

**DECEPTIVE HEALTH INSURANCE INDUSTRY
PRACTICES: ARE CONSUMERS GETTING
WHAT THEY PAID FOR?—PART I**

HEARING

BEFORE THE

**COMMITTEE ON COMMERCE,
SCIENCE, AND TRANSPORTATION
UNITED STATES SENATE**

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 26, 2009

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ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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**DECEPTIVE HEALTH INSURANCE INDUSTRY
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THURSDAY, MARCH 26, 2009

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Committee met, pursuant to notice, at 10:34 a.m. in room SR-253, Russell Senate Office Building, Hon. John D. Rockefeller, Chairman of the Committee, presiding.

**OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV,
U.S. SENATOR FROM WEST VIRGINIA**

The CHAIRMAN. Good morning, everybody. Today's hearing is the first of two hearings—which works out very well, the setup of the two hearings—that we're holding to look at deceptive payment practices that the health insurance industry has gotten away with for the last decade, probably longer. The victims of this deceptive practice were probably most of the people sitting in this hearing room today, along with the more than 100 million Americans who pay for health insurance coverage that allows them to go outside of their provider network for, you know, medical care. Having the ability to get health care service outside of the network is a very important option for American consumers, and it's an option that they pay for—and they know they're going to pay for that—in the form of higher premiums, higher deductibles, and higher coinsurance payments.

Now, Dr. Jerome should be sitting here today. We are—Dr. Mary Jerome—she's a resident of Yonkers, New York. She has been fighting ovarian cancer since 2006. She had planned to be here, but she just can't physically make it, today. But, I'm still going to say something about her.

According to her testimony, Dr. Jerome received her health care coverage through a point-of-service plan, which encouraged her to get care within a provider network, but also allowed her to see out-of-network providers, if she so desired and it was necessary.

So, here's what she says in her testimony, "I had always been confident that paying for the out-of-network option provided peace of mind with respect to the financial burdens associated with catastrophic medical costs."

After her cancer diagnosis, Dr. Jerome and her in-network primary-care physician decided that she needed to be treated at a health care provider that was outside of her network; that one

being in Memorial Sloan-Kettering Hospital in New York City. Dr. Jerome knew she was going to have to pay some portion of these costs out of her own pocket, but she also assumed, in good faith, that the treatment was going to be covered by her insurance.

What we're going to learn today is that American consumers like Dr. Jerome, people who have been paying higher premiums for the choice to see out-of-network doctors, have not been getting what they have been paying for. We're going to hear testimony suggesting that the health insurance industry has been systematically low-balling American consumers. And this is a very upsetting situation, one which has been revealed in New York. And if we have to have 50 hearings for 50 states, I'll be glad to do that, too.

They have been promising, these insurance companies, to pay a certain share of the consumers' medical bills, but they have been rigging health care-charge data to avoid paying their fair share. The result is that billions of dollars in health care costs have been unfairly shifted to Dr. Jerome and millions of other American consumers like her; as I said, probably many in this room.

So, here's how it works. The insurance company generally promises to reimburse out-of-network medical services at what they refer to in the industry as the "usual, customary, and reasonable rate." Usually, just the word "usual and customary." Well, the problem is that it's been the insurance industry who has been deciding what is "usual, customary, and reasonable," what that means. They make that decision. Consumers have not had any input. Doctors and other health care providers have not had any input. The chairman of the American Medical Association has not had any input. Only the insurance companies have been getting to decide what's reasonable, which is like letting the fox define "usual, customary, and reasonable" in the henhouse.

You understand that.

Senator McCASKILL. I do. We have both, in Missouri. Fox and henhouse.

The CHAIRMAN. So, the good news is that, thanks to a series of lawsuits and a year-long investigation by the New York Attorney General's Office, the insurance companies that operate in New York, including, most importantly, UnitedHealth Group, and its medical information subsidiary, Ingenix, have been forced to change the way they do business. And Ms. Laceywell has a lot to do with that.

Conclusion—our goal for today is to get an update on how the reforms proposed in New York are being implemented, and to understand how the deceptive practices uncovered in New York have been harming customers in the other 49 States.

I'm looking forward to this testimony, especially at a time when our country is going through all kinds of murderous economic situations for people to pay any kind of health insurance at all.

I would, finally, like to note that missing from our hearing today is one group of stakeholders who played an indispensable role in creating and perpetuating this unfair reimbursement system, but who will also play an essential role in changing it, and that is a little group called the insurance industry.

On March 9, I invited the CEOs of UnitedHealth Group and Ingenix to testify at this hearing, because we wanted to hear their

side of the story, because we're always fair here. Because UnitedHealthcare told us that their CEO, Mr. Stephen Hemsley, was not available to testify today, we agreed to hold a second hearing, next week. So that's what we're going to do on Tuesday. That's very important, for observers and for press and for members here to know that.

It's perfect. We get—we have the good guys, and then we have the other guys.

[Laughter.]

The CHAIRMAN. The good guys are today, the other guys—you're going to set up next Tuesday.

So, at 10 a.m. next Tuesday, we'll be holding a hearing, during which we hope to gain a better understanding of the insurer's perspective.

Now, I, at this point, usually call on the Ranking Member, and I don't see one, so what I would like to do is call—is simply to ask you to present your testimony, unless any of our members would care to make a statement. Short statement. Very short statement.

**STATEMENT OF HON. FRANK R. LAUTENBERG,
U.S. SENATOR FROM NEW JERSEY**

Senator LAUTENBERG. It just keeps getting shorter?

The CHAIRMAN. Yes. Because I was long.

Senator LAUTENBERG. You're very generous to make that offer. In a place like this, people don't usually make that kind of an offer, so I will take advantage, for a moment, of the Chairman's latitude with allowing just a short statement.

Mr. Chairman, as I'm sure you mentioned, in New Jersey and across the country, people are working harder than ever, still struggling to get by. And the worst thing to do is to have to be caught in the middle of a scheme—for them, for the individual—that permits the insurance companies to siphon off more of the profit than they're entitled to. And they do pretty well in that provider—health provider business.

And so, we're pleased to have you here. We've had terrible problems, the State of New Jersey. In 2000–2007, premiums in New Jersey rose 71 percent, while workers' earnings increased 15 percent. So, the health care costs in New Jersey, seeing a doctor, getting a prescription, need grew 50 percent from 1999 to 2008.

So, we're pleased to have—that you chose to have this hearing, Mr. Chairman, and that we have a chance to learn more about it from people who are directly involved. And we thank you for being here.

Thank you very much.

[The prepared statement of Senator Lautenberg follows:]

PREPARED STATEMENT OF HON. FRANK R. LAUTENBERG,
U.S. SENATOR FROM NEW JERSEY

Mr. Chairman, in New Jersey and across the country, people are working harder than ever before, but still struggling to get by.

They are being forced to make devastating choices between paying their mortgage and paying for health care.

In these difficult economic times, the cost of health care is putting a tremendous strain on families in my state.

Between 2000 and 2007, health care premiums in New Jersey rose seventy-one (71) percent while worker's earnings increased just fifteen (15) percent.

In addition, total health care costs in New Jersey—from seeing a doctor to getting the prescriptions people need—grew fifty (50) percent from 1999 to 2008.

So when we learn that the insurance industry may be manipulating data to make consumers overpay for their health care, Congress has reason to be concerned and Americans have reason to be angry.

One patient in New Jersey was left owing thousands of dollars in health care bills for her breast cancer treatment because her insurance company cooked the books to cover far less of the cost than it should have.

This New Jersey patient—like many other patients and families—was forced to pay for care that her insurer should have covered under the terms of her insurance plan.

And if that wasn't bad enough, the so-called "independent organization" that was supposed to protect all patients by objectively determining how much of the cost should be covered by insurance was owned by an insurance company.

That arrangement was a conflict of interest and undermined all Americans' faith in the health care system.

I'm pleased that this problem has been resolved, but we must remain vigilant on behalf of consumers.

People are willing to do their part. They are willing to pay a fair price for the health care they get.

But Americans who work hard to pay their premiums rightfully expect their insurance companies to keep up their end of the bargain.

Along with my colleagues, I will fight to keep insurance companies working for Americans—not against them.

I look forward to hearing from today's witnesses and seeing how we can stop consumers from getting a raw deal.

The CHAIRMAN. Thank you, Senator Lautenberg.

Any other statements?

Senator UDALL. Let's get to the witnesses.

The CHAIRMAN. Well, I like that.

The first one is Ms. Linda Lacewell. And this is her title. She is Counsel for Economic and Social Justice, and Head of the Healthcare Industry Task Force, and she knows her business very, very well. Obviously, as I indicated, Mary Jerome—Dr. Mary Jerome, could not be here. Dr. Nancy Nielsen, President of the American Medical Association, with the incredible fortune of having been born in Elkins, West Virginia.

Dr. NIELSEN. That's right.

The CHAIRMAN. And Mr. Chuck Bell, Programs Director for the Consumers Union.

So, we look forward to your statements, starting with you, Ms. Lacewell.

STATEMENT OF LINDA A. LACEWELL, COUNSEL FOR ECONOMIC AND SOCIAL JUSTICE AND HEAD OF THE HEALTHCARE INDUSTRY TASKFORCE, OFFICE OF THE NEW YORK STATE ATTORNEY GENERAL

Ms. LACEWELL. Thank you very much, Mr. Chairman. Thank you to the Committee, for inviting me here today with respect to this hearing. It's a pleasure to be here, and it is my privilege to represent the Attorney General of the State of New York, Andrew Cuomo, at this hearing.

For the past year, the Attorney General in New York has been conducting an industry-wide investigation with respect to the insurance industry concerning a scheme that is truly, in our view, staggering in scope and impact, affecting, as the Chairman noted, over 100 million Americans around the country—that is one in

three people in this country—a scheme run by the Nation’s largest health insurers, as we found, which left working families across the country wrongly stuck with at least hundreds of millions of dollars in unreimbursed medical expenses, a scheme that ran for at least 10 years, and one that is finally coming to an end.

The Attorney General is the people’s lawyer and seeks to be responsive to their concerns. As a result of that, he travels the State of New York and learns what the issues are of concern to the people. And time and again, the primary concern raised by the people in the State of New York is health care and health care costs and whether or not they’re getting the benefit of the bargain of their health insurance.

A key concern raised by them with respect to health care is reimbursement for what is known as out-of-network medical costs. About 70 percent of insured Americans have a plan that allows them to choose their own doctor outside of the network of insurers—outside the network that insurers have put together by contract with their doctors. These consumers, it’s important to note, do pay more; they pay a higher premium. It costs them more money for this right to go out of network. And that balance of—that bargain is an important one to ensure is met. And they choose to pay more for the right to go out of network because it is fair to say that health care can be a matter of life and death, and choosing a doctor is a critical issue in that regard.

Under these out-of-network plans, in exchange for the higher premium, the insurer typically promises to pay a substantial portion, a huge portion, of the anticipated cost, which they refer to as a “usual and customary rate.” Frequently, the insurer says, “I will pay 80 percent of what the usual and customary rate is.” And that is understood to mean—in the industry, to mean “the prevailing rate the doctors charge when they have not negotiated a lower rate with the insurer on an in-network basis.”

And this is a critical consumer issue, because in the out-of-network setting, when the insurer does not reimburse the entire bill to the consumer, it is the consumer who is responsible to the doctor to pay the balance of the bill, which would not ordinarily be the case in an in-network setting.

So, our investigation sought to determine why the reimbursement rates to consumers were so low, who was determining the rates, and how, and whether, in fact, these rates were fair or not fair.

We, therefore, surveyed health insurers operating in the State of New York, which includes some of the largest insurers in the country that operate in New York, UnitedHealth Group, Aetna, CIGNA, WellPoint, which is the largest in the country. And time and again we received the same answer, “When we determine these rates, we are relying on this independent company, known as Ingenix.” We then went to Ingenix and said, “How are you determining these rates?” And time and again from Ingenix we received the same answer, “Well, we collect fee information, billing information, from insurers around the country, the largest insurers that there are—United, Aetna, CIGNA, WellPoint, and everybody else. We take all their data, we put it in a database, we mix it up, and we issue

these fee information schedules that go to the industry to determine usual and customary rate.”

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—health 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.

The Attorney General found, and health insurers have since acknowledged, that there are conflicts of interest here, a picture of conflicts of interest from top to bottom, because each of the health insurers has a reimbursement obligation toward the consumer and therefore has an interest in keeping the reimbursement rate low.

So, if the rates are being determined and agreed upon, essentially, by the insurers, and the database is based on their product, there is a significant danger to consumers of underpayment. And our investigation found that, in fact, Ingenix did lead to underpayments.

The other problem that we found with this system is that Ingenix has been essentially a black box to consumers, who do not know, first of all, that it is the insurance industry determining what this—what these rates, and second, they don’t know how to challenge the rates, and they are almost never given, by the industry, an opportunity to do so.

It is important to note, as the Chairman did, that, although this issue may sound technical, it affects almost everyone in the country, and it has a human impact, as demonstrated by the story of Mary Jerome, referred to by the Chairman, who was stuck with tens of thousands of dollars of unanticipated medical costs at a time when she was fighting, not only for her health, but for her life.

Having identified this problem, the Attorney General set about to determine an appropriate reform. And when the problem is framed, the answer becomes simple and clear to note, and that is, there must be an independent system that does not have the conflicts of interest that currently exist; there should be a database that is independent; we feel it should be run by a not-for-profit company associated with a university, which has an interest in the database being accurate, because it will also be used for academic research; and the system should be reformed in that way. And also, it is critical that consumers across the country get some transparency into their reimbursement rates so that they know ahead of time what their costs are going to be, what their out-of-pocket expense is going to be, before they shop for a doctor. And in that regard, it is the Attorney General’s goal that there be a website ultimately available to consumers where they can go to find out, in their area, what their reimbursement rates are likely to be for various medical services.

UnitedHealth Group and Ingenix have agreed to sign on to these reforms, and we have commended them for that, and we continue to do so. When the new database is ready, they will shut down the

existing Ingenix database. They are funding the new, independent not-for-profit with \$50 million, and the rest of the industry, like dominos, has quickly followed suit, and we have now collected about \$95 million to institute these reforms.

We are also working closely with the New York Department of Insurance to make these reforms permanent, and we believe there is a need for a new regulation to end, once and for all, the conflicts of interest that derailed the existing system, and to bring new rigor and transparency so that this problem can never happen again.

The Attorney General strongly believes that states are a laboratory for reforms and advancements in many areas, including health care, and we hope that the new regulation in New York will serve as a model for the Nation so that the goals of accuracy, transparency, and fairness in out-of-network reimbursement for consumers like Mary Jerome can be met.

Thank you.

[The prepared statement of Ms. Lacewell follows:]

PREPARED STATEMENT OF LINDA A. LACEWELL, COUNSEL FOR ECONOMIC AND SOCIAL JUSTICE AND HEAD OF THE HEALTHCARE INDUSTRY TASKFORCE, OFFICE OF THE ATTORNEY GENERAL, STATE OF NEW YORK

I thank Chairman Rockefeller, Ranking Member Hutchison, and the Members of the Committee on Commerce, Science, and Transportation for inviting me to speak this morning. It is my pleasure to be here today on behalf of New York State Attorney General Andrew Cuomo.

Background

Over the last year-and-a-half, the Office of the Attorney General has conducted an investigation into how the health insurance industry reimburses consumers for out-of-network health care services. During the course of the investigation, we uncovered a fraudulent and conflict-of-interest-ridden reimbursement scheme. These deceptive, industry-wide practices affected millions of patients and their families and cost them hundreds of millions of dollars in unexpected and unjust medical costs.

As the Attorney General travels around the State of New York and addresses local community forums, the number one concern people raise is health care. It is easy to see why the results of this investigation have struck a chord with the public. Our nation faces a health care crisis. In addition to the obvious problems of the uninsured and the underinsured, our investigation has found that under-reimbursement of the insured is a major problem. Until now, it has been a hidden problem. This is not just a problem in the State of New York. Nationwide, medical costs are the leading cause of individual bankruptcy, even though the individual usually had insurance. Fraudulent under-reimbursement for insured Americans is one part of this negative equation for consumers.

Of insured Americans, about 70 percent pay higher premiums for the right to select their own doctor. That's 110 million people or 1 in 3 insured Americans. The reasons vary. Some people want the freedom to make decisions about their families' health care while others cannot find the best physician to treat a particular condition in their insurer's network. Those who carry out-of-network coverage sometimes need it when they least expect it. Patients are admitted to in-network hospitals and through no choice of their own are treated by out-of-network doctors there, resulting in anticipated, high medical costs for the consumers involved.

In exchange for higher premiums, the insurer promises to pay a large portion of the bill when a consumer has seen an out-of-network doctor. Typically, health insurers promise to pay a percentage of the bill, often it is 80 percent, of market rate, which the industry calls the "usual and customary" or "reasonable and customary" rate, also known as "UCR." The "usual and customary" rate is supposed to be a fair reflection of the market rate of doctors across the country for all kinds of medical services, and we found that consumers read the term that way.

