National Association of Insurance Commissioners

2009 Fall National Meeting
Washington, DC

Joint MARKET REGULATION AND CONSUMER AFFAIRS (D) COMMITTEE
and HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

PUBLIC HEARING

USUAL, CUSTOMARY AND REASONABLE (UCR) PRACTICES

Thursday, September 24, 2009
8:00 – 9:30 a.m.
Gaylord Convention Center—Maryland Ballroom A

Purpose of the Hearing

This hearing will focus on how usual, customary and reasonable (UCR) rates—including the issue of balance billing—are determined and disclosed to consumers. The hearing will focus on the following issues:

- An explanation of what constitutes a UCR charge.
- An explanation of how insurers use UCR charges.
- A discussion of how UCR practices (including balance billing) have affected consumers.

Agenda

1. Opening Remarks *(5 minutes)*
   – Commissioner Kim Holland (OK) and Commissioner Sandy Praeger (KS)

2. Marty Mitchell, America's Health Insurance Plans *(12 minutes)*

3. Dr. Robert Wah, Trustee, American Medical Association *(12 minutes)*

4. Kevin Lucia, Georgetown University *(12 minutes)*

5. Bonita A. Kallestad, Mid-Minnesota Legal Assistance *(12 minutes)*

6. Ellen Kuhn, Maryland Assistant Attorney General *(12 minutes)*

7. Open Dialogue *(20 minutes)*
   – Commissioner Holland and Commissioner Praeger

8. Closing Remarks *(5 minutes)*
   – Commissioner Holland and Commissioner Praeger

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Testimony of

America's Health Insurance Plans

Before the

National Association of Insurance Commissioners'

Market Regulation and Consumer Affairs (D) Committee

And

Health Insurance and Managed Care (B) Committee

September 24, 2009

Good morning Commissioner Holland and Commissioner Praeger and members of the D and B Committees. My name is Marty Mitchell and I am here today on behalf of America's Health Insurance Plans (AHIP). AHIP is the national trade association representing nearly 1,300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

Protecting consumers from runaway charges billed by some providers who decline to participate in provider networks is an important responsibility. A new report[1] released by AHIP shows that some physicians who do not participate in networks are charging fees that are several hundred percent – and in some cases, several thousand percent – of the Medicare reimbursement rate for the same service in the same geographic area. For example, in one state, a physician billed a patient $6,791 for "cataract surgery with insertion of artificial lens" – more than 1,100% of the Medicare fee of $581. Despite glaring examples of excessive charges by out-of-network providers, recent public discussions regarding out-of-network services and usual, customary, and reasonable determinations have focused **only** on how much insurers pay – without addressing the critical issue of how much patients are charged by out-of-network providers.

We believe it is time to broaden this discussion and appreciate the opportunity to appear before you and contribute to the dialogue on this important issue. Research by the Dartmouth Institute for Health Policy and Clinical Practice has shown that spending more on health care does not necessarily equate to better quality; rather, the opposite is true.[2] "Over the past ten years, a number of studies have explored the relationship between higher spending and the quality and outcomes of care. The findings are remarkably consistent: higher spending does not result in better quality of care, whether one looks at the technical quality and reliability of hospital and ambulatory care, or survival following such serious conditions as a heart attack or hip fracture.

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[1] *The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs: A Survey of Charges Billed by Out-of-Network Physicians*, released by America's Health Insurance Plans (AHIP), August 2009. The report can be accessed at http://www.ahipresearch.org/ValueofProviderNetworksSurvey.html.

[2] *Health Care Spending, Quality and Outcomes: More Isn't Always Better*. Dartmouth Atlas Project Topic Brief (February 27, 2009).

This finding holds even when we consider changes over time."[3] Indeed, even such generalist publications such as the *New Yorker* magazine recently noted in an article that "costlier care is often worse care," providing examples of variation of costs of 100% for similar treatments, without an indication of better quality healthcare.[4] Many regions of the nation with higher spending actually have poorer quality of care and exhibit wide variations in practice and treatment patterns.[5]

1. Background

One tool that health insurance plans, third-party payers (e.g., employers who provide self-funded coverage), and public programs use to improve quality and control costs is the establishment of provider networks. Through contracting with credentialed providers, health plans and payers create networks that provide consumers with lower cost, high-quality care. Nevertheless, the majority of private health insurance plans, employer self-funded arrangements, and public programs offer consumers the choice of obtaining care from a network of contracted physicians, hospitals, and other health care professionals or receiving care from out-of-network physicians, hospitals, and other providers.

Consumers see measureable savings if they see a contracted provider. The in-network provider is prohibited, by contract with the health plan and often by law, from charging the patient the difference between the billed charge and the payment negotiated under the contract with the health plan (in other words prohibited from what is commonly referred to as balance billing). In addition, if the consumer receives services from an in-network provider, the deductible, coinsurance, and co-payment obligations are typically lower than if the services are received from an out-of-network provider. By providing access to high quality provider networks at substantially discounted rates, health insurance plans save consumers billions of dollars each year in out-of-pocket costs and premiums.

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[3] Id. at 2.
[4] Atul Gawane, *The Cost Conundrum: What A Texas Town Can Teach Us About Health Care*, The New Yorker (June 2009).
[5] Id.

The establishment of networks also offers tangible benefits to participating providers – with the overwhelming majority of physicians and hospitals in the United States participating in provider networks. Specifically, by participating in networks and agreeing to provide services at negotiated rates, providers and facilities obtain direct claims payment from the health plan or payer and an increase in patient volume resulting from incentives (described above) that encourage consumers to use in-network providers and facilities.

2. Usual, Customary, and Reasonable Determinations

The issue of what constitutes a "usual, customary, and reasonable" (UCR) payment arises when out-of-network providers seek reimbursement for covered services under a network-based health insurance plan, a self-funded arrangement, or a public program. Out-of-network providers and facilities are free to charge whatever fee they choose and, without a contract or law that establishes the amount to be paid, an approach or system is needed to determine how out-of-network providers will be compensated for covered services.

The following approaches are typically used in these circumstances:

- *UCR determinations:* A common approach for calculating the payment to out-of-network providers involves a determination of the "usual, customary and reasonable" amount, or UCR amount. Most approaches use a compilation and statistical analysis of provider charge data for identical or similar services in a certain geographic area to determine a UCR amount. The health plan or payer then selects the amount – usually expressed as a percentile (e.g., 75th percentile) – that it will consider as the covered charge from out-of-network providers. Remitting payment based on the percentile is different from remitting payment based on a percentage of the provider's billed charges. The percentile chosen represents the point at which that percentage of billed charges would be paid in full. In other words, if the 75th percentile is used, the amount deemed eligible for payment will be equal to or greater than the amount billed for that procedure by 75 percent of the providers in the area.

  There are several databases available for health plans, self-funded plan administrators, and government instrumentalities to use to determine their UCR

reimbursement rates. In addition, several states (e.g., Massachusetts, New Jersey, and Vermont) set a minimum UCR rate by reference to a specific database that must be paid to out-of-network providers for covered services by a health plan, the state employee plan, and/or a state guaranty fund. Some health plans and payers engage in a similar analysis, but compile information using charge data from their own claims.

- *Fee schedule:* Another methodology uses a reimbursement schedule that may be fixed (e.g., no more than $500 per hospital bed day, $100 for an office visit) or pays out-of-network providers based on the negotiated fee schedule used for contracted providers in the same geographic region (e.g., 70 percent of the health plan's or payer's contracted rate for the same service in the same geographic region).

- *Reference to Medicare rates:* Another approach reimburses out-of-network providers based on a percentage of the Medicare published rate for the same or similar service in a specific geographic area (e.g., 150 percent of the Medicare published rate).

3. Impact on Consumers

When a health plan or payer offers coverage for services received out-of-network, consumers may choose to receive covered services from out-of-network providers and facilities. To encourage utilization of in-network providers, consumers who go outside the network to receive covered services will likely be subject to higher deductible, coinsurance, and/or co-payment obligations. In addition, when services are provided out-of-network, the consumer is responsible and can be billed by the provider or facility for any amounts not paid by the health insurance plan, payer, or public program. As demonstrated by the AHIP report mentioned earlier, this balance billing can expose consumers to excessive and unpredictable liability each time consumers receive services out-of-network.

As commentators have noted in a Michigan Law Review article, the out-of-network market for medical services is "a calamity. Patients can rarely amass enough information about services and prices to make good decisions about hiring doctors and buying care. Patients are frequently committed to their doctors, and their doctors normally decide which hospitals

to use. Doctors and hospitals commonly require patients to sign contracts obliging them to pay whatever bills the provider cares to present. Providers regularly present and aggressively collect staggering bills unrelated to their costs or to the prices they negotiate with insurers. This is a market few can negotiate wisely…"[6]

There are many reasons why a consumer may choose to receive services outside their network. As such, a number of strategies – rather than a one-size-fits-all solution – are needed to address the issue of charges by out-of-network providers. AHIP believes that disclosure is a critical part of any solution to afford consumers the opportunity to determine what their out-of-pocket costs will be prior to services being rendered by an out-of-network provider. Disclosure of a provider's network status and charges, along with information about the consumer's cost-sharing and potential out-of-pocket exposure, will allow consumers to make more informed decisions when selecting a provider, can avoid situations where consumers receive surprise bills for out-of-network charges, and also allows patients to plan ahead for out-of-pocket costs.

It is also important that policy solutions on this issue encourage the development of networks, including initiatives to strengthen the incentives for individuals to seek care within their networks whenever possible and for providers to participate in those networks. In addition, we urge policymakers to study the amounts charged by providers and facilities for services before any policy solutions are adopted, particularly since high charges are not proxies for high-quality care. AHIP members believe further careful study of this topic is necessary to ensure fair treatment of consumers and providers. We are committed to working with the NAIC and others to develop solutions that protect consumers who receive care out-of-network from receiving bills that are unreasonable and unaffordable and that bend the cost curve to make health care coverage more affordable for all consumers.

[6] Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 Mich. L. Rev. 643 (2008)

Balance Billing – The Consumer Perspective

Ellen L. Kuhn

Assistant Attorney General

Maryland Office of the Attorney General

What is balance billing?

- Balance billing is when the consumer is liable to the provider for the difference between the amount charged by the provider for a service and the portion of the allowed amount paid by the carrier for that service.

What do consumers think balance billing is?

- Consumers believe that when they are balance billed, they are liable to a provider for the difference between what the carrier lists on the explanation of benefits as the allowed amount and the amount the carrier actually paid.

Let's look at the math….how it really works

- Provider's Charge: $1200.00
- Carrier's Allowed Amount: $800.00
- Carrier pays 80% of $800.00: $640.00
- Consumer pays coinsurance (20 % of $800.00): Total: $160.00
- Balance owed by consumer to provider = $1200.00-$800.00: $400.00
- Total for consumer: $560.00 ($160.00+$400.00)

How consumers think the math works….

- Provider's Charge: $1200.00
- Carrier pays 80% of $1200.00: $960.00
- Consumer pays coinsurance (20 % of $1200.00): Total: $240.00

Or, consumers think the math works like this….

- Provider's Charge: $1200.00
- Carrier's Allowed Amount: $800.00
- Carrier pays 80% of $800.00: $640.00
- Consumer pays coinsurance (20 % of $800.00): Total: $160.00
- Balance consumer believes he/she owes: $160.00
- Consumer believes the $400.00 difference between the provider's charge and the allowed amount is written off by the provider.

So why the confusion?

- Most consumers do not understand that their balance consists not just of the 20% of the allowed amount not paid by the provider ($160.00 in our example), but also the difference between the provider's charge ($1200.00) and the allowed amount ($800.00).

Plan summaries are not clear to consumers

Example of language from a plan summary:

- For PPO Out-of-network services, the plan pays: "80% of allowed benefit after deductible." (found on page 26)
- The definition of "allowed benefit" is "The maximum fee a health plan will pay for a covered service or treatment." (found on page 76)

Problems Consumers Encounter: The In-patient Setting

- Emergency situations
- The hospital is participating – aren't all the providers?
- Inability to get information about providers regarding participation

Problems Consumers Encounter – The Medical Office

- Depending upon the area, in-network providers may not be readily available – especially in specialty areas.
- Most consumers do not understand the difference between what a provider charges and the allowed amount.

Legislative Action

- Some states have passed prohibitions on balance billing
- Some states have passed hold harmless legislation
- Some states have passed both balance billing prohibitions and hold harmless clauses.

Maryland Law – Hold Harmless

- Maryland requires HMOs to have agreements with providers that include a hold harmless clause.
- "The hold harmless clause shall provide that the provider may not, under any circumstances, … bill … the subscriber … for services provided in accordance with the provider contract." Md. Code Ann., §19-710 (i) (2005 Repl. Vol.)

Maryland Law – Balance Billing Prohibition

- Maryland law also prohibits providers from balance billing HMO members.
- "… [I]ndividual enrollees and subscribers of health maintenance organizations … shall not be liable to any health care provider for any covered services provided to the enrollee or subscriber." Md. Code Ann., §19-710 (p) (2005 Repl. Vol.)

Issues To Consider

- How to calculate appropriate reimbursement of providers who treat out-of-network HMO patients.
- Should balance billing prohibitions extend to PPO consumers in emergency room and hospital settings?
- Should balance billing prohibitions extend to PPO consumers in all settings?

Contact Information

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Summary of UCR Senate Hearing Report

Senator John D. (Jay) Rockefeller, IV, chair of the U.S. Senate Commerce, Science and Transportation Committee, held two hearings in March 2009 on payment practices in the insurance industry. Senate Commerce Committee staff conducted a nationwide investigation into how the insurance industry pays benefits to consumers who purchase "out-of-network" health insurance coverage. They determined that, in every region of the United States, large health insurance companies have been using two faulty database products owned by Ingenix to under-pay millions of valid insurance claims without providing even the most basic information about them to consumers or health care providers.

Background on "Usual and Customary" Reimbursement Rates

More than 100 million American consumers pay extra premiums for health insurance coverage that allows them to receive care outside their insurance company's network of doctors and other health care providers. Consumers pay more for "out-of-network" coverage, because they believe it gives them access to the medical care that will provide them or their family members the best chance for recovery from a serious accident or illness.

Over the past several years, a succession of private lawsuits and government investigations has revealed that the largest health insurance companies in the United States have been under-reimbursing their customers for out-of-network health care services. While insurance carriers have been promising to provide their customers with a certain level of coverage, they have actually been paying out-of-network claims at a lower level. The result of this practice is that consumers have paid billions of dollars for health care services that their insurance companies should have paid.

Data benchmarking tools like those sold by Ingenix to the health insurance industry systematically underestimate the cost of out-of-network services by providing the insurance industry with data it claimed were the prevailing, "usual and customary" market rates for medical services in specific geographic regions. These "usual and customary" data tables were used to pay tens of millions of medical claims for out-of-network services.

Flawed Data

Insurers present Ingenix as an accurate, objective and independent source of medical-charge information. However, Ingenix is, in fact, a wholly owned subsidiary of UnitedHealth Group. Therefore, it has financial incentive to produce data that shifted costs from insurers to consumers.

The data used to calculate its products comes from health insurers that purchase Ingenix's products and that often "scrub" their data to remove high charges, forming a "closed loop" of information between Ingenix and the insurance industry. Ingenix then uses its own statistical "scrubbing" methods to remove valid high charges from their calculations. Confidentiality agreements between Ingenix and insurers prohibit the disclosure of information about the database products to patients or doctors.

