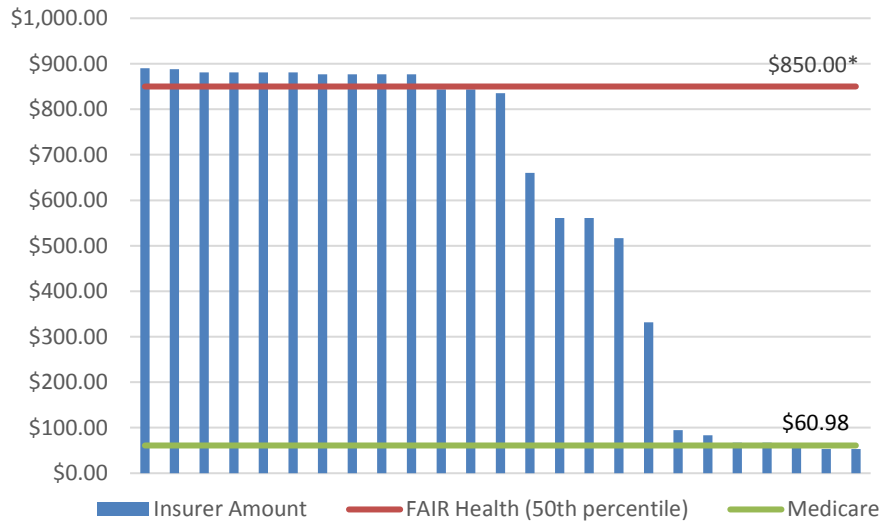
**99282 - Emergency department visit - low to moderate severity
Brownsville 78521**



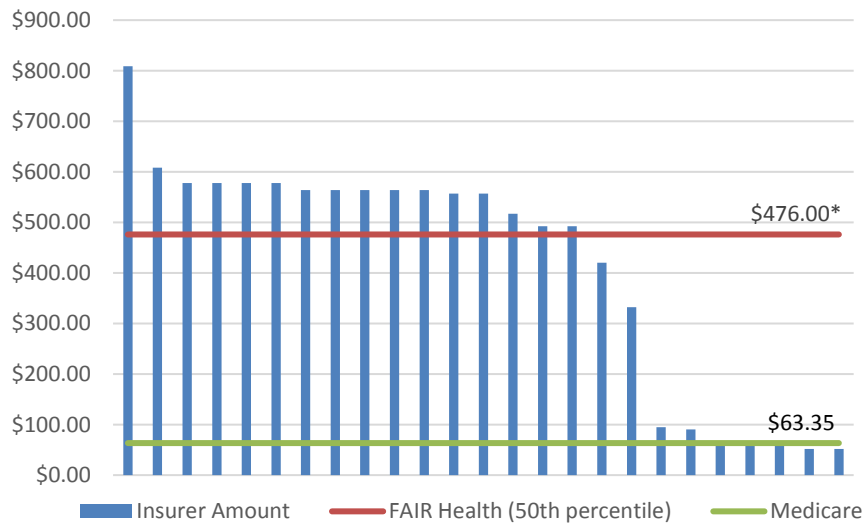
**99282 - Emergency department visit - low to moderate severity
Dallas/Fort Worth 75052**