If the insurer does not reimburse the consumer at that level because the insurer did not deem the doctor's charges to be usual, customary or reasonable, the consumer is responsible for paying *the balance of the bill*. As a result, consumers who choose to go out of network have to pay more for medical care than they anticipated.

In this way, out-of-network policies can be a financial trap for consumers, leading to unexpected health care debts. Moreover, when health insurers fail to explain accurately or clearly what they will pay for out-of-network care, consumers are unable to make intelligent and informed decisions about their health care.

I will take the next few minutes to elaborate on the inherent conflicts of interest in the consumer reimbursement system, and how we are moving the industry away from this self-serving model and toward reform of the out-of-network reimbursement system.

Conflict of Interest

For 10 years, the “usual and customary” rate for the entire industry has been decided by one company: Ingenix. As we learned, the largest health insurers throughout the country use Ingenix to determine “usual and customary” rates. Who is Ingenix? Early on in our investigation we discovered that Ingenix is a wholly-owned subsidiary of the Nation’s second largest health insurer, UnitedHealth Group. As both a user of and contributor to the Ingenix database, UnitedHealth clearly had an interest in depressing reimbursement rates, causing consumers to pay more. Shortly thereafter, we learned that many other national health insurers also contributed their billing data to this database and then used the database as a benchmark for reimbursement rates. This resulted in the creation of a closed system, leaving no real options for consumers.

Reasonable and customary rates are supposed to fairly reflect market rates, but our investigation revealed that Ingenix is nothing more than a conduit for rigged information that is defrauding consumers of their right to fair reimbursements for their out-of-network health care costs. All the while consumers are left to sort through confusing policy language and are then stuck with the balance of their doctors’ bills. To make matters worse, health insurers routinely hide this conflict of interest from their members in obscure policy language making it a problem that is nearly impossible to detect.

Lack of Transparency

During the investigation, our Office subpoenaed a broad range of plan documents describing out-of-network policies. Our review of these materials revealed a shocking lack of transparency and accuracy. Most insurers failed to disclose accurately and clearly what they would pay or how they would determine payment for out-of-network care. In one case, we found that a national insurer had filled an entire page with alternative ways of how it purported to calculate out-of-network rates in language that was unintelligible. As expected, none of the insurers accurately described the role Ingenix played in determining those reimbursement rates.

The Ingenix Data base Under-Reimburses Consumers

Ultimately, our investigation found that the Ingenix schedules themselves, created in a well of conflicts, are unreliable, inadequate, and wrong—often forcing consumers to bear an even greater burden of the cost of care. UnitedHealth had a financial incentive to understate the “usual and customary” rate so as to reduce the amount reimbursed to consumers. For the same reason, other insurers had a financial incentive to manipulate the data they provided to the Ingenix database so that the pooled data would skew reimbursement rates downward. When combined with Ingenix’s lack of incentive to audit the data it received and pooled, consumers were continually at risk of being under-reimbursed.

As part of our investigation, in an effort to determine the level of accuracy of the Ingenix database, we collected and analyzed millions of health care bills from a variety of sources, including a range of insurers operating within New York State. Our analysis showed that insurers systematically under-reimburse New Yorkers for doctor’s office visits and that there were wide disparities when comparing various regions across the State. Underpayments of up to 10 to 20 percent in Manhattan alone translated to millions of dollars in underpayments. When extrapolated across the State and the country, it is fair to say that the Ingenix database have caused Americans to be under-reimbursed by hundreds of millions of dollars over the past 10 years.

Ingenix has been a “black box” for consumers who do not know their out-of-pocket cost of medical services before receiving them and has driven up costs when consumers cannot get the best value for their dollar before choosing a provider because they cannot comparison shop.

Mary Jerome’s story stands out in my mind and illustrates the point. Mary Jerome is a college professor in New York who was found to have ovarian cancer in 2006 and was left with tens of thousands of dollars in unreimbursed medical bills. Her doctor recommended she be treated at leading cancer center Memorial Sloan Kettering where she expected to pay no more than her \$3,000 deductible for going

out of network. Soon she faced bills that left her \$70,000 to \$80,000 in debt and was forced to navigate a complicated appeals process with her health insurer while trying to recover from a devastating illness.

Cases like Mary Jerome's inspired us to think more broadly about the kinds of industry reforms that were needed to protect patients, who could be focused on recovering physically instead of having to spend time and energy trying to recover their health care costs.

Solutions

After consulting with a number of stakeholders, including consumer advocates, representatives from the physician community, and health care economists, our primary objectives became clear. First, the "usual and customary" or market rates for health care charges have to be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database. Second, before consumers choose an out-of-network doctor, they should have a range or estimate of what it will cost them. Consumers need more information about how they will be reimbursed and they need it earlier in the decision-making process.

To resolve this industry-wide issue, we zeroed in on the source of the problem: Ingenix and UnitedHealth, Ingenix's parent company. Once UnitedHealth acknowledged that there were inherent conflicts of interest in the reimbursement system, it not only agreed to stop making the Ingenix database available to other insurers for purposes of calculating usual and customary rates, but also agreed to contribute fifty million dollars for the creation of a new, independent database that will become a new industry standard. After the agreement with UnitedHealth was announced, our Office quickly secured agreements with the other leading insurers around the country, as well as the largest insurers in New York State, to stop using Ingenix to calculate out-of-network reimbursement rates and contribute resources to the new database. To date, in addition to the agreement with UnitedHealth, we have also entered into agreements with WellPoint, Aetna, CIGNA, MVP Health Care/Preferred Care, Independent Health, HealthNow, CDPHP, Excellus, GHI/HIP (EmblemHealth), and Guardian Life Insurance Company.

The funds we collect will go toward the creation of a not-for-profit entity that will operate the new, independent database designed to fairly reflect the market and create a website available to consumers to provide reimbursement information so that consumers can make more informed decisions and better manage their health care costs before they shop.

The not-for-profit entity will set up the database, which will:

- be a credible source for the industry and consumers
- not be controlled by the industry
- determine rates fairly reflecting the market, and
- collect information that goes beyond the limited information collected and provided by Ingenix.

These industry reforms will bring accuracy, transparency, and independence to a broken system and keep hundreds of millions of dollars in the pockets of over one hundred million Americans.

Need for Additional Regulation

Our office has also been working with the New York State Department of Insurance to revise and improve the rules regarding consumer reimbursements.

We believe there is a need for a new regulation to end once and for all the conflicts of interest that derailed the previous system and to bring new rigor to the system. First, insurers should not be permitted to use as a source or basis for determining usual and customary rate any entity that has a pecuniary interest in the rates. That includes any insurer, HMO, medical association, or health care provider. Second, insurers should base consumer reimbursements in this area on accurate schedules that fairly reflect the market and are regularly updated. And they should disclose to consumers ahead of time how much they will be reimbursed.

National Action

The Attorney General believes that the states can serve as laboratories for advances and reforms in areas such as health care. New York should adopt a regulation that serves as a model for the Nation in advancing the goals of accuracy, transparency and fairness in out-of-network reimbursement for consumers.

The issue of out-of-network reimbursement is just one example of how our complex health care system burdens consumers without necessarily delivering better outcomes. By the time individuals reach out to our Office for help, they have often spent countless hours trying to decipher coverage language, filling out claims forms,

filing appeals with their insurers, negotiating with their providers and trying to make sense of mountains of paperwork—all in an effort to manage their health care costs, and frequently at a time of coping with serious illnesses. Building clarity and accuracy into the reimbursement system can also alleviate these unnecessary burdens on patients and consumers.

Conclusion

As this Congress tackles the reform of our health care system, the Attorney General asks that it consider ways to make health care transactions more transparent, provide clearer information to consumers about their rights and responsibilities, and hold insurers accountable for providing accurate and complete information to their members.

The Attorney General looks forward to providing any assistance the Committee may require to help achieve these goals.

The CHAIRMAN. Thank you, Ms. Lacewell.
Dr. Nielsen?

STATEMENT OF NANCY H. NIELSEN, M.D., PH.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. NIELSEN. Good morning, Chairman Rockefeller, Members of the Committee. I'm Dr. Nancy Nielsen. I'm originally from West Virginia, as you heard, and I now live in Buffalo, and I am a practicing internist and also President of the American Medical Association. Thank you very much for inviting me here today to testify about this important issue. We have been involved in this issue for nearly a decade.

You have already heard how it worked, that the database was used to determine "usual, customary, and reasonable fees" that insurers paid when a patient went out of network. And the patients, as you've also heard, paid extra for the privilege of going out of network.

There have been, as you heard from Ms. Lacewell, two precedent-setting settlements by United, one with the AMA and the other with Attorney General Cuomo. And therefore, this abuse is being addressed. My comments will focus on the AMA's lawsuit and its implications for physicians and patients.

You might wonder why a doctor would not belong to a network and why people would have to go out of network. Patients understand that all physicians are not part of every network, either because the payer sometimes restricts the network deliberately, or because the physician decides that the fee schedule is not adequate, or that the hoops that they have to jump through are not worth it to get the care that their patients need, or the administrative burdens are too high, or there's simply no benefit to taking a discounted rate when there's no volume that is going to follow. So, there are lots of reasons why physicians sometimes do not join networks.

And you've also heard, from Ms. Lacewell, how it works. There is usually a percentage that the insurer agrees to pay for the out-of-network charge. And the patients believe, the consumer believes, that the insurer will pay that percentage of what the doctor charges. What actually happens, as you've heard, is that it's the insurers themselves, through the Ingenix database, that are actually lowering the amount and deciding what is, quote, "allowed."

That is a rude awakening for patients like Dr. Mary Jerome.

It's also very harmful to patients—to physicians. And the harm is not just financial. This drives a stake in the heart of the doctor-patient relationship, because if you're a patient and you're told that X is the "usual, customary, and reasonable," and your doctor charged Y, what is your assumption? That it is an "unreasonable" charge. And that is unfair, and that has damaged the doctor-patient relationship throughout this country, not just in New York.

In the year 2000, the AMA and the Medical Societies of the State of Missouri and New York filed suit against United on this issue, exactly. It lay aborning in the courts for many years, despite the best efforts, until the Attorney General took it on. And we are very pleased that the consumers and the doctors worked together with the Attorney General's office. They did the groundbreaking work, got the information that no one else was able to get.

How did the database lower those fees? Let me just give you, quickly, four ways. First, they deleted higher charges and any charges with cases that had complications. They included outdated information, discounted rates, and even charges from nonphysicians. They failed to collect relevant information about the site of service, the length of training, the physician qualifications. And when there was no data available in an area, they derived some. Those were the ways that the flaws occurred.

The conflicts of interest, you have heard described quite readily, both by the Chairman and by Ms. Lacewell.

Ultimately, to be fair, United recognized the importance of restoring its relationship with patients and physicians, and is settling its court battle with the AMA. It agreed to pay \$350 million, the largest settlement against any insurer in this country, to compensate under-reimbursed patients and physicians, and to transfer this UCR database from Ingenix to the new not-for-profit entity. These settlements will help make sure that patients understand what they're being promised when they purchase an out-of-network service, what their obligation will be, and what the obligation of their insurer will be.

We urge Congress to ensure that everyone, including Federal workers, who may have also been shortchanged through these out-of-network benefits, to receive reasonable compensation. We also urge you to pursue payment transparency, because the transparency of the health industry, for payments and for other things, is in everyone's best interest—patients, doctors, and the country as a whole.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Nielsen follows:]

PREPARED STATEMENT OF NANCY H. NIELSEN, M.D., PH.D., PRESIDENT,
AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on Commerce, Science, and Transportation regarding usual and customary reimbursement for out-of-network providers. We commend Chairman Rockefeller, Ranking Member Hutchison, and Members of the Committee for your leadership in recognizing the far-reaching implications of the recent settlements involving the Ingenix usual, customary, and reasonable (UCR) databases owned by United Health Group (United).

These databases were used for over a decade as the basis for determining the UCR fees that United and many other third-party payers paid for medical services provided out of network, that is, by physicians who had not contracted with the pa-

tient's health insurer to accept a discounted rate. These databases employed flawed data to determine out-of-network payment rates, resulting in increased health insurer profits at the expense of patients and physicians. As a result of two precedent-setting settlements entered into by United, one with the AMA and the other with Attorney General Cuomo, this practice is finally being eradicated.

The elimination of these UCR databases represents a major step toward improving the health insurance system in the United States. Most of the medical care provided pursuant to health insurance today is provided by physicians and other clinicians who have agreed to provide care to the patients covered by that health insurance product for a discount. Physicians generally try to contract with health insurers because they may receive significant benefits in return—(1) a promise of prompt payment, (2) increased patient volume by virtue of inclusion in provider directories and benefit plans that give patients a substantial financial incentive to go to in-network providers, and (3) maintenance of patient loyalty by meeting their patients' requests that they be "in-network." These benefits can justify a significant discount from a physician's retail charges.

However, at least 70 percent of people in the United States who have health insurance, have a product that covers out-of-network care for an additional premium.¹ Patients understand that not all physicians are contracted, either because the payer has restricted the network, or because the physician did not agree to the contract terms—the fee schedule offered was too low, the administrative or other burdens imposed were too high, or the health insurer was promising little or nothing with respect to benefits. Out-of-network coverage varies, but typical health insurance policies call for the insurer to pay a percentage of the UCR charge of the out-of-network provider, for example 50 percent. While health insurers have in recent years used various iterations of this language, the traditional definition of UCR charge is as follows:

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

Most patients expect their physicians to bill at a rate which is typical for their specialty and community for the services provided. Thus, assuming they have health insurance which includes an out-of-network benefit of 50 percent of UCR, patients expect that if they receive a bill of \$100 for a service provided by a non-contracted physician, the health insurer will pay \$50 of the bill, and they will be responsible for the remainder—in this case \$50. But if the insurer systematically "allows" less than the UCR charge, the patient is left with a larger bill. For example, if the payer "allows" only \$80 for the \$100 service, the health insurer pays \$40 (50 percent of \$80) and the patient is now left with a \$60 obligation (\$100 - \$40 = \$60).

Obviously, the size of the underpayment will vary based on the size of the claim and the way in which the insurer calculated the UCR payment, which may magnify the underpayment dramatically. For example, an insurer that bases its payment on the 50th percentile of the Ingenix database, will pay substantially less than an insurer that bases its payment on the 80th or 90th percentile. As demonstrated in several of Attorney General Cuomo's settlements, insurers that use older versions of the Ingenix database will pay less than those who are using the current database. These problems may be further compounded depending on how the benefit package is structured, particularly the deductible and coinsurance responsibilities. To the extent these are structured in a way that the patient is only "credited" with expenditures based on the understated "allowable" amount, rather than on the amount the patient has truly been responsible to pay out-of-pocket, the patient is harmed twice.

Financial harm to the patient is not the only damage caused by this scheme. First, the patient-physician relationship may be unfairly undermined, and physicians may be unfairly defamed if patients wrongly believe they have been overcharged. As Attorney General Cuomo found in his report, "The Consumer Reimbursement System is Code Blue," states:

The responsible consumer reads the plan documents and sees a thicket of words. One term seems intelligible: the "usual and customary rate" of a similar

¹2008 Kaiser/HRET Employer Health Benefits Survey.

physician for a similar service in a similar area. That sounds reasonable. The consumer makes the leap out of network and submits the bill to the insurer, only to be told the consumer will not be fully reimbursed because the doctor's charge exceeded the usual and customary rate. The fog of ignorance continues, thanks to the insurer. The physician-patient relationship is undermined, as the physician has been branded a charlatan whose bills are inflated.

Health Care Report, "The Consumer Reimbursement System is Code Blue," State of New York, Office of the Attorney General, January 13, 2009, which can be found at, http://www.oag.state.ny.us/bureaus/health_care/HIT2/reimbursement_rates.html.

Through the Litigation Center of the AMA and the State Medical Societies, the abusive practice is being eliminated. In 2000, the AMA was joined by the Medical Society of the State of New York, the Missouri State Medical Association and several other parties in initiating a class-action lawsuit against United Health Group for using skewed data to determine out-of-network payment rates. The AMA's lawsuit alleged that the Ingenix data was artificially reduced in the following ways:

- Inadequate data—The Ingenix database lacks information which is relevant to a physician's retail charges, such as the physician's training and qualifications, the type of facility where the service was provided, and the patient's condition.
- Corrupted data—Ingenix manipulates the database in numerous ways to reduce the charges, including but not necessarily limited to all of the following:
 - By deleting valid high charges and by deleting proportionately more high charges than low charges.
 - By deleting charges that have modifiers to indicate procedures or services with complications.
 - By failing to collect information affecting the value of the service, such as whether the service was performed by someone other than a physician.
 - By pooling data from dissimilar providers (such as nurses, physician assistants, and physicians) for use in the database.
 - By maintaining outdated information.
 - By commingling negotiated or discounted rates with retail charges.
 - By accepting data from contributors who had already deleted higher charges from the data they submitted.
 - By using defective data in the database and a deficient methodology to derive charges which are artificially low. For example, if Ingenix does not have a UCR rate for a particular geographic area, it will attempt to infer or derive the rate from other geographic areas. These derived charges, however, are faulty.
- Conflict of interest—Last, but certainly not least, the entire enterprise was permeated with conflicts of interest. All of the insurers that contributed data to the Ingenix UCR databases had a financial motive to manipulate it in ways that reduced the UCR charges.