In testimony before the Senate Commerce Committee in March 2009, UnitedHealth Group's CEO publicly expressed his regret that there was a conflict of interest inherent in his company's relationship with Ingenix.

The results of these questionable statistical methods were estimates of "usual and customary" charges that consistently skewed reimbursement rates downward — in a direction that has allowed insurers to reduce their claims payments. New York State Attorney General Andrew M. Cuomo concluded that the "prevailing rates" Ingenix generated for doctor visits in New York were as much as 30% lower than the actual market rates for these services. In other words, insurance companies were paying only 70 cents on each dollar they owed their customers under the terms of their policies, which has cost consumers billions.

The Senate Commerce Committee Investigation

In March 2009, pursuant to its authority under Senate Rules to oversee interstate commerce and the regulation of consumer products and services, the Senate Commerce Committee held two hearings to examine how the Ingenix medical charge databases were used to reimburse consumers for their out-of-network health care. In order to gain a better understanding of how the insurance industry calculates out-of-network reimbursements, Chairman Rockefeller sent information requests to the 18 largest health insurers that were not affected by the New York State Attorney General's investigation. These 18 carriers occupy about one-third of the health insurance market in the United States. He also asked the U.S. Office of Personnel Management (OPM) to provide information about how federal workers are reimbursed for their out-of-network health services.

Using information compiled during prior investigations, the Senate Commerce Committee's March hearings and new information provided in response to Chairman Rockefeller's information requests, this report summarizes what Senate Commerce Committee staff learned about the insurance industry's out-of-network payment practices.

Significant Findings

The Use of Ingenix Data Was Widespread in the Insurance Industry

With one exception, all of the 18 insurance companies that received Chairman Rockefeller's April 2 letter responded that they, or at least one of their affiliates or subsidiaries, purchased and used Ingenix data to pay claims for out-of-network health care or dental services. These responses demonstrate that the use of the Ingenix products was pervasive throughout the health insurance industry, not just among the largest national insurers involved in the New York settlement. They also suggest that the number of consumers harmed by such under-reimbursements might be substantially higher than previously estimated.

Lack of Transparency to Consumers about the Data

The Senate Commerce Committee's review of disclosure materials shows that the insurance industry failed to provide consumers with accurate, understandable information about Ingenix or the way it used Ingenix's data to calculate out-of-network allowances. The Committee even found consumer disclosures that contained patently false information. A review of contracts between Ingenix and the insurance industry shows that Ingenix explicitly prohibited insurers from disclosing information about the Ingenix databases to consumers and doctors.

Evidence that the Ingenix Data Was Faulty

In spite of Ingenix's testimony before the Senate Commerce Committee that it closely monitors the data it receives from insurers for completeness and accuracy, Committee staff reviewed persuasive evidence that this statement is inaccurate. Some insurance companies improperly "scrubbed" valid charges before submitting their data to Ingenix. Committee staff also uncovered new evidence that a major contributor of data to Ingenix submitted its data in a manner that violated the Ingenix data-submission guidelines and harmed consumers by skewing prevailing rates downward.

More than 2 Million Federal Employees and Military Family Members Have Plans that Used Ingenix Data

In response to Chairman Rockefeller's March 31 letter, OPM informed the Committee that in 2008, approximately 911,000 of the 4 million federal employees and retirees who received health coverage through the Federal Employees Health Benefits Program (FEHBP) were enrolled in plans that used Ingenix data to calculate out-of-network reimbursement rates. In addition, more than 1 million military family members were enrolled in health coverage through the TRICARE program, which also used Ingenix data to calculate out-of-network benefits.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

OFFICE OF OVERSIGHT AND INVESTIGATIONS

UNDERPAYMENTS TO CONSUMERS BY THE HEALTH INSURANCE INDUSTRY

Staff Report for Chairman Rockefeller
June 24, 2009

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Executive Summary

Since Chairman Rockefeller held two hearings in March 2009 on payment practices in the insurance industry, Senate Commerce Committee staff have been conducting a nation-wide investigation into how the insurance industry pays benefits to consumers who purchase "out-of-network" health insurance coverage. In the course of this investigation, Committee staff have determined that in every region of the United States, large health insurance companies have been using two faulty database products owned by Ingenix, Inc., to under-pay millions of valid insurance claims. The companies have used these Ingenix database products without providing even the most basic information about them to consumers or health care providers.

Background on "Usual and Customary" Reimbursement Rates

More than 100 million American consumers pay extra premiums for health insurance coverage that allows them to receive care outside their insurance company's network of doctors and other health care providers. Consumers pay more for "out-of-network" coverage because they believe it gives them access to the medical care that will afford them or their family members the best chance for recovery from a serious accident or illness.

Over the past several years, a succession of private lawsuits and government investigations has revealed that the largest health insurance companies in the United States have been under-reimbursing their customers for out-of-network health care services. While insurance carriers have been promising to provide their customers with a certain level of coverage, they have actually been paying out-of-network claims at a lower level. The result of this practice is that American consumers have paid billions of dollars for health care services that their insurance companies should have paid.

The tools the health insurance industry used to systematically underestimate the cost of out-of-network services were two "data benchmarking" products sold by a Minnesota health care services company called Ingenix, Inc. Ingenix provided the insurance industry with data it claimed were the prevailing, "usual and customary" market rates for medical services in specific geographic regions. Ingenix's "usual and customary" data tables were used to pay tens of millions of medical claims for out-of-network services.

Ingenix's Flawed Data

Although the insurance industry represented the Ingenix data as accurate and objective, subsequent investigations have revealed that the reliability of the Ingenix data was fatally undermined by faulty statistical methods and a fundamental conflict of interest.

While insurers presented Ingenix as an independent source of medical charge information, Ingenix was actually a wholly-owned subsidiary of UnitedHealth Group, one of the largest health insurance companies in the country, and therefore had a financial incentive to produce charge data that shifted costs from insurers to their customers. Furthermore, all of the

data Ingenix used to calculate its benchmark products came from the very same health insurers that purchased Ingenix's products, forming a "closed loop" of information between Ingenix and the insurance industry. Confidentiality agreements between Ingenix and its customers prohibited the disclosure of information about the database products to patients or doctors.

In testimony before the Senate Commerce Committee in March 2009, UnitedHealth Group's CEO publicly expressed his regret that there was a conflict of interest inherent in his company's relationship with Ingenix. Pursuant to an agreement reached in January 2009, with the New York Attorney General, UnitedHealth and several other large national insurance companies agreed to stop using the Ingenix database products and to fund a new non-profit entity that will be able collect and analyze medical charge data in a truly independent manner.

Evidence collected during private litigation and the New York Attorney General's investigation demonstrated how the less-than-arms-length relationship between Ingenix and the insurance industry led to reimbursement practices that cost American consumers billions of dollars. Insurers that contributed charge data to Ingenix often "scrubbed" their data to remove high charges. Ingenix then used its own statistical "scrubbing" methods to remove valid high charges from their calculations.

The results of these questionable statistical methods were estimates of "usual and customary" charges that consistently skewed reimbursement rates downwards – in a direction that allowed insurers to reduce their claims payments. The New York Attorney General concluded that the "prevailing rates" Ingenix generated for doctor visits in New York were as much as 30% lower than the actual market rates for these services. In other words, insurance companies were paying only 70 cents on each dollar they owed their customers under the terms of their policies.

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In March 2009, pursuant to its authority under Senate Rules to oversee interstate commerce and the regulation of consumer products and services, the Commerce Committee held two hearings examining how the Ingenix medical charge databases were used to reimburse consumers for their out-of-network health care. In order to gain a better understanding of how the insurance industry calculates out-of-network reimbursements, Chairman Rockefeller sent information requests to the 18 largest health insurers that were not affected by the New York Attorney General's investigation. These 18 carriers occupy about one-third of the health insurance market in the United States. He also asked the Office of Personnel Management (OPM) to provide information about how federal workers are reimbursed for their out-of-network health services.

Using information compiled during prior investigations, the Committee's March hearings, and new information provided in response to Chairman Rockefeller's information requests, this report summarizes what Commerce Committee staff have learned about the insurance industry's out-of-network payment practices. Below are some of the significant findings:

- ***The Use of Ingenix Data Was Widespread in the Insurance Industry*** With one exception, all of the 18 insurance companies that received Chairman Rockefeller's April 2 letter responded that they, or at least one of their affiliates or subsidiaries, purchased and used Ingenix data to pay claims for out-of-network health care or dental services. These responses demonstrate that the use of the Ingenix products was pervasive throughout the health insurance industry, not just among the largest national insurers involved in the New York settlement. They also suggest that the number of American consumers who were harmed by under-reimbursements based on the Ingenix data may be substantially higher than previously estimated.

- ***Lack of Transparency to Consumers About the Ingenix Data*** The Committee's review of disclosure materials shows that the insurance industry failed to provide consumers accurate, understandable information about Ingenix or the way it used Ingenix data to calculate out-of-network allowances. The Committee has even found consumer disclosures that contain patently false information. A review of contracts between Ingenix and the insurance industry shows that Ingenix explicitly prohibited insurers from disclosing information about the Ingenix databases to consumers and doctors.

- ***More Evidence that the Ingenix Data Was Faulty*** In spite of Ingenix's testimony before the Committee that it closely monitors the data it receives from insurers for completeness and accuracy, Committee staff have reviewed persuasive evidence that this statement is inaccurate. Some insurance companies improperly "scrubbed" valid charges before submitting their data to Ingenix. Committee staff have uncovered new evidence that a major contributor of data to Ingenix submitted its data in a manner that violated the Ingenix data submission guidelines and harmed consumers by skewing prevailing rates downwards.

- ***More than Two Million Federal Employees and Military Family Members Participated in Plans that Used Ingenix Data*** In response to Chairman Rockefeller's March 31 letter, OPM informed the Committee that in 2008, approximately 911,000 out of the 4 million federal employees and retirees who received health coverage through the Federal Employees Health Benefits Program (FEHBP) were enrolled in plans that used Ingenix data to calculate out-of-network reimbursement rates. In addition, more than a million military family members were enrolled in health coverage through the TRICARE program that used Ingenix data to calculate out-of-network benefits.

I. "Usual and Customary" Rates in the Health Insurance Industry

Most Americans covered by private sector health insurance participate in plans that encourage them to use health care providers within their insurance carrier's network, but that also allow them to see an "out-of-network" provider if they choose. Consumers pay higher premiums and cost-sharing for this so-called "out-of-network" option.

Over the past few decades, insurance companies have developed the practice of basing their payments for out-of-network claims on what they call the "usual, customary, and reasonable" (UCR) charge for a service, rather than on a doctor's or other provider's actual charge for the service. In the late 1990s, a subsidiary of insurance giant UnitedHealth Group ended competition in the market for "usual and customary" data by purchasing the two databases that provided charge information to the insurance industry.

A. The "Out-of-Network" Health Care Option

Approximately 170 million Americans have health insurance coverage through the private insurance market.[1] The majority of these consumers are covered through "Preferred Provider Organization" (PPO) or "Point-of-Service" (POS) insurance products. These plans encourage consumers to seek care from "in-network" providers who have contracted with the insurer to provide services at a negotiated price.[2] In general, when consumers receive a service from an in-network provider, they are responsible only for applicable deductibles, copayments, or co-insurance payments.

Under most PPO and POS plans, however, consumers can also choose to receive services from an "out-of-network" provider, a doctor or other provider who has not contracted with the insurer. But when they choose to go out of network, consumers are likely to face higher out-of-pocket costs. They are responsible for any balance left after the insurance company has made its payment (or "allowance"), and they are often required to share a higher portion of the costs of an out-of-network service.

As a general rule, consumers pay significantly higher premiums for the choice to see out-of-network health insurance providers. For example, the Blue Cross Blue Shield family coverage currently offered to federal employees charges federal employees who choose to have coverage for out-of-network visits an additional $1,680 per year (see table below).[3]

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[1] Kaiser Family Foundation, *How Private Health Coverage Works: A Primer. 2008 Update.* (April 2008) (Online at http://www.kff.org/insurance/upload/7766.pdf).

[2] According to the Kaiser Family Foundation, 70% of the 158 million Americans who have health insurance through their employers have PPO or POS policies. Kaiser Fam ily Foundation and Health Research Educational Trust, *Employer Health Benefits 2008 Annual Survey* (2008), 1, 64. (Available at: http://ehbs.kff.org/pdf/7790.pdf)

[3] *Blue Cross and Blue Shield Service Benefit Plan. A Fee-for-Service Plan (Standard and Basic Option) with a Preferred Provider Organization* (2009), 134. (Online at: http://www.fepblue.org/benefitplans/2009-sbp/SBP2009Brochure_English.pdf).

Plan	Description	2009 Family Monthly Premium
Blue Cross Blue Shield "Basic" PPO Policy	"Under Basic Option, you must use Preferred providers in order to receive benefits."	**$216.48**
Blue Cross Blue Shield "Standard" PPO Policy	"Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – plus any difference between our allowance and the charges on the bill."	**$356.59**

During the Committee's March 26 hearing, testimony from a New York consumer named Mary Reinbold Jerome helped explain why millions of American consumers choose to pay higher premiums to have the option of seeing out-of-network health care providers. Ms. Jerome was enrolled in a Point of Service (POS) plan when she was diagnosed with advanced stage ovarian cancer in July 2006. After reviewing her treatment options, Ms. Jerome and her primary care physician decided her best option was the Memorial Sloan Kettering Cancer Center in New York City. As she explained this decision in her testimony:

> At the time, that hospital was the only recognized, comprehensive cancer treatment center in the New York City area. Even though the hospital was not in my insurer's network, I had paid for out-of-network coverage; part of a point-of-service plan. I had always been confident that paying for the out-of-network option provided a peace of mind with respect to the financial burdens associated with catastrophic medical costs.[4]

What Ms. Jerome discovered instead was that her insurance company's payments for her cancer treatments were so far below Sloan Kettering's actual charges that she soon owed the hospital almost $50,000. Ms. Jerome told the Committee that these large unexpected expenses for her cancer treatment made her feel like she was fighting two battles, "one against an illness and another against the insurance company."[5]

B. The Development of "Usual and Customary" Reimbursement Rates

Over the past several decades, the health insurance industry has developed the practice of reimbursing consumers such as Ms. Jerome at what it calls "usual, customary, and reasonable" (UCR) rates for out-of-network services. The insurer will not necessarily reimburse the consumer based on the actual charge for the out-of-network service, but based on a calculation of

[4] Senate Committee on Commerce, Science, and Transportation, *Hearings on Health Insurance Industry Practices – Are Consumers Getting What They Paid For?*, 111th Cong. (March 26 and March 31, 2009), Testimony of Dr. Mary Reinbold Jerome (hereinafter "*March 2009 Health Care Hearings").*

[5] *Id.*

the prevailing UCR (or "usual and customary") market cost of a particular service delivered in a particular area.

