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before the

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Hearing on

Consumer Reimbursement for Health Care Services

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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 Union[1] is the independent, non-profit publisher of *Consumer Reports*, with circulation of about 7 million (*Consumer Reports* plus ConsumerReports.org 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.

[1] Consumers 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.

Consumer 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, copayments 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%, compared with cumulative inflation of 29% and cumulative wage growth of 34%. Th 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% of insured consumers spent 10% or more of their incomes annually on out-of-pocket costs and premiums in 2007, compared to 19% 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% of working age adults

in the U.S. had difficulty paying medical bills or accumulated medical debt last year, compared with about 33% 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.'"

Consumer 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 physicans 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 reasonabl" 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% 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 in 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% 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% of the doctor's bill – they only agreed to pay 80% 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% 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% 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 ten 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% of the UCR charge, they effectively got 70%, 60% 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 ten 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 affiliates, 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.*
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> *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 US 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 NewYork 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 investigation 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% 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 web site, 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 Commissioners, 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.