A detailed description of one court's findings concerning the Ingenix databases and their shortcomings is available in Judge Hochberg's thoughtful decision approving a recent class action settlement on behalf of HealthNet patients of approximately \$250 million in *McCoy v. HealthNet*. See generally, 569 F. Supp. 2d 448 (D.N.J. 2008).

After nearly a decade of litigation, the AMA is very pleased that United Health Group recognized the importance of restoring its relationship with patients and physicians and is settling the AMA's lawsuit by agreeing to pay \$350 million toward reimbursing the patients and physicians it short-changed, and by confirming in Federal court its separate agreement with New York Attorney General Cuomo to end the use of this database and trust its repair and operation to a not-for-profit institution.

Indeed, evidence gathered during the course of this litigation was brought to the attention of New York Attorney General Cuomo. The AMA urged Attorney General Cuomo to investigate the abuses, and we are gratified that his office devoted such substantial resources to that effort. Attorney General Cuomo's report documenting that investigation, "Health Care Report—The Consumer Reimbursement System is Code Blue," does an excellent job of describing how the lack of transparency which characterizes the current health insurance payment system for out of network services works to disadvantage patients and their physicians, while benefiting the health insurance companies. The further specificity contained in Attorney General

Cuomo's Agreements of Discontinuance with individual health insurers, which document knowing practices by certain insurers to exacerbate the problems with the Ingenix databases by using out-dated versions of those databases is especially troubling, as is the finding in his report that one national payer has been paying the same rates for in-network and out-of-network care, despite charging higher premiums for the out-of-network benefit.

The AMA commends Attorney General Cuomo for successfully negotiating the transition of the UCR database from Ingenix to an independent, not-for-profit, and for his further success in gaining the commitment of virtually all of the health insurers that do business in New York to support that transition financially and with data going forward for the next 5 years.

Eliminating the long-standing underpayment of patients based on the faulty Ingenix database, these settlements will ensure that patients receive the benefit of the higher premiums they have paid to have out-of-network coverage. There will finally be an accurate, legitimate data warehouse compiling all physician billed charges for out-of-network services. The information from the newly created database will be available not only to payers but also to the public, including patients who are shopping for health insurance and those who are seeking medical services. This welcome transparency should go a long way toward resolving the issues with out-of-network coverage uncovered by the AMA lawsuit and confirmed by Attorney General Cuomo's investigative report and settlements.

We urge the Congress to ensure that everyone who was injured by this scheme, including Federal workers who may have been shortchanged on out-of-network benefits, are provided with reasonable compensation. We also urge the Congress to pursue health insurance payment transparency. The entire health insurance payment system is marked by complexity and confusion. This is graphically illustrated by the AMA's National Health Insurer Report Card, which provides objective measures of the claims processing activities of the major health insurers. See *attached*. The AMA believes enormous savings would accrue to patients, physicians, health insurers, and other third-party payers if there were complete transparency. Enhancement of the Health Insurance Portability and Accountability Act (HIPAA) standard transactions by the adoption of additional standards governing payment policies and additional enforcement of the existing standards, would also lead to dramatic efficiencies throughout the system.

The AMA appreciates the opportunity to provide our views to the Committee on these critical matters affecting the nations patients and physicians and we look forward to working with the Committee and Congress to ensure accurate and transparent health insurance payments.

2008 National Health Insurer Report Card

The purpose of the AMA's National Health Insurer Report Card (NHIRC) is to provide physicians and the general public a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying these claims. Billions of dollars in administrative waste would be eliminated each year if third-party payers sent a timely, accurate and specific response to each physician claim.

The NHIRC is for informational purposes only. Physicians and payers are encouraged to review the NHIRC results and begin healing the health care claims process by supporting the AMA's "Heal the Claims Process" campaign and committing to the goal of reducing the cost of claims administration to 1 percent of collections. Visit the AMA Practice Management Center Website at www.ama-assn.org/go/pmc for information on the "Heal the Claims Process" campaign.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
Payment Timeliness								
Metric 1 Payer claim received date disclosed	100%	99.21%	0%	100%	99.76%	0.07%	99.98%	99.99%
Metric 2 First remittance response time (median days)	13	7	14	4	11	13	10	14
Metric 3 ERA activity during the data period	Not Reported (NR)	NR	NR	NR	NR	NR	NR	NR
Accuracy								
Metric 4 Allowed amount disclosed	97.77%	97.37%	19.25	99.30%	65.72%	97.33%	93.40%	98.53%
Metric 5 Contracted payment rate adherence	70.78%	72.14%	66.23%	86.74%	NR	84.20%	61.55%	98.12%
Transparency of contracted fees and payment policies on payer Web sites								
Metric 6 Contracted fee schedule	No	Yes	No	No	No	Yes	Yes	Yes
Metric 7 Contract fee schedule codes allowed per request	0	25	0	0	0	30	30	All
Metric 8 Payer-proprietary claim edits	Yes ¹	Yes ¹	Yes ¹	No ³	Yes ¹	Yes ¹	Yes ¹	Yes
Metric 9 Medical payment policies	Yes ²	Yes ²	Yes ²	No	Yes ²	No	Yes ²	Yes

¹ At least some payer proprietary edits are available.

² At least some medical payment policies are available.

³ May not be applicable given that no payer-proprietary claim edits were identified by this analysis.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare						
Compliance with generally accepted pricing rules														
Metric 10 Percentage of claim lines reduced to \$0 by edits	3.75%	3.40%	7.33%	0.31%	NR	3.17%	9.15%	1.40%						
Metric 11* Source of payer claim edits														
CPT	1.4%	2.5%	0.6%	32.4%	NR	1.5%	4.5%	9.2%						
ASA	0.0%	0.0%	0.0%	0.0%	NR	0.0%	0.0%	2.6%						
NCCI	2.7%	50.4%	6.1%	50.0%	NR	9.2%	5.2%	19.0%						
Medicare reimbursement policies	41.8%	31.1%	92.9%	17.6%	NR	17.3%	57.3%	49.9%						
Payer-proprietary claim edits	54.1%	16.0%	0.4%	0.0%	NR	71.9%	33.0%	19.3%						
Denials (Payer allows the physician's billed charge, but payment is \$0)														
Metric 12 Percentages of claim lines denied	6.80%	4.62%	3.44%	2.88%	3.88%	2.90%	2.68%	6.85%						
Metric 13* Reason codes (Claim adjustment reason codes [CARC]) given for denials out of 190 available reason codes.	Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
	97	65.8%	16	20.1%	1	37.6%	28	53.6%	27	34.2%	27	37.9%	16	27.8%
	17	7.8%	27	14.9%	B11	17.0%	109	11.5%	109	14.2%	29	17.5%	50	20.9%
	1	6.8%	96	11.8%	96	13.7%	1	6.6%	99	9.7%	1	7.9%	109	13.8%
	other	19.6%	31	10.4%	18	5.7%	29	4.4%	16	9.4%	204	4.7%	96	8.5%
			204	8.9	38	5.5%	197	3.7%	96	5.9%	96	4.5%	31	5.8%
			1	7.7%	17	2.6%	160	3.1%	26	5.4%	51	3.0%	49	3.9%
			109	4.3%	other	17.8%	other	17.1%	38	4.9%	26	2.5%	other	19.3%
			29	3.7%					other	16.4%	49	2.5%		
			other	18.1%					other	19.6%				
Metric 14* Remark codes (RC) given for denials out of 675 available remark codes	Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%
	N19	62.4%	N197	16.1%	MA67	83.1%	N418	37.4%	N/A		N174	59.2%	N115	16.2%
	N130	16.2%	N4	11.4%	other	16.9%	N130	11.0%			M86	13.1%	M25	15.0%
	N102	8.5%	M81	11.3%			M127	9.2%			MA130	8.2%	N365	10.2%
	other	12.9%	N225	9.7%			N179	9.2%			other	19.5%	M27	8.0%
			N155	7.3%			N59	9.2%					N286	6.0%
			N179	6.7%			N29	8.6%					N285	4.5%
			M20	5.6%			other	15.3%					N269	4.4%
			M50	5.6%									N270	4.4%
			M51	5.6%									N290	4.2%
			M64	5.6%									M15	4.0%
			other	15.1%									M16	2.8%
													other	20.2%
The AMA NHIRC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic standard transactions. The technical references for these transactions are the electronic remittance advice (ERA) (HIPAA ASC X12 835 Health Care Claim Payment/Advice Transaction) submitted to a physician in response to the receipt of an electronic claim submission (HIPAA ASC X12 837 Health Care Claim—professional transactions).														
* may not total 100% due to rounding error														

2008 National Health Insurer Report Card—Complete Metrics

Payment Timeliness

Metric 1—Payer claim received date disclosed

Description: What percentage of time does the payer provide the date it received the claim (payer claim received date) in its electronic remittance advice (ERA) or explanation of benefits (EOB) response to the physician?

Metric 2—First remittance response time (median days)

Description: What is the median time period in days between the date the physician claim was received by the payer and the date the payer produced the first ERA or EOB? If a payer did not provide the payer claim received date, the most current date of service that was reported on the claim was used to perform the calculation, as noted in the disclaimer.

Metric 3—ERA activity during the data period (We have chosen not to report at this time)

Description: How many ERAs (one, two, three or more) does the physician receive for the same claim within the data period?

Accuracy

Metric 4—Allowed amount disclosed

Description: On what percentage of records (lines on claims) does the payer provide the physician contracted rate (allowed amount) in its ERA response to the physician?

Metric 5—Contracted payment rate adherence

Description: On what percentage of records does the payer’s allowed amount equal the contracted payment rate?

Transparency of Contracted Fees and Payment Policies on Payer Web Sites

Metric 6—Contracted fee schedule

Description: Is the physician’s contracted fee schedule (payer allowed amount) available on the payer’s Website?

Metric 7—Contract fee schedule codes allowed per request

Description: If the contracted fee schedule is available on the payer’s Website, how many procedure codes are available per request?

Metric 8—Availability of payer proprietary code edits

Description: If the payer uses proprietary code edits, are they available on the payer’s Website? Proprietary code edits are edits other than those found in one or more of the following: AMA Current Procedural Terminology¹ (CPT®), National Correct Coding Initiative (NCCI), Centers for Medicare and Medicaid Services (CMS) Publication 100–04 and the American Society of Anesthesia (ASA) Relative Value Guide.

Metric 9—Medical payment policies

Description: Are the payer’s medical payment policies available on its Website?

Compliance with Generally Accepted Pricing Rules

Metric 10—Percentage of claim lines (i.e., records) reduced by edits

Description: On what percentage of records does the payer apply a claim edit that reduces the payment (allowed amount) of the line to \$0?

Metric 11—Source of claim edits

Description: On what percentage of records is the source of the claim edit applied by the payer based on one or more of the following: CPT, NCCI, CMS Publication 100–04, ASA Relative Value Guide or payer proprietary edits?

Denials

Metric 12—Percentages of claim lines (i.e., records) denied

Description: What percentage of records submitted are denied by the payer for reasons other than a claim edit? A denial is defined as: allowed amount equal to the billed charge and the payment equals \$0.

Metric 13—Reason codes (Claim Adjusted Reason Codes [CARC]) given for denials*

Description: What are the most frequently reported reason codes for a denial?

Reason Code	Description	Effective Date	Modified Date
B9	Services not covered because the patient is enrolled in a Hospice.	1/1/1995	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
1	Deductible Amount.	1/1/1995	

¹ CPT is a registered trademark of the American Medical Association.

Reason Code	Description	Effective Date	Modified Date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	9/30/2007
18	Duplicate claim/service.	1/1/1995	
26	Expenses incurred prior to coverage.	1/1/1995	
27	Expenses incurred after coverage terminated.	1/1/1995	
29	The time limit for filing has expired.	1/1/1995	
31	Claim denied as patient cannot be identified as our insured.	1/1/1995	
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/1995	6/30/2003
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	
51	These are non-covered services because this is a pre-existing condition	1/1/1995	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	1/1/1995	10/31/2006
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/1995	
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. This change to be effective 4/1/2008: Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
197	Payment adjusted for absence of precertification/authorization.	10/31/2006	
204	This service/equipment/drug is not covered under patient's current benefit plan.	2/28/2007	

Metric 14—Remark codes given for denials

Description: What are the most frequently reported remark codes for a denial?

Remark Codes	Description	Effective Date	Modified Date
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1/1/1997	
M16	<i>Alert:</i> Please see our website, mailings, or bulletins for more details concerning this policy/procedure/decision.	1/1/1997	4/1/2007
M20	Missing/incomplete/invalid HCPCS.	1/1/1997	2/28/2003

Remark Codes	Description	Effective Date	Modified Date
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	1/1/1997	11/5/2007
M27	<i>Alert:</i> The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	1/1/1997	8/1/2007
M50	Missing/incomplete/invalid revenue code(s).	1/1/1997	2/28/2003
M51	Missing/incomplete/invalid procedure code(s).	1/1/1997	12/2/2004
M64	Missing/incomplete/invalid other diagnosis.	1/1/1997	2/28/2003
M81	Missing/incomplete/invalid provider/supplier signature.	1/1/1997	2/28/2003
M86	Service denied because payment already made for same/similar procedure within set timeframe.	1/1/1997	6/30/2003
M127	Missing patient medical record for this service.	1/1/1997	2/28/2003
MA67	Correction to a prior claim.	1/1/1997	
MA130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intra-ocular lens used.	1/1/1997	2/28/2003
N4	Missing/incomplete/invalid prior insurance carrier EOB.	1/1/2000	2/28/2003
N19	Procedure code incidental to primary procedure.	1/1/2000	
N29	Missing documentation/orders/notes/summary/report/chart.	1/1/2000	8/1/2005
N59	<i>Alert:</i> Please refer to your provider manual for additional program and provider information.	1/1/2000	4/1/2007
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	10/31/2001	
N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd , or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.	5/30/2002	4/1/2004
N130	Consult plan benefit documents for information about restrictions for this service.	10/31/2002	4/1/2007
N155	<i>Alert:</i> Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	10/31/2002	4/1/2007
N174	This is not a covered service/procedure/equipment/bed; however, patient liability is limited to amounts shown in the adjustments under group "PR."	2/28/2003	

Remark Codes	Description	Effective Date	Modified Date
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	2/28/2003	
N197	The subscriber must update insurance information directly with payer.	2/25/2003	
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	8/1/2004	8/1/2005
N269	Missing/incomplete/invalid other provider name.	12/2/2004	
N270	Missing/incomplete/invalid other provider primary identifier.	12/2/2004	
N285	Missing/incomplete/invalid referring provider name.	12/2/2004	
N286	Missing/incomplete/invalid referring provider primary identifier.	12/2/2004	
N290	Missing/incomplete/invalid rendering provider primary identifier.	12/2/2004	
N365	This procedure code is not payable. It is for reporting/information purposes only.	4/1/2006	
N418	Misrouted claim. See the payer's claim submission instructions.	8/1/2007	

The CHAIRMAN. Thank you, Dr. Nielsen.
Mr. Bell.

**STATEMENT OF CHUCK BELL, PROGRAMS DIRECTOR,
CONSUMERS UNION**

Mr. BELL. Mr. Chairman, Members of the Committee, thanks very much for the opportunity to testify on consumer reimbursement for health care services.

Consumers Union is the nonprofit, independent publisher of *Consumer Reports* magazine, with a circulation of 8 million readers, both print and online. And we regularly poll our readership and the public about key consumer issues, and the high cost of health care consistently ranks among their top concerns.

I work for Consumers Union's advocacy and public policy division in the New York office, where I've represented Consumers Union's positions on health care issues for the last 19 years in the Northeastern States on issues relating to health insurance, prescription drugs, patient safety, and restructuring of nonprofit health plans in hospitals.

I think, as all of us are painfully aware, health insurance costs for employers are going up at a very steep rate. But, in addition to that, they're going up a lot for consumers, too, and consumers are having to dig a lot deeper to pay for health care.

The average employee contribution for company-provided health insurance has increased more than 120 percent since 2000, and for consumers and employer-provided plans, average out-of-pocket costs for deductibles, co-payments for drugs, and coinsurance for physician and hospital visits have also risen 115 percent since 2000. So, this is the context. And in the midst of this escalating crisis of out-of-pocket costs, consumers have been struggling with a gravely flawed out-of-network reimbursement system, which has been described here today.

And the scale of the issue is huge. Over 110 million Americans, roughly one in three consumers, are covered by health insurance

plans which provide an out-of-network option, and that's—including about 70 percent of people who have employer-sponsored coverage.

