HCCI HEALTH CARE COST INSTITUTE

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The Impact of the Mental Health Parity and Addiction Equity Act on Inpatient Admissions

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) sought to improve access to mental health and substance use services. The Health Care Cost Institute, Inc. (HCCI) analyzed mental health, substance use, and medical/surgical inpatient per capita spending, utilization, prices, and out-of-pocket payments for individuals younger than age 65 and covered by employer-sponsored health insurance (ESI) for 2007 through 2011. During the study period, ESI per capita spending nearly doubled for behavioral health admissions and grew to 3.2 percent of inpatient spending. In 2011, mental health admissions grew by 5.9 percent, and substance use admissions grew by 19.5 percent. After 2009, out-of-pocket payments per admission were nearly equivalent for mental health and medical/surgical stays. In all years, out-of-pocket payments per substance use stay remained greater than out-of-pocket payments per mental health or medical/surgical admission. In this initial examination, the role MHPAEA played in the changes observed in 2011 remains unclear.

KEY FINDINGS

11.7% increase in per capita spending on mental health inpatient admissions (2010–2011)

5.9% increase in mental health inpatient admissions (2010–2011)

11.5% increase in out-of-pocket spending per capita for mental health inpatient admissions (2010–2011)

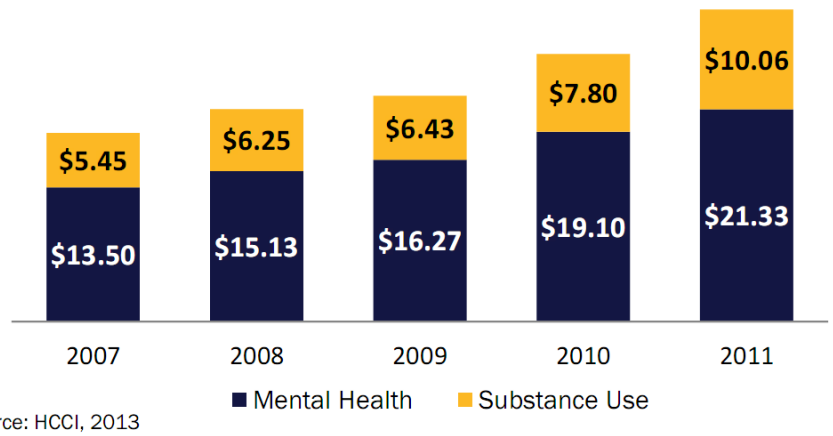
28.9% increase in per capita spending on substance use inpatient admissions (2010–2011)

19.5% increase in substance use inpatient admissions (2010–2011)

32.2% increase in out-of-pocket spending per capita for substance use inpatient admissions (2010–2011)

Figure 1

Per Capita Inpatient Spending on Mental Health and Substance Use (2007-2011)



Source: HCCI, 2013

In February 2010, the Department of Health and Human Services (HHS) released an interim final rule (IFR) outlining the insurance requirements for the MHPAEA.[1,2] The MHPAEA enhanced earlier legislation and extended parity to substance use benefits.[3,4] The IFR defined how insurers could implement the new policy for individuals whose large group plans offered mental health and substance use benefits.[1,4] These efforts were expanded by the Patient Protection and Affordable Care Act's (ACA) extension of behavioral health parity to more insured in the United States.[5,6] As of February 15, 2013, no final rule on parity had been released by HHS.

To assess changes in the costs and utilization of inpatient mental health and substance use stays during the implementation period of the MHPAEA and

WHAT IS PARITY?

Under MHPA and MHPAEA, insurers were required to make formulation of benefits, utilization management, and out-of-pocket payments equivalent between behavioral health services and other medical services.

As of February 15, 2013, no final rule has been released defining parity and how it should be operationalized.

Under MHPA (1996):

- Lifetime and annual dollar limits for mental health services had to be equivalent to other health services.
- Parity applied only to commercial plans offering mental health benefits.