According to insurance industry representatives, the UCR system developed as a way to counteract health care providers who charged exorbitant prices for their services. UnitedHealth CEO Stephen Hemsley testified to the Committee that "physician reimbursement based on nothing but the doctor's bill is simply not economically tenable for consumers nor our health care system."[6] The CEO of a large regional health insurer wrote the Committee:

> For patients seeking care within provider networks, the insurer has the ability to negotiate payment on behalf of members, and to see the delivery of the appropriate level of care. This ability is lost when patients use hospitals and doctors who opt out of healthcare networks. Concepts like usual and customary charges were designed to permit payment amounts that would be predictable, change with market-based changes in prevailing payments, and keep insurance costs in check by eliminating excessive charges from the insurance pool.[7]

In her testimony before the Committee, Dr. Nancy Nielsen, the president of the American Medical Association (AMA), explained why doctors sometimes refuse to contract with insurance companies. Some doctors decide to stay out of a network because they think the fees offered by the payer are too low or because the network will not provide them adequate patient volume. Other doctors, Dr. Nielsen explained, refuse to join certain networks because "the hoops that they have to jump through are not worth it to get the care that their patients need."[8]

C. Ingenix: the Only Commercial Source of Medical Claims Data

The industry's main source of UCR information is the Prevailing Healthcare Charges System (PHCS). The PCHS database was created in 1973 by the Health Insurance Association of America (HIAA), at that time the health insurance industry's trade association.[9]

In 1998, HIAA sold the database to Ingenix, the information technology business unit of United HealthCare, one of the nation's largest insurance companies.[10] A year earlier, in 1997, Ingenix had purchased the Medical Data Resource (MDR) database, the largest direct competitor to the PCHS database.[11] Since 1998, Ingenix has continued to market PHCS and MDR as

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[6] *Id.*, Testimony of Stephen Hemsley, President and CEO, UnitedHealth Group.

[7] Letter from William J. Marino, President and CEO, Horizon Blue Cross Blue Shield of New Jersey, to Senator John D. Rockefeller IV (Apr. 23, 2009).

[8] *March 2009 Health Care Hearings*, Testimony of Dr. Nancy Nielsen, President, American Medical Association.

[9] As will be discussed further below, in 2003, HIAA and the American Association of Health Plans (AAHP) merged to form America's Health Insurance Plans (AHIP).

[10] Health Insurance Association of America, *HIAA Sells Prevailing Healthcare Charges System to Ingenix, Inc.* (Oct. 19, 1998) (Online at http://hiwire.hiaa.org/news/content.cfm?ContentID=454).

[11] *United HealthCare Buys HIAA Pricing System*, Bestwire (Oct. 22, 1998) ("Both systems [PHCS and

separate product lines, although the company appears to have consolidated the two databases in 2001.[12]

Since these acquisitions in the late 1990s, the insurance industry has overwhelmingly relied on the Ingenix PHCS and MDR "data benchmarking" products to estimate reimbursements for out-of-network charges. As one health care executive told the Committee in recent correspondence: "We know of no alternative sources of national health care charge databases."[13]

II. Ingenix's Close Ties with the Health Insurance Industry

In the private health insurance industry, Ingenix has been the predominant source of information about the market price of medical services. While the industry has long represented the "usual and customary" estimates of medical charges compiled by Ingenix as "independent" and objective, Ingenix is a subsidiary of one of the country's largest insurance companies, UnitedHealth Group. Moreover, the insurance industry both contributes medical charge data to Ingenix and purchases Ingenix's products. This close, conflicted business relationship between Ingenix and the health insurance industry existed for more than a decade before industry officials publicly acknowledged that it created the appearance of a conflict of interest.

A. The Business Relationship Between Ingenix and Individual Health Insurance Companies

In the words of one health care CEO, insurance companies' method of calculating usual and customary costs has been "the great black box of the healthcare industry."[14] Documents produced to the Committee during this investigation shine some light into this black box by providing details about the business relationship between Ingenix and its insurance industry partners.

The business relationship was formed when the two parties signed a "Master Services and License Agreement."[15] Under this agreement, an example of which is attached to this report as "Exhibit A," Ingenix agreed to provide the insurer (the "Customer") with the software and

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MDR] are used to guide health insurers in determining reasonable fees for medical services. Combined, the two products have more than 50% of the market, said Melissa Tzourakis, Ingenix director of product management for benchmarking database products.").

[12] *See McCoy v. Health Net, Inc.*, 569 F.Supp.2d 448, 464 (D.N.J. 2008). According to Ingenix, the PHCS data modules are developed using "actual" data when sufficient amounts of claims data are available for a particular service delivered in a particular area. MDR data modules are based on actual data, but are "derived" from the application of a set of relative values and conversion factors.

[13] Letter from William J. Marino, President and CEO, Horizon Blue Cross Blue Shield of New Jersey, to Senator John D. Rockefeller IV (Apr. 23, 2009).

[14] *The Fuzzy Math of Health Insurance, When an Insurer's Idea of Usual, Reasonable, and Customary Comes Up Short, You're Stuck Paying*, CNNMoney (Aug. 30, 2005).

[15] Master Services and License Agreement Between Ingenix, Inc. and [Insurer] (July 7, 1999) (hereinafter "Exhibit A").

data it needed to calculate UCR rates for various services. In exchange, the Customer agreed to pay Ingenix for the software and data, and agreed not to share them with third parties.[16]

Ingenix and its customers executed actual purchases of data and software through subsequent "Product Schedules." In a typical Product Schedule, an example of which is attached to this report as "Exhibit B," the customer purchased a license to particular database "modules," and agreed to pay a certain annual fee for access to each module. Customers' fees were based on the size of their businesses. In the case of the PHCS products, the fees were based on the number of persons covered by the insurer ("covered lives"), while MDR fees were calculated based on claims volume. In Exhibit B, a Customer reporting 3.1 million covered lives paid Ingenix $120,000 in annual fees for three PHCS modules.[17]

In the Product Schedule document, the Customer once again agreed to a number of restrictions on the use of the data, including a provision stating that "Customer may disclose to providers or clients a single fee per code from the Data, but only as required and necessary in the claim administration and review process."[18] This provision restricting insurance carriers' ability to share information about the Ingenix data helps explain the frustration many doctors and consumers experienced when they tried to get more information about the products. For example, AMA President Dr. Nancy Nielsen testified that when doctors asked insurers how they had calculated their "usual and customary" rates, they were told that information was "proprietary."[19]

Anticipating legal challenges to the reliability of the data from "aggrieved third parties," Ingenix also promised to provide customers with technical and legal assistance in the case of a "Database Challenge." At the same time Ingenix promised to provide legal support to defend attacks on the integrity of its data, however, Ingenix also disclaimed responsibility for the data. A paragraph labeled, "Information Tool," said the following:

> The Data is provided to Customer for informational purposes only…Any reliance upon, interpretation of and/or use of the Data by Customer is solely and exclusively at the discretion of Customer. Customer's determination or establishment of an appropriate reimbursement level or fee is solely within Customer's discretion, regardless of whether Customer uses the Data.[20]

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[16] *Id.*("Customer shall have no right to allow any person or entity who is not a party to this Agreement to access the Software or Data directly or indirectly in any way, at Customer's site or via remote communication methods.")

[17] Prevailing Healthcare Charges System (PHCS) Product Schedule Agreement Between Ingenix, Inc., and [Insurer] (May 1, 2005) (hereinafter "Exhibit B").

[18] *Id.*

[19] *March 2009 Health Care Hearings,* Testimony of Dr. Nancy Nielsen.

[20] Exhibit B.

B. Data Contribution Agreements Between Ingenix and Insurers

Insurers could receive large discounts on the Ingenix database products by participating in Ingenix's "Data Contribution Program." Invoices reviewed by Committee staff show that insurers could receive "data credits" entitling them to discounts of more than 50% if they submitted medical claims data to Ingenix. According UnitedHealth Group CEO Stephen Hemsley, about one hundred different parties contributed data to Ingenix.[21] As Exhibit B demonstrates, data submitters agreed to submit "non-manipulated, complete, useable data for all covered members for all submitted claims." They also agreed to the following data submission rules:

> Customer shall include all data fields that Customer currently collects that are required in the data contribution format, and Customer shall not manipulate or present the data so as to provide only a particular subset of its data. Customer will submit its full claims experience for the number of total contracted covered lives.[22]

In the course of the legal challenges and investigations into the Ingenix database products over the past decade, a number of doubts have been raised about whether Ingenix data submitters followed these rules, and whether Ingenix effectively enforced them. In an expert report submitted to a New Jersey federal court in 2006, a statistical expert testified that insurance companies did not contribute complete sets of their medical claims data to Ingenix, and that some data contributors performed "scrubs" that skewed the contributed data downwards.[23]

According to this expert testimony, which is attached as "Exhibit C" to this report, Aetna, Ingenix's single largest data contributor, eliminated ("pre-scrubbed") the highest 20% of valid medical charges before sending its claims data to Ingenix.[24] Once the contributed data arrived at Ingenix, the company employed yet another "scrubbing" process that again had the effect of inappropriately eliminating valid high charges from the database.[25] The overall effect of these flawed statistical methods was to make the distribution of medical charges appear lower than it was in the actual marketplace.

When Chairman Rockefeller directly asked the CEO of Ingenix, Mr. Andy Slavitt, whether he was concerned that data contributors were submitting incomplete, "pre-scrubbed"

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[21] *March 2009 Health Care Hearings,* Testimony of Stephen Hemsley. In a Power Point presentation shown at a meeting of the Financial Solvency Standards Board of the California Department of Managed Health Care in April 2005, Ingenix represented that it had nearly 200 data contributors, 180 of which contributed California claims data. *Ingenix Benchmarking Products Power Point Presentation* (April 2005) (Online at: http://www.dmhc.ca.gov/aboutTheDMHC/org/boards/fssb/notes/050419ipp.pdf).

[22] Exhibit B.

[23] Plaintiffs' Supplemental Expert Report Dated June 15, 2006, Bernard R. Siskin, Ph.D., *McCoy v. HealthNet, Inc.* (D N.J.) (Docket No. 03-CV-1801) (June 15, 2006). (hereinafter "Exhibit C").

[24] *Id.*

[25] *Id.*

data to Ingenix, Mr. Slavitt responded that, "we run a number of analyses to check and make sure" that the data is accurate and complete."[26]

Mr. Slavitt's statement is not entirely consistent with testimony that Ingenix's Manager of Research and Development for the PHCS and MDR products, Ms. Carla Gee, has provided in court proceedings over the past few years. In these proceedings, Ms. Gee testified that while Ingenix performed occasional audits of the data, her firm was ultimately "at the mercy" of the insurance providers to submit accurate and complete data.[27] She also conceded that:

> Ingenix has never tested its results to determine if its statistical conclusions bear any relationship to the actual high, low, median or 80th percentile or actual marketplace CPT [Current Procedural Terminology] code service rates charged by health care providers in any given area.[28]

As will be discussed in Section IV below, Committee staff have reviewed new evidence demonstrating that another large data contributor to Ingenix did not submit accurate and complete claims data to Ingenix. The effect of this improper data manipulation – which Ingenix either allowed to occur or neglected to discover – was to skew reimbursement rates downwards and harm consumers.

C. How Ingenix Products Were Used to Determine Reimbursements

The payment "modules" Ingenix sold to the insurance industry provided information on the prevailing costs of specific medical services in specific geographic zip code groups ("geozips"). The modules do not provide subscribers with a single average price. Instead, they present a statistical distribution of the varying market prices Ingenix claims that providers charge in a particular geozip area.

The standard module starts from the mid-point of the distribution (the 50th percentile) and provides charges at regular intervals up to the highest point in the distribution (the 100th percentile). On its website, Ingenix provides the following examples of usual and customary costs in its 301 geozip area.

CPT Code[29]	Description	50th	60th	70th	75th	80th	85th	90th	95th
45378	Diagnostic Colonoscopy	$764	$783	$859	$887	$907	$939	$1,008	$1,105
71020	Chest X-Ray	$102	$103	$106	$107	$107	$107	$113	$122

[26] *March 2009 Health Care Hearings*, Testimony of Andy Slavitt, CEO, Ingenix, Inc.

[27] *See Davekos v. Liberty Mutual*, 2008 Mass.App. Div. 32, 2009, WL 241613 (Mass. App. Div.).

[28] *Id.*

[29] Ingenix employs the American Medical Association's proprietary "Current Procedural Terminology" (CPT) coding system to describe the services rendered.

The general practice of insurers has been to pay consumers an allowance equal to a certain percentile level provided in the Ingenix module. For example, many insurers promise to reimburse consumers at the 80th percentile for out-of-network services. If a consumer chooses to go out of network to receive a colonoscopy from a doctor located in Geozip 301, the insurer pays $907 for the service, no matter what the doctor actually charges for the colonoscopy. The consumer pays the co-payment, co-insurance, or deductible due on the $907 allowance, and then pays 100% of the difference between the $907 allowance and the doctor's actual charge.

The key assumption behind this method of reimbursing out-of-network charges was that the Ingenix tables presented the accurate distribution of medical charges in a given area. Evidence reviewed during this investigation and in other inquiries show that this assumption was unfounded. The Ingenix tables consistently underestimated the distribution of medical charges and, as a result, consumers ended up paying a higher portion of the cost of their health care than they owed under the terms of their insurance coverage.

D. Health Insurers Acknowledge Their Conflict of Interest with Ingenix

Since Ingenix purchased the two leading medical charge databases a decade ago, critics have charged that Ingenix's role as the only source of UCR data conflicted with its business status as a wholly-owned subsidiary of UnitedHealth Group. UnitedHealth and the other insurance companies that contributed data to Ingenix and purchased Ingenix products had a strong financial interest in keeping reimbursement rates low. Linda Lacewell, a senior attorney from the New York Attorney General's office, described to the Committee how her office became aware of this conflict:

> The natural question then became, Who is Ingenix? And on that question, when you look behind the curtain of this oracle of usual and customary rates, one finds UnitedHealth Group, the second largest insurer…in the United States, because Ingenix is a wholly-owned subsidiary of UnitedHealth Group, making this essentially a closed-loop system of the health insurance industry collecting the information among itself, pooling the information together, all relying on the same rate information, a system that is impenetrable to the consumer.[30]

Ms. Lacewell also testified that insurers failed to disclose this conflict to consumers. Insurers did not inform consumers that the source of their UCR data was a company owned and controlled by the insurance industry, and they sometimes even "affirmatively misstated" the source of their UCR numbers, saying they came from "independent" sources.[31]

On January 13, 2009 - more than ten years after it purchased the competing PHCS and MDR databases - UnitedHealth Group publicly stated for the first time that there was an "inherent conflict of interest" in its business relationship with Ingenix, and signed an agreement

[30] *March 2009 Health Care Hearings*, Testimony of Linda Lacewell, Counsel for Economic & Social Justice, Head of the Healthcare Industry Taskforce, State of New York, Office of the Attorney General.

[31] *Id.*

with the New York Attorney General to shut down the PHCS and MDR databases.[32] Under the agreement, the companies promised to contribute $50 million to start a new non- profit entity that would create and administer an independent medical claims database. The new database will be housed at a New York academic institution and will make its price data available to the public through a website.[33]

UnitedHealth's CEO, Stephen Hemsley made a similar expression of regret when he testified before the Committee on March 31, 2009. He said:

> We have a number of regrets related to this. We regret we did not recognize the appearance of this conflict sooner. We regret that we were not more forceful in our broad disclosures with respect to the relationship of this database relative to other aspects of our company. And we regret that there has been any breach in terms of the perception of trust in terms of the consumers' participation in this.[34]

Andy Slavitt, the CEO of Ingenix, told the Committee:

> There is no denying that Mr. Hemsley's company owns my company and another company that uses our product. And it is clear that we were myopic and being perhaps so analytical about defending our integrity that we missed the bigger picture.[35]

III. **Challenges to the Reliability of the Ingenix Databases**

For a number of years, alert consumers and health care providers sensed that the "usual and customary" cost estimates insurers were using to pay out-of-network claims were lower than market rates. But because insurers refused to explain how they developed their estimates, health care consumers could do very little to challenge the insurance industry's practices.