So, as a national organization that represents consumers, we emphatically agree with Attorney General Cuomo's conclusion that the structure of the out-of-network reimbursement system is broken. We believe that it needs to be rebuilt from the ground up so that consumers will be assured of being reimbursed fairly, and that there will be appropriate public oversight and accountability for collection of data regarding physician and provider charges.

This investigation, as you've heard, has exposed a swamp of financial shenanigans, and has now reached a critical juncture. We believe that we need coordinated action by State and Federal policymakers and regulators to help consolidate the investigation's gains and ensure that the new database for calculating out-of-network charges will be broadly used across the entire marketplace.

Some of the implications of the investigation that we think are important are the following:

First, we think that regulators need to hold insurance companies accountable to their contractual promises on an ongoing basis. Consumers clearly have the right to expect that their health insurance policies will pay the bills that they are legally obligated to pay.

Everyone can easily agree that insurance companies should not engage in deceptive and unfair practices against consumers, but there's nothing automatic about that process. It takes sustained effort and political will to achieve the vigorous comprehensive enforcement of State and Federal insurance and consumer-protection laws and regulation.

And in this case, the technical nature of the subject matter and the obscure veiled nature of the Ingenix database resulted in a persistent ripoff that took far too many years to rein in.

Attorney General Cuomo, to his great credit, plunged in and—as soon as he learned about the problem, and drove hard to get a consumer-friendly solution, but it—I think this case raises some troubling questions about why financial ripoffs like this one persist in the marketplace for so many years without effective intervention at the State or Federal level. Why didn't the alarms go off earlier about these unfair practices?

So, we believe that oversight of the insurance industry can be tightened up at the State level by more intervention by attorneys general and insurance commissioners, and by establishing independent offices of insurance consumer advocates.

Second, we think consumers do need a trusted system that they can rely on to ensure that the UCR rates will be calculated for out-of-network reimbursements, and that they'll be accurate and up to date. We believe the independent databases proposed by Attorney General Cuomo will have great benefits and give consumers a fix on what their reimbursements will be.

We believe, also, that the insurance regulation that's being proposed in the State of New York to apply to all insurers in our State, and basically encourage them to use an independent source for this data, will be a very popular regulation, and it will be quickly adopted. But, it still begs the question—consumers need protection across the entire country on these issues, and we really hope that the regulation will be adopted as a model by the NAIC, or per-

haps the Federal Government could set some minimum standards in this area.

We also would note that Attorney General Cuomo's done a fabulous job in lining up some of the largest insurers in the country to support the settlements, but there are still many other insurance companies around the country, particularly State and regional companies, that use data from the Ingenix databases, who have—do not have operations in New York State, and have not been reached by this investigation. So, they have not necessarily halted their use of the Ingenix database or notified consumers of its shortcomings. And so, we would therefore urge 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 to seek possible remedies or solutions for halting this practice.

The New York investigation suggests that tens of millions of consumers have been directly hurt by industry practices that led to the underpayment of their health insurance bills. And at this point, nobody can say for sure exactly how much consumers were underpaid as a result of the broken out-of-network reimbursement system, but we believe that the financial damage sustained by consumers is clearly very substantial. We know it runs at least into the hundreds of millions of dollars.

Finally, for the health care system to function effectively, we need strong ongoing financial accountability and oversight. We believe that this important reform of the out-of-network system prefigures much larger changes that we need to make as a country to ensure transparency and accountability in the health care system. Consumers need more and better information about the costs of medical procedures and treatments, and their therapeutic benefits, to ensure that we're getting good value for the precious dollars that we spend.

Mr. Chairman and Members of the Committee, thank you very much for your efforts to assure appropriate Federal oversight of consumer reimbursement issues. We look very much—to working with you to shape solutions on this area, and to help transform the health care system in the United States.

Thanks very much for considering our views.

[The prepared statement of Mr. Bell follows:]

PREPARED STATEMENT OF CHARLES BELL, PROGRAMS DIRECTOR, CONSUMERS UNION

Introduction

Mr. Chairman, Members of the Committee:

Thank you very much for the invitation to testify on the issue consumer reimbursement for health care services. We commend you for holding this hearing to focus attention on issues related to consumer reimbursement and consumer protection in health insurance.

Consumers Union¹ is the independent, non-profit publisher of *Consumer Reports*, with circulation of about 7 million (*Consumer Reports* plus *ConsumerReports.org*)

¹Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

subscribers). We regularly poll our readership and the public about key consumer issues, and the high cost of health care consistently ranks among their top concerns.

I work in Consumers Union's advocacy and public policy division, where I have represented Consumers Union's positions on health care issues for the last 19 years in the Northeastern states on issues relating to health insurance, prescription drugs, patient safety and the restructuring of nonprofit health plans and hospitals. I also serve on the steering committee of New Yorkers for Accessible Health Coverage, a statewide organization representing consumers with chronic illnesses and disabilities.

Consumers Face A Growing Financial Burden for Health Care—Especially for Out-of-Pocket Costs

The financial burdens on consumers related to health care have been steadily increasing over the last 15 to 20 years. As the Committee is no doubt painfully aware, the cost of health insurance has increased dramatically in recent years. Consumers are both paying more in premiums, AND shouldering a higher burden for out-of-pocket expenses, including deductibles, co-payments and other expenses not covered by their health insurance.

According to the Kaiser Family Foundation, the cumulative growth in health insurance premiums between 1999 and 2008 was 119 percent, compared with cumulative inflation of 29 percent and cumulative wage growth of 34 percent. The rapid growth in overall premium levels means that both employers and workers are paying much higher amounts than they did a few years ago.

Policymakers and the media often focus on the economic challenges posed by high cost of rising health insurance premiums for employers—and that is absolutely appropriate. But a lot of money comes directly out of the consumer's pocket as well. *The average employee contribution to company-provided health insurance has increased more than 120 percent since 2000.*

Consumers are also paying significantly more for out-of-pocket health expenses. For consumers in employer-sponsored plans, average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits have risen 115 percent since 2000. Consumers who buy their own coverage also have high out-of-pocket expenses.

As result of these trends, health expenses are taking up a rising share of family income. *30 percent of insured consumers spent 10 percent or more of their incomes annually on out-of-pocket costs and premiums in 2007, compared to 19 percent in 2001, according to a recent report from the Commonwealth Fund.*

The steady, accelerating shift of costs to individuals and families results both in financial stress and increasing financial barriers to needed care. In 2007, more than 40 percent of working age adults in the U.S. had difficulty paying medical bills or accumulated medical debt last year, compared with about 33 percent in 2005, according a study by the Commonwealth Fund. The Fund also reports that “an increasing number of adults who are insured have such high out-of-pocket costs relative to their income that they are effectively ‘underinsured.’”

Consumers Confront Serious Problems in Obtaining Fair Out-Of-Network Reimbursement

In the midst of this escalating crisis of out-of-pocket costs, consumers have also been forced to contend with a gravely-flawed out-of-network reimbursement system. According to a recent investigation by New York Attorney General Andrew Cuomo, and recent settlements with some the Nation's largest insurance carriers, it now appears that consumers may have been underpaid for their out-of-network reimbursements by hundreds of millions of dollars. The databases used to calculate out-of-network reimbursements are riddled with serious data quality problems and massive financial conflicts of interest.

Over the last several years, Consumers Union has become increasingly concerned about consumer problems in obtaining fair, appropriate and timely reimbursement for out-of-network health services. These problems came to our attention as a result of consumer complaints, concerns expressed by physicians and employers, reports in the news media, and litigation.

In particular, in New York state, we were aware that the American Medical Association, the Medical Society of the State of New York, other state medical societies, New York State United Teachers, Civil Service Employees Association (CSEA), other public employee unions and other consumer plaintiffs had sued UnitedHealth Group in 2000, alleging that they were being systematically shortchanged regarding out-of-network payments. From a consumer point of view, the implications of the lawsuit were potentially very significant, because over 1 million public employees

in New York state are covered by the Empire Plan, which is insured by UnitedHealth Group, one of the Nation's largest for-profit insurance companies.

We were therefore very pleased when Attorney General Andrew Cuomo initiated a national investigation of problems relating to out-of-network charges in February, 2008. The methods used by insurance companies to calculate "usual, customary and reasonable" rates (also known as UCR rates) have long been obscure and mysterious to consumers. It was not easy for consumers to verify the basis of the alleged UCR rates, or to contest perceived underpayments. Companies are supposed to disclose the details of how they calculate these charges upon request. But in practice many consumers found it difficult to find out how the charges are calculated, and what they are based on.

Over 110 million Americans—roughly one in three consumers—are covered by health insurance plans which provide an out-of-network option, such as Preferred Provider Organizations (PPOs) and Point of Service (POS) plans. This includes approximately 70 percent of consumers who have employer-sponsored health coverage.

Consumers and employers often pay higher premiums to participate in an out-of-network insurance plan, because it gives patients greater flexibility in seeking care from doctors, specialists and providers who are not in a closed health plan network. In most out-of-network plans, the insurer agrees to pay a fixed percentage of the "usual, customary and reasonable" rate for the service (typically 80 percent of the rate), which is supposed to be a fair reflection of the market rate for that service in a geographic area. Because the health plan does not have a contract with the out-of-network doctor or provider, the consumer is financially responsible for paying the balance of the bill—whatever the insurance company doesn't pay. By law, the provider may pursue the consumer for the entire amount of the payment, regardless of how little or how much the insurer reimburses the consumer.

Even if UCR charges were calculated accurately, consumers could still experience "sticker shock" when they get the medical bills for out-of-network care. Why? They may not understand that the insurance company didn't agree to pay 80 percent of the doctor's bill—they only agreed to pay 80 percent of "usual and customary" rate, which is an average of charges in a geographic area. For example, suppose a patient went to visit the doctor for a physical, and charged \$200. 80 percent of \$200 is \$160. But if an impartial and accurate calculation of "usual and customary rate" shows that what other comparable doctors charge for physicals is an average of \$160, the insurance company would only pay \$128, or 80 percent of \$160. The consumer would be responsible for paying the balance of \$72.

The key problem with the out-of-network reimbursement system is that the UCR rates were not calculated in a fair and impartial way. For the last 10 years or so, the primary databases that are used by insurers to determine "usual, customary and reasonable" rates have been owned by Ingenix, a wholly-owned subsidiary of UnitedHealth Group. Ingenix operates a very large repository of commercial medical billing data, and prepares billing schedules that are used to calculate the market price of provider health services. In 1998, Ingenix purchased the Prevailing Healthcare Charges System (PHCS), a database that was first developed by the Health Insurance Association of America, an insurance industry trade association, beginning in 1974. Also in 1997, Ingenix purchased Medical Data Research and a customized Fee Analyzer from Medicode, a Utah-based health care company.

Thanks to Attorney General Cuomo's investigation, however, we now know that there were serious problems with the Ingenix database that appear to have consistently led to patients paying more, and insurers paying less.

In January, 2009, Attorney General Cuomo announced key findings from his office's investigation regarding the out-of-network reimbursement system:

- According to an independent analysis of over 1 million billing records in New York state carried out by the Attorney General, the Ingenix databases understate the market rate for physician visits by rates ranging from 10 to 28 percent across New York state. Consumers got much less than the promised UCR rate, so that instead of getting reimbursed for 80 percent of the UCR charge, they effectively got 70 percent, 60 percent or less. Given the very large number of consumers in out-of-network plans—110 million—this translates into hundreds of millions of dollars in losses over the last 10 years for consumers around the country.
- Ingenix has a serious financial conflict of interest in owning and operating the Ingenix databases in connection with determining reimbursement rates. Ingenix is not an independent database—it is wholly-owned by UnitedHealth Group, Inc. It receives billing data from many insurers and in turn furnishes data back to them, including to its own parent company, UnitedHealth. UnitedHealth had a financial incentive to understate the UCR rates it provided to its own affili-

ates, and other health insurers also had an incentive to manipulate the data they submit to Ingenix so as to depress reimbursement rates.

- In general, there is no easy way for consumers to find out what the UCR rates are before visiting a medical provider. The Attorney General characterized Ingenix as a “black box” for consumers, who could not easily find out what level of reimbursement they would receive when selecting a provider. When they received a bill for out-of-network services, consumers weren’t sure if the insurance company was underpaying them, or whether the physician was overcharging them.
- As an example of the lack of transparency, when UnitedHealth members complained their medical costs were unfairly high, the United hid its connection to Ingenix by claiming the UCR rate was the product of “independent research.”
- The Ingenix database had a range of serious data problems, including faulty data collection, outdated information, improper pooling of dissimilar charges, and failure to conduct regular audits of the billing data submitted by insurers.

As a result of Attorney General Cuomo’s investigation, on January 13, UnitedHealth agreed to close the 2 databases operated by Ingenix, and pay \$50 million to a qualified nonprofit organization that will establish a new, independent database to help determine fair out-of-network reimbursement rates for consumers throughout the U.S.

As a central result of his investigation, Attorney General Cuomo wisely concluded that:

“ . . . the structure of the out-of-network reimbursement system is broken. The system that is meant to reimburse consumers fairly as a reflection of the market is instead wholly owned and operated by the [insurance] industry. The determination of out-of-network rates is an industry-wide problem and accordingly needs an industry-wide solution.

Consumers require an independent database to reflect true market-rate information, rather than a database owned and operated by an insurance company. A viable alternative that provides rates fairly reflecting the market based on reliable data should be set up to solve this problem . . . Consumers should be able to find out the rate of reimbursement before they decide to go out of network, and they should be able to find out the purchase price before they shop for insurance policies or for out-of-network care.”

While UnitedHealth did not acknowledge any wrongdoing in the settlement, its agreement with the New York Attorney General ended the role of Ingenix in calculating UCR charges, and created a new national framework for a fair solution. In fact, in a press release announcing the settlement, Thomas L. Strickland, Executive Vice President and Chief Legal Officer of UnitedHealth Group, expressed strong support for a nonprofit database to maintain a national repository of medical billing information:

“We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy. We are pleased that a not-for-profit entity will play this important role for the marketplace.”

Shortly after settling with the Attorney General’s office, UnitedHealth also settled the lawsuit brought by the AMA and Medical Society of the State of New York, other physician groups, unions and consumer plaintiffs for \$350 million, the largest insurance cash settlement in U.S. history. As sought by MMSNY and the other physician groups, United also agreed to reform the way that out-of-network charges were calculated.

Since January, nine other insurers with operations in New York state, including huge national insurers such as Wellpoint, Aetna and Cigna, have also agreed to stop using data furnished by Ingenix, and to contribute funds in support of the new nonprofit database. The leaders of other insurance companies have also expressed support for a new nonprofit database to increase transparency and reduce conflicts of interest, and pledged to use the database when it becomes available. Two insurance companies agreed to also reprocess claims from consumers who believe they were underpaid for their out-of-network charges.

All told, the Attorney General has now collected over \$94 million to support the new independent database, which will be based at a university in New York state.

Implications of the New York State Investigation

From a consumer point of view, Attorney General Cuomo’s intervention has been extremely helpful for consumers in New York state and across the U.S. This inves-

tigation squarely exposed the problems resulting in underpayment of consumers and physicians, and created a sweeping new framework for a national solution. The plan set out in the agreements reached by Attorney General Cuomo will help bring comprehensive, sweeping reform to the out-of-network reimbursement system.

The investigation has exposed a swamp of financial shenanigans, and now reached a critical juncture. Consumers Union is calling for coordinated action by state and Federal policymakers and regulators to help to consolidate the investigation's gains, and ensure that the new database for calculating out-of-network charges will be broadly used across the entire marketplace.

First, regulators need to hold insurance companies accountable to their contractual promises, on an ongoing basis. Consumers clearly have the right to expect that their health insurance policies will pay the bills that they are legally obligated to pay. We rely on the promises our insurance companies make in their contracts, and we expect the provisions of those contracts to be enforced by regulators and the courts. If your policy says it will pay you 80 percent of the "usual and customary" charge for a medical service, it should pay that amount.

To enforce this principle in New York state, Attorney General Cuomo used his authority under New York's General Business Law §349 and §350, which prohibits deceptive acts and practices against consumers, to bring the insurance industry into compliance in New York state, as well as sections of the insurance law and the common law. Other states have similar laws, and they should be appropriately used when needed to prevent egregious consumer ripoffs.

Everyone can easily agree that insurance companies should not engage in deceptive or unfair practices against consumers. But the reality is that it takes sustained effort and political will to achieve the vigorous, comprehensive enforcement of state and Federal insurance and consumer protection laws and regulations. In this case, the technical nature of the subject matter, and the obscure, veiled nature of the Ingenix database, resulted in a persisting ripoff that unfortunately took far too many years to rein in.

To his great credit, Attorney General Cuomo stepped in quickly upon learning about the problem, and drove hard to achieve a consumer-friendly solution. At the same time, this case raises some troubling questions about why financial ripoffs persist in the marketplace for many years without effective intervention at the state or Federal level. Why didn't the alarms go off earlier about unfair practices that created very large financial losses for consumers?