Under MHPAEA (2008) and the interim final rule (2010):

- Parity was extended to substance use services.
- Financial requirements for mental health and substance use had to be equivalent to other health services.
- Quantitative treatment limitations for mental health and substance use had to be equal to other health services.
- Utilization management techniques had to be formulated in a manner similar to that for mental health and substance use and other services.
- Application of benefits design for mental health and substance use and medical/surgical services had to be equivalent by classification and network.

the IFR, HCCI analyzed substance use and mental health admissions for individuals younger than 65 and covered by ESI. This brief provides data on inpatient ESI spending, utilization, prices, and out-of-pocket payments observed for this population between 2007 and 2011.

From MHPA to MHPAEA

Historically for the insured, some behavioral health services benefits, such as those for mental health and substance use treatment, had been subject to more constraints than other health care services.[7] While mental health and substance use coverage was not offered by every ESI plan, when behavioral health coverage was offered, benefits design may have deterred insureds from seeking medically appropriate behavioral health treatment.

In 1996, Congress attempted to address these issues through the Mental Health Parity Act (MHPA).[3] The MHPA required lifetime and annual dollar limits for covered mental health services to be equivalent to medical/surgical services. The MHPA did not require mental health and other health care to have equivalent treatment limitations. The legislation also did not try to achieve parity for other behavioral health services or address out-of-pocket spending.[4] As well, the MHPA applied only to health plans that offered behavioral health benefits.[4,6]

To address these limitations, Congress enacted in 2008 the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The MHPAEA's intent was to extend benefit parity by allowing the insured to use substance use services with restrictions similar to medical and surgical services covered by their health plan.[1] The MHPAEA extended parity to individuals covered by large group plans (ESI, local, and state) and to employers that offered behavioral health benefits. The MHPAEA did not mandate that health plans offer mental health or substance use benefits.

The interim rule and defining parity

In February 2010, HHS released an IFR outlining the parity requirements.[1] The IFR outlined the financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) for mental health and substance use services.[1] The IFR also defined how inpatient in-network and out-of-network services would be treated.

The IFR defined what financial requirements were and how plans could comply with the parity regulations.[1] Plans that offer mental health and substance use benefits must formulate financial requirements (including co-pays, deductibles, coinsurance, and out-of-pocket maximums) for behavioral health services in such a way as to be equivalent with the predominant or most common medical/surgical treatments. That does not mean that the cost of an admission needs to be the same or that the share of out-of-pocket payment be the same—only that the same calculations occur for determining copays, deductibles, coinsurance, and out-of-pocket limits. Therefore, financial parity could be assessed by comparing like benefits to like: that is, copays to copays or out-of-pocket maximums to out-of-pocket maximums.

The IFR specified that QTLs also had to be equivalent between behavioral health and the most common medical/surgical treatements.[1] Therefore, if ben-

efits covered a certain number of medical/surgical admissions, they also had to cover the same number of mental health or substance use admissions.

The IFR also required that the factors (including processes and evidence-based standards of care) used to apply NQTLs for mental health and substance use benefits be applied no more stringently than those for medical/surgical benefits.[1] NQTLs include management techniques such as, but not limited to, prior authorization, utilization review, fail-first policies, and prescription design. The IFR also allows for NQTLs to be applied differently when clinically appropriate.

The IFR classified services as inpatient, outpatient, emergency room, or prescription.[1] It also classified services as in-network or out-of-network. A provider who offered substance use and mental health inpatient out-of-network admissions would need to formulate benefits, financial requirements, QTLs, and NQTLs equivalent to those for inpatient out-of-network medical or surgical admissions.

The IFR extended parity only to private and public group plans with more than 50 employees.[1] The MHPAEA does not require health plans to offer behavioral health benefits and allows health plans to exclude coverage for specific diagnoses.[1] Health plans can avoid parity requirements by not offering mental health and substance use benefits. However, recent research suggests that 96 percent of health plans offered the same mental health and substance use benefits without changes in the type or number of diagnoses covered after the MHPAEA.[8]

DEFINITIONS

Financial requirements include deductibles, co-payments, coinsurance, out-of-pocket payments, and annual limits.

Quantitative treatment limitations (QTLs) are defined as any restrictions on the scope or duration of treatment including frequency of treatment, number of visits, or days of coverage.