During the Committee's March 31 hearing, for example, Chairman Rockefeller discussed the case of a consumer in Seattle, Washington, named Jill Faddis. In 2001, Ms. Faddis' husband was billed $140 for a periodontist visit, but their insurance carrier, Aetna, informed them that the "usual and customary" charge for this service was $65. Ms. Faddis thought Aetna's figure seemed low, so she took out her Yellow Pages and called every periodontist in her area to find out how much they charged for the service her husband received. As the figure (Figure 1) attached to the end of this report illustrates, she found that periodontists in her area billed between $110 and $163 for the service. But because Ms. Faddis had no effective way to challenge Aetna's obviously incorrect estimate, she and her husband paid the $75 difference.[36]

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[32] *UnitedHealth Settles New York Reimbursement Probe*, Reuters (Jan. 13, 2009).

[33] State of New York, Office of the Attorney General, Assurance of Discontinuance Under Executive Law §63(15), *In the Matter of UnitedHealth Group Incorporated* (Investigation No. 2008-161) (Jan. 13, 2009) (Online at http://www.oag.state.ny.us/bureaus/health_care/HIT2/pdfs/United%20Health.pdf).

[34] *March 2009 Health Care Hearings*¸ Testimony of Stephen Hemsley.

[35] *Id.*, Testimony of Andy Slavitt, CEO, Ingenix, Inc.

[36] Senate Commerce Committee Staff Telephone Conversation with Jill Faddis (March 30, 2009); *See*

Only through a series of private lawsuits and an investigation by the New York Attorney General's office did American consumers and health care providers finally begin to discover why insurance companies' reimbursements were consistently lower than the real costs of their care.

A. Private Legal Actions

In March 2000, the American Medical Association (AMA), the Medical Society of the State of New York, the Missouri State Medical Association, and a number of other interested parties filed a class action suit against UnitedHealth in a New York court. The suit alleged that the Ingenix database products improperly reduced the reimbursements UnitedHealth paid to its policy holders and, by extension, their health care providers.[37] At the time the suit was filed, an AMA trustee, Dr. Donald Palmisano, claimed that "the case calls into question the entire payment mechanism that the insurance companies have used for years in paying physicians."[38]

On January 15, 2009, the AMA publicly announced it had reached a tentative settlement in the suit, in which UnitedHealth agreed to pay $350 million towards reimbursing patients and health care providers who received low payments due to the faulty data generated by Ingenix.[39] On May 7, 2009, however, the federal judge presiding over the class action suit refused to approve the settlement. In his opinion, the judge raised concerns about the sufficiency of the settlement amount and the quality of the data provided to the plaintiffs in reaching the settlement amount.[40]

In addition to the AMA legal challenge, other plaintiffs have filed suit against the health insurance industry challenging the validity of Ingenix's UCR rates.[41] One of these cases, a class action suit brought by New Jersey consumers against the health insurance carrier Health Net, was settled in August, 2008. Under this settlement, Health Net agreed to provide $215 million to policyholders who had been under-reimbursed for out-of-network health care services. Health Net also agreed to temporarily increase its Ingenix-derived reimbursement amounts by 14.5%, and to stop using the Ingenix data as soon as possible.[42] The federal judge approving the

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Exhibit C, at 18.

[37] *American Medical Association, et al. v. United Healthcare Corporation, et al.,* S.D.N.Y. (No. 00 Civ. 2800).

[38] *AMA Alleges HMO Uses Faulty Data In Reimbursements*, Wall Street Journal (Mar. 16, 2000).

[39] Settlement Agreement Dated as of January 14, 2009, *American Medical Association, et al. v. United Healthcare Corporation, et al.,* S.D.N.Y. (No. 00 Civ. 2800); *See also, UnitedHealth Settlement Near, but Faces a Protest*, New York Times (Jan. 16, 2009).

[40] Memorandum and Order (May 7, 2009), *American Medical Association, et al. v. United Healthcare Corporation, et al.,* S.D.N.Y. (No. 00 Civ. 2800).

[41] In addition to the cases discussed in this section, *See, e.g.*, Weintraub v. Ingenix, Inc. (C.A. No. 3:08-654) (D. Ct.) (transferred to D. N. J. on Apr. 8, 2009) and Cooper v. Aetna (C.A. No. 2:07-3541) (D. N.J.).

[42] *McCoy v. Health Net, Inc.*, 569 F.Supp.2d 448, 468 (D.N.J. 2008).

settlement determined that the Ingenix database products suffered from "serious flaws" due to the way they collected and "scrubbed" medical claims data.[43]

In *Davekos v. Liberty Mutual,* a case involving a dispute over the amounts an insurance company paid for chiropractic services, a Massachusetts appeals court ruled that Ingenix data lacked the "requisite indicia of reliability to be admissible" in Massachusetts courts.[44] The court reached this conclusion on the basis of evidence showing that Ingenix did not verify the accuracy or completeness of the data it used to develop its database products.[45]

B. The New York Attorney General's Investigation

The Ingenix database products were also the subject of an investigation by the New York Attorney General's office. In February 2008, Attorney General Andrew Cuomo announced his office was conducting "an industry-wide investigation into a scheme by health insurers to defraud consumers by manipulating reimbursement rates."[46]

On January 13, 2009, the same day it was announced that UnitedHealth and Ingenix would move the databases to a new non-profit entity,[47] the Attorney General's office issued a report summarizing the results of its year-long investigation. The report concluded that there was a conflict of interest between Ingenix and the insurance industry, and that this conflict resulted in under-payments to New York consumers. After comparing the Ingenix "usual, customary, and reasonable" (UCR) rates with insurance claims actually filed in New York for doctor office visits, the Attorney General's office found that insurers systematically under-reimbursed New York consumers by up to 28%.[48]

The New York Attorney General's office has subsequently entered into written settlements with 11 other insurers doing business in the State of New York, including insurance giants Aetna, CIGNA, and Wellpoint. All of these insurance carriers have agreed to discontinue using the Ingenix database to determine UCR reimbursement rates, and to contribute to the new non-profit UCR database.[49]

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[43] *Id.*

[44] *Davekos v. Liberty Mutual*, 2008 Mass.App. Div. 32, 2009, WL 241613 (Mass. App. Div.).

[45] *Id*.

[46] Attorney General of New York, *Cuomo Announces Industry-Wide Investigation into Health Insurers' Fraudulent Reimbursement Scheme* (Feb. 13, 2008) (Online at http://www.oag.state.ny.us/media_center/2008/feb/feb13a_08.html).

[47] See Part II.D above.

[48] State of New York, Office of the Attorney General, *Health Care Report: The Consumer Reimbursement System is Code Blue* (Jan. 13, 2009), 20 (Online at http://www.oag.state.ny.us/bureaus/health_care/HIT2/pdfs/FINALHITIngenixReportJan.13,%202009.pdf).

[49] The other insurance companies entering into these settlements were: MVP Health Care, Inc., HealthNow New York, Inc., Independent Health Association, Inc., Excellus Health Plan, Inc., and Capital District Physicians' Health Plan Inc., Guardian Life Insurance Company of America, and Group Health

On June 19, 2009, as a result of the Attorney General's investigation, the New York Department of Insurance issued a new regulation requiring insurance companies operating in New York to use "usual and customary" reimbursement schedules that accurately reflect market rates. The regulation prohibits insurance companies from obtaining usual and customary (UCR) data from any individual or company "with a pecuniary interest in the development or use of the UCR schedule, including any insurer, health maintenance organization, medical association, or health care provider."[50]

IV. **The Senate Commerce Committee Investigation**

On March 26 and March 31, 2009, pursuant to its authority under Senate Rules to oversee interstate commerce and the regulation of consumer products and services, the Commerce Committee held hearings on the use of Ingenix database products to determine out-of-network reimbursement rates for consumers. During the March 26 hearing, the Committee received testimony from witnesses representing consumers, health care providers, and the New York Attorney General's office. The March 31 hearing featured testimony from the CEOs of UnitedHealth and Ingenix.

The testimony provided at these hearings made it clear that private lawsuits and the New York Attorney General's investigation had successfully exposed and begun to remedy the reimbursement practices of health insurers operating in New York. It also suggested that little was known about the reimbursement practices of insurance carriers that were not operating in New York. Mr. Chuck Bell from Consumer's Union praised Attorney General Cuomo's work in reforming the industry's practices, but he also noted that:

> There are many other health insurance companies who used data from the Ingenix databases, including state-based and regional health plans in the South, Midwest, and Western states, who do not have operations in New York state. These companies were not reached by the investigation or the agreements, so they have not necessarily halted their use of the Ingenix database, or notified consumers of its shortcomings. We therefore would encourage the Senate Commerce Committee to investigate the nature and extent of the use of the Ingenix databases by other health insurance companies throughout the U.S., and possible remedies or solutions for halting this practice and securing restitution for consumers.[51]

In order to gather information on how insurance carriers in other regions of the country reimbursed consumers for out-of-network services, on April 2, 2009, Chairman Rockefeller sent letters to the 18 largest insurance carriers that had not been involved in settlements with the New York Attorney General. Collectively, these 18 companies represent about 33% of the health

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Incorporated and HIP Health Plan of New York, and Health Net **(**Links to the text of these settlements are online at http://www.oag.state.ny.us/bureaus/health_care/HIT2/agreement.html).

[50] New York State Department of Insurance, *Proposed 43rd Amendment to Regulation No. 62 (11NYCRR 52), Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards for Full and Fair Disclosure* (June 18, 2009).

[51] *March 2009 Health Care Hearings*¸ Testimony of Chuck Bell, Programs Director, Consumers Union.

insurance market in the United States.[52] These letters asked the companies for the following information:

- If they subscribed to the Ingenix PHCS and MDR products;
- If they contributed claims data to these products;
- If they used the Ingenix products to calculate reimbursements for out-of-network health care services;
- The number of claims they paid using Ingenix data; and
- How they planned to calculate out-of-network reimbursement rates after the Ingenix products are discontinued.[53]

In addition, on March 31, 2009, Chairman Rockefeller wrote a letter to the Inspector General of the Office of Personnel and Management (OPM) requesting:

- The names of the insurance carriers participating in the Federal Employees Health Benefits Plan (FEHBP) that used Ingenix data to calculate out-of-network expenses;
- The number of federal employees enrolled in these plans; and
- Whether plans disclosed their use of the Ingenix databases to their federal employee subscribers.[54]

The Committee has received voluntary responses from all 18 of the insurance companies that received Chairman Rockefeller's April 2 letter, as well as from OPM. These responses include detailed information about how each company pays out-of-network claims and thousands of pages of contracts and policy disclosure documents. Because of the proprietary nature of the information submitted by the insurance company respondents, the information they provided will not be discussed in this report in a manner that would allow their individual identification.

A. The Use of Ingenix Database Products Was Widespread

The Committee's investigation has confirmed that health insurance companies in all regions of the United States used the Ingenix databases to determine-out of-network benefits, and in so doing paid many millions of claims a year based on the numbers provided by Ingenix.

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[52] National Association of Insurance Commissioners, *2007 Market Share Reports for the Top 125 Accident and Health Insurers by State and Countrywide* (2008). The group of insurance companies that have settled with the New York Attorney General's office represent about 31% of total health insurance market share.

[53] The insurance companies that received the April 2 letter were the following: Kaiser Foundation Group, Humana Group, HCSC Group, American Family Corp Group, Highmark Group, Independence Blue Cross, BlueCross BlueShield of Michigan Group, BlueCross BlueShield of California, Coventry Corp. Group, Health Net of California, Inc., BlueCross BlueShield of Florida Group, BlueCross BlueShield of New Jersey Group, BlueCross BlueShield of Massachusetts Group, American International Group, Inc., Regence Group, CareFirst, Inc., Unum Provident Group, and Metropolitan Group.

[54] At the request of the OPM Inspector General, Chairman Rockefeller sent an identical request letter to OPM Director John Berry, on April 14, 2009. Since receipt of this letter, OPM has been directly providing the requested information to the Committee.

With the exception of one company that only offers fixed-benefit indemnity coverage, all of the 18 insurance companies that provided information to the Committee represented that they, or at least one of their affiliates or subsidiaries, used Ingenix data to calculate reimbursements for out-of-network health care or dental services. These responses demonstrate that the use of the Ingenix products has been pervasive throughout the health insurance industry, not just among the largest national insurers involved in the New York Attorney General's settlement.

While virtually all of the insurance companies that provided information to the Committee have used the Ingenix products in some way to calculate out-of network reimbursements, practices among companies - and often between the various subsidiaries of a company - vary widely. Some companies used the Ingenix databases for calculating all of their out-of-network reimbursements. Other insurers used the Ingenix databases for calculating only some of their out-of-network claims, such as claims filed for health care services rendered outside of their region, or claims for emergency room services. Still others used Ingenix as a benchmark or check against the out-of-network rates they developed using their own charge data. One company even told the Committee that it uses the Ingenix data to "work around" a technical glitch in one of its claims processing systems.

Many insurance companies that provided information to the Committee correctly pointed out that because the payments they made using the Ingenix products only involved out-of-network claims, such payments represented a small percentage of the total number of claims they paid. But even a small percentage of the tens of millions of claims these insurance companies pay every year is a substantial number. For example, one large insurer reported that in 2008, the majority of its claims for approximately 5 million out-of-network doctor visits were paid using the Ingenix database. A smaller carrier with business in just one state represented that in 2008 it processed fewer than 2% of its claims using Ingenix data, but even that small percentage accounted for 286,000 total claims. While one insurance company informed the Committee that only 1.3% of its claims had been paid using Ingenix data, it also disclosed that this small percentage totaled more than 1.4 million claims over the past ten years.

Even those companies that used Ingenix databases for only some types of out-of-network claims often used the Ingenix database to determine payment of a substantial number of claims. For example, one company that uses Ingenix primarily for determining how much to reimburse subscribers for out-of-network dental services used Ingenix in determining reimbursement rates for 85,600 dental claims during the last fiscal year.

B. The Deliberate Lack of Transparency in Disclosure Materials

The consumer disclosure materials submitted by the health insurance companies in response to Chairman Rockefeller's letters showed the same "shocking lack of transparency and accuracy" observed by the New York Attorney General's office.[55]

[55] State of New York, Office of the Attorney General, *Health Care Report: The Consumer Reimbursement System is Code Blue* (Jan. 13, 2009), 17.

Most of the disclosure materials reviewed by Committee staff did not mention the role of Ingenix in developing out-of-network allowances, did not provide any meaningful explanation of terms such as "usual and customary," and used vague, confusing language to describe out-of-network benefits to consumers.[56] For example, one insurance company informed the Committee that its small business products used Ingenix data to calculate out-of-network allowances. But the disclosure consumers received about how these charges were paid was the following:

> Health Plan's payment for covered out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable, and customary. This means a fee that:
>
> i. Does not exceed most Charges which providers in the same area charge for that Service; and
> ii. Does not exceed the usual Charges made by the provider for that Service; and
> iii. Is in accord with standard coding guidelines and consistent with accepted healthcare reimbursement payment practices.

While the materials insurance companies provide consumers to disclose their out-of-network payment practices are consistently ambiguous and convoluted, other evidence shows that insurers are capable of explaining their practices in very clear, direct language if they choose. For example, federal employees who chose dental insurance coverage offered by Aetna for the 2009 calendar year received a typically indecipherable description of the company's out-of-network benefits in their "Service Benefit Plan."