In the future, we hope that Attorneys General and Insurance Commissioners—as well as Members of Congress—will step up and act quickly to prevent financial abuses of health insurance consumers, and coordinate their work where lines of jurisdiction are unclear. In New York, the state Attorney General's health bureau served as a early warning system to monitor consumer problems, and intervene when things were going wrong.

Attorneys General around the country maintain similar units, and some even have the power to intervene before government when insurance rates are established. A few other states have established an "Office of Public Insurance Counsel" or independent consumer advocate to fulfill a similar function. But in many states, consumers with insurance problems have little recourse, and consumer problems in getting fair reimbursement are not routinely investigated or publicized. Consumers Union and other consumer groups support expansion of Attorney General health care oversight, and the establishment of independent consumer advocates in every state.

Second, consumers need a trusted system they can rely on to ensure that the UCR rates calculated for out-of-network reimbursements are accurate and up-to-date. By establishing a new nonprofit organization to maintain the database on "usual and customary charges," the New York Attorney General's agreements help assure those charges will be calculated and maintained in a fair, up-to-date and transparent way, free from financial conflicts of interest. Consumers will be able to obtain up-to-date information on usual and customary charges through a national, free website, and have a good fix on what their potential reimbursements will be when they visit physicians and other health care providers.

In New York, the Attorney General is developing a state insurance regulation which will require health insurers who utilize UCR databases to ensure that they are fair, accurate, free from conflicts of interest and transparent to consumers. We expect that such a regulation will be very popular and will quickly be adopted in New York state.

However, because this is a national problem, there is still a huge need for a national or 50-state solution, to ensure that the out-of-network reimbursement system is fixed for ALL U.S. consumers. A regulation based on the New York model could potentially be adopted as a model by the National Association of Insurance Commis-

sioners, or otherwise codified into law at the state and Federal level. It could also be enacted as part of overall Federal health reform legislation.

Third, by arranging for some of the largest health insurers in the country to support the new database, Attorney General Cuomo has paved the way for a comprehensive national resolution of these issues. We would note, however, 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.

Fourth, as mentioned above, the New York investigation suggests that tens of millions of consumers have been directly hurt by industry practices that led to underpayment of their health insurance bills. At this point, no one can say for sure how much consumers were underpaid as a result of the broken out-of-network reimbursement system. But the financial damage sustained by consumers is clearly substantial.

There are few things that are more frustrating in life than getting shortchanged on your medical expenses by your health insurance company. We expect consumers across the country will be very concerned about the issues in this case, and where they have been shortchanged, would want to be fairly compensated by their insurer.

Fifth, consumers know that for the health care system to function effectively, we need strong, ongoing financial accountability and oversight. We believe that the proposed reform of the out-of-network reimbursement prefigures much larger changes we need to ensure transparency and accountability in the health care system. Consumers need more and better information about the cost of medical procedures and treatments, and their therapeutic benefits, to ensure we're getting good value for the precious dollars we spend. As mentioned above, health care costs are skyrocketing. Consumers want very much to get better value for our dollars, to ensure that when we visit a physician or provider, that we will get safe, appropriate, quality health care, that is based on the best medical evidence that is available.

In the case of the proposed new nonprofit database for out-of-network charges, Consumers Union is pleased to see that it will be specifically developed to be an independent database that is protected from financial conflicts of interest. The architecture of the health care system must specifically incorporate safeguards that protect against inappropriate bias or financial influence from insurance companies or others operating in the commercial marketplace. We also believe that this new non-commercial database can help to create much greater transparency regarding physician and provider fees, and be an important resource for medical researchers and others who are working to improve the quality, safety and affordability of care for consumers.

Conclusion

Mr. Chairman, Members of the Committee, the problem of ensuring effective state and Federal oversight of consumer reimbursement for health care services calls out for your prompt attention. We look forward to working with you to shape solutions that will assure that the United States rises to the challenge of transforming our health care system so that we are no longer at risk of facing financial hardship or financial barriers to care just when we need care the most. Thank you very much for considering our views.

The CHAIRMAN. Thank you very much, Mr. Bell.

I should have said at the beginning that all statements are automatically included in the record, so—you just sort of gave yours, but if you have something written, it goes in, Dr. Nielsen. So, that—

Dr. NIELSEN. Yes.

The CHAIRMAN. That's our practice.

Dr. NIELSEN. Yes.

The CHAIRMAN. Ms. Laceywell, I'd like to start with you. In January, your office issued a report that discussed some of the findings from your investigation. In your report, on page 20, there is a

table, which I believe people have, now, before them, do they not? And I would like to ask you about it.

[The information referred to follows:]

Payments for Doctor Visits
Erie County, NY (2007)

Doctor Office Visit Codes	Ingenix "usual and customary" Reimbursement Rate	NYAG Estimate of Prevailing Cost	Difference (%)
99211	\$36–\$37	\$45	18–20%
99212	\$53–\$61	\$68	10–22%
99213	\$70–\$78	\$84	7–17%
99214	\$105–\$122	\$130	6–19%
99215	\$145–\$182	\$200	9–28%
99245	\$276–\$340	\$373	9–26%

Source: State of New York, Office of the Attorney General, *Health Care Report: The Consumer Reimbursement System is Code Blue* (Jan. 13 2009), 20.

It's a table that lays out the Ingenix reimbursement rates for out-of-network doctor visits in Erie County. In Erie County, where you live, right?

Ms. LACEWELL. That's correct.

The CHAIRMAN. And I'd like to give you a copy—or, you now have one. The first column contains the various billing codes that doctors cover—that cover doctor visits. And they're simply—don't get too hung up on them, they just say what was the—what was being treated, what was the subject at hand. And the second column presents the range of "usual and customary" reimbursements, as calculated by Ingenix.

Now, here's where it gets interesting. It's my understanding, Ms. Lacewell, that you and your staff went back and gathered the insurance claims data for Erie County—just Erie County—and performed your own calculation of the prevailing wages for doctor visits in the area. Is that correct?

Ms. LACEWELL. Yes, that's correct, Mr. Chairman.

The CHAIRMAN. The third and fourth columns of the chart show that the numbers you came up with indicate that the insurance industry's reimbursement rates, as now calculated by Ingenix, were anywhere from 10 to 25 percent lower than what the doctors were actually charging their patients in this area. Is that correct?

Ms. LACEWELL. Yes, sir, that's correct.

The CHAIRMAN. So, let's take an example from this table. If a doctor in Buffalo is charging \$84 for an office visit, but the insurance company is only paying \$74 for that visit, consumers get stuck paying the \$10 balance themselves, correct?

Ms. LACEWELL. That's right.

The CHAIRMAN. Ten dollars doesn't sound like a lot of money, but if you have a lot of—you know, you just have a lot of doctor's visits, and you multiply this throughout the population, it escalates rapidly into millions or hundreds of millions of dollars. And they're—the customers are paying it out of their own pockets, and they shouldn't be.

So, Ms. Lacewell, correct me if I'm wrong here, but doesn't this table show that families in Erie County are being stuck with the

millions of dollars of health care costs that should be paid for by the insurance companies?

Ms. LACEWELL. Yes, Mr. Chairman, that's exactly what it shows.

The CHAIRMAN. How did the health insurance companies react when you showed them this data? Your data.

Ms. LACEWELL. They settled.

[Laughter.]

The CHAIRMAN. But, what did they do before they settled. I mean, people don't just sort of settle on the spot.

Ms. LACEWELL. That's right, Mr. Chairman. The reason that we conducted this analysis is because many of the insurers said to us, "Well, you say it's a conflict of interest. It's hypothetical. Show me the database is wrong. Show me I owe money." So, we collected billing information and put this together and demonstrated to them that there was a difference in what they were paying, based on Ingenix. And for insurers that didn't have a clear window, themselves, into the Ingenix data, it was actually useful for them, because some seemed more inclined to settle if they could be shown this kind of information. For others, who were more obstinate, it sort of left them less of a choice, in our view. But, they did not have any explanation. They said, "Well, if there are errors in the database that are leading to under-reimbursement, they're just errors, there's no intent." And our response was that the error was always in favor of the insurer and against the consumer.

The CHAIRMAN. Wouldn't, sometimes, they just cut 50 percent right off the top?

Ms. LACEWELL. They would cut a percentage off the top, which is important, because if you're talking about a prevailing rate, it's what most doctors charge. So, if you throw out charges at the high end, that's going to depress the reimbursement rate.

The CHAIRMAN. Now, let me turn to you, Dr. Nielsen. You're from Buffalo. You've practiced medicine there for many years. Are you surprised to learn that the insurance companies' industry reimbursement rates for your visits in your community are 10 to 25 percent lower than the actual market rate?

Dr. NIELSEN. We were surprised to know exactly how low, because—you might wonder why we didn't do what the Attorney General's office did, and collect that data. And it's very clear. It's because of concerns about antitrust enforcement. Doctors are not allowed to talk to other doctors about fees. It does sound crazy. So, we knew that the underpayment was occurring. That's why we filed this lawsuit, back in 2000. We didn't know the magnitude of it. We knew it from the doctors who came forward. But, the pervasive nature of it is amazing.

And if you look—if you look at the numbers, those numbers correlate very well with another suit that was settled in the State of New Jersey with Health Net. And there, it appears that, on exactly the same issue, the Ingenix database underpayment and the rigging, and the numbers of—the amount of underpayment was, in the settlement, estimated to be between 14 and 28 percent. And that winds up very well with this third column that you're seeing.

The CHAIRMAN. My final point, before going to Senator McCaskill, is that—you know, make what comparisons you want, but Erie County, New York, any county—West Virginia—you find a lot of

parallels, a lot of people trying to make it, not being able to make it, insufficient health insurance, every \$10 counts, every \$25 counts. You add them up, it makes an enormous amount of difference. The thing that's hardest to understand about this practice is that the insurance companies, had they behaved as they should have, would have still been making an enormous amount of money. Is that correct?

Ms. LACEWELL. That's correct.

The CHAIRMAN. I think it's inexcusable. I'm glad this practice has been exposed and that we're beginning to correct it.

I have one final question for you. You settled, and it became very reasonable, because, you said, like dominos, everybody else began to do that. Now, you're going to have to prove that to me, because—I don't know why you didn't go after them for fraud. Or maybe you did, and that's why they settled.

Ms. LACEWELL. Well, we alleged to them—and we had to threaten to sue some of them under our consumer fraud and deceptive practices statutes. And we gave them the option of litigating and defending against a fraud lawsuit or signing onto the reform practice and stepping away from this deceptive system and moving toward a new system of reform. And the insurers that operate in the State of New York chose to join onto reform.

The CHAIRMAN. But, what's important to me is, you were prepared to go the fraud route, and they knew it.

Ms. LACEWELL. That's right.

The CHAIRMAN. I thank you.
Senator McCaskill?

**STATEMENT OF HON. CLAIRE MCCASKILL,
U.S. SENATOR FROM MISSOURI**

Senator MCCASKILL. First, let me say, for the record, that I'm a big fan of Andrew Cuomo. And I don't mean, by the comments I'm about to make, that I want to diminish his accomplishments as a crusader on behalf of consumers. But, I think it's important to point out for the record that this journey began with a lawsuit that was filed. And I find it a little ironic that the Missouri Medical Association and the AMA turned to America's trial lawyers to right a wrong as it related to the way they were being reimbursed. Because generally when I'm speaking to the members of the Missouri Medical Association, they're explaining to me that Missouri's trial lawyers are nothing short of Satan and that they are the evil that has cast such problems upon the practice of medicine that it makes it impossible for doctors to do their work.

So, I wanted the record to show that the AMA turned, in fact, to a class-action lawsuit handled by trial lawyers. And the reason that it had not been settled by the time that Andrew Cuomo took office, some 7 years after the lawsuit had been filed, was because the defendants in that lawsuit refused to acknowledge the proof that those trial lawyers were willing to show the court, and they were delaying and delaying and bumping up the costs of that lawsuit for UnitedHealthcare and for the defendants in that lawsuit. And had UnitedHealthcare taken cognizance of the facts that those trial lawyers had brought to the court, and immediately capitulated and admitted that they had this collusive system of data that was

flawed, we wouldn't have had to rely on Andrew Cuomo to come to the rescue.

Dr. Nielsen?

Dr. NIELSEN. You bet. We don't hate all lawyers. We just haven't had remarkable luck with the trial bar, as you know. The issue here was the facts, unearthing the facts, and having enough persuasive muscle to make sure that the flawed database was exposed. And it took the muscle of the people's lawyer. And so, it did take a lawyer. It took the people's lawyer. We are grateful for that. We are also grateful for the help that we had from the attorneys. And sometimes things lie aborning in the courts because of other reasons, other than the skill of the attorneys.

Senator MCCASKILL. I think that's—you know, I appreciate that. And I don't mean to—you know, to pick on you. I—but, I do think it's important to note that, even the American Medical Association, when they need a justice to be addressed, turn to America's trial lawyers to try to get into court and fix a problem. And that's why America's trial lawyers are so important to our system of justice in this country. And I just wanted to point that out.

Now, let me ask you, Dr. Nielsen, do the doctors generally agree to take the reduced rate for the out-of-network payment from the consumer? And is this difference in payment one that the consumer is generally going on the line for, or is there a general—I know there have been times in my life that I believe that my doctors have taken a reduced rate for an out-of-service medical charge.

Dr. NIELSEN. Some do.

Senator MCCASKILL. Out-of-network, I mean.

Dr. NIELSEN. Some do. They don't have to, of course. What should be—what should happen is, the patient going out of network should have access to the information as to what they will pay. Just as you heard from the consumer, the patient who was unable to be here today; she thought she knew what she was going to owe. She knew what the charge was.

Senator MCCASKILL. Right.

Dr. NIELSEN. The problem wasn't the charge. The problem was the amount of reimbursement from the insurer, which left her holding the rest.

Some doctors do negotiate lower fees when the patient is left holding the bag. Some do not. Some give uncompensated care, as you know—

Senator MCCASKILL. Right.

Dr. NIELSEN.—70 percent of doctors give uncompensated care to patients who have no insurance.

But, this is different. This is a situation of a promise made and a contract between a health insurance plan and a consumer. And the promise wasn't kept.

Senator MCCASKILL. Do—how does the UCR rate compare to the Medicare rate, generally speaking? Can you speak to that? Can any of the witnesses speak to that? How far off is the Medicare rate for reimbursement to doctors from the UCR rate that this data—the phony data was supporting?

Ms. LACEWELL. Senator, we did look at that issue, and we found that typically the Medicare rate is much lower, and, of course, we believe this is one of the reasons why insurers charge a higher pre-

mium for the structure of this out-of-network system, because the insurer's saying, "It's going to cost me more. I'm going to pass on a little more of the cost to you." And we think it's important that the consumer get the benefit of that bargain, because if the insurer's taking a little bit more, they shouldn't be holding on to that and not complying with their obligations.

Senator MCCASKILL. Well, once again, that fact underlies our desperate need for health care reform in this country, because if the Medicare rate has been lower than the UCR rate, that we now know was artificially too low, then therein you see all the kinds of incentives in the system to try to game it in order for doctors to come out whole at the end of the day. So, I think that's important.

Final question. Was there any evidence of collusion that you all saw between these insurance companies as this data company was bought by UnitedHealthcare? Did all the other insurance companies know that this was now becoming their's—that they were going to own this and it wasn't going to be independent and it wasn't going to be audited, or there wasn't going to be any oversight of it?

Ms. LACEWELL. We believe that the insurers that use the Ingenix system were aware of Ingenix's relationship with UnitedHealth Group, and they were aware that, once Ingenix and United bought up the competitors, that there was nothing else in the marketplace. And we believe that they were content with that, because it was a system that worked for all of them, collectively. It was the consumers who were not aware of this.

Senator MCCASKILL. OK. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator McCaskill.

Senator Udall, to be followed by Senator Lautenberg.

**STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO**

Senator UDALL. Thank you, Chairman Rockefeller. And I want to congratulate you for holding this hearing today. I think it's a very important topic that you're highlighting. It impacts my State of New Mexico.

And I'd like to also say that the Senator from Missouri, I think, raised a very interesting question, here, the AMA hiring trial lawyers to bring justice to a situation, and I hope that that portends a rapprochement, or something like that, between the trial lawyers and the AMA, so that you can step forward and offer proposals for reasonable reform in the malpractice area. This is an exciting opportunity, I think, here for you.

But, Dr. Nielsen, the "double harm" you cite in your testimony, where the patient actually ends up paying more than the fees outlined in her network of benefits, speaks to a current situation in my home State of New Mexico. Recently, industry interests have pushed for the right to form exclusive PPOs, something New Mexico's Medical Society opposes. In terms of timely access to health care, do exclusive PPO plans pose another kind of double-harm threat for consumers? And, in your estimation, is the push for exclusive PPOs cause for concern, given the Attorney General's findings from the UnitedHealthcare settlement?

Dr. NIELSEN. You'll need to educate me about what's happening in New Mexico, because when you say an "exclusive PPO," are you talking about a restricted network?