Non-quantitative treatment limitations (NQTLs) are defined as any efforts to manage medical care of the insured. Also known as non-quantitative management techniques (NQMTs).

Fail-first policies or step therapy protocols involve the use of lower-cost treatments prior to the authorization of more expensive therapies.

Parity and health care spending

Typically, an extension of health care benefits should lead to more health care spending as more people access services. In one state that enacted a behavioral health parity law, spending growth was slightly higher after parity was enacted, out-of-pocket spending continued to rise, and the probability of using mental health and substance use services increased.[9] Studies of mental health and substance use parity implementation for federal employees suggested that large cost increases could be avoided by the increased use of NQTLs.[10]

The parity requirements for out-of-pocket payments are complicated and contingent on benefits design of copayments, deductibles, coinsurance, and out-of-pocket maximums. How parity for financial requirements is achieved could affect out-of-pocket payments for mental health, substance use, or medical/surgical admissions. For example, financial requirements parity might result in changes to out-of-pocket spending for mental health and substance use services. Alternatively, it might lead to changes in medical surgical out-of-pocket spending.

Methods

HCCI examined changes in spending, utilization, prices, and out-of-pocket payments for mental health and substance use inpatient admissions between 2007 and 2011.[11, 12] Behavioral health outpatient and prescription services were excluded from this analysis. The spending and prices associated with inpatient claims represent facility fees and do not include payments to medical personnel for procedures.

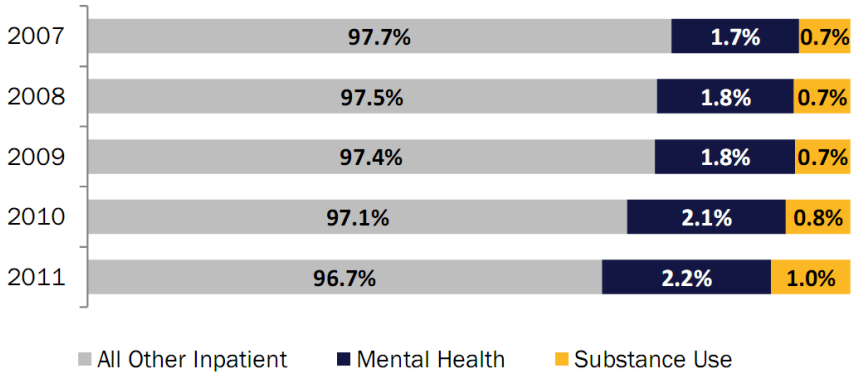
HCCI used annual metrics although the implementation of the MHPAEA IFR occurred on July 1, 2010. Per capita spending estimates were calculated across all insureds in each calendar year, including those who did not make a claim.[12]

Limitations

Any policy analysis is constrained by the timeliness of the review. The MHPAEA IFR was implemented on July 1, 2010 and applies to plan years after that date. This analysis ends in December 2011. Therefore, the 2011 findings are informative of the initial period of the MHPAEA's IFR. Moreover, during the initial period, consumers may have been unaware of benefit changes or slow to use mental health and substance use services. Only a single year of post-IFR data may not be enough to assess the full effect of the MHPAEA.

Figure 2

Share of Inpatient Per Capita Spending (2007-2011)



Note: Not to scale. Source: HCCI, 2013

HCCI limited the analysis to annual aggregated prices, utilization, and spending. All dollars are nominal and, therefore, are not inflation adjusted. HCCI's annual aggregation methods meant some of the 2010 service use occurred prior to the MHPAEA implementation.

The analysis was also limited to facility fees for inpatient stays. No analysis was performed on outpatient visits, professional procedures, or use of prescription drugs. HCCI did not assess NQTLs.

The HCCI database contains de-identified claims data with limited benefit information. The data used for this study were de-identified and compliant with Health Insurance Portability and Accountability Act (HIPAA). Therefore, the identities of the people whose claims were used in this study were not known. HCCI's database does not contain detailed benefit information and does not contain information on mental health and substance use carve-out plans. The database also lacks information on the number of employees covered by each plan. Therefore, parity may not apply to all persons included in the analysis because some may be covered under plans with fewer than 51 employees.

