Assessing the Usability of Insurance Payment Rate Data Under the Price Transparency Rules: A Case Study of Ohio Mental Health and Behavioral Health Services

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Introduction

- Approximately 60% of the United States population is covered by private health insurance.
- Historically, the negotiated prices between a private insurer and mental health service provider were confidential.
- Recent price transparency regulations were designed to lower societal costs of treatment through price comparisons.
- On July 1, 2022, the United States (US) government required insurers to publish their negotiated rates by service provider.
  - A key benefit of this rule compared to other claims data is the availability of all insurers, plan types, procedure types, and price information.
- Providers may use this information for negotiations and the public may benefit from lower prices due to transparency.
- The objective of this study was to assess the feasibility of accessing and utilizing this information in mental and behavioral health services in Ohio.

Methods

- Payment rates for Anthem Ohio PPO (Anthem) and Medical Mutual of Ohio SuperMed (MMO), were downloaded in November 2022.
- The data were imported and synthesized into one file using python and organized by unique employer identification number.
  - Variable names were cross-walked between the files and standardized.
- Mental and behavioral health professional services were identified by CPT© codes.
  - 90832-90840, 90845, 90847, 90849, 90853, 96152-96159,96164, 96165, 96167, 96168
- Data were imported into Tableau and dashboards created to explore and summarize the data.
- Summary statistics by plan, CPT, place of service, negation type, and billing arrangement were generated.
- Institutional Review Board was not required because all data was a negotiated payment rate and not an individual claim.

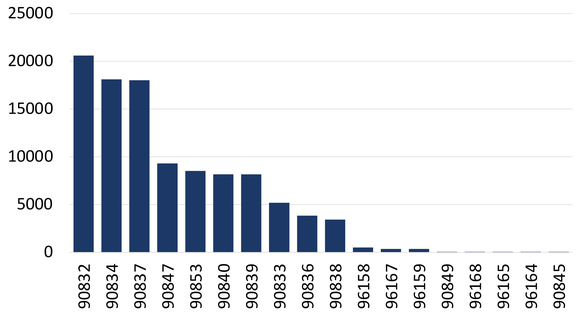
Results

- There were 104,883 payment observations (99.3% Medical Mutual of Ohio) for 14,793 unique providers in Ohio [Table 1].
- Mental and behavioral office payment rates comprised 78,357 (74.7%) of the observations.
- The most frequent CPT codes were 90832, 90834, 90837 – Psychotherapy W/ Patient 30, 45, and 60 minutes – which comprised 54.1% of the observations [Figure 1].
- Group Therapy, CPT 90853, comprised 8.1% of the observations [Figure 1].
- The median payment rates were $52.37, $73.43, and $108.41 for CPT codes 90832, 90834, and 90837. The median payment rate for group therapy was $17.24 [Figure 2, Table 2]

Table 1. Descriptive Characteristics of Insurer Price Data

Insurers	Unique Observations	Percent
Total	104883	100%
Medical Mutual Ohio (MMO)	104117	99%
Anthem	766	1%
Billing Class		
Institutional	93	<1%
Professional	104790	>99%
Negotiation Type		
Fee Schedule	692	1%
Negotiated	104119	99%
Percentage	72	<1%

Figure 1. Frequency of Mental Health Billing Codes



Results

Figure 2. Median Payment by Code

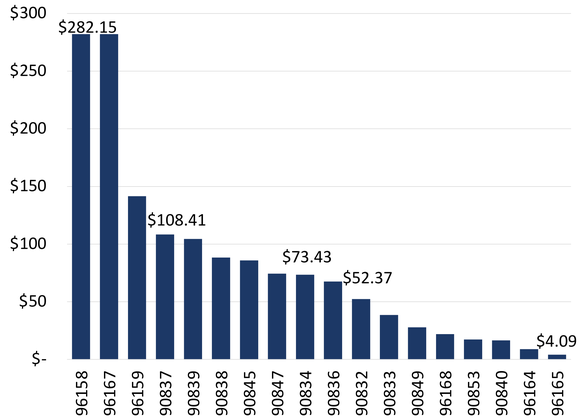


Table 2. Inter-Quartile Range, Mean, & Standard Deviation of Payments by Code

Code	Inter-Quartile Range		Mean	Standard Deviation
	25th	75th		
90832	$49.88	$52.37	$54.09	$14.22
90833	$38.53	$60.08	$49.38	$18.00
90834	$66.17	$73.43	$79.00	$37.50
90836	$67.50	$67.50	$70.35	$11.32
90837	$97.83	$108.41	$114.56	$49.99
90838	$88.29	$88.29	$90.25	$14.24
90839	$104.42	$104.42	$104.51	$2.25
90840	$16.48	$16.48	$16.86	$4.16
90845	$57.69	$97.97	$79.34	$20.69
90847	$74.43	$74.43	$89.74	$50.33
90849	$20.97	$37.31	$38.58	$46.16
90853	$17.24	$17.24	$18.88	$13.16
96158	$109.90	$282.15	$206.82	$91.53
96159	$141.55	$141.55	$125.24	$40.96
96164	$7.18	$10.97	$15.03	$21.68
96165	$3.32	$4.83	$10.63	$22.92
96167	$282.15	$282.15	$251.58	$75.85
96168	$18.47	$28.50	$27.56	$18.56

Discussion

- This data may be a valuable resource for mental health service providers and researchers to better understand pricing structures and allow for more informed negotiations between mental health service providers and private insurers.
- The current usefulness of the data is constrained by high processing processing costs and lack of standardization of data files by insurer.
- Enforcement of the insurer price transparency rules is shared by the Centers for Medicare and Medicaid Services, and state regulators.
- Insurers are not required to provide data on plan size, utilization, beneficiary characteristics or quality outcomes.
- Structure of data and lack of additional service provider identifiers limit the ability to link data to third-party databases.
- The price transparency rules are a first step towards a value-based and cost-efficient health system in mental health treatment.

Conclusion

- Insurer negotiated rates are available for public consumption and are regularly updated.
- However, the resources and technology required to use the data and inform decisions is currently beyond the capacity and capabilities of most mental health service providers.

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