STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

LINDA A. LACEWELL
COUNSEL FOR ECONOMIC & SOCIAL JUSTICE
HEAD OF THE HEALTHCARE INDUSTRY TASKFORCE

TESTIMONY

UNITED STATES SENATE

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Washington, D.C.
March 26, 2009

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 towards reform of the out-of-network reimbursement system.

Conflict of Interest

For ten 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 Database 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 ten 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 towards 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 entitywill 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.