> Out-of-Network Services You pay the coinsurance percentage of the prevailing allowance (usual and customary at the 75th percentile) for covered services. You will be responsible for the difference between the plan payment and the amount billed by the dentist.

After Aetna reached a settlement with the New York Attorney General, however, it sent out a pamphlet to its federal employee subscribers providing additional information about Aetna's use of Ingenix products, which is attached to this report as "Exhibit D."[57] Entitled, "How Aetna pays claims for out-of-network benefits," this pamphlet provides a very clear, plain-English explanation of the company's practices:

> Step 1: We Review the Data
>
> We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge.

[56] One company defended its decision not to disclose its use of Ingenix products to its customers in the following manner: "Because Ingenix is not a name that is likely to have any meaning to members, referring to Ingenix in member disclosure documents would be unhelpful and possibly confusing."

[57] Aetna, *How Aetna Pays Claims for Out-Of-Network Benefits*, (2009).

> Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code….
>
> Step 2: We calculate the portion we pay
>
> For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code. If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed.
>
> Step 3: We refer to your health plan
>
> We pay our portion of the Plan allowance as listed in your health plan. You pay your portion (called "coinsurance") and any deductible. Sometimes what we pay is less than what your provider charges. In that case, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum…

This clear, easy-to-follow explanation of Aetna's use of Ingenix data answers most of the questions consumers and health care providers have been fruitlessly asking the health insurance industry for the past decade. It suggests that insurance companies have always been able to clearly disclose and explain their business practices, but that they have instead chosen to cloak them in language that the average health care consumer could not understand.

C. The Continuing False Attribution of Data to HIAA

Disclosures produced to the Committee from five insurance companies falsely attributed the source of their usual and customary data to the Health Insurance Association of America (HIAA). As discussed in Part II above, Ingenix purchased the PHCS database from HIAA in 1998. In spite of the fact that the relationship between HIAA and the medical charge database ended more than a decade ago and that HIAA went out of existence in 2003, one large regional insurer included the following language in a 2008 plan description:

> For non-preferred physicians and other professional providers who do not have a payment agreement with [Insurer], the *allowed charge* that is used to calculate your benefits is based on the 90th percentile of the Health Insurance Association of America's (HIAA) schedule of allowed charges.

Even more troubling was an explanation-of-benefits letter sent on September 16, 2008, by a large insurance company to a patient seeking reimbursement for an out-of-network dental service, attached to this letter as "Exhibit E." The letter rejecting the patient's appeal for a higher payment said:

> Please be advised that the reasonable and customary allowance for procedure D2330 (resin-based composite-one surface) of $250.00 is correct and in accordance with the Health Insurance Association of America (HIAA). Therefore, no further benefits are payable. [58]

D. New Evidence of Ingenix Data "Scrubbing"

As discussed above in Section II, according to Ingenix, its PHCS and MDR database products are based on millions of individual medical charges that insurance companies provide to Ingenix on an ongoing basis. These so-called "Data Contributors" certify to Ingenix that their data is "non-manipulated, complete, useable data for all covered members for all submitted claims." Ingenix CEO Andy Slavitt explained to the Committee that "we run a number of analyses to check and make sure" that the contributed data is accurate and complete."[59]

One insurance company's description of how it contributes dental charge data to Ingenix, however, conflicts with Mr. Slavitt's testimony. According to the response of this company, which contributes more than 5 million dental claims a month to the Ingenix database, it did not submit all of its claims data to Ingenix. Instead the insurer "aggregates the data in the relevant time period by zip code for each procedure code . . . [and] provides Ingenix the average charge regarding each procedure." The insurer informed the Committee that it transmits its data in the form of averages because of the high volume of its claims.

This practice not only violates Ingenix's requirement that its data contributors transmit a complete set of its claims; it also introduces faulty data into the Ingenix database. By contributing averages of data points to Ingenix, rather than a complete set of the data points themselves, the insurer dramatically distorts the distribution of charges in the Ingenix database. For instance, if the insurer submitted an average cost of $75 for two medical procedures, Ingenix would have no way to determine if the charges that averaged to $75 were from an original distribution of $74 and $76 or from a distribution of $50 and $100. This practice, when applied to millions of submitted charges across hundreds of geozips could have dramatically skewed the distribution of Ingenix's data and made charges like a valid $100 charge appear to be much higher in the distribution than they actually were.

If Ingenix were truly checking the inputs it received from its contributors, as Mr. Slavitt told the Committee it did, it would have discovered this obviously incorrect statistical methodology and rejected the insurer's data. According to the insurance company, however, it has submitted its data to Ingenix in this form for many years, and has received discounts indicating that Ingenix has accepted the data as valid.

This new evidence of defective data "scrubbing" is consistent with the testimony of experts who have found other serious problems in the Ingenix data contribution and analysis process. As discussed above in Section II of this report, one expert testified that CIGNA

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[58] [Insurer] Second Appeal Process Letter to Policy Holder (Sept. 16, 2008).

[59] *March 2009 Health Care Hearings*¸ Testimony of Andy Slavitt.

contributes data from only four of its nine claims systems, and that Aetna automatically eliminates the highest 20% of its charges before sending them to Ingenix.[60]

E. Ingenix Was Used to Pay Federal Employees' Claims and Military Family Claims

In response to Chairman Rockefeller's March 31 letter, the Office of Personnel Management (OPM) provided the Committee with information on the use of Ingenix data by insurance plans participating in the Federal Employees Health Benefits Program (FEHBP). Approximately four million federal workers are enrolled in FEHBP plans. According to OPM's response to Chairman Rockefeller, in 2008, 39 FEHBP participating plans used Ingenix database products to determine their out-of-network reimbursement rates. These 39 plans covered approximately 911,000 federal workers, almost a quarter of FEHB enrollment.

Fourteen out of the 39 plans exclusively used Ingenix data to calculate out-of-network reimbursements, while the remaining 25 supplemented Ingenix data with additional sources or calculations. Seventeen of the 39 plans failed to disclose to their customers that Ingenix data was being used to determine out-of-network allowances. These 17 plans with no disclosure covered approximately 276,000 federal employees.

In addition to federal employees, information provided to the Committee indicates that more than a million military family members, National Guard members, and Reservists participating in the TRICARE program were enrolled in plans that used Ingenix to calculate out-of-network benefits. The Committee estimates that in the past two years, Ingenix data was used to calculate at least 1.7 million payments to TRICARE members.

F. Regulatory Mandates to Use Ingenix Data

Demonstrating just how pervasive the use of Ingenix databases has become, a few insurance companies informed the Committee that state regulators in New Jersey and California authorized or even required the use of Ingenix data to pay certain out-of-network charges. New Jersey law requires insurers providing coverage to small employers to pay most non-negotiated charges for medical services "on a reasonable and customary basis or actual charges."[61] The regulation defines "reasonable and customary" as "a standard based on the Prevailing Health Charges System profile" that is "published and available from the Ingenix Inc."[62] The regulation further specifies that the "maximum allowable charge shall be based on the 80th percentile of the [Ingenix] profile."[63] Thus, New Jersey citizens employed by small businesses are virtually all subject to use of the Ingenix database for determining the reimbursement rates for their out-of-network claims.[64]

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[60] Exhibit C.

[61] NJ Admin. Code 11:21-7.13(a).

[62] *Id.*

[63] *Id.* at 11:21-713(a)(1).

[64] New Jersey Law also requires insurance companies providing individual health insurance to use the

California state law requires HMOs and other insurers overseen by the California Department of Managed Care to reimburse non-contracting physician providers of emergency services based on, "the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually."[65] In order to demonstrate compliance with this law, some insurers have informed the Department that they reimburse providers of emergency services using Ingenix products. Because the California Supreme Court recently held that it is unlawful for emergency medical care providers to bill a consumer for the balance unpaid by the consumer's insurance company ("balance billing"), the use of the Ingenix data under this provision would potentially under-reimburse providers, but not impose any extra out-of-pocket costs on consumers.[66]

G. The Use of Ingenix Data by Self-Funding Insurers

In addition to offering "fully-insured" health coverage, a number of the insurance companies informed the Committee that they also performed "Administrative Services Only" (ASO) contracts for companies and municipal governments that "self-fund" their employees' health insurance coverage. Insurance companies performing this administrative role manage employees' health benefits and process employees' medical claims, including their claims for out-of-network services.

In their responses to the Committee, a number of insurers claimed that they did not use Ingenix database products to determine out-of-network reimbursement rates for their own policyholders, but, at the request of self-insured employers, used Ingenix database products to calculate the reimbursement rates for the employees of their self-insured clients.

To further investigate this claim that employers – rather than the insurance companies – chose to use Ingenix data, Committee staff spoke to a number of the human resource specialists for employers that had hired the insurance companies to provide ASO services. Every employer Committee staff spoke with about this issue stated emphatically that they were not aware they had specifically requested the use of Ingenix database products. The majority of them had never heard of Ingenix database products. Many human resource specialists said they trusted the insurance company to make the out-of-network reimbursement calculations because "that was what they were hired to do."

Based on the Committee staff's investigation of this issue to date, it appears that the Ingenix database products were widely used and understood by the insurance companies, while self-insuring employers knew very little about how insurance companies were calculating their out-of-network reimbursement rates.

Ingenix data when calculating most out-of-network claims. NJ Admin. Code 11:20-24.5.

[65] 28 California Code of Regulations 1300.1(a)(3)(B).

[66] *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal. 4th 497, 198 P.3d 86, 87 Cal. Rptr.3d 299 (Cal. Sup.2009).

H. Ingenix Was Used in Other Health Insurance Products

While the Committee's investigation has focused on the use of Ingenix data in health insurance products, Ingenix data appears to be regularly used to calculate reimbursements in many other insurance products that pay medical claims. This evidence suggests that the universe of harmed consumers may be much larger than currently estimated.

As has been noted several times in this report, Ingenix data has been very commonly used to calculate reimbursements for out-of-network dental charges. In addition, one respondent disclosed to the Committee that its workers' compensation affiliate uses Ingenix data in states without workers' compensation fee schedules. Another respondent disclosed to the Committee that the catastrophic medical and accident insurance policies it sold through its affiliates used Ingenix data to calculate claims payments. The *Davekos* case discussed in Section III above demonstrates that insurance companies sometimes use Ingenix database products to calculate personal injury payments incurred through auto insurance policies.[67]

[67] A New Jersey regulation allows auto insurers in that state to use Ingenix data to calculate whether a provider's fee for a service treating an injury covered by an auto insurance policy is "usual, reasonable, and customary." NJ Admin. Code 11:3-29.4.

CALIFORNIA
HEALTHCARE
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Unexpected Charges:
What States Are Doing About Balance Billing

Prepared for
CALIFORNIA HEALTHCARE FOUNDATION

by

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About the Foundation

The **California HealthCare Foundation** is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Contents

I. Introduction

TO MOST CONSUMERS, HEALTH INSURANCE means protection against large bills from health care providers. But in some situations involving managed care organizations (MCOs), the provider expects a higher payment than the amount the health insurer is willing to pay. The result can be a bill for the remaining balance, sent to the patient—a practice known as balance billing.

Most people with private health insurance are covered by an MCO, a category that includes both health maintenance organizations and preferred provider organizations. MCO members take comfort in the belief that if they follow MCO rules they will not face costs greater than their premium and required cost sharing (copayments, deductibles, and co-insurance). MCOs have networks of providers with whom they have negotiated reimbursement contracts. For the most part, members understand that they must use these network providers to minimize their out-of-pocket expenses. However, even a careful consumer can end up being treated by an out-of-network provider. When this happens, the patient is at risk of receiving a bill from the provider for the difference between the provider's charge and the amount the MCO is willing to pay. In some cases, patients face hundreds of dollars in charges—referred to as balance bills—above their expected cost sharing.

Many states have struggled to produce legislative or regulatory solutions to address balance billing. To date, relatively few states have passed laws protecting patients from balance billing by out-of-network providers. Those laws appear relatively successful in protecting MCO members from large balance bills. But they have been less successful in navigating the competing interests of MCOs and health care providers in determining an appropriate, equitable payment; most laws seem to impose higher costs on one group or the other. The fundamental conflict is how to protect MCO members while establishing a clear means of determining a payment level appropriate for both MCOs and providers.

This paper provides context on the extent of out-of-network service utilization and the potential problem imposed by balance billing, and then describes how some states have responded. It shares observations based on an examination of state laws and interviews with regulators, providers, MCOs, and consumer advocacy organizations that may be helpful for policymakers considering balance billing legislation in California and elsewhere.

II. How Does Balance Billing Happen?

An Introduction to Balance Billing

Balance billing is when a provider seeks to collect from an MCO member the difference between the provider's billed charges for a service and the amount the MCO paid on that claim.

Key Concepts

Balance bill: A bill sent to an MCO member by a provider to collect the difference between the provider's charge and the amount paid by the MCO (does not include the copayment, deductible, or co-insurance).

Assignment: A patient can request that payment be made directly by the MCO to the provider. Assigned claims are normally submitted directly to the MCO by the provider, making it easier for the provider to receive payment.

Mandatory assignment: An MCO must pay a provider directly for services when a member assigns a bill to the provider. Depending on state law, payment on assignment may or may not be available for non-network providers.

Hold harmless: An MCO must make certain that the patient does not receive a balance bill from a provider.

Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured person paid the provider directly and then sent the bill to the insurer. The insurer reimbursed the patient, minus any cost sharing, up to a certain amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed. Today, most privately insured people are covered by an MCO, which contracts with a network of providers to offer medical services to members. In return, providers agree to deliver services at a negotiated rate that is generally below their usual charges. Providers also agree to "hold harmless" (i.e., not to balance bill) members for the difference between the contracted rate and their typical billed charge.[1] This benefits providers by offering a steady flow of insured patients for whom they are paid promptly and directly by the MCO.

Why Does Balance Billing Occur? How Often Does It Happen?

There are many reasons why a provider may choose not to contract with an MCO. The decision may be based on a clinical preference or economic consideration. In the absence of a contract between an MCO and an out-of-network provider, there is no negotiated reimbursement rate.[2] When outside the network, providers expect to receive their billed charges for services provided. Some providers use balance billing as a mechanism to put pressure on the plan in negotiations to join the network at a favorable rate. Since patients who are balance billed are more likely to complain to the government, MCOs may agree to pay a higher rate or even the full billed charges to reduce the possibility of regulatory attention. Balance billing also allows providers the potential to recoup their full billed charges, though collecting the amount from the patient is often a challenge and may not be successful. Some providers require payment in advance of providing a service—a situation that makes it particularly difficult to avoid a balance bill. But not all providers collect balance bills. Some report that they would prefer not to balance bill their patients because it intrudes on their clinical relationship. Nevertheless, state regulators and consumer advocates report

that some patients pay the balance of the bill even when not required under state law or the terms of their insurance contract—perhaps out of a sense of obligation or to avoid the risk of debt collection or an adverse credit report.

MCOs use the benefit of "prompt, fair, and direct payment" as a primary incentive to encourage providers to join a network.[3] Insurers argue that paying out-of-network providers their billed charges creates a disincentive for providers to join the plan's network. Unless required under state law, some MCOs will not reimburse out-of-network providers directly (on assignment), instead sending the reimbursement to patients and forcing the providers to bill the members.