Findings

The MHPAEA sought to reduce barriers on behavioral health utilization, to change the formulation of behavioral health benefits, and to extend parity protections to substance use services. HCCI examined 3 years prior to the IFR (2007-2009), the year the IFR was issued (2010), and 1 year post-IFR (2011). Some trends were consistent across all 5 years and some potential new trends appeared in 2010 and 2011.

Per capita spending

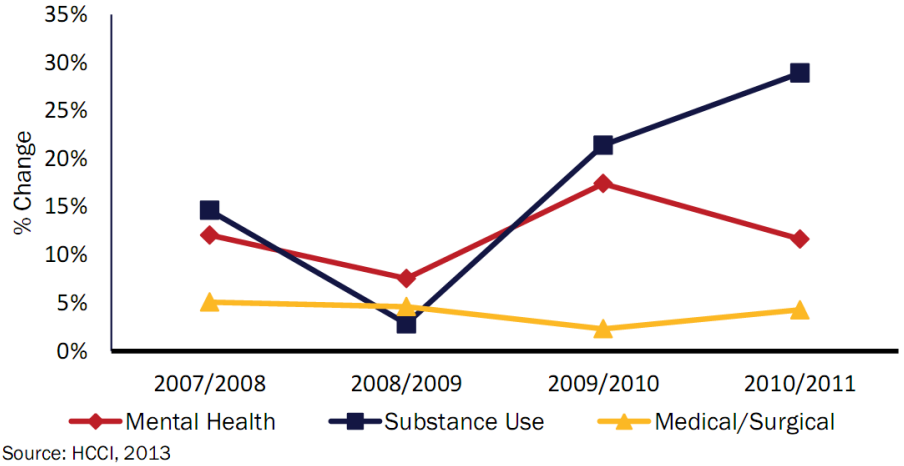
Relatively small amounts are spent on mental health and substance use admissions for individuals covered by ESI. In 2009, per capita inpatient spending was $16.27 for mental health and $6.43 for substance use admissions (Table 1). In 2011, per capita inpatient spending increased to $21.33 for mental health and $10.06 for substance use (Figure 1). In comparison, per capita spending on medical/surgical admissions was $769.16 in 2011.

Behavioral health admission spending, as a share of inpatient spending, grew between 2007 and 2011 (Figure 2). As a share of total inpatient spending, mental health admission spending rose from 1.8 percent in 2009 to 2.2 percent of spending in 2011. Spending on substance use stays rose from 0.7 percent of inpatient spending in 2009 to 1.0 percent of spending in 2011.

Spending on mental health and sub-

Figure 3

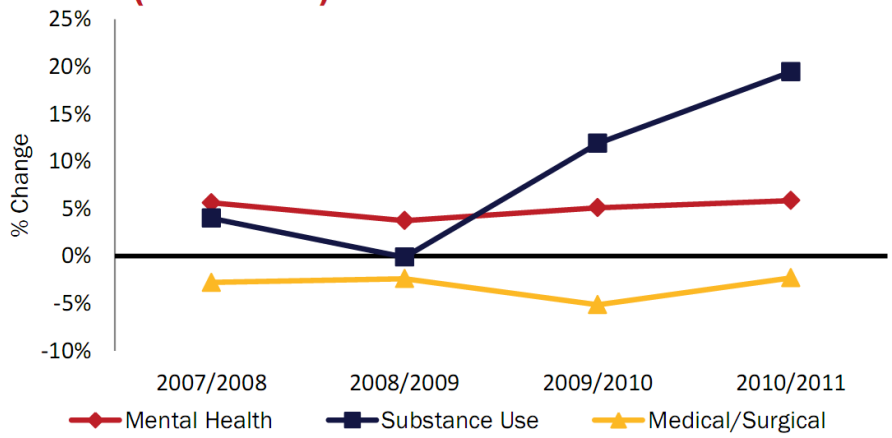
Changes in Annual Per Capita Inpatient Spending (2007-2011)



Source: HCCI, 2013

Figure 4

Changes in Inpatient Utilization per 1,000 Insureds (2007-2011)



Source: HCCI, 2013

stance use stays grew faster than spending on medical/surgical admissions for most years (Table 2 and Figure 3). Medical/surgical admissions (which are the most common type of hospital admission) had slower per capita spending growth for most years. Per capita spending on mental health admissions grew 17.4 percent from 2009 to 2010 and 11.7 percent from 2010 to 2011. Per capita spending on substance use admissions grew by 21.3 percent from 2009 to 2010 and 28.9 percent from 2010 to 2011.

