



HEALTH CARE REPORT

**THE CONSUMER REIMBURSEMENT
SYSTEM IS CODE BLUE**

**STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL**

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EXECUTIVE SUMMARY

The nation's health care system is in need of reform. This Report focuses on one aspect of that system: the insurers' reimbursement of members for out-of-network bills.¹ We conclude that the consumer reimbursement system is code blue and needs dramatic reform to protect consumers.

This is an important consumer issue. Seventy percent of insured working Americans pay for insurance plans that allow them to choose their own doctors.² This means that 110 million Americans — one in three people — are potentially affected by this issue. Consumers typically pay more for this right because the choice of physician is such a critical decision. The consumer is generally responsible to pay the bill irrespective of how much the insurer decides to reimburse, because the doctor has no contract with the insurer.

These health care bills are a burden for working families and the number one cause of individual bankruptcy. The cost of health insurance itself by way of premiums, deductibles, and coinsurance also continues to climb disproportionately to other household expenses. In a struggling economy, the burden on working families is especially heavy.

When the Attorney General and his senior staff tour the State to hear directly from consumers as part of the Community Partnership Initiative, consumers report that health care is their number one concern. Consumers complain that they pay a great deal for health insurance, but are cheated when it comes to reimbursement. All too often, health insurers play a game of deny, delay, and deceive, and consumers pay the price. In this consolidated industry, the imbalance of power between giant health insurers and the individual is staggering. As the "People's Lawyer," the Attorney General seeks to restore the balance.

For the past year, the Attorney General’s Healthcare Industry Taskforce has been conducting an investigation into allegations that insurers unfairly saddle consumers with too much of the cost of out-of-network care.

The investigation to date has determined that most health insurers use schedules compiled by Ingenix, Inc. (“Ingenix”) in determining reimbursement rates for out-of-network care. Ingenix gathers billing data from the largest health insurers in the country, including UnitedHealth Group Incorporated (“UnitedHealth”), Aetna, CIGNA and Wellpoint,³ and then sends back schedules to those health insurers and others, based on the pooled data, which the insurers use as a benchmark to set their reimbursement rates.

As a wholly-owned subsidiary of UnitedHealth, Ingenix has a conflict of interest in preparing schedules that are supposed to fairly reflect the market. Other subsidiaries of UnitedHealth, and many other insurers, use these schedules to determine reimbursement rates for consumers. Health insurers also have an incentive to manipulate the data they submit to Ingenix so as to depress reimbursement rates based on the data pool, which forces consumers to pay more. Moreover, the Ingenix databases are a “black box” to the consumer, who does not know before choosing a doctor what reimbursement rate to expect from the insurer.

Our investigation has shown that the conflicts of interest inherent in the current system have a real impact on working families in New York. Analysis discloses that for ordinary doctor’s office visits, the Ingenix databases understate market rate by up to 28 percent across the state. This translates to at least hundreds of millions of dollars in losses for consumers over the past ten years across the country.

This Report lays out our central finding: the out-of-network system is broken. Insurers mislead and obfuscate in their policy language. They promise to reimburse based on usual and

customary rates — a form of market rate — but then reimburse based on schedules compiled by one of their own, the nation’s second largest health insurer, which has an interest in depressing reimbursement rates. They hide this conflict of interest from their members. They pretend an independent database underlies these rates — it does not. Our investigation found that the Ingenix schedules themselves, created in a well of conflicts, are unreliable, inadequate, and wrong — usually at the expense of the consumer.

The Report concludes that certain reforms are necessary to fix this broken system. First, the “usual and customary” or market rates for health care charges should be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database. We reject the notion that an insurer can credibly decide the fair market rate of health care charges, given the insurer’s obligation to reimburse the consumer a portion of that rate. The insurer has an untenable conflict of interest — one that must be cured.

Second, before consumers choose an out-of-network doctor, they should have a range or estimate of what it will cost them. The lack of transparency in the health care industry is striking. It is one of the most important consumer purchases, yet pricing information is practically nonexistent in the out-of-network setting. Consumers need more information about how they will be reimbursed and they need it earlier in the decision-making process. A website tool available to the public, showing at least common health care services and the market rates in relevant geographic areas, would be a giant leap forward in the battle for transparency in health care. Working families deserve no less, and all in the industry would benefit from greater accuracy, transparency and fairness in out-of-network reimbursement. In short, the consumer reimbursement system is code blue, but there is a cure: a new, independent database that fairly

reflects the market, and a website available to consumers to provide reimbursement information before they shop.