An analysis conducted for the California HealthCare Foundation by Thomson Reuters among a sample of 1.2 million Californians with employer-sponsored, fully or partially capitated commercial insurance for 2006 found that almost 11 percent of the study population used out-of-network services at some point during the year.

The greatest proportion of out-of-network utilization involved a hospital admission or emergency department visit without resulting admission. Researchers calculated the gap between out-of-network provider charges and provider reimbursement under the plan provisions in order to measure the potential magnitude of balance billing. Reimbursement was tracked by summing payments made by the plan or any third party (such as a secondary insurer) and patient cost sharing (in the form of copayments, deductibles, and co-insurance). The data do not indicate if patients were balance billed or, if they were billed, the extent to which providers sought to collect the full cost.

Among the 11 percent of the population with some out-of-network services, the average potential balance bill amount (across facilities, physicians, and other professional providers) was $1,289, in addition to the average patient cost-sharing amount of $433. At an individual health care service level (such as a single procedure), potential balance billing amounts associated with a facility substantially exceeded those associated with a physician or other provider. For example, the average potential balance bill for an emergency department service was $27 for a physician as opposed to $188 for a facility. Among the 476,000 claims for emergency department services in the study's sample, about 18 percent were out of network. Potential balance bills for inpatient settings were much larger. Among the 57,000 inpatient stays in the study sample, 17 percent included some out-of-network service. The potential balance bill for hospital stays averaged $6,812 when all professional and facility charges for inpatient services delivered during a stay were aggregated.

These findings show how often patients land in situations where they do not choose a network provider and tally the potential added costs they may incur. The California Association of Health Plans reported in 2007 that 1.76 million Californians who visited emergency rooms in a two-year period were balance billed by providers for an average of $300 each; about half of these patients paid the bill.[4] Anecdotal reports have called attention to specific cases where individuals have received bills, but otherwise information on the actual frequency or magnitude of balance billing is unavailable.

Scenarios Likely to Result in Balance Billing

In general, MCO members face balance billing only when treated by an out-of-network provider. Members can avoid this by seeking care through network providers, and should expect balance billing when they choose out-of-network care. However, through no fault of their own, patients sometimes

end up being treated by out-of-network providers and may face balance billing.

Care from an Out-of-Network Provider on an Outpatient Basis

Sometimes a member selects an out-of-network provider for outpatient care. For example, a patient may want to see a well-regarded provider outside the network. In a preferred provider organization (PPO) or other open-network plan, the member typically would face higher cost sharing and the likelihood of being balance billed. In a closed-network health maintenance organization (HMO), this type of care would be uncovered and the member would be responsible for the entire bill. In either case, consumers should be aware of the consequences of seeking care outside the network, and most providers inquire about insurance coverage when the appointment is made.

Even when an MCO approves a referral to an out-of-network provider and agrees to treat the care as a network service, a member may still face balance billing, depending on the MCO's payment rules. For example, some PPOs approve the use of an out-of-network provider for care but reimburse the provider using their network fee schedule. Since the non-network provider is under no obligation to accept the PPO's fee as payment in full, a member may receive a balance bill.

Care from an Out-of-Network Hospital in an Emergency

In emergency situations, a person often goes to the closest hospital with an emergency room. If the hospital does not contract with the member's MCO, the member may face balance billing. If a patient is treated in an emergency department at a hospital that does contract with the member's MCO, the patient could still receive a balance bill if the treating physician is not part of the network. That situation is further discussed below.

Care from an Out-of-Network Physician at a Network Hospital

MCO members typically do not expect to face balance bills when receiving inpatient care at a network hospital, especially when they choose a hospital that is in the network. Nonetheless, members may encounter out-of-network providers at network hospitals—such as anesthesiologists providing services during surgical procedures—and face the possibility of balance billing. While radiologists, anesthesiologists, and pathologists are hospital-based physicians, they are almost never hospital employees and may or may not contract with the same MCOs as the hospital. In addition, members may receive services from out-of-network providers if their network physician consults with an out-of-network specialist. For example, before a patient is cleared for surgery, a non-network cardiologist may be consulted to evaluate whether the patient is capable of tolerating the surgery.

III. State Restrictions on Balance Billing in Private Markets

Balance Billing by Network Providers

Contracts between participating providers and MCOs typically include hold harmless provisions that protect members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a patient beyond payment of applicable cost-sharing requirements such as copayments, co-insurance, or deductibles for services covered by the HMO.[5] In most states, including California, state law requires hold harmless provisions in contracts between HMOs and participating providers.[6] States may also require this type of language in contracts between providers and PPOs.

Balance Billing by Non-Network Providers

In California, the Department of Managed Health Care (DMHC) has a longstanding interpretation that state law prohibits balance billing by non-network providers. This position, with regard to emergency services, was upheld by the California Supreme Court on January 8, 2009, although it left unresolved payment issues between the MCOs and the providers.[7] At the direction of Governor Schwarzenegger, DMHC enacted a regulation that took effect October 15, 2008, prohibiting balance billing of HMO members by network and out-of-network providers for care administered in emergency room settings. In the meantime, in addition to pursuing legal action against a provider group for improper balance billing, DMHC has attempted to address the "root causes of balance billing" by assisting providers in recovering payments, fining HMOs for underpayment and late payment of claims, offering dispute resolution to mediate disputes between providers and HMOs, and initiating a fair claims payment initiative.[8] In September 2008, the California Legislature passed two bills that directly addressed balance billing of privately insured MCO members, but only one was signed into law: AB 1203, which was approved in 2008 (Chapter 603), prohibits in some situations non-contracting hospitals from billing patients for care after the patient is stabilized.[9] The second bill—SB 981, which was vetoed in 2007—would have addressed balance billing by emergency room doctors.[10] In the past, California has attempted various legislative and regulatory approaches to addressing balance billing of MCO members.

A 2006 survey published by the American Health Lawyers Association identified nine states with laws that prohibit non-network providers from balance billing members of HMOs.[11] The nine states were Colorado, Delaware, Florida, Indiana, Maryland, New York, Rhode Island, West Virginia, and Wisconsin. In addition to these nine, Connecticut has language in statute that, if interpreted broadly, may restrict balance billing of HMO members by some out-of-network providers.[12] Protections vary significantly from one state to another.[13]

State Approaches to Protecting Patients from Balance Billing by Non-Network Providers; Stakeholder Perspectives

This project selected four states with laws that take varying approaches to balance billing. The four—Colorado, Florida, Maryland, and Texas—were chosen because they offer unique policy approaches

to balance billing. Researchers conducted a systematic review of the statutory provisions and interviewed key stakeholders in each state, including regulators from relevant departments and agencies, hospitals, physicians, MCOs, and consumer advocacy organizations.[14] Because the project entailed only a small set of interviews, it is not a fully representative assessment of stakeholders, but the interviews should capture the essence of stakeholder perspectives. The objective of this project was to identify promising options for policymakers wishing to protect MCO members from balance billing by non-network providers.

Each of the four states profiled differs in its approach to protecting consumers from balance billing by non-network providers and, depending on the stakeholder perspective, its degree of success (Table 1, page 16). In Colorado, a requirement that insurers hold PPO and HMO members harmless protects consumers from paying beyond standard network cost sharing for care received from non-network providers at network facilities. In Florida, HMO members are protected from being balance billed by non-network providers for emergency care by a law that provides reimbursement guidelines and direct payment of non-network providers by HMOs. In Maryland, a general restriction against balance billing of HMO members for "covered services" is supplemented by standardized reimbursement rates for hospitals and non-network providers. Finally, Texas recently passed "transparency" legislation that attempts to ensure HMO and PPO members have access to data, such as pricing and network participation information, needed to estimate their financial liability for medical services.

State Profiles

Colorado: MCOs Required to Hold Members Harmless from Balance Bills

Colorado law requires that if an MCO (in this case, a PPO or an HMO) does not maintain an "adequate" network, then the MCO must arrange for a patient to see an out-of-network provider at no greater cost than if the member had been treated by a network provider.[15] A separate state law requires that patients who receive care from an out-of-network provider at a network facility must be held harmless by the MCO for costs above what they would have faced for treatment by a network provider.[16] Under state law, there is no explicit rule against an out-of-network provider balance billing a patient. But since the patient must be held harmless, the MCO is essentially responsible for resolving the bill before the provider pursues action against the member, thus precluding a balance bill. Typically, the MCO either pays the billed charges or comes to an agreement with the provider for less.

In most situations where consumers might face balance bills, HMO and PPO members are not asked to pay them. In interviews, however, stakeholders emphasized that members are not protected from receiving a balance bill but are, because they are held harmless, protected from paying such a bill. Even so, the Colorado Division of Insurance reports some anecdotal evidence that members sometimes receive balance bills and may not understand their right not to pay.[17]

Although Colorado law does not impose reimbursement standards for these situations, MCOs generally comply by paying out-of-network providers' billed charges. In addition, under the state mandatory assignment law, MCOs must pay these providers directly when a patient assigns a bill to the provider. For out-of-network providers, the combination of direct payment and receipt of billed charges appears to eliminate the need to balance bill MCO members.

Colorado MCOs argue that the combination of the requirement that they pay billed charges and a broad mandatory assignment law acts as a disincentive for providers to join managed care networks. In support of this, regulators point out that some MCOs are having difficulty contracting with some specialty groups, even when the MCO has network agreements with the hospitals in which these providers practice. MCOs further suggest that the current regulatory

State Profiles, *continued*

Colorado, *continued*
framework hampers their ability to negotiate discounted rates with network providers and ultimately may increase insurance costs for everyone. In addition, MCOs point out that with fewer network providers, members of self-insured plans that are not protected by state law may be more likely to receive balance bills.

Florida: Balance Billing Restrictions with Payment Rate Requirements in Emergency Settings

In general, out-of-network providers in Florida may not balance bill an HMO member when an HMO is liable for services covered and authorized by the HMO.[18] When services are provided for an emergency condition or to evaluate if such a condition exists, a separate law makes the HMO liable and restricts the non-network provider from balance billing the member. Florida law specifies that in these emergency situations, HMOs must pay non-network providers the lesser of: (1) the provider's billed charge, (2) the usual and customary provider charge (not specifically defined in statute) for similar services in the community where the services were provided, or (3) the charge mutually agreed to by the HMO and the provider.[19] HMOs must make these payments directly to the non-network provider of emergency services.[20]

The Florida stakeholders interviewed agreed that HMO members are protected from balance billing in most situations. Regulators indicate that the law has been effective for HMO members. Complaint data support this conclusion. Florida reports only 24 complaints for the year between June of 2007 and June of 2008, although the number of actual consumer calls may have been significantly higher. However, state law does not protect PPO members from balance billing by out-of-network providers. Regulators suggest that PPO members face the same concern HMO members did before the state intervened with legislation. One regulator cited "repeated complaints and concerns from PPO policyholders," particularly where the PPO has no contract with a provider.

Florida providers of emergency room services are guaranteed their "provider charges" (billed charges) or their "usual and customary" fee. In addition, emergency physicians are guaranteed direct payment from the HMO on assigned claims. Florida's emergency physicians successfully lobbied against including the term "reasonable" in the state's rate setting standards, in part because of their concern that insurers have used that term to justify reimbursing providers at rates below what providers believe to be usual and customary. Providers indicate concern, however, that even though the statute excludes the term "reasonable," some HMOs are setting reimbursement rates too low (i.e., only 120 percent of the Medicare rate).

The law establishes clearly that out-of-network providers cannot balance bill HMO members for covered, authorized care for which the HMO is "liable." Outside of the emergency setting, HMOs have the opportunity to negotiate reimbursement rates with out-of-network providers. Generally, the industry finds that this works well. However, in the emergency setting, the inability to make advance agreements leads to debate about the term "usual and customary." Providers and HMOs continue to debate the definition of the term on an individual basis and in the court system. Florida has a dispute resolution process, but it has not proved helpful in many cases.

Maryland: Balance Billing Restrictions with Payment Rate Requirements

In Maryland, out-of-network providers may not balance bill an HMO member for a "covered service."[21] In general, a covered service is one authorized under the terms of a contract.[22] Emergency care and out-of-area urgent care are generally considered covered services. Because hospital rates are set by the Maryland Health Services Cost Review Commission, hospitals must be paid at this rate. Under Maryland law, reimbursement rates for covered services provided by non-network physicians to HMO members are also standardized. In general, an HMO must pay the greater of (1) 125 percent of the rate it pays in the same geographic area for the same service to a provider under written contract or (2) the rate it paid in 2000 to a non-contract provider in the same geographic area for the same service. For trauma physicians providing care at a trauma center, a Medicare-based rate is substituted for the HMO's contract rate. Thus payment is the greater of (1) 140 percent of the rate paid by Medicare for the same covered service to a similarly licensed provider or (2) the rate paid by the HMO in 2001 in the same geographic area for the same covered service to a similarly licensed provider.

State Profiles, *continued*

Maryland, *continued*

Stakeholders interviewed in Maryland report that consumers are generally protected from balance billing by out-of-network providers for care that has been authorized by the HMO. This restriction has been in place for over 20 years, and most providers are aware of the rule. Inappropriate balance billing, though it does happen, is minimal. The Maryland Insurance Administration received 37 balance billing-related complaints from HMO members in 2006 and 27 in 2007. The state is considering a proposal to make changes to these rates.[23]

Providers, however, expressed serious concerns about reimbursement rates, complaining that some HMOs manipulate the standards so that rates are most advantageous for the HMO. For example, providers report that in setting rates for a specific geographic area, some HMOs look to the lowest rate they paid a single provider in that area, even if that provider's billed charge was significantly less than that of most other providers in the area. One physician suggested that current payment standards in Maryland may be a factor in driving providers to other markets. HMOs, by contrast, were satisfied with the law, suggesting that the same approach might work in the PPO market.

Texas: Increased Transparency with Regard to Balance Billing

In Texas, MCO members are not protected, per se, from balance billing by non-network providers.[24] In part as an alternative to a direct ban on balance billing, Texas in 2007 passed SB 1731, which attempts to increase transparency by providing consumers access to data, such as pricing and network participation information, needed to estimate their financial liability for medical services. Specific reporting and disclosure requirements are placed on facilities, physicians, and insurers, including MCOs. For example, MCOs must disclose, in writing, whether a network facility uses non-network providers and that a member may be balance billed by a non-network provider. In addition, this law requires state regulators to publish a "Consumer Guide to Health Care" providing, among other information, (1) pricing information and variation among providers, (2) information on the correlation between billed charges and actual charges, (3) member liability for costs, and (4) advice to members for obtaining cost information in advance of treatment.[25] When the legislation is fully enacted, MCO reporting requirements will provide detailed data, including billed charges and reimbursement rates for a variety of medical services. Aggregated data will be made available online. In addition, regulators are collecting additional data from MCOs to show the extent to which members receive care from facility-based, non-network providers. This one-time effort will be evaluated to see whether it might help consumers understand situations that could lead to balance billing.[26]

SB 1731 is yet to be fully implemented, and stakeholders report concerns about how effective this law will be in helping MCO members evaluate their risk for being balance billed by non-participating providers. For example, one stakeholder questioned how valuable this information would be for patients receiving emergency room services, without a per se restriction against balance billing. Another considered the challenges the state faces in gathering and presenting these data in a way that would allow patients to accurately evaluate their potential financial risk for medical care.