Utilization and average length of stay

For inpatient services, the QTLs defined in the IFR refer in part to frequency of admissions and days.[1] The number of inpatient admissions for mental health and substance use increased in most years, whereas medical/surgical admissions fell every year between 2007 and 2011 (Table 1). Mental health admissions rose from 2.4 admissions per 1,000 insureds in 2009 to 2.7 admissions per 1,000 insureds in 2011. Substance use admissions increased from 1.0 per 1,000 insureds in 2009 to 1.4 admissions per 1,000 insureds in 2011.

Growth in substance use admissions accelerated to 11.8 percent from 2009 to 2010 and to 19.5 percent from 2010 to 2011(Table 2 and Figure 4). From 2010 to 2011, mental health admissions grew 5.9 percent and medical/surgical admissions declined 2.3 percent.

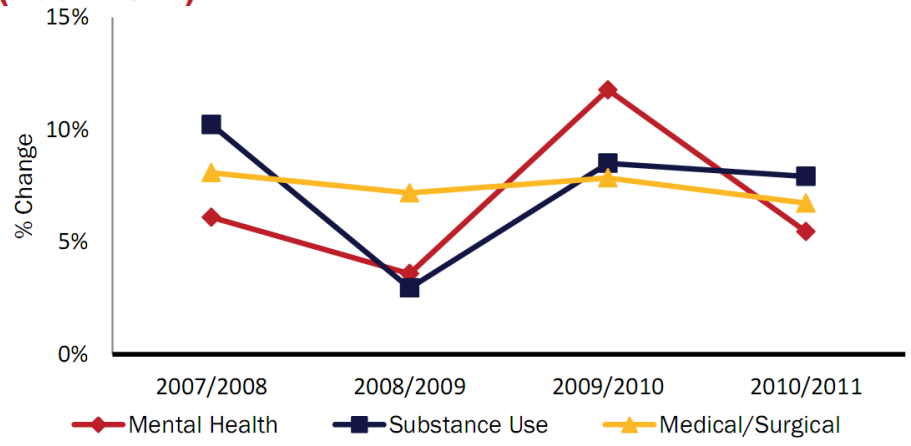
Average length of stay for mental health, substance use, and medical/surgical admissions increased over time (Table 1). In 2007, the average mental health admission was 6.1 days, and the average substance use admission was 6.9 days. In comparison, medical/surgical admissions averaged 3.9 days in 2007. By 2011, the average mental health admission was for 7.3 days, and the average substance use admission was for 8.0 days. Medical/surgical admissions also increased in length to 4.1 days in 2011.

Prices

Prices rose faster for mental health and substance use admissions than for medical/surgical admissions (Table 1). The average facility price for a mental health admission was $6,652 in 2009, and the average price was $7,842 in 2011. The average facility price of a substance use admission increased from $6,174 in 2009 to $7,230 in 2011. The average facility price for a medical/surgical admission increased from $17,462 in 2009 to $20,103 in 2011. Price growth was positive for mental