INTRODUCTION AND OVERVIEW

The nation's health care system is in need of reform. This Report focuses on one part of that system: out-of-network reimbursement. As explained in this overview, we conclude that the consumer reimbursement system is code blue and needs dramatic reform to remove conflicts of interest, generate fair rates, and bring transparency of pricing information to consumers.

Health care is a vital consumer issue. The cost of health care is a growing burden for working families and businesses large and small. Health insurance is a valuable employee benefit and consumer purchase, which mitigates these costs. But the cost of health insurance by way of premiums, deductibles, and coinsurance continues to climb disproportionately to other household expenses.

In a struggling economy, the burden on working families is especially heavy. The recent economic slowdown in this country makes life more difficult for working families in New York. Time and again, the People of the State of New York have complained to the Office of the Attorney General about health care issues and the deceptive practices of certain health insurers. When the Attorney General and his senior staff tour the State to hear directly from consumers as part of the Community Partnership Initiative, consumers in every community uniformly say that health care is their number one concern.

Consumers complain that they pay a great deal for health insurance, but question the value in return, as insurers deny coverage, delay payment, and deceive them. All too often, health insurers play this game of deny, delay, and deceive, and consumers pay the price. In this

consolidated industry, the imbalance of power between giant health insurers and the individual is staggering, and we seek to restore the balance on behalf of the People.

Families and employers are entitled to the benefit of the premiums they pay for health insurance. When insurers lure their customers with false or opaque promises, they reap undue profits and unfairly shift the burden of health care costs to others. This is true whether the care is rendered in network or out of network. Each comes with its own set of issues. With respect to in-network care, the Attorney General's Healthcare Industry Taskforce previously reformed doctor ranking programs, in which insurers rank or rate doctors according to measures of quality and cost efficiency.⁴ The investigation found that insurers have a potential conflict of interest when they essentially recommend doctors to consumers. The insurer pays for the care rendered by the very doctors it recommends, and therefore has a financial interest in representing that certain doctors are the best in quality when actually they may just be the cheapest. That investigation led to reform through the creation of a code of conduct, in consultation with national medical and consumer groups, which has been adopted by the largest health insurers in the State and the nation. The code is based on principles of accuracy, transparency and oversight, all to protect the consumer in the in-network setting, and is now the industry standard.

In the area of out-of-network care, insured Americans incur unforeseen and unduly high costs. Insurers frequently promise to reimburse patients as much as eighty or ninety percent of the "usual and customary rate" for health care services when the patient has seen an out-of-network doctor. Because an out-of-network doctor, by definition, has no contract with the insurer and has not agreed to accept a lower negotiated rate, the doctor by law is allowed to pursue the patient for the balance of the bill. If consumers do not understand how they will be reimbursed out of network, or if insurers promise more than they deliver or make unintelligible

promises, it is the consumer who suffers because it is the consumer who gets stuck with the bill. This frequently leads to unexpected debt, bad credit, and, in many cases, bankruptcy. It can also lead families to forego the medical care they need for fear of incurring additional debt. In addition, the consumer pays a higher premium for the right to go out of network and has not received the benefit of the bargain made with the insurer.

For the past year, the Attorney General's Healthcare Industry Taskforce has been conducting an investigation into allegations that insurers unfairly saddle consumers with too much of the cost of out-of-network care. The industry-wide investigation is ongoing. This Report lays out our central finding: the out-of-network system is broken. Insurers mislead and obfuscate in their policy language. They promise to reimburse based on usual and customary rates — a form of market rate — but then reimburse based on schedules compiled by one of their own, the nation's second largest health insurer, which has an interest in depressing reimbursement rates. They hide this conflict of interest from their members. They pretend an independent database underlies these rates — it does not. Our investigation found that the schedules themselves, created in a well of conflicts, are unreliable, inadequate, and wrong — usually at the expense of the consumer.