**99283 - Emergency department visit - Moderate severity
El Paso 79936**

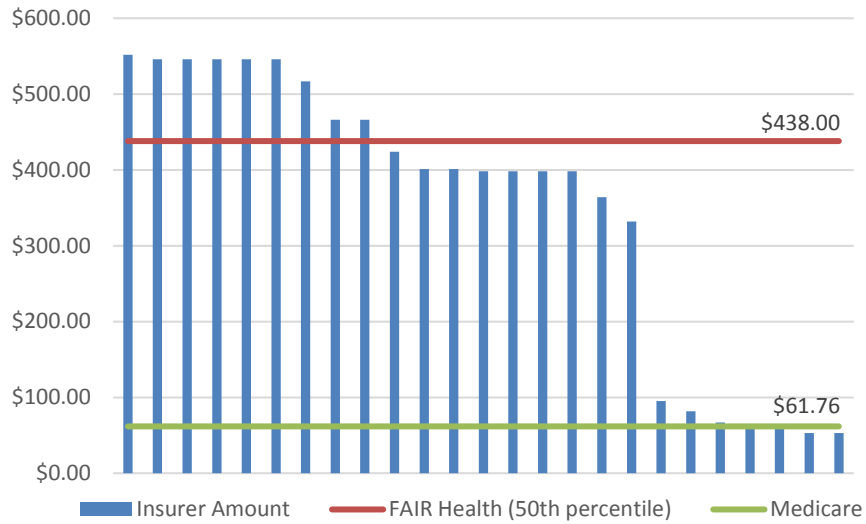


**99283 - Emergency department visit - Moderate severity
Houston 77084**

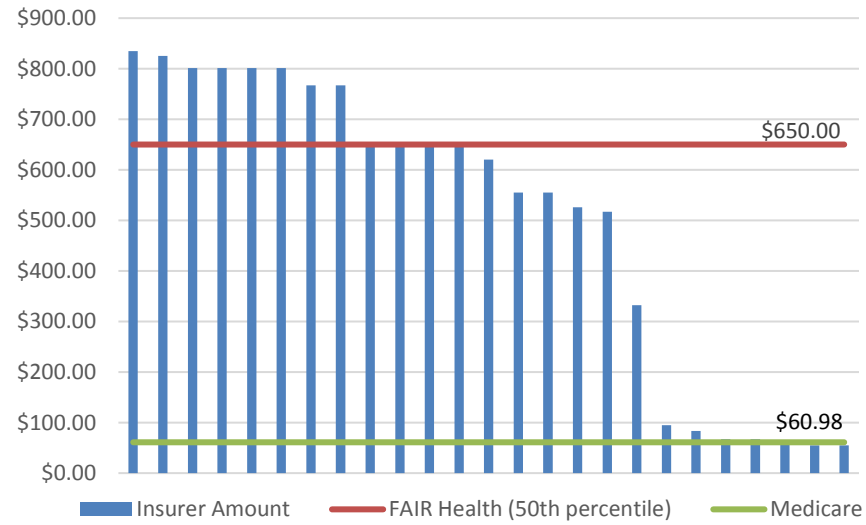


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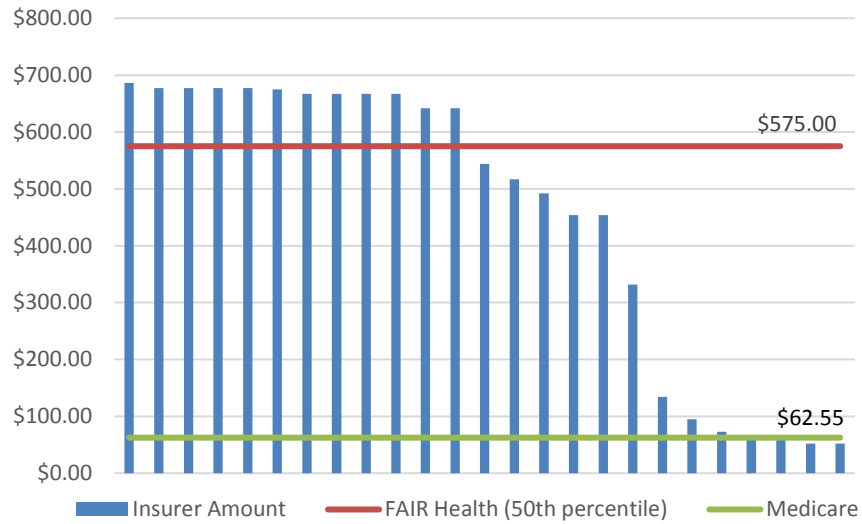
**99283 - Emergency department visit - moderate severity
Austin 78745**