Figure 5

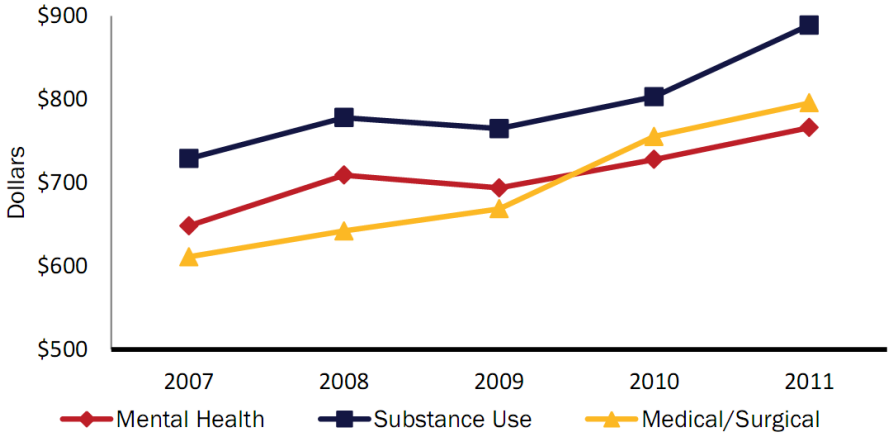
Changes in Price Paid per Inpatient Admission (2007-2011)



Source: HCCI, 2013

Figure 6

Average Out-of-pocket Payment per Inpatient Admission (2007-2011)



Source: HCCI, 2013

health, substance use, and medical/surgical admissions in all years (Table 2 and Figure 5).

Determinants of per capita spending

HCCI's reports have shown that in the ESI health care market, prices rather than utilization have been the major driver of spending growth for the commercially insured.[11] After 2009, mental health admissions grew steadily, and substance use stays accelerated even as medical/surgical admissions declined (Table 2). In 2010, for mental health admissions, prices grew faster than utilization; in 2011, mental health admissions grew faster than mental health admission prices. In both 2010 and 2011, prices for substance use stays grew slower than utilization. As a result, in 2010, spending growth for inpatient mental health admissions was driven more by prices, whereas spending growth for substance use admissions was driven more by utilization. In 2011, inpatient per capita spending on both mental health and substance use admissions was determined more by utilization than prices.

Out-of-pocket spending and payments

The IFR required financial requirements for mental health and substance use and medical/surgical benefits to be at parity. Because HCCI did not have information on benefits design or out-of-pocket maximums, HCCI bundled together copayments, deductibles, and coinsurance rather than conducting requirement-by-requirement analysis of parity implementation.

For 2011, out-of-pocket per capita spending on mental health admissions was only $2.08, and out-of-pocket per capita spending on substance use stays was $1.24 (Table 1). Per capita out-of-pocket spending on medical/surgical admissions was $30.45 in 2011. Per capita out-of-pocket spending is higher for medical/surgical admissions than for mental health or substance use stays due to high rates of utilization and higher average prices per admissions.

The insured's share of inpatient per capita spending declined over this period (Table 1). The share of mental health admission spending paid out-of-pocket decreased from 11 percent in 2007 to 10 percent in 2011. For substance use admissions, the share decreased from 13 percent in 2007 to 12 percent in 2011. However, the share of spending for medical/surgical admissions remained at a constant 4 percent.

HCCI also compared the total out-of-pocket payments per admission for mental health, substance use, and medical/surgical admissions (Figure 6). Substance use admissions had the highest out-of-pocket payments for each year from 2007 to 2011 and reached an average payment per admission of $889 in 2011 (Table 1). Medical/surgical out-of-pocket payments were $669 per admission in 2009, $25 lower than the average mental health admission out-of-pocket payment of $694. Starting in 2010, out-of-pocket payments were greater for medical/surgical admissions than for mental health admissions but still lower than for substance use admissions. Out-of-pocket payments per medical/surgical admission were $796 in 2011, $30 higher than the average mental health out-of-pocket payment per admission of $766.

Summary

Between 2007 and 2011, inpatient mental health and substance use admissions increased. Prices and out-of-pocket payments for these services also increased. As a result, per capita spending on these admissions grew much faster than per capita spending on medical/surgical admissions. Yet, the role played by the MHPAEA and the IFR in growing spending and utilization is not clear.

In all years, behavioral health inpatient admissions were increasing even as medical/surgical admissions declined. Changes such as new health plan designs, increased stress caused by the economic downturn, and greater public acceptance of behavioral health care, could have led to rising utilization.

Out-of-pocket payments per admission, although not a perfect measure of financial regulation, remained higher for substance use than for other inpatient services. The continued increase in out-of-pocket payments suggests that, so far, the MHPAEA may not have the effect of lowering the out-of-pocket payments per substance use admission. However, the percent of spending borne by consumers for inpatient behavioral health admissions decreased after 2008. Out-of-pocket payments for mental health and substance use treatments should be closely observed in the future, particularly in light of the cap on out-of-pocket maximums for essential health benefits under the ACA beginning 2014.