Our investigation has shown that the conflicts of interest inherent in the current system have a real impact on working families in New York. Analysis discloses that for ordinary doctor's office visits, the Ingenix databases understate market rate by up to 28 percent across the state. This translates to at least hundreds of millions of dollars in losses for consumers over the past ten years across the country.

The current industry model for reimbursing out-of-network care is fraudulent. The industry uses a conflict-laden database riddled with errors at the expense of the consumer. The

database is neither independent nor fair. This leads to chronically flawed decisions. Given the heavy burden of health care costs that working families must bear when insurers fail to pay what they owe, the out-of-network system must be fixed.

We conclude that the consumer reimbursement system is code blue and certain reforms are necessary. First, the “usual and customary” or market rates for reimbursement of health care charges should be determined by an independent third party free of conflicts of interest, using a fair, objective, and reliable database. We reject the notion that an insurer can credibly decide the fair market rate of health care charges, given the insurer’s obligation to reimburse the consumer a portion of that rate. The insurer has an untenable conflict of interest — one that must be removed.

Second, before consumers choose an out-of-network doctor, they should know what it will cost them. It is one of the most important consumer purchases, yet pricing information is practically nonexistent in the out-of-network setting. The lack of transparency in the health care industry is striking. Consumers need more information about how they will be reimbursed and they need it earlier in the decision-making process. A website tool available to the public, showing common health care services and the market rates in relevant geographic areas, would be a giant leap forward in the battle for transparency in health care. Knowing the price helps the consumer shop, and transparency helps the market and the entire industry function efficiently.

These points are described in detail throughout this Report. The Report has several parts. Part I describes the inception of the industry-wide investigation. Part II, to provide context, details the burden of health care costs on working families. Part III describes the lack of transparency in out-of-network reimbursement policies, which are often a financial trap for consumers. The Report ends in Part IV with our recommendations for reform.

I.

INCEPTION OF INDUSTRY-WIDE INVESTIGATION

“I frequently go to out-of-network providers and get low-balled by [my insurer]. . . . There is no doctor in that zip who will charge me so little, yet [my insurer] won’t tell me on whose billing they’ve based their [rate].

Consumer complaint to OAG, June 2008

Health care is the number one concern expressed by New Yorkers to the Office of the Attorney General (the “OAG”). Consumers repeatedly complain that health insurers fail to honor their promise to cover health care charges, and instead deny coverage or delay or reduce payment. Consumers also say that they cannot fight alone against huge corporate health insurers. Throughout the State, this is the most common refrain.

The Attorney General is “the People’s Lawyer” and seeks to be responsive to the needs of the community. To fulfill this goal, in September 2007, the Attorney General launched the Community Partnership Initiative.⁵ The Initiative started with a community forum in Binghamton and since then has spanned the Capital District (Albany), Central New York (Syracuse and Utica), the Finger Lakes Region (Rochester), the Hudson Valley (Middletown), Long Island (Brentwood, Riverhead, and Freeport), New York City (the Upper West Side and Staten Island), the North Country (Watertown), Westchester (White Plains), and Western New York (Buffalo and Niagara).

The breadth of regions toured “on the road” (“OTR”) is illustrated on the following map.

Map 1 – Regions Toured on the Road



One of the specific complaints that the OAG receiving during 2007 and early 2008 was that health insurers in New York and nationwide were underpaying consumers and their physicians for out-of-network care. Consumers also expressed confusion about how insurers were determining the rate of reimbursement for out-of-network care.

As a result, on February 13, 2008, the Attorney General announced an industry-wide investigation into allegations that health insurers defraud consumers by manipulating reimbursement rates. The center of the investigation is Ingenix, Inc., the nation’s largest provider of health care billing information and a subsidiary of UnitedHealth Group, Inc. (NYSE: UNH), the second largest insurer in the United States. Ingenix collects physician billing data

from a variety of health insurers, pools the data, and produces schedules that it supplies to the industry.⁶ The industry typically uses these schedules as a benchmark for the “usual and customary rate” for medical services, and reimburses consumers on that basis.

As the Attorney General stated in February, this system creates a conflict of interest because a giant health insurer through its subsidiary, Ingenix, provides