Senator UDALL. That's right. That's right.

Dr. NIELSEN. That is not new. That is not new. That's been around a long time. They've been done under the HMO umbrella. They've been done under—even a point-of-service sometimes has an exclusive extended network.

The problem there is that the balance of power between an insurer and a physician, there is no comparison between the imbalance of power, particularly if that insurer is one of the large ones that services many employers in that State. We saw this in Nevada, for example, when one company bought up another health insurance company.

So, it is a problem, because then sometimes insurers say to the doctors, "Take it or leave it." It's then up to the doctor to either take or leave it. And if they feel that the volume—number of patients that they would see would justify the discount, then they make an informed decision to accept and be part of that network. And that's a fair negotiation. The problem of unfairness comes when the doctor does not have the ability to say no, because they would lose their entire practice.

Senator UDALL. Now, the settlement agreements in these two cases are great first steps to reining in managed-care's ad hoc cost-containment strategies. Is the case precedent set by the AMA's example enough, going forward? How do you see the Federal Government best addressing the conflict-of-interest questions raised by these two cases?

Dr. NIELSEN. I think your hearing is a remarkable first step.

I want to be sure that there—that it's clear that there are basically two parts to the kinds of settlements. And that's really very important. The settlements that you heard described by Ms. Lacewell that the Attorney General negotiated were essentially fixing this database, ceasing and desisting using the flawed database, and going to a new unbiased database, going forward. But, the other part is the settlement that UnitedHealthcare has reached with the AMA and the other medical societies, and that's really very important. It's different. That's reparation for the past actions.

So, United has solved both of those, from their standpoint. There are three others that we are helping to come to that conclusion by filing lawsuits. The recent one was against WellPoint, yesterday. So, Aetna, CIGNA, and WellPoint have not yet reached a settlement on reparations; whereas, United has.

We think that everyone needs to understand this. What the Federal Government will do, what the jurisdiction of the Federal Government is, compared to State laws, I—that's beyond my expertise as a physician, so I would have to turn to Mr. Chairman and ask, What is the role of the Federal Government here?

Senator UDALL. Well, I'm not sure you're allowed to ask the Chairman a question, but I'll defer to our distinguished chairman, here.

The CHAIRMAN. You have 13—12 seconds left.

Senator UDALL. I'm going to yield it to you.

The CHAIRMAN. I know.

[Laughter.]

The CHAIRMAN. That's why I'm offering you 12, now 10 seconds.

[Laughter.]

The CHAIRMAN. All right.

Senator Lautenberg?

Thank you very much.

Senator LAUTENBERG. Thank you very much, Mr. Chairman.

And it's a great idea to hold this hearing and learn from what experienced people like our witnesses here know something about.

And when you see that—though I think that you did mention that—Dr. Nielsen, that the agreement with UnitedHealthcare is still awaiting formal approval by the Federal court—is that right?

Dr. NIELSEN. That's correct, Mr. Senator. And that is going to be happening—we believe that that happens next week, the first hearing.

Senator LAUTENBERG. And the area of discussion is about \$350 million, is it?

Dr. NIELSEN. That's correct.

Senator LAUTENBERG. \$350 million. It's outrageous. You know, a scam is a scam is a scam, whether or not it's a street thug or a well-dressed corporate executive. That's been an interest of mine for a long time—I'm on the board of the Columbia University School of Business, and I was able to grant them a chair, some 8 years ago, in my subject, and I'd led one of America's great companies for 30 years—in business ethics. And we don't have that sprinkled in our dialogue often enough.

Ms. Lacewell, last summer at the Federal court—and I think the Chairman touched on this—you proved your settlement with a New Jersey insurer, as you know, and detailed significant problems with the insurance companies underpaying patients. Now, your investigation found similar problems with the insurance companies operating in New York. What can be done to stop these companies across the country that are engaged in similar practices, but are not included in the New Jersey and New York settlements? Do you have any recommendations? I know it's outside of your direct province. What do you think?

Ms. LACEWELL. Senator, it's—obviously, it's a very important question. The Attorney General finds that transparency—bringing light to a problem has a very powerful effect, which is why, as Dr. Nielsen has noted a few times, this hearing is important. Because if the problem is in the shadows, probably no one will do anything about it. But, when light is brought to the problem, and the problem is articulated with detail and with proof and with vigor, the insurance companies really could not dispute that this was a real problem. And once it was brought out into the light of day, it became really too much for them to bear. And when you get the first to settle—and Ingenix being at the center of the problem—that generates a momentum of its own.

Senator LAUTENBERG. So, you're saying they must pursue it with—helped by the knowledge that you've established in the State of New York. And when we look at the chart, we see this breach of conduct throughout. And despite what we heard before, we can't berate the activities of attorneys in trying to resolve these issues. So—I have a daughter who's one of them.

There are—Mr. Bell, nine—there are nine States, plus D.C., that allow health insurance to deny coverage to women buying insurance on their own because they have been victims of domestic violence. And I've authorized a law protecting victims of domestic violence from having to live with a gun-carrying spousal abuser.

How can insurance companies justify the denials of coverage? It's my understanding that, typically, pregnancies are not covered in their health care costs. So, (a) if that's true; (b) isn't that discrimination against women, also?

Mr. BELL. Yes, I agree that that's a pretty shocking finding. I think that these issues were recently investigated by the National Women's Law Center, that did a report called "Nowhere to Turn: How the Individual Health Insurance Market Fails Women," where they looked at how flawed the individual insurance market is for women who are seeking coverage. They found, in many States, women had very difficult time purchasing maternity coverage; in some cases, the out-of-pockets were enormous, even if they were successful in securing it.

And I think it's—is actually—the situation is even worse than that, in the sense that the individual insurance market is really a deeply flawed market, not only across gender lines, but for people who are older and sicker, or who have chronic illnesses and disabilities. There are all types of problems that consumers have getting access to affordable coverage in the individual market. And so, we would favor efforts to give consumers other options to get coverage, frankly. I mean, giving them a choice of enrolling in a public plan, like Medicare, or putting them into a larger pool. In states like New York, we have community rating, which broadly spreads the risks out across the entire marketplace. It gets rid of some of those discrimination issues. But, we still have affordability issues for younger people. So, clearly that's not a panacea.

But, I think that the—this is a very important question. It could be addressed by tighter state oversight. I mean, why are the states permitting insurance companies to operate in this fashion in those states? And so, I think we need much more consumer-oriented oversight and enforcement. And we're certainly happy that we have it in New York; we'd like to see it strengthened there, as well, and strengthened in other states.

Senator LAUTENBERG. Yes. When you're—if you're a card player, in the vernacular, it's good to know the deck is fixed. In the case of Ingenix, the deck was fixed. And that was kind of the reference that the companies were using. Quite unfair.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Lautenberg.
Senator Begich, to be followed by Senator Klobuchar.

**STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA**

Senator BEGICH. Thank you very much, Mr. Chairman.

Thank you all for being here today and giving your presentation.

If I can ask—and I want to ask, just, some general questions about the status of, kind of, what's next with the lawsuit, and then some policy questions, generally. But, now that it's been—it's in the

process of settlement, where do you see the timetable in regards to the database development and availability for the public?

Ms. LACEWELL. Senator, the Attorney General has estimated about 6 months as an aggressive timetable to get the not-for-profit up and running and have an initial database that can be available to the Nation. And when that happens, Ingenix will close its database to the Nation. So, insurers who have not yet signed on to the reform are going to need someplace to go, and we hope—

Senator BEGICH. Sure. But—

Ms. LACEWELL.—they'll go there.

Senator BEGICH. But, it'll be, you think, 6 months or a little bit longer.

Ms. LACEWELL. Yes, possibly a little bit longer, that's right.

Senator BEGICH. And then, how do you give access to that database for those that may not have Internet access or computer access? I know that may be difficult to think about, from New York, but I'm from Alaska, and we have some very small, remote communities that do not even have access to broadband or dial-up.

Ms. LACEWELL. That's a very important question. One of the things that we're looking at with respect to the proposed regulation in New York with the Department of Insurance is requiring insurers to tell the insured, upon request, what the amount of reimbursement will be, and to do it before they seek the medical treatment from an out-of-network physician. And so, whatever means of communication that is available to the member would entitle them to that information.

Senator BEGICH. And would the database also have information, if you access it and you want to protest the fees, or whatever the right term is, it will show them how to do that?

Ms. LACEWELL. We do—

Senator BEGICH. They—

Ms. LACEWELL. Senator, we do want to include some consumer education efforts there, and we also hope that the amount of money that we've collected will enable us to embark on some of those efforts with some of those funds.

Senator BEGICH. Right. And then, I guess all of you know—as you know, the Congress is working, and the President is working, on massive health care reform. Do you see, within that reform, some sort of process or nationwide approach to this as, now, you have done through New York? I don't know what the right—who the right person to ask would—

Dr. Nielsen, you've grabbed the mike, so you're it.

Dr. NIELSEN. Let me take a first crack at it. We are privileged to have been part of that discussion, and we look forward to being part of the discussion, both within the Senate and the House. So, absolutely, what you've seen is something that needs to be corrected. What you've heard about the pre-existing conditions, not allowing a patient to get insurance—let alone afford it, not even get it—those are issues that concern us deeply, and have for years, and we are on the brink, we think, of some very meaningful health system reform that will help all Americans.

Senator BEGICH. And I do—I recognize that—meeting with Senator Baucus last week in regards to the issue of those that can't get insurance now, and how that can be fixed. But, I guess I'm kind

of honing in on the permanency of the database. How do you make sure it's reviewed? How do you make sure it's consistent and that everyone has to participate? I mean, that's, I guess my—is that—have you, or any of you, proposed ideas to some of the leads in this area of health care—Senator Kennedy, Senator Baucus, and others?

[No response.]

Senator BEGICH. If not—it's not a trick question—if not, then would you do that? And would you do that in a timely manner?

Dr. NIELSEN. Well, it's going to be transparent, so anybody who has an out-of-network bill that would be submitted—that amount would be submitted to the database, and there would be no incentive to alter that database. So, it should be transparent to all. It would be available to consumers, to physicians, to a health plan. So, I guess we are hoping that the transparency will be what we need.

Senator BEGICH. I guess—I don't know—I want to make sure you—you've done it through a lawsuit, but to make sure it's codified, from a national perspective. That's what I'm trying to get to. In other words, it's great that you've done it through a lawsuit, in your own way, but we're about to do massive health care reform. Is there a way to codify this to ensure that we don't have to go through this process again? And then, to regulate it, to a certain extent, because, you're right, it should be transparent, but, I think, 10 years ago, some people might say, it should have been transparent. So.

Ms. LACEWELL. That's right, Senator. And in New York, we're seeking to make those reforms permanent through a regulation in the State of New York, and Attorney General Cuomo would be more than happy to cooperate and facilitate other efforts that could be applied nationwide or, you know, as part of a Federal program.

Senator BEGICH. Can I just—my time is out, but can I encourage you to talk to the Attorney General and see if he would submit some information to—at least to Senator Baucus, Senator Kennedy, and myself? I mean, they're doing the legislation, but I have real interest in this issue.

Ms. LACEWELL. Absolutely.

Senator BEGICH. Thank you very much.

**STATEMENT OF HON. AMY KLOBUCHAR,
U.S. SENATOR FROM MINNESOTA**

Senator KLOBUCHAR. Thank you very much—am I next, Chairman?

The CHAIRMAN. You are next, thank you.

Senator KLOBUCHAR. Thank you. I jumped ahead.

Thank you, all of you, for being here and for your work. And just to clarify this—a little bit of what Senator Begich was doing—do, is UnitedHealthcare the only company that's settled, now, of these lawsuits?

Ms. LACEWELL. With respect to the Attorney General's efforts, UnitedHealth Group and Ingenix were the first. And that was important, since Ingenix was at the center of the problem. And then, all the other large national insurers that operate in the State of New York—Aetna, CIGNA, WellPoint—and large regional insurers

that operate in New York—have all signed on to settlements to move away from Ingenix and to use the new system.

There are, of course, West Coast-based national insurers that don't operate in New York that, at this point, we were not able to reach, but the new database is available to any insurer that wants to explore using it.

Senator KLOBUCHAR. So, the—I mean, the lawsuit involved, as you discussed, some—righting the past wrongs, and then also looking forward, which I appreciate, so that this database, paid for by the UnitedHealthcare settlement money, is used, then, for other people that aren't even on their—that weren't even customers of theirs. Is that correct?

Ms. LACEWELL. That's right, Senator.

Senator KLOBUCHAR. OK. And so, the other thing that I wanted to ask about was, Dr. Nielsen, in your testimony, you referenced the American Medical Association's National Health Insurer Report Card. And in AMA's analysis of major health insurers, Medicare was included. And, as you know, Medicare has been discussed here as the largest purchaser of health care services. And, while it appears that Medicare adheres strictly to a contract rate, we also know that there are issues with those rates. And, in fact, Mayo Clinic just came out—one of the most efficient health care providers in the country—came out to say that they lost \$765 million in 2008 from Medicare patients. What do you think needs to be done to—for health care reform with this reimbursement rate?

Dr. NIELSEN. Let me quote Dr. Denny Cortese, who is the CEO of the Mayo, who actually—

Senator KLOBUCHAR. Who we both know.

Dr. NIELSEN. Who we both know, who was quoted in yesterday's *New York Times*, and he said, "Medicare has systematically been underpaying for services," and he goes on to say, "If more patients are enrolled in a Medicare-like program," he predicted, "your very best providers will go out of business or stop seeing patients covered by the government plan." We can't let that happen. I mean, the Mayo obviously is a model of efficiency, as well as expertise.

So, I think everyone knows, and there isn't anybody in the Senate who doesn't know, the problem with physician payments, and we will be back, talking about it, toward the end of this year, as well. So, it really is a problem. We have to—this is a safety-net program for our elderly, and we really must make sure that it's fiscally responsible and sustainable.

Senator KLOBUCHAR. Thank you.

And the other thing Denny Cortese has focused on is the fact that if we're going to make it sustainable, we have to make it as efficient as possible. And one of the things that has most struck me is this geographic disparity issue. And I know it's hard when you're representing a national group, but an independent study out of Dartmouth showed that if the rest of the hospitals in the country simply used the protocol that the Mayo Clinic uses in the last 4 years of a chronically ill patient's life, where the quality ratings are incredibly high—if we want to save money, Mr. Chairman—\$50 billion, every 4 years, in taxpayer money. So, as we talk about these rates and the Medicare rates and the good work that you've done

here, I just think we cannot neglect this issue of making sure, as we look at reform, that these are offered in the most efficient way.

And I think people would be shocked to know that, in fact, the highest quality often comes from States with the lowest costs. Is that not correct?

Dr. NIELSEN. That is correct. And, in fact, in the White House Forum on Healthcare Reform, that issue was addressed, and I was asked directly by Nancy-Ann Min DeParle, you know, "What is your profession going to do at looking at the geographic variation?" It's an appropriate question that actually was originally addressed by Senator Baucus. They are both right to ask that. Our profession is very concerned about that.

In our experience, the biggest variations occur when there is not a clear-cut path for the one right thing to do—

Senator KLOBUCHAR. Exactly.

Dr. NIELSEN.—such as beta blockers after a heart attack or aspirin on the way in to the hospital. So, we really need, very quickly, to make sure that we generate the evidence that we need to see what is absolutely necessary, and that we promulgate it. And we will be your partners in that regard.

Senator KLOBUCHAR. Thank you. It often seems that, also, this team—the medical team idea of—whatever you call it—the medical home or—what they do at Mayo and—or in many of our more rural areas, where you have a primary physician and then you have a team that works with them, is where you often find the lower rates, I think.

So, thank you very much.

The CHAIRMAN. Thank you, Senator Klobuchar.

And then Senator Pryor and then Senator Snowe.

**STATEMENT OF HON. MARK PRYOR,
U.S. SENATOR FROM ARKANSAS**

Senator PRYOR. Thank you, Mr. Chairman.

Let me ask, if I may—Ms. Lacewell, if I can start with you—if a consumer, John Q. Public, called his or her insurance company and asked them to explain the—what "usual, customary, and reasonable reimbursement rate" means, what kind of answer would they get?

Ms. LACEWELL. Well, Senator, that's an excellent question. Assuming the consumer could get through on the telephone, which is another big complaint that we get, in our experience the people who answer the phones are really not trained to answer that question and would simply refer the consumer to their written materials, which vary from plan to plan, and from area to area. And we took a look at the written materials, and they are frequently—they're simply unintelligible. And we met, then, with in-house counsel for a number of these large health insurance companies, and we pointed them to the page and said, "What does this mean? What are you saying here, when you go, paragraph after paragraph, 'the lowest—the maximum allowable rate'" and all this other legal jargon and five different ways that they may compute it? And when pressed, it was amazing, they sometimes said, "I really don't know. I can't explain it to you." So, even in-house counsel couldn't explain it. So, I don't think the customer reps could, either.