IV. Considerations for State Policymakers

THIS SECTION DRAWS UPON THE EXPERIENCE of states with laws regulating balance billing. Although it is difficult to draw firm conclusions, some considerations may be useful to state policymakers.

Factors That Can Be Included in a Clearly Defined Payment Standard

Whether legislation starts from a hold harmless approach or a direct ban on balance billing, the path to a satisfactory solution encompasses the establishment of a clear, state-defined reimbursement standard. The availability of a well-defined payment rate avoids placing all the leverage on either the provider or the MCO side, as occurs without a payment standard. Such approaches are found in some existing state laws, such as in Florida and Maryland, but the results in these states have left some stakeholders dissatisfied. Florida law indicates that providers should receive "the usual and customary provider charges for similar services in the community where the services were provided," and part of Maryland's formula is based on the rate paid by the HMO in the same geographic area. Such standards may create as many problems as they settle. MCOs and providers debate the standards for establishing "usual and customary" fees, and providers claim that some Maryland HMOs manipulate the historical rate standard. These examples illustrate the challenges that policymakers face in trying to identify an approach for setting rates.

The Medicare Fee Schedule offers another basis for setting rates. It is part of the approach used in Maryland for paying trauma physicians, and was included in a recently vetoed bill in California.[27] Under this approach, the Medicare fee is the baseline for a rate structure, but a multiplier is applied so that actual payment levels are higher than Medicare's. California's approach would have set an interim payment rate at 250 percent of the Medicare rate for 2007 for the California region.[28] In Maryland, the rate is much lower. For trauma care, insurers pay the higher of their historical rate or 140 percent of the Medicare rate.

The advantage in using the Medicare Fee Schedule approach is that the underlying relative value scale (RVS) used by Medicare is reasonably well accepted as a means of avoiding reliance on submitted charges. The Medicare RVS sets a value for the work and practice expense entailed in delivering a given service, measured relative to all other services. The relative value is the same regardless of the type or location of the physician delivering the service, but the multiplier used to determine the actual fee can vary by payer or geographic location. Although some issues regarding the fairness of relative fees are still being debated, many private payers use the Medicare Fee Schedule as the basis for payment.

Policymakers considering the Medicare Fee Schedule approach would need to decide on a multiplier as low as the 140 percent multiplier used in Maryland or as high as the 250 percent in California's vetoed bill. Policymakers should consider local market circumstances and regional variations in making this decision. A subsidiary question is whether all specialties should be treated equally. Even though the theory of the Medicare Fee Schedule says that relative values are determined to reflect the relative work involved across specialties, local market

circumstances might call for variations. For example, emergency physicians argue that their higher level of uncompensated care should support higher rates for them.

Structure for Monitoring and Enforcing Balance Billing Protections

In passing legislation that restricts balance billing, states should consider a comprehensive means of implementing, monitoring, and enforcing the law.

States may need more information than consumer complaint data to determine whether providers and MCOs are compliant with balance billing laws. Many consumers who are faced with a balance bill pay it to avoid problems, while others may call their MCO. But few know to contact the state. State regulators recognize that many consumers are unaware of existing protections and that complaint data may underestimate the extent to which consumers are inappropriately balance billed. In addition, depending on how the state documents complaints, the information collected may not provide the level of detail policymakers need. For example, a state may identify whether a caller is covered under a state-regulated plan but not identify the exact type of plan. To supplement consumer complaint data, Maryland also monitors provider complaints. A trend may prompt a market examination by the Maryland Insurance Administration or an investigation by the attorney general's office. Texas, looking beyond complaint data, recently directed MCOs to report data regarding the number of claims where members were seen by facility-based, non-network providers as well as the billed charges and reimbursed rates on those claims. Policymakers should recognize the limitations of relying only on consumer complaint data and consider other mechanisms to monitor compliance with a state balance billing restriction.

The challenge with enforcement is that such legislation affects both providers and MCOs. Approaches such as hold harmless provisions are aimed at MCOs, while direct bans on balance billing are aimed at providers. Ideally, the insurance department, with jurisdiction over MCOs, would coordinate with the board of medicine, which regulates providers.[29] In reality, state medical boards typically focus on licensure and medical practice and rarely, if ever, become involved in billing disputes. Since state insurance departments generally lack jurisdiction over providers, improper balance billing may go unchecked. In Maryland, the Health Education and Advocacy Unit in the office of the attorney general has used the state's Consumer Protection Act to claim jurisdiction over unlawful balance billing of consumers. This office works closely with the insurance department to investigate and mediate unlawful balance billing practice by providers and MCOs. Several observers have suggested that this coordinated effort has helped drive down the number of balance billing complaints in Maryland. In California, two regulators oversee different segments of the health insurance industry, further complicating monitoring and enforcement.[30] Policymakers seeking to address balance billing should consider collaboration among agencies that have jurisdiction over implementation and enforcement.

Avenues for Member Education, Disclosure, and Transparency

Many MCO members are not well informed of their payment responsibilities when seeing an out-of-network provider. Members may find guidance in the summary plan description or certificate of coverage provided by their plan, but many do not read these documents. Further, without exact pricing information for a specific service (i.e., how much

the provider will charge and how much the MCO will pay), it is difficult for members to determine their financial liability for a balance bill. Regulators report that most consumer calls about balance billing are resolved with a discussion about what is permitted under law and a review of the terms of the consumer's coverage policy. However, regulators also note that consumers, unaware of their rights, may unwittingly pay the balance bill.

Some states require that MCOs provide certain information to members about payment responsibilities when receiving out-of-network care. In Colorado, MCOs must disclose when the member may be balance billed by an out-of-network provider, the "usual, customary, and reasonable rate" that an MCO pays for a service, and how the member can obtain the rates the MCO pays to an out-of-network provider.[31] In addition, the MCO must inform members of any "material change" to the MCO network.[32] Even with these requirements, regulators in Colorado noted that consumers might not know that the law protects them from paying balance bills from out-of-network providers in a network facility.[33] A 2007 Texas law takes a transparency approach by requiring providers and MCOs to make available pricing and network participation information to help members estimate their financial liability for out-of-network services. In addition, regulators are collecting "reimbursement data" from MCOs, including billed charges and rates for a variety of medical services, and will make this information available online. Policymakers may want to consider disclosure requirements for MCOs and providers to promote transparency and ensure that members understand their rights and responsibilities with regard to member liability for out-of-network care.

Dispute Resolution Mechanism for Arbitrating Payment Disagreements

In 2000, the Florida Legislature created the Statewide Provider and Health Plan Claim Dispute Resolution Program to "provide assistance to contracted and non-contracted providers and managed care organizations for resolution of claims disputes that are not resolved by the provider and the managed care organization."[34] Providers were encouraged by the possibility of resolving billing disputes without the high cost of litigation. In 2002, the program was expanded to mediate provider disputes with plans other than HMOs. Although participation is optional for providers, the review organization's determination is binding on both parties with the losing party paying the cost of the review. Since the program's inception, Florida has contracted with a private company (Maximus) to review claims disputes. Since 2005, the number of claims submitted for review has declined significantly, from 175 cases in 2005 to 59 in 2006 and just 15 in 2007. Some observers suggest that providers grew dissatisfied with early rulings, which generally favored MCOs. Of the nine cases that were fully reviewed in 2005, Maximus found for the MCO in two cases and split the decision in the other seven.[35] In the split decisions, providers were awarded significantly less than what they sought. Hospitals have all but abandoned using the process. Similarly, few physicians have turned to the program in recent years (one interviewed for this project called it a "tortuous process"). California has an independent dispute resolution process that has seen little activity.[36] Although some see dispute resolution as a valuable component of balance billing legislation, policymakers may want to limit their expectations for its usefulness.

Comprehensiveness of Balance Billing Protections

Most state protections against balance billing apply only to members of HMOs, not PPOs. These different regulatory approaches may be justified, as the PPO model is designed to offer patients the flexibility of going outside the network for care. The option to see out-of-network providers, even with greater out-of-pocket costs, is a primary reason for choosing a PPO over an HMO. However, some regulators point out that balance billing complaints are not received exclusively from HMO members. PPO members may not complain about balance bills for elective services from out-of-network providers, but, like HMO members, they may be unhappy with balance bills from out-of-network providers seen in emergency situations, or from hospital-based physicians in connection with care at a network hospital. In addition, many states do not maintain the same network adequacy standards for PPOs as for HMOs, so PPO members may be more likely to seek specialty care from out-of-network providers. Colorado has extended the same balance billing protections to both HMO and PPO members. Both HMO and PPO members in Colorado who receive care from an out-of-network provider at a network facility are held harmless by the plan from any higher costs. Some stakeholders interviewed in other states expressed interest in seeing either stronger network adequacy standards or balance billing protections extended to PPO members.

Another limitation, imposed by the federal Employee Retirement Income Security Act, prevents states from regulating self-insured employer health plans. Approximately 55 percent of covered workers nationally—30 percent in California, or roughly 5 million Californians—are enrolled in self-insured employer health plans and therefore are not affected by the state balance billing restrictions described in this paper.[37] For example, the Colorado law that requires MCOs to hold members harmless regarding costs above what they would have faced had they been treated by a network provider does not apply to members of self-insured plans even if they use a managed care model to administer the plan. Regulated plans typically include those sold on the individual market and employer-sponsored plans for companies (especially smaller firms) that choose not to self-insure. Certainly, there is the possibility that a state solution to balance billing, especially one that has a large impact on provider networks, may ultimately affect members of self-insured plans to the extent that they use the same provider networks as MCOs. However, policymakers should be aware that state legislation would not directly apply to a large segment of their insured population and should consider the impact of this limitation. Furthermore, it is unclear whether providers or consumers understand what type of plan is involved and thus whether state laws might apply. This limitation could compromise broad efforts to educate MCO members about their rights.

The Market Environment

A state must consider its unique market environment when crafting laws to protect consumers from balance billing. For example, when a single MCO dominates the state's insurance market, providers who choose not to join its network run the risk of reducing the number of insured patients they may be able to see. As a result, dominant MCOs are more likely to have large provider networks and can reduce the likelihood of balance billing in the absence of legislation. But even in such markets, physicians in some specialties (such as anesthesiology) may choose to stay out of the dominant MCO's network. In a market with a dominant MCO, physicians have less bargaining power to obtain favorable contracted

rates. The reverse may be true where physicians in a particular specialty are organized into larger groups and obtain greater bargaining leverage. In such situations, physicians may stay out of networks and insist on collecting their full billed charges. California's tradition of organizing physicians into large groups may increase their leverage with MCOs, but it adds complexity by building in an additional organizational layer when MCOs delegate risk—and thus payment rates—to the physician groups. Policymakers need to understand their state's market environment in establishing how best to protect consumers in addressing balance billing. For example, market differences might influence the relative effectiveness of the hold harmless approach versus direct bans on balance billing.

When providers are not paid for services delivered to those without insurance, they tend to cover the cost of that uncompensated care through higher charges to other payers. Since payment rates set by public and private payers are lower than providers' billed charges, balance bills can help cover the cost of uncompensated care. On the other hand, billed charges may be well above the amounts needed to cover actual costs.[38] If uncompensated care volume is higher for physicians in some geographic areas or specialties, their incentive to collect balance bills is considerably higher.[39] For example, emergency physicians may experience more uncompensated care (and more Medicaid patients) since they are required under federal law to provide certain services to any patients who come to the emergency room. One emergency physician interviewed for this report suggested that physicians might be willing to see balance billing restricted if they received some compensation for the 30 percent of patients who pay nothing today. Those who set policies to restrict balance billing and to set payment levels where services are provided in the absence of a contracted payment amount may want to take into account these variations in uncompensated care volume by location or provider type.

V. Conclusion

THE FEW STATES WITH BALANCE BILLING laws have been relatively successful in developing and implementing policies to protect MCO members from unexpected bills when using out-of-network health care providers. States typically ban balance billing by providers or require that MCOs hold their members harmless from balance billing. Either approach generally ensures that the member is not liable for balance bills. But no matter how states choose to address balance billing and the related payment standards, it will be important to recognize each state's particular market environment. The relative market strength of MCOs and providers, together with the need to cross-subsidize low public program payments and costs associated with treating the uninsured, may influence the effectiveness of different policy approaches such as direct bans or hold harmless requirements.

Successful state policies appear to require additional strategies to enhance their effectiveness. Some important strategies that states are likely to find valuable include: (1) ensuring patients are educated by regulators, MCOs, and health care providers about balance billing policies and potential member liability when seeking out-of-network services; (2) monitoring member, MCO, and health care provider complaints; and (3) incorporating an enforcement program that promotes collaboration between MCOs, providers, consumers, and regulators. As part of monitoring and enforcement, states may choose to consider a formal dispute resolution program. The success with those programs to date, where they have been tried, is quite limited.

State policies considered for this report, however, have been less successful in preventing payment disputes between MCOs and providers. Identification of a fair payment standard for out-of-network claims continues to impose a significant challenge. Rate standards such as "usual and customary" are complicated by longstanding disagreements between MCOs and providers. An external standard, such as Medicare's fee schedule, although with higher levels than paid by Medicare, offers an approach that might prove more acceptable to both sides.

Table 1. Examples of State Laws Protecting Patients from Balance Billing by Non-Network Providers*

	SCOPE OF LAW			BILLING SCENARIO, BY SERVICE					REGULATORY FRAMEWORK
	PLANS	TYPE OF SETTING	TYPE OF CARE	COVERED BUT NOT AUTHORIZED, ON AN OUTPATIENT BASIS	COVERED AND AUTHORIZED, ON AN OUTPATIENT BASIS	ER, AT A NETWORK FACILITY	ER, AT AN OUT-OF-NETWORK FACILITY	COVERED AND AUTHORIZED, AT A NETWORK FACILITY	
Colorado	HMOs and PPOs	All	Arranged by insurer, in cases of inadequate network	No	Yes	Yes	No	Yes	• Hold harmless • Assignment
		Network hospital	Covered services						
Florida	HMOs	All	Services for which HMO is "liable"	No	Yes	Yes	Yes	Yes	• Hold harmless • Assignment† • Standardized reimbursement (ER services only)
		ER	Emergency care services						
Maryland	HMOs	All	Covered services	No§	Yes	Yes	Yes	Yes	• Hold harmless • Assignment‡ • Standardized reimbursement

*Although this project selected four states with laws that take varying approaches to balance billing, this exhibit excludes Texas (which does not restrict balance billing, per se, by non-network providers, but instead relies on an approach intended to make information more available to consumers). Colorado's law was enacted in 2006, but the 2006 legislation restated an interpretation that had been in place earlier. Florida passed legislation dealing with emergency services in 1998 and added broader protections in 2000. Maryland enacted legislation protecting balance billing by non-participating providers starting in 1989, and the current framework for reimbursement was established in 2002 and 2003 with amendments in 2005.

†Florida law requires HMOs to pay directly out-of-network providers that provide emergency services to HMO members (Florida Statutes § 641.513[5][2008]).

‡In Maryland, although there is no general mandatory assignment law, the state balance billing law requires HMOs to pay directly out-of-network providers that provide "covered services" to HMO members.

§If the HMO contract does not require authorization for the out-of-network services, then Maryland law would prohibit the out-of-network provider from balance billing. In Maryland, a "covered service" is generally considered authorized if it was included under the health benefit package of the HMO and provided by the out-of-network provider, in accordance with the member's contract, per referral, or otherwise approved by the HMO or a provider under contract with the HMO (Annotated Code of Maryland, Health-General § 19-701 [d][2][i][ii][iii]).