It may also be too soon to determine the effect of the MHPAEA and the IFR on health care spending and utilization. Although the study period spanned the time before legislation, between legislation and interim final rule, and 1 year after the interim final rule, the final rule for the MHPAEA has not been released. More time may be needed to better assess the impact of this legislation, particularly the financial requirements and NQTLs.

However, it is clear that mental health and substance use admissions for individuals with ESI insurance increased in a time when other types of inpatient admissions declined. In particular, substance use admissions grew faster after 2009 than before 2009. Health care leaders and policy makers should continue to monitor substance use admissions to see whether the trends observed here persist after implementation of the final rule.

Notes

[1] Centers for Medicare and Medicaid Services. Interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Washington (DC): HHS, CMS, 2010, Feb. Report No. [CMS–4140–IFC] 45 CFR Part 146 RIN 0938–AP65.

[2] 110th Congress. PUBLIC LAW 110-343. Title V Subtitle B–Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Washington (DC): 110th Congress, 2008, Sept.

[3] 104th Congress. PUBLIC LAW 104–204. Title VII–parity in the application of certain limits to mental health benefits. Washington (DC): 104th Congress, 1996, Sept.

[4] United States Department of Labor, Employee Benefits Security Administration. Fact sheet: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) [Internet]. Washington (DC): DOL EBSA [updated 2010 Jan. 29, cited 2012 Dec. 11]. Available from http://www.dol.gov/ebsa/pdf/fsmhpaea.pdf

[5] 111th Congress. PUBLIC LAW 111-148 SEC. 1302. Essential health benefits requirements. Patient Protection and Affordable Care Act. Washington (DC): 111th Congress, 2010, Mar.

[6] Sarata, AK. Mental health parity and the Patient Protection and Affordable Care Act of 2010. Washington (DC): Congressional Research Service; 2011, Dec. Report No. R41249.

[7] Substance Use and Mental Health Services Administration. Mental Health Parity and Addiction Equity Act [Internet]. Rockville (MD): SAMHSA [updated 2011 May 5, cited 2012 Dec. 11]. Available from http://www.samhsa.gov/healthreform/parity/

[8] United States Government Accountability Office. Mental health and substance use: Employer's insurance coverage maintained or enhanced since parity act, but effect of coverage on enrollees varied. Washington (DC): US GAO, 2011, Nov. Report No. GAO-12-63.

[9] McConnell KJ, Gast SHN, Ridgely MS, Wallace N, Jacuzzi N, Rieckmann T, McFarland BH, McCarty D. Behavioral health insurance parity: Does Oregon's experience presage the national experience with the Mental Health Parity and Addiction Equity Act? Am J Psychiatry, 2012, Jan, 169(1): 31–38.

[10] Barry CL, Ridgely MS. Mental health and substance use insurance parity for federal employees: How did health plans respond? Policy Anal Manage, 2008, 27(1):155–170.

[11] Health Care Cost Institute. Health Care Cost and Utilization Report: 2011. Washington (DC): HCCI; 2011, Sept.

[12] Health Care Cost Institute. Health Care Cost and Utilization Report: 2011 Analytic Methodology. Washington (DC): HCCI; 2011, Sept.

Table 1 – Selected Inpatient Admissions Spending, Utilization, Prices, and Out-of-Pocket Payments (2007-2011)