Senator PRYOR. Dr. Nielsen, let me ask you the same question. If a doctor calls and—

Dr. NIELSEN. Sure.

Senator PRYOR.—asks, you know, what does “usual, customary, and reasonable” mean, what do they tell the doctor?

Dr. NIELSEN. Well, they would tell the—Senator, they would tell the doctor the same gobbledygook, but when it gets down to the real question, which is—from the doctor—and this happened many, many times before the lawsuit was filed in 2000—they said, “How”—the doctor would say, “How in the world did you really calculate that in this area?” And the answer was always, “It’s proprietary.”

Senator PRYOR. Yes, OK.

Let me follow up on that with you, Ms. Lacewell, if I can, and that is—you’ve spent a lot of time on this subject dealing with this issue, and I appreciate that. In all of your time and all your efforts there, were you able to find any written material that was available to anyone outside the insurance company about how these “usual and customary rates” were calculated?

Ms. LACEWELL. No, we were not.

Senator PRYOR. So, in other words, even if a customer said—or a consumer said—a policyholder—“Send me something in writing so I can understand this,” there is nothing that you’ve ever found, that’s gone outside the insurance company, to tell you how that works.

Ms. LACEWELL. No, that’s right.

Senator PRYOR. And also, in terms of disclosure to policyholders, did the insurance companies ever disclose about the sources of information and the company that we—is Ingenix, you know—and whether—who owns that, and how that’s set up? Have they ever—did they ever disclose that to consumers, as far as you can tell?

Ms. LACEWELL. Senator, another excellent question. Not only did the insurers not disclose Ingenix was doing this or that Ingenix was part of the health insurance industry, they frequently affirmatively misstated how they were determining this, by either referring to entities that used to do it, because they hadn’t updated their materials, or by saying, “We rely on, you know, independent data,” and things that really misled consumers who were reading that language.

Senator PRYOR. OK.

Mr. Bell, I don’t want to leave you out of this conversation, so let me ask you—if John Q. Policyholder is trying to get information from their insurance company so they understand how their policy works and, when they pay their premiums, what they’re actually going to have covered, and the insurance company sort of stone-walls them, you get an 800 number, maybe you get someone who doesn’t know what they’re talking about or some gobbledygook you can’t read, what can a consumer do to get that basic information about how their particular insurance policy works?

Mr. BELL. Well, we certainly encourage people to seek outside help, and particularly to contact their state’s insurance departments or the Attorney General in their state. In our state, we have a health care bureau at the Attorney General’s office that serves

as a great early warning system for all kinds of consumer complaints and problems.

But, in the case of this issue, I mean, I think our overall takeaway is, the consumer was really in a fog about how the charges were calculated. It was hard to go up against the word of the insurance company. I've seen some websites of insurance departments around the country, where they basically said, "We can't help you with this," you know, "We don't regulate this practice. You're basically on your own." So, the consumer wasn't sure if the doctor was charging too much, as Dr. Nielsen mentioned, or whether the insurance company was underpaying, and it just persisted for many, many years like that.

So, my experience is just that people often—their eyes glaze over when it comes to insurance, and they just feel like they can't dig into it. And I'm sure that that happened many, many times with these types of billing underpayments.

Senator PRYOR. Mr. Chairman, I just have one quick follow-up on that. In our state, our state insurance department and insurance commissioner, he or she has a team of, sort of, consumer helpers there, a hotline or something that you can call and talk to them about this. And I think they try to be helpful. But, I also understand that a lot of insurance departments around the country, they have this other mission, and that is, they want to provide a good business climate for insurance companies so they'll have a lot of insurance companies doing business in their state. Do you think there's an inherent conflict there?

Mr. BELL. There is a longstanding tension between, sort of, the role of the insurance department to promote the financial health and solvency of companies—because clearly they don't want companies to go out of business, and that is often considered to be "job one," is to look out for that. And so, sometimes consumer protection issues, they both get less emphasis, but also can sometimes conflict with that mission. And that's why we think it's useful to have—to establish an independent unit, such as an independent office of consumer advocate, as Texas and some other States have done, to ensure that there's someplace in the government that really is working just for the consumer. Just like we have units that intervene on utility-rate hearings, you know, why not have similar counterbureaucracies or counter—you know, public counsel that would work on behalf of the consumer?

Senator PRYOR. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Pryor.
Senator Snowe?

**STATEMENT OF HON. OLYMPIA J. SNOWE,
U.S. SENATOR FROM MAINE**

Senator SNOWE. Thank you, Mr. Chairman.

Well, one of the things that we're learning today is that millions of Americans who required health care services were at the mercy of a small medical data company called Ingenix and produced these tables, those "usual and customary rates" that were accepted as gospel truth in the industry. If Ingenix said, "Your doctor was charging you above the going market rate," then you had no choice

but to pay. I mean, you were simply out of luck, because Ingenix always got the last word, it appears.

But, it looks like the reality was that the data was all smoke and mirrors. For example, Ingenix said its data was based on actual provider charges, the actual amount that doctors were charging the patients. So, let me ask you, Dr. Nielsen, did Ingenix ever call you or your organization to collect the fees that the doctors were charging their patients?

Dr. NIELSEN. Let me make sure, Senator, that I've understood your question. Did they ever call the AMA to—

Senator SNOWE. That's correct.

Dr. NIELSEN.—to find out what the fees were?

Senator SNOWE. Yes.

Dr. NIELSEN. We are prohibited from collecting that information, because of antitrust concerns.

Senator SNOWE. OK. So, the medical data came from the insurance, but—the medical data that came from the insurance company, is that correct? I mean, that's—

Dr. NIELSEN. The medical data came from individual physicians who submitted their claims. So, they got the information. The actual claims went in. It's what they did with it thereafter that's the issue.

Senator SNOWE. But, the medical-charge data came from the insurance company or specifically from the physician.

Dr. NIELSEN. Came from the physician—

Senator SNOWE. Physician to the—

Dr. NIELSEN.—to the insurer.

Senator SNOWE.—insurance company.

Dr. NIELSEN. Or—either through the patient or directly to the insurer. And then, the insurer decided what they would pay, and the patient was left with the rest.

Senator SNOWE. So, what we're discovering, today, is that obviously all of the information wasn't turned over to Ingenix and, you know, the health—the insurance companies would throw out some of their higher-cost charges so that the rates would be much lower. Is that correct?

Dr. NIELSEN. That's correct.

Senator SNOWE. Yes.

Dr. NIELSEN. And in the written testimony, we go through the various ways in which that was done.

Senator SNOWE. OK. So, you've been trained as a doctor and as a medical researcher, so maybe you can answer this question. Statistical experts who looked at this Ingenix database have concluded it's—that it is a convenient sample of medical charges, not a representative sample of medical charges. Can you explain that difference—

Dr. NIELSEN. Yes. It's a—

Senator SNOWE.—between the two?

Dr. NIELSEN. It's a pretty simple difference. If it's representative, the individual doing the sampling works very hard to make sure that it accurately represents the full range. A convenient sample is left to the person doing the sampling to decide how to do the sample. And it's a very big difference.

Senator SNOWE. The big difference, in terms—because they don't analyze the data.

Dr. NIELSEN. Sure.

Senator SNOWE. Obviously, in this instance—in these instances, they did not analyze what was—you know, but—

Dr. NIELSEN. What was inconvenient.

Senator SNOWE.—what was inconvenient. So, obviously it was a very convenient sample for the insurance company, but a raw deal for consumers. They underestimated the real charges, and consumers obviously paid billions of dollars out of their own pockets that clearly the insurance companies should have been paying.

Ms. LACEWELL, I understand that part of the settlement that you reached with the insurance companies is set up a new independent database to estimate the “usual and customary” data charges. Can you tell us how this new database would be better than the old one?

Ms. LACEWELL. Yes, Senator. What we intend to do is have a qualified university be involved with an independent not-for-profit that will create the new database. And what we have looked to here are the incentives. So, whereas the incentives we found with the database being run by the health insurance industry, that has an obligation to reimburse, was to skew it downward, we feel that, with a not-for-profit company, that is independent from the industry and that is associated with a university that will do academic research based on the database, and therefore has an incentive in it being accurate, that we will be moving the system out of conflicts and into independence and more accuracy.

Senator SNOWE. And when is this system going to be established?

Ms. LACEWELL. We anticipate it'll take, on the aggressive side, about 6 months.

Senator SNOWE. Ms. LACEWELL, on the out-of-network premium increase and—in your investigation of these procedures, did you find any justification for insurers to charge customers going out of network a higher—for higher prices than were charged the providers who were given the same—given the in-network rate—I mean, they weren't charged any more, but yet, the customer going outside of the network was charged a higher premium—

Ms. LACEWELL. Yes, Senator, I—

Senator SNOWE.—for those services?

Ms. LACEWELL.—I think the theoretical justification by the insurer is, the insurer has not been able to negotiate a lower rate with the doctor and, therefore, is going to have to pay more. And so, they're passing on some of that cost to the consumer. The problem, of course, lies when the insurer does not keep their promise to make sure that the balance of the economic cost is fair, based on that promise.

Senator SNOWE. What about balance billing, which is another issue that—you know, that, unfortunately, so many individuals are having to pay because of an underpaid insurance, so the doctor goes directly to the patient to recover those charges. Now, in California they have, you know, prohibited this practice. What's your evaluation of it? Is it unfair to allow balance billing?

Ms. LACEWELL. Senator, what we have found, at least in New York, is that balance billing is allowed when the patient is out of network, has gone out of network, because there's no contract between the doctor and the insurer. So, the doctor doesn't look to the insurer, they look to the patient. In other more ordinary circumstances involving in-network, it's generally prohibited, because the doctor must look to the insurer.

The reason that this is such a huge consumer issue is because balance billing is typically allowed, in that it is the consumer who's then stuck in between the doctor and the insurer, and is the one who has to pay the cost.

Senator SNOWE. But, generally that's a practice that occurs in network and not—and not under any other circumstance.

Ms. LACEWELL. Generally, we find balance billing being allowed and occurring out of network.

Senator SNOWE. In out of—

Ms. LACEWELL. When it happens in network, it's frequently—

Senator SNOWE. As—

Ms. LACEWELL.—illegal.

Senator SNOWE. OK. So, it's generally illegal—

Ms. LACEWELL. That's right.

Senator SNOWE.—in that case, but it's out-of-network that is more conventional practice.

Ms. LACEWELL. That's right, Senator.

Senator SNOWE. Thank you.

Well, let me just make another point, Mr. Chairman. You know, a Government Accountability report came out recently, at the request of Senator Bond, Senator Durbin, and Lincoln and myself, and it's even more troubling to see what's happening here, because there's very little competition in the insurance market. And based on the study that, you know, I requested back in 2005, and to compare that study to the results of the study that was released last week, that the combined market share of the five largest insurance companies now controls 75 percent of the market in 34 of the 39 States that we surveyed, and more than 90 percent in 23 of these States. So, it tells you that there, you know, dramatic, direction toward less competition, if any, in many of the States across this country. So, when you see—combine it with all of these deeply troubling practices, I think it really is an enormous burden to consumers all across this country, because there's virtually nowhere to go with respect to competitive—competition in the health insurance industry. There are no options, essentially, in many of these States, as, you know, indicated by this report.

Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Snowe.

This is kind of a—what I would call an investigative hearing, and the first of two, so we're trying to lay predicates, which is why we're trying to establish a base from you all, not just ask you questions, to give you a chance to talk about all kinds of things.

Dr. Nielsen, you bring up an issue in your testimony that I want to talk about a little bit more. You say that when the insurance industry uses those Ingenix numbers to reimburse a doctor or other health care provider, they just look at the service delivered, but not the person who delivered the service. Is that correct?

Dr. NIELSEN. That's correct.

The CHAIRMAN. So, let me give you an example and ask you to comment on it.

Say, a patient with a heart problem goes to see a doctor to discuss the results of an EKG—an electrocardiogram test—the patient could go in to see his general practitioner and discuss test results, or he could make an appointment—or she—with a board-certified cardiologist who is a chair, for example, of a cardiology department at a major university.

Now, let me ask if I have this right. Ingenix doesn't make any adjustment for the fact that a board-certified heart surgeon might charge more for this service than a general practitioner. There is one code for this service, listed on here, and everybody who performs it gets reimbursed at exactly the same rate. Is that correct?

Dr. NIELSEN. That's our understanding, Senator Rockefeller. And it's even worse than that. It's—it may be that the service was rendered by a nonphysician, so those fees were also mixed into this mix.

The CHAIRMAN. So, a non——

Dr. NIELSEN. So, you're absolutely right.

The CHAIRMAN. But, a nonphysician could do an EKG?

Dr. NIELSEN. They can.

The CHAIRMAN. What kind of nonphysician?

Dr. NIELSEN. Nurse practitioner, physician assistant.

The CHAIRMAN. I've got a healthy respect for physician assistants, but your point is still——

Dr. NIELSEN. So do we. So do we. And that's——

The CHAIRMAN. I mean, a place like West Virginia, we——

Dr. NIELSEN. A place like New York, too.

The CHAIRMAN. Yes.

Dr. NIELSEN. We value members of the health care team, and there are many. That really isn't the issue. The issue is, this is America, and when a patient elects to go out of network, they need to know where they're going, what the charge is going to be, and they have a right to ask for that. They also have a right to know what they're going to be reimbursed from their insurer. That really is the issue.

It—to do anything different is to essentially price-fix. We don't do that anywhere else within our economy.

The CHAIRMAN. I want to come back to that in a minute.

So, anyway, Ingenix only collects service-code data. And it doesn't collect data on who was delivering the service. The so-called modifier data is available, but Ingenix does not use it.

Dr. NIELSEN. That's correct. It's not that it isn't collected. It would be on the claim. It is not used. It's what happens after the claim gets there that——

The CHAIRMAN. It might be——

Dr. NIELSEN.—is the problem.

The CHAIRMAN.—part of what's cut off——

Dr. NIELSEN. Correct.

The CHAIRMAN.—the top, yes.

I can see what the problem would be with this system. It's an apples-and-oranges comparison. You could be a cardiologist whose charges are reasonable compared to other cardiologists with the

same level of training, but if you compare your charges to when general practitioners charge to read an EKG, all of a sudden your charges look excessive.

Dr. Nielsen, do you know why Ingenix and the insurance industry do not collect information about providers' experience or qualifications when they calculate the "usual and customary"?

Dr. NIELSEN. I guess you would have to ask them why they did all the things that they did—

The CHAIRMAN. Well, we're—

Dr. NIELSEN.—that did not represent the actual charges. I don't know the answer to that.

The CHAIRMAN. Yes, well, we're going to.

Can you explain to us why the American Medical Association believes that insurers need to consider the experience and expertise of the person delivering the service?

Dr. NIELSEN. Sure. Sure. Where do you want—

The CHAIRMAN. Please do.

Dr. NIELSEN. Where do you want me to start? Where do you want me to start? There is—

The CHAIRMAN. Laying the case, just—

Dr. NIELSEN. I'm an internist. I also have a subspecialty in infectious diseases. I read EKGs. I have billed for the reading of an EKG. If there was a complication on that EKG that I wasn't certain that I could interpret, I would certainly send the patient to the best cardiologist or electrophysiologist I could find, and that person would be entitled to charge for their expertise, for their years of training, beyond what I have.

The CHAIRMAN. OK. I appreciate that response. But, next week there's going to be an insurance executive sitting right where you are. And let me give you a preview of what they're going to say. They're going to say that "usual and customary" rate services serve to restrain doctors from overcharging the patients. Higher doctor bills are good for doctors, but not for everybody else. So, how do you respond to their argument?

Dr. NIELSEN. I'm warming up the chair, here. I hope—

The CHAIRMAN. You can come back.

Dr. NIELSEN.—it's still warm by the time—by the time he gets here.

The American Medical Association has strong ethical policy prohibiting excessive charging. The insurance industry would like you to believe that what they did, this scheme, kept costs down. It didn't. What it did is, it passed costs on to patients. That's the problem. They got the profits at the plan, the patients got stuck with the bill. That's the issue. Don't let them kid you.

The CHAIRMAN. With your forbearance, Senator Begich, just one more quick question.

You mentioned earlier about not being able to do some things because of collusion. It's a very interesting word in American law and practices of all sort. After 9/11, the first bill that the Congress passed was to allow—make it legal for the Central Intelligence Agency and the FBI to talk to each other. They were not allowed to share information or to talk to each other about any case, even though one might have information that bore directly on what another—the other was doing. You know, the FBI arrested, the CIA

surveilled, and the twain shall never meet. And I think we paid a terrible price for that, in terms of national security, over many, many years. And we changed that law. As I say, that was the first one we passed.

Where do you—if you can't find out something—and I'm not a lawyer, so I don't know how collusion—good collusion, bad collusion, allowable collusion, not allowable collusion—but, where does collusion—where do you think the collusion laws are misplaced?