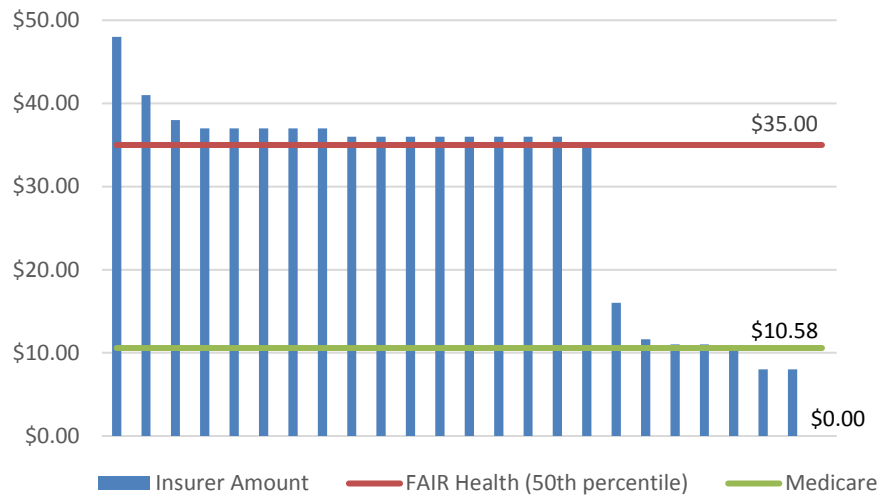
**99283 - Emergency department visit - moderate severity
Brownsville 78521**



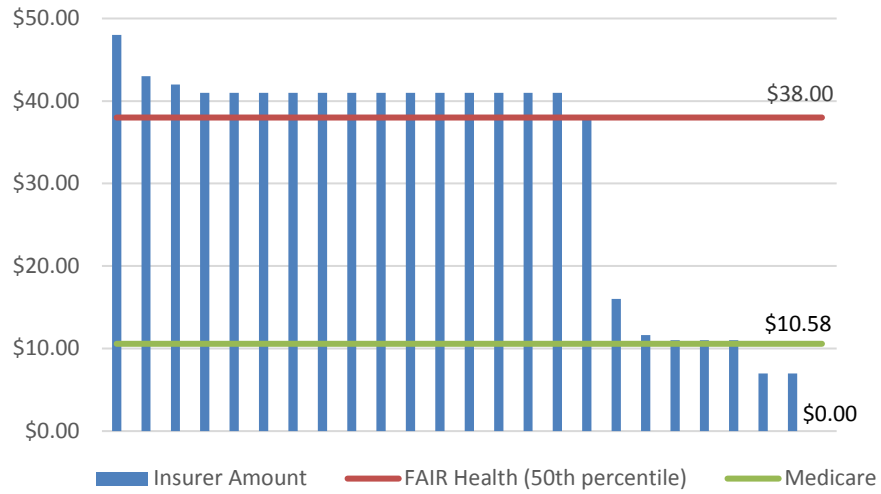
**99283 - Emergency department visit - moderate severity
Dallas/Fort Worth 75052**



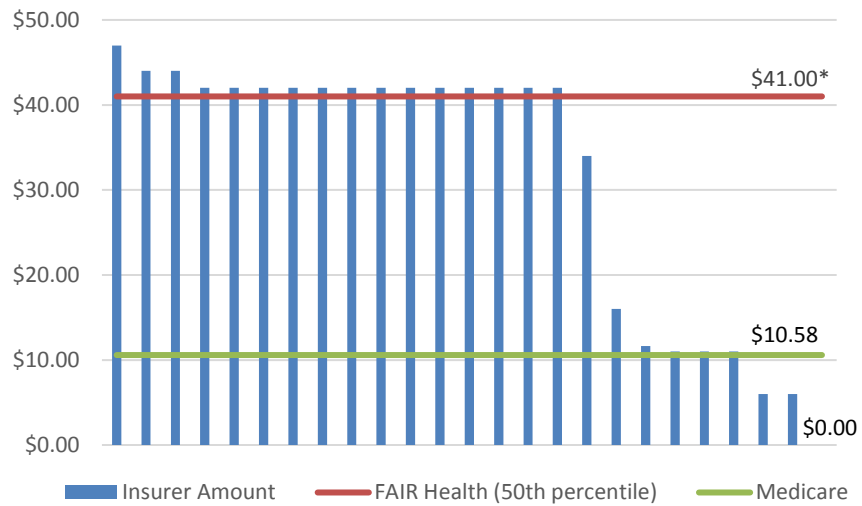
**85025 - Complete blood cell count
El Paso 79936**