Appendix: Balance Billing and Medicare

Most Medicare beneficiaries have traditional Medicare coverage that resembles indemnity insurance. From the start of the Medicare program in 1965, physicians were permitted to decide on a claim-by-claim basis whether to submit bills on assignment and accept Medicare's fee as payment in full or to bill the patient directly, leaving the patient responsible for the balance bill amount. In the program's early years, physicians accepted assignment for over half of all claims, with the share rising to about two-thirds by the mid-1980s. As of 1985, Medicare-allowed charges were usually below the billed charges (85 percent of the time), with a typical balance bill of about one-fourth of the billed charge.[40]

In 1984, Medicare initiated a participating physician program in which physicians agree to accept assignment for all beneficiaries. In return the doctors are listed in published directories (now available on the Web) and receive a slightly higher allowed charge on their claims. About one in four physicians initially signed up for this program, with participation rising to over 50 percent by the early 1990s.[41] Legislation in the 1980s also placed limits on the actual charges by physicians, somewhat limiting the size of balance bills. But even with these changes, more than half of all beneficiaries were paying balance bills at some point each year. Furthermore, a 1988 survey of Medicare beneficiaries found that a majority did not understand concepts such as assignment and participation and rarely discussed these matters with their doctors.

In 1989, Congress completely revamped Medicare's approach to paying physicians, including changes to the rules for balance billing. The legislation limits balance billing amounts to no more than 9.25 percent of the Medicare Fee Schedule amount received by those in the participating physician program. The program monitors the claims of nonparticipating physicians; if frequent violations are found, more intensive monitoring follows, and more serious cases can be referred to the inspector general. Reviews can also be initiated in response to beneficiary complaints.

As a result of these policy changes, 99.4 percent of all Medicare claims were paid on assignment in 2006, so balance billing has become a rare event in Medicare. Apparently, the small size of the allowed balance bill means that the advantages of being able to submit bills as assigned claims mostly outweigh the value of collecting an extra payment from the beneficiary. In fact, 93 percent of physicians now enroll in the participating physician program, thus agreeing never to balance bill.[42]

Endnotes

1. "Hold harmless" provisions are standard in most contracts between managed care plans and network providers and in most states are required by law in HMO contracts. *See* Lucas, C., et al. 2006. *Fifty State Survey of Balance Billing Laws.* American Health Lawyers Association.

2. Generally, except when authorizing care in advance, an HMO will not reimburse an out-of-network provider at all, leaving the patient responsible for the entire bill. If the care is authorized by the HMO, the situation is comparable to an in-network service and the patient should not face balance billing. By contrast, members of PPOs or similar open-network plans generally may choose to receive services from a network or out-of-network provider and receive reimbursement from the PPO. But when care is received out of network (unless authorized or in an emergency), the patient may expect to pay a higher cost-sharing rate and may be balance billed.

3. *Mandatory Assignment of Benefits.* Anthem Fact Sheet, January 2006. On record with authors.

4. California Association of Health Plans. October 24, 2007. "CAHP Calls For Ban On 'Balance Billing.'" News release and related fact sheet (www.calhealthplans.org/documents/pr102307.pdf, www.calhealthplans.org/documents/balance%20billing%20fact%20sheet.pdf).

5. In Kentucky, for example, "A managed care plan shall file with the executive director sample copies of any agreements it enters into with providers for the provision of health care services. The executive director shall promulgate administrative regulations prescribing the manner and form of the filings required. The agreements shall include the following: (a) A hold harmless clause that states that the provider may not, under any circumstance, including 1. Nonpayment of moneys due the providers by the managed care plan, 2. Insolvency of the managed care plan, or 3. Breach of the agreement bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, co-insurance amounts, and amounts for non-covered services." *See Kentucky Revised Statutes Annotated* § 304.17A-527(1)(a) (2008). In Michigan, although the term "hold harmless" is not specifically stated, "an affiliated provider contract shall prohibit the provider from seeking payment from the enrollee for services provided pursuant to the provider contract, except that the contract may allow affiliated providers to collect copayments, co-insurances, and deductibles directly from enrollees." *See Michigan Compiled Laws Service* § 500.3529(3)(2008).

6. In California, a law governing HMOs states that "(a) every contract between a plan and a provider of health care services shall be in writing, and shall set forth that in the event the plan fails to pay for health care services as set forth in the subscriber contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the plan. (b) In the event that the contract has not been reduced to writing as required by this chapter or that the contract fails to contain the required prohibition, the contracting provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the plan. (c) No contracting provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan." *See California Health and Safety Code* § 1379 (2008). Note that this statute addresses written contracts as well as a contract that "has not been reduced to writing." The California Department of Managed Health Care (DMHC) has interpreted this language, along with other provisions of the Knox-Keene Act, as a total restriction on balance billing of HMO members by emergency providers, even by non-network providers. *See* Lucas, *Fifty State Survey,* p. x, p. 5.

7. *Prospect Medical Group Inc. v. Northridge Emergency Medical Group,* 45 Cal. 4th 497 (Cal. January 8, 2009).

8. California Department of Managed Health Care. August 2008. "DMHC Builds on Efforts to Protect Patients from Unfair and Unexpected Bills." Press release (www.hmohelp.ca.gov/library/reports/news/prbbregs.pdf).

9. In addition, SB 697 (Chapter 606), prohibiting health care providers from balance billing members of two state programs (Healthy Families and Access for Infants and Mothers), was signed into law in 2008.

10. In addition, AB 2220 was passed by the legislature in 2007, but vetoed by the governor. Although it did not address balance billing directly, AB 2220 would have established a process for mandatory mediation in physician-HMO contract negotiations where the physician sees more than 5 percent of the HMO's members and a hospital contracting with the HMO requests the physician enter into a contract negotiation with the HMO.

11. For more information about these specific laws, *see* Lucas, *Fifty State Survey.* Some states, such as Virginia, have read into state law a protection for HMO members from balance billing by out-of-network providers in certain situations, although this is accomplished by interpretation and not expressly stated in statute. *See* Virginia Bureau of Insurance. June 16, 2008. Administrative Letter 2008–09, Commissioner of Insurance to All Health Maintenance Organizations Licensed in Virginia and Interested Parties (www.scc.virginia.gov/division/boi/webpages/adminlets/08-09.pdf).

12. In Connecticut, questions of interpretation remain about a statute sometimes reported as prohibiting non-network providers from balance billing HMO members. Connecticut specifies under Connecticut General Statutes § 20-7f(b) (2008) that "it shall be an unfair trade practice for any health care provider to request payment from an enrollee, other than a copayment or deductible, for medical services covered under a managed care plan." A recent court ruling suggests a very broad reading of this statute to include restricting balance billing of HMO members by out-of-network providers. *See Charles D. Gianetti, M.D. v. Fortis Insurance Company* et al., 2007 Conn. Super. LEXIS 838.

13. Some states, such as Delaware and Colorado, also extend protections to PPO members. A state protection may broadly apply to all covered services, as in Maryland, or apply only to a limited number of services, as in New York, where the protection only applies to two specific types of services: pre-hospitalization emergency care provided by a licensed ambulance company (*N.Y. Insurance Law* § 3221[l][15] [Consol. 2008], *N.Y. Insurance Law* § 3216[i][24] [Consol. 2008] and *N.Y. Insurance Law* § 4303[aa] [Consol. 2008]) and end-of-life care exclusively for those with terminal cancer (*N.Y. Insurance Law* § 4805 [Consol. 2008] and *N.Y. Public Health Law* § 4406-e [Consol. 2008]). Finally, a state protection may apply to all settings, as in Maryland, or only in limited settings, as in Indiana, which protects HMO members from balance billing by out-of-network providers only in emergency care settings. A state may take a broader approach to protecting patients from balance billing by also regulating provider reimbursement in these situations. For example, West Virginia law requires payment of the "provider's normal charges" for emergency care services. Four other states (Delaware, Florida, Indiana, and Maryland) also provide statutory guidance for reimbursement rates of out-of-network providers in certain circumstances. Finally, Delaware and Florida make available a formal dispute resolution system to help resolve reimbursement issues between providers and insurers. Some states have also sought to increase the transparency around provider payments with better information for consumers on what they should be paying and what they can expect their insurers to pay.

14. Researchers conducted 33 interviews from May through September 2008. Most interviews were conducted by the two senior investigators on the project, with another team member taking notes.

15. *Colorado Revised Statutes* § 10-16-704(1) and (2) (2008).

16. *Colorado Revised Statutes* § 10-16-704(3) (2008). This statute codifies the Colorado General Assembly's intent to require MCOs to hold patients harmless for covered services received from non-network providers at in-network hospitals. Interestingly, in 1997, the general assembly passed legislation later interpreted by the Colorado Division of Insurance (CDI) to do the same. This regulatory interpretation was challenged by insurers and ultimately overturned by a Colorado Court of Appeals ruling in 2006. That year, almost 10 years after the original legislation, the general assembly passed legislation that confirmed that the CDI had "correctly interpreted" the original legislation.

17. In 2005, public hearings conducted by CDI noted that "some consumers in fully insured plans may not know of the law and may pay balance-billed charges." *See* Report by the Colorado Division of Insurance on the issue of balance billing. 2005. p. 2. On file with author.

18. *Florida Statutes* § 641.3154 (2008).

19. *Florida Statutes* § 641.513(5) (2008).

20. *Florida Statutes* § 641.513(5) (2008). Per discussion with the Florida Office of Insurance Regulation, February 2009.

21. *Annotated Code of Maryland, Health-General* §19-710(i) and (p) (2008).

22. *Annotated Code of Maryland, Health-General* § 19-701 (d)(2)(i)(ii)(iii) (2008).

23. *Annotated Code of Maryland, Health-General* § 19-710.1 (b)(1)(ii) (2008). In a recent draft report, the Maryland Task Force on Health Care Access and Reimbursement recommended a change in the statutory rule regarding these reimbursement standards. Generally the recommendation would set reimbursement for evaluation and management services as the greater of 140 percent of the Medicare fee or 125 percent of the average network rate. Procedures, tests, and imaging services would be reimbursed at 125 percent of the average network rate (using an average is intended to address the concern that some MCOs use the lowest fee paid in an area). *See* Maryland Department of Health and Mental Hygiene. December 2008. *Draft Report of the Task Force on Health Care Access and Reimbursement. Final Report and Recommendations.* Recommendation #3, p. 34 (www.dhmh.state.md.us/hcar/pdf/nov2008/nov25/draft_hcar_final_report.pdf). Proposed legislation, consistent with the recommendation, was recently introduced to the 424th session of the Maryland General Assembly.

24. Under a Texas law, PPO members have virtually no protection against balance billing. There is not a "per se" rule restricting non-network providers from balance billing HMO members, but the Texas Department of Insurance interprets the HMO Act to allow an HMO to contract with a physician practicing in a network facility to honor the facility's hold harmless agreement. This interpretation is limited by a 2003 Texas attorney general's opinion concluding that, in the absence of such a contract, "the Act does not prohibit a physician who is not under contract with an HMO from balance billing." However, this opinion does not consider "whether state law permits a network facility to require non-network physicians with privileges at the facility to honor the facility's hold harmless agreement with an HMO." *See* Attorney General of Texas. March 2003. *Opinion No. GA-0040* (www.oag.state.tx.us/opinions/opinions/50abbott/op/2003/pdf/ga0040.pdf).

25. Longley, Dianne. February 18, 2008. *Health Care Pricing Transparency For Consumer: Senate Bill 1731 Implementation.* Presentation prepared by the Texas Department of Insurance; *House Research Organization Bill Analysis for Senate Bill 1713* (www.hro.house.state.tx.us/pdf/ba80r/sb1731.pdf); Enrolled Summary for Senate Bill 1731 (www.legis.state.tx.us/billlookup/billsummary.aspx?legsess=80r&bill=sb1731).

26. For more detail, *see* Texas SB 1731 (2007).

27. SB 981 (2007).

28. Earlier versions of this legislation had different payment standards. One defined the interim payment rate as the 50th percentile of submitted Medi-Cal charges related to emergency care and adjusted annually for inflation. A later version used the 50th percentile of physician charges as collected for a commonly used commercial database. By contrast, the regulation (28 *California Code of Regulations* §1300.71.39 [2008] [wpso.dmhc.ca.gov/regulations/docs/regs/19/1221585440921.pdf]) issued by the Department of Managed Health Care in 2008 builds on the existing requirement that plans pay the reasonable and customary value of the services rendered as stated in the department's explanation of its regulation (www.oal.ca.gov/pdfs/notice/13z-2008.pdf).

29. California's situation is more complex because two different agencies regulate health plans.

30. Oversight of health insurance carriers in California is divided between two state departments. The Department of Managed Health Care regulates health care service plans whose products have historically emphasized service delivery through HMOs. The California Department of Insurance has jurisdiction over health insurers whose products have historically emphasized the financial protection aspects of insurance, rather than service delivery. Roth, Debra L., and Kelch, Deborah Reidy. December 2001. *Making Sense of Managed Care Regulation in California.* California HealthCare Foundation.

31. *Colorado Revised Statutes* §10-16-704(2)(d),(e) (2008).

32. *Colorado Revised Statutes* §10-16-704(2.5)(a) (2008).

33. Report by the Colorado Division of Insurance on the issue of balance billing. 2005. p. 2. On file with author.

34. Florida Agency for Health Care Administration. 2008. *Statewide Provider and Health Plan Claim Dispute Resolution Program: Annual Report 2008* (www.fdhc.state.fl.us/mchq/managed_health_care/sphpclaimdrp/annualreport2008.pdf).

35. The number of cases reviewed in full was significantly less than the number of applications. For example, of 175 cases submitted in 2005, only 14 were found to be eligible for review; the rest were ineligible because they did not meet basic eligibility criteria or had incomplete data. Ultimately, after three parties withdrew from the process, only 11 cases were fully reviewed. By the time of the printing of the *Annual Report 2006,* only nine cases were completed with final decisions posted. Florida Agency for Health Care Administration. 2006. *Statewide Provider and Health Plan Claim Dispute Resolution Program: Annual Report 2006.*

36. DMCH Director Cindy Ehnes stated in a prepared statement issued October 14, 2008, regarding balance billing regulations: "The DMHC has also made available a fair, fast, and free way for providers to solve their claims disputes, through our Independent Dispute Resolution process. Unfortunately, physician advocates have discouraged their members to use this process, opting instead for other avenues. Therefore, the DMHC is conducting a test to prove its effectiveness. We recently submitted 10 provider complaints to this independent review and findings should be available in mid-November." (www.hmohelp.ca.gov/library/reports/news/tpbbeffpub.pdf).

37. National Opinion Research Center. December 2008. *California Employer Health Benefits Survey.* California HealthCare Foundation (www.chcf.org/topics/healthinsurance/index.cfm?itemID=133543).

38. For physicians, unlike institutional providers, the concept of actual costs is not well defined because compensation to the physician—the physician's net income—is a major component of actual costs. Still, it is clear that uncompensated care means a reduction in physicians' income.

39. In states with low Medicaid payment rates, high Medicaid caseloads may have the same effect.

40. Physician Payment Review Commission. March 1, 1987. *Medicare Physician Payment: An Agenda for Reform: Annual Report to Congress.*

41. Physician Payment Review Commission. 1992. *Monitoring the Financial Liability of Medicare Beneficiaries.*

42. Medicare Payment Advisory Commission. March 2008. *Report to the Congress: Medicare Payment Policy.*

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