Dr. NIELSEN. I'm not a lawyer, either. We do use them when we have to go to court, but we also take care of them when they get sick, so—

I—we are very—we have been very concerned, over the years, about what has been a pretty aggressive interpretation by the Federal Government of antitrust regulation. We have not—against physicians; that's a very important thing to understand—we have not seen similar antitrust enforcement actions against insurers. You heard Senator Snowe describe the consolidation of the health insurance market, to the point of real market control, without enforcement action. So, doctors are afraid of enforcement action.

There is one thing that will help. The new database, with the transparency of out-of-network charges, that will be transparent to all. It will be available to everyone. A doctor can find that out, as well. And that avoids the collusion allegation, I believe.

I'm not sure I can answer it any better than that, Senator Rockefeller.

The CHAIRMAN. No, you did a good job. Dr. Lacewell. I mean, Ms. Lacewell.

Ms. LACEWELL. Yes, sir. Two comments on the anticipated position of the insurance industry about overcharging by doctors.

One is, we're a consumer advocacy organization, and what we have endeavored to do is to make sure that the promise made by the insurer is kept. And the promise is, "We will reimburse you, based on what doctors typically charge," not on what they should have charged, in the view of the insurer. And the insurer extracts that higher premium, based on that promise. And if they think that that particular arrangement is not satisfactory for them, economically, then what they ought to do is to change what they promise and not break the promise that they've made.

In addition, the Attorney General believes that, to the extent that there are inefficiencies in the market, for health care charges or health care services, transparency will be a good thing. So, this Ingenix database that kept everything in the dark and didn't allow anybody to know what the rates were going to be, or the reimbursement rates were going to be, we think, for the insurers, actually did more harm than good. And to bring to light what doctors are charging in various parts of the country for various kinds of services, we believe, will bring efficiencies and competition to the market, and therefore, be a good thing in that regard.

The CHAIRMAN. Thank you. Thank you.

Senator Begich, it's your turn.

Senator BEGICH. I'll be very brief. I just have a—I want to do a little follow-up there. And it was an interesting question the Chairman asked you in regards to AMA medical folks in regards to ex-

cess charges. How do you—in your code of conduct, how do you monitor that if you can't talk to each other?

Dr. NIELSEN. It's not easy.

Senator BEGICH. No, that's—

Dr. NIELSEN. I will tell you that this is a problem. I have it with me. I'm—anticipated that it might—the issue might come up, so I brought the ethical policy with me. I have it here somewhere.

Senator BEGICH. That's OK. I recognize—

Dr. NIELSEN. Well, but—

Senator BEGICH.—that that's part of the—

Dr. NIELSEN.—but, let me tell you what we used to do—

Senator BEGICH. OK.

Dr. NIELSEN.—because—in the old days, before there was this aggressive antitrust enforcement concern. What we used to do is, county medical societies used to be able to sanction doctors—

Senator BEGICH. Oh.

Dr. NIELSEN.—who charged excessively. And how did they know? Because a patient would complain to the Ethics Committee. That—we can't do that anymore. It's really very difficult to figure out what should be charged.

Now, if someone is totally gouging a patient, what's the most important thing that happens? The patient figures that out, leaves the doctor, tells everybody they know—and they all know a lot—and the doctor's reputation is ruined. The problem is, that's what happened with the Ingenix database, and the doctor didn't gouge them. But, if the doctor was charging excessively, patients figure that out, they switch doctors, and they tell everybody they know.

Senator BEGICH. Then, on the information database—it was interesting to hear discussion of how—when the information is put in—or the future—let's talk about the future, not the past—when the new database is established, who determines—is all the data going in, and then it's just calculated from that, or is it a selective batching that's done? I'm just trying to understand that piece of it.

Ms. LACEWELL. Yes, Senator. What we anticipate is that qualified people, from the university, who are experts in these areas will make independent decisions about what kinds of information should go into the database, what the sources of that information should be, and how it should be collected, audited—which, by the way, Ingenix did not audit its data, either—but, what kinds of protocols and sampling are appropriate. We want independent experts to do that, and to make those decisions independently, with an incentive that they're getting it right.

Senator BEGICH. So, they'll set some protocol process that then will adhere to—throughout the database collection—

Ms. LACEWELL. That's exactly right.

Senator BEGICH. OK.

Do you think that—any one of you can answer this, or hopefully all of you might have a comment on this—do you think—again, in health care reform—that we should require all health insurance companies to submit data, if there is a protocol set up for a database—require them all—in other words, you talked about the East Coast ones—I mean, we've got Blue Cross. Huge. Controls a sizable amount of our market. Had huge adjustments last year, of 25 percent. That's why our city is self-insured now.

Ms. LACEWELL. Right. The Attorney General would certainly like to see all insurers contribute data, if they can. Now, within New York State, we have some smaller not-for-profit local Upstate insurers—

Senator BEGICH. Sure.

Ms. LACEWELL.—as to whom it might be a burden.

Senator BEGICH. OK.

Ms. LACEWELL. But—

Senator BEGICH. But, with some limitations, would you think some of the larger ones—would it make sense to require them to do this?

Ms. LACEWELL. Yes, it would, and it would help bring rigor to the database.

Senator BEGICH. Do—the other two, do you agree with that?

Mr. BELL. Yes.

Dr. NIELSEN. Yes.

Senator BEGICH. And do you think that's something that we should think about with our health care reform legislation.

Mr. BELL. Yes.

Ms. LACEWELL. Yes.

Senator BEGICH. OK.

That's all, Mr. Chairman. I appreciate it.

The CHAIRMAN. It's going to be a large piece of legislation.

Senator BEGICH. Well, you know, it's a big—it's a big issue.

[Laughter.]

The CHAIRMAN. It's interesting, you know, that—and this a side comment on my part, but I think the President chose to take on everything—you know, climate change, energy, education, health care, banks, housing—and do it all at once. And I happen—to think that's the right way to do it. And then people talk about everything—you know, climate change is just an absolutely huge subject, one which I'm confronting in West Virginia, to unhappy reviews, but, nevertheless, you know, West Virginia has the most to gain by acting well, and the most to lose by continuing practices that have taken place for over 100 years.

So, I mean, this is a big risk we're taking, and never has there been so much asked of the Congress. And so, Senator Begich's question is very interesting, because, you know, we had a 2-hour meeting yesterday, so-called "Board of Directors" of health care reform, which I think is an obscene title to give to what—we should just say "nine Senators on a bipartisan basis"—and, there are a lot of people that don't want health care reform. They don't necessarily want it, because they don't want the President to get credit for it. They don't want it because they have, as so—is so typically the case—I mean, as you found, this morning, we started the discussion yesterday on the—on broad health care reform, and immediately somebody pounced right on trial lawyers, "Well, until we get the trial-lawyer thing, we can't—obviously can't talk about health care reform." So, it's going to be incredibly complicated. And it's going to take time, but it's going to be worth it, because I think all of these things have to work in tandem. And I left out education. All these things have to work in tandem, at the same time. If we don't do climate change, what the heck difference does it make what our national debt is, to our great-grandchildren? I

mean, they're going to be underwater and won't be thinking about that very much. I mean, it's a very interesting time, and your contributions here are huge.

I just want to wrap up with a couple of points.

What I think we've learned today is that there's a reality-based prevailing market price for medical services, and then there is a fictional "usual"—UCR rate used by the insurance companies. Thanks to Attorney General Cuomo and you and others, we know that the insurance industry's reimbursements were just dramatically lower than reality in New York—in some cases, by 25 to 30 percent.

Now, Ms. Lacewell, if I wanted to find out if the people in my State of West Virginia, which doesn't have the resources of your Attorney General's office, or maybe the vigor of your Attorney General's office—if I wanted to find out if people were getting underpaid in the same way that your consumers in New York were, how would I figure that out?

Ms. LACEWELL. Well, Senator, the way that we did it was, we subpoenaed two sets of information. One, we subpoenaed the rate information coming out of Ingenix for the particular medical codes and—for particular ZIP Codes. And then we went to the insurance companies, and we subpoenaed—that operated in those areas—and subpoenaed them for the medical bills they had received from doctors for the same services in the same areas. So, we had, sort of, Ingenix and mini-Ingenix—or bad Ingenix, good Ingenix—and then we could compare the two. And we did that through an economist.

It seems to me that—with subpoena power, that could be replicated anywhere.

The CHAIRMAN. Do you know we've added that on, in this Committee—

Ms. LACEWELL. So I have heard.

The CHAIRMAN. We've never heard it—we've never had it before. And it's wonderful. I mean—actually, I—it wasn't Olympia Snowe, but her colleague from Vermont and Senator Levin mentioned to the EPA, who had been refusing to give information for a long time—they just mentioned, "Well, OK, then we'll come subpoena it." The next day, they had all of the information.

Ms. LACEWELL. Yes.

The CHAIRMAN. So, it's just not having it—

Ms. LACEWELL. Yes.

The CHAIRMAN.—it's what—it's just saying it, sometimes will get you your result.

Ms. LACEWELL. That's right.

The CHAIRMAN. Please.

Dr. NIELSEN. Could I just make a suggestion, and maybe ask Linda Lacewell to comment on it?

It is now clear, by view of the settlements, that the Ingenix database was flawed. And it's pretty clear the range by which the underpayment occurred. So, I wonder, Senator Rockefeller, if you could simply go to the insurers, the health insurers who operate in your State, and say to them, "How many out-of-network claims did you pay? And what were they?" And then extrapolate that. I—and I don't know if that's statistically something that could be done without hiring—because we know they're flawed—

The CHAIRMAN. And that's the point. The—obviously, that could be done. But—for example, insurance commissioners in states, like ours, are always—you know, there's no money for them. There's never enough money for them to do anything except sort of basically keep up with keeping their shops running. That can also be true in attorneys general offices. You know, they have—the attorneys general spent a lot of time on the road, but they don't really have the resources to do the kind of deep investigative research, which we're trying to here to lay the predicate for the meeting on Tuesday. We're going to do a lot of that, on behalf of consumers, because we think this committee ought to relate to consumers as well as railroads and airplanes. So, that's a problem.

Ms. LACEWELL. Mr. Chairman, it seems to me that the Attorney General's investigation has created enough doubt about the integrity of this database that—

The CHAIRMAN. That would—

Ms. LACEWELL.—it is incumbent—

The CHAIRMAN. That'll help.

Ms. LACEWELL.—incumbent upon any insurer to demonstrate how they think that what they're using is accurate, because they are promising to pay, based on a certain kind of rate. And we've demonstrated, as Dr. Nielsen indicated, that the database is defective, that it does result in under-reimbursement, at least in some areas that we've affirmatively proven. And so, the burden really ought to be on these other insurers to demonstrate to the country—

The CHAIRMAN. Well, this is, in effect, what you meant by the domino—

Ms. LACEWELL. Yes.

The CHAIRMAN.—effect.

Ms. LACEWELL. That's right.

The CHAIRMAN. Yes.

OK, final—the final thing is—has already been asked, I think, by somebody else, and that is, Why didn't we get to all of this earlier? I'll ask that to you, Mr. Bell. I mean, why didn't we get at this problem earlier? I mean, people have been—we're talking about hundreds of millions of dollars. They settled for 350, 325, whatever it was, and they're probably thrilled to do that, and they're still making a ton of money. And there are many, many others out there, and one of them you just sued yesterday. They have lots and lots of money. I mean, you know, you can—there are always ways to avoid these things, and we seem to have avoided them pretty well, up until New York took these steps.

Mr. BELL. Senator, I think it partly goes back to the resource question that you just mentioned, is that the—as we've discussed earlier, the insurance commissioners have a primary mission of assuring financial safety and soundness. A lot of them don't have sufficient resources or—and sometimes they don't have the orientation or the inclination to aggressively pursue an investigation like this one.

So, I—what I hope will come out of this is that—a lesson for the country, that when you get it right, when somebody steps up and exposes a financial abuse, that's something that consumers are

very concerned about, and they are going to support solutions that create greater accountability and transparency.

And so, we've said a lot of nice things about Attorney General Cuomo, because he has done an excellent job for consumers, and—just as the plaintiffs did in these lawsuits by challenging this practice. And I think that they also have a role. There's a role for private rights of action to bring accountability, in some cases, where public officials are unable to act.

So, I think a heightened sense of—you know, more resources for regulators, and more inclination to go after consumer problems, is something that we absolutely need.

The CHAIRMAN. But, you know what? It's also a question of zeal, isn't it? You know, I was a Governor for 8 years, and the last appointment that I made was the insurance commissioner. Now, I don't know why that was, but it was a fact. And I had a very, very hard time trying to find anybody, in a small state, with a small salary for that position, who would be willing to take that position. And, as a result, I got a good person, but the energy level wasn't, perhaps, as high as I would have hoped.

And I think that part of what motivates the Attorney General of New York and you, Ms. Laceywell, is that you are zealous on this. I mean, you're going to get to the bottom of—you seek malevolence, you relish malevolence, you want to expose it—

[Laughter.]

The CHAIRMAN.—and you want to correct it. And it's just—it's all very interesting to me, and I just—I thank you very much for being here.

Ms. LACEWELL. It's—

The CHAIRMAN. I think we have laid a predicate for next Tuesday—that is, if we should all be here. Maybe we can videostream it to you all.

Ms. LACEWELL. That would be great.

The CHAIRMAN. Thank you so much.

This hearing is adjourned.

Senator Begich, did you have any other questions?

Senator BEGICH. No, thank you.

The CHAIRMAN. OK.

Thanks so much.

[Whereupon, at 12:23 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF MARY REINBOLD JEROME, M.D., YONKERS, NEW YORK

My name is Dr. Mary Reinbold Jerome and I live in Yonkers, New York. I thank Chairman Rockefeller, Ranking Member Hutchison, and the Members of the Committee on Commerce, Science, and Transportation for inviting me to speak this morning.

In July 2006, I was diagnosed with advanced stage ovarian cancer. I am currently being treated at Memorial Sloan Kettering cancer center, where I have received excellent care. Since my diagnosis, I have had a series of operations, and I received two separate rounds of chemotherapy, the second of which just ended. I did have a recurrence of the disease, but thankfully, now I am currently in remission.

When I was diagnosed with cancer, my primary care physician recommended that I get treatment at Memorial Sloan Kettering. 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 an 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 peace of mind with respect to the financial burdens associated with catastrophic medical costs.

In reviewing the massive number of bills for my treatment, I noticed that over and over again, Memorial Sloan Kettering was not being reimbursed at an amount that was anywhere close to the cost of their services. I was then responsible for what my insurance company would not pay.

When I was diagnosed with cancer, I thought the most difficult hurdle I would face would be the disease. Little did I know, that dealing with my insurance company would be my greater battle, because unknown to me, they were operating with deceptive methods of reimbursement. I had to battle cancer—and I am still battling it—and I had to battle my insurance company to try and get fair coverage. It was almost too much to bear.

It was also shocking to discover firsthand how callously and deceptively insurance companies treat people while they are fighting for their lives. Throughout my life, I have believed that people had principles, that they abided by a code. My Mom and Dad were in the military—the “Service” is what we called it. When we were younger, my brother and I tried to live up to our parents call to service; he was in the army and I joined the Peace Corps. Our parents are now buried at West Point, but we have always tried to live by the values of duty, honor, and country.

But even at this point in my life, I was surprised to see an American company not abiding by any code at all. These insurance companies showed no regard for duty; they have no regard for honor; they have no regard for the citizens of this country. They take advantage of their countrymen when these countrymen are most vulnerable, and they try to bury them in paper and doubletalk while they are still alive.

My parents also taught their children to fight back. At first it was not easy. I wrote to several law enforcement agencies about the inordinate, unfair charges from my insurance company. Attorney General Cuomo's office was the only one that responded to me and helped me to fight the insurance company for proper coverage.

I am grateful that Attorney General Cuomo's work on behalf of people like me has led to nationwide agreements to end the deceptive practices of insurance companies, and I am glad to have been a part of the effort.

I am more fortunate than many others because I had funds to offset the costs that were unfairly passed to me by my insurance company—I had money left by my parents and other family members. But so many people are not as fortunate and do not have that ability. I cannot imagine the hardship that they must face.

Since originally appearing with Attorney General Cuomo earlier this year to announce his reform of the out-of-network reimbursement system, I have received letters of support from all over the United States from people who have been in my situation. A woman in Louisiana wrote: “I want to shout out to you go, Mary, go! Your actions have helped your neighbors across America.” Another one from New

York wrote: “Your story and spirit are truly inspiring. It shows that one person can take on a big business and make a difference; you are in my thoughts and prayers.”

These people, like me, have been fighting two battles—one against an illness and another against their insurance company—and are looking to the work of the Attorney General with great hope. They are also looking to you.

The crisis in our health care system is a national problem that demands a national solution. The problems in the insurance industry that Attorney General Cuomo has exposed and the pioneering solutions he has achieved should guide the Congress in a much-needed reform of our Nation’s health care system.

As a patient, as a cancer survivor, as a person who believes in duty, honor, and country, and as an American, I urge you to help make sure that in the future, patients can focus their energies on getting better, not on getting their rightful insurance benefits.

Thank you.