**85025 - Complete blood cell count
Houston 77084**

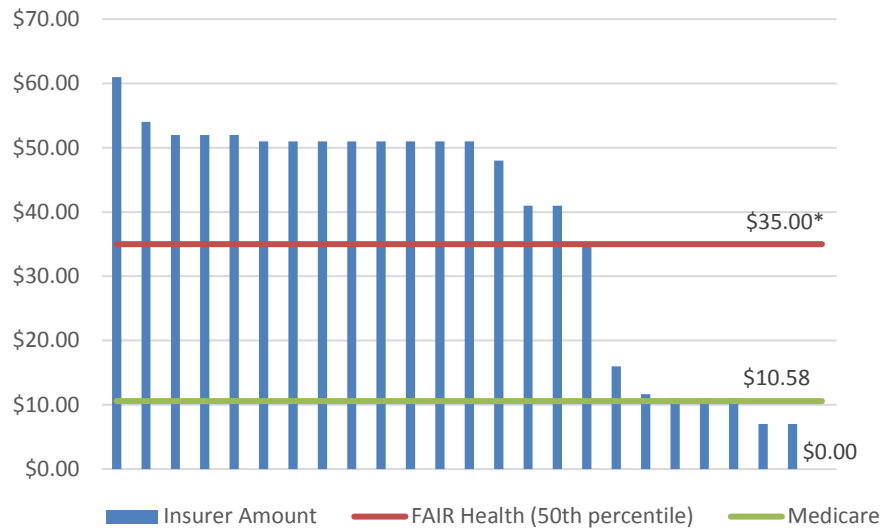


**85025 - Complete blood cell count
Austin 78745**

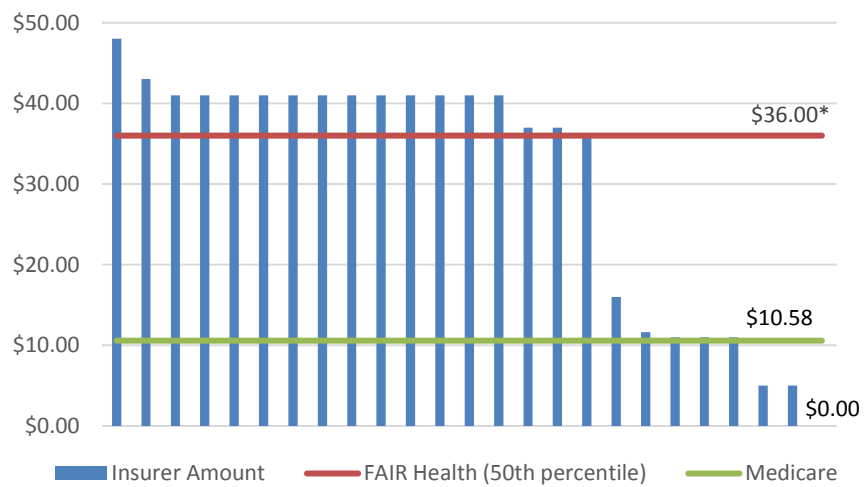


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**85025 - Complete blood cell count
Brownsville 78521**



**85025 - Complete blood cell count
Dallas/Fort Worth 75052**



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