	2007	2008	2009	2010	2011
Per Capita Spending					
Mental Health	$13.50	$15.13	$16.27	$19.10	$21.33
Substance Use	$5.45	$6.25	$6.43	$7.80	$10.06
Medical/Surgical	$655.53	$688.89	$721.29	$737.46	$769.16
Utilization (Admissions per 1,000 Insureds)					
Mental Health	2.2	2.4	2.4	2.6	2.7
Substance Use	1.0	1.0	1.0	1.2	1.4
Medical/Surgical	43.5	42.3	41.3	39.2	38.3
Price per Admission					
Mental Health	$6,053	$6,422	$6,652	$7,436	$7,842
Substance Use	$5,440	$5,997	$6,174	$6,699	$7,230
Medical/Surgical	$15,073	$16,292	$17,462	$18,834	$20,103
Per Capita Out-of-Pocket Spending					
Mental Health	$1.45	$1.67	$1.70	$1.87	$2.08
Substance Use	$0.73	$0.81	$0.80	$0.94	$1.24
Medical/Surgical	$26.58	$27.16	$27.63	$29.59	$30.45
Out-of-Pocket Payment per Admission					
Mental Health	$648	$709	$694	$728	$766
Substance Use	$729	$778	$765	$803	$889
Medical/Surgical	$611	$642	$669	$756	$796
Share of Spending Out-of-Pocket					
Mental Health	11%	11%	10%	10%	10%
Substance Use	13%	13%	12%	12%	12%
Medical/Surgical	4%	4%	4%	4%	4%
Average Length of Stay (Days)					
Mental Health	6.1	6.4	6.7	7.3	7.3
Substance Use	6.9	7.4	7.5	7.7	8.0
Medical/Surgical	3.9	4.0	4.1	4.1	4.1

Note: All data weighted and completed to represent the total population of beneficiaries younger than 65 and covered by ESI. All per capita dollars calculated from allowed costs. All figures rounded. Rounding may lead some percentage totals to not equal 100 percent. All percentage changes calculated before rounding. The medical/surgical category excludes any transplants or ungroupable admissions.

Table 2 – Percentage Change for Selected Inpatient Admissions Spending, Utilization, Prices, and Out-of-Pocket Payments (2007-2011)

	2007/2008	2008/2009	2009/2010	2010/2011
Per Capita Spending				
Mental Health	12.1%	7.6%	17.4%	11.7%
Substance Use	14.6%	2.9%	21.3%	28.9%
Medical/Surgical	5.1%	4.7%	2.2%	4.3%
Utilization (Admissions per 1,000 Insureds)				
Mental Health	5.6%	3.8%	5.0%	5.9%
Substance Use	4.0%	-0.1%	11.8%	19.5%
Medical/Surgical	-2.8%	-2.3%	-5.2%	-2.3%
Price per Admission				
Mental Health	6.1%	3.6%	11.8%	5.5%
Substance Use	10.2%	3.0%	8.5%	7.9%
Medical/Surgical	8.1%	7.2%	7.9%	6.7%
Per Capita Out-of-Pocket Spending				
Mental Health	15.5%	1.6%	10.2%	11.5%
Substance Use	11.0%	-1.7%	17.4%	32.2%
Medical/Surgical	2.2%	1.7%	7.1%	2.9%
Out-of-Pocket Payment per Admission				
Mental Health	9.4%	-2.2%	4.9%	5.3%
Substance Use	6.8%	-1.7%	5.0%	10.7%
Medical/Surgical	5.1%	4.1%	13.0%	5.3%
Average Length of Stay (Days)				
Mental Health	5.0%	4.0%	8.7%	0.8%
Substance Use	7.0%	1.4%	2.9%	4.3%
Medical/Surgical	1.1%	3.1%	-0.4%	0.2%

Note: All data weighted and completed to represent the total population of beneficiaries younger than 65 and covered by ESI. All per capita dollars calculated from allowed costs. All figures rounded. Rounding may lead some percentage totals to not equal 100 percent. All percentage changes calculated before rounding. The medical/surgical category excludes any transplants or ungroupable admissions.

Data

HCCI analyzed adjudicated claims incurred by 40 million people younger than 65 years and having fee-for-service ESI in the United States for every year between 2007 and 2011. HCCI completed those claims and then weighted the data to make them representative of the national population covered by ESI.[13] The data were contributed to HCCI by a set of large health insurers who collectively represent almost 40 percent of the U.S. private health insurance market. The data were de-identified, compliant with the Health Insurance Portability and Accountability Act, and included the allowed cost or actual prices paid to providers for services.

For more information about HCCI please visit the HCCI Website: www.healthcostinstitute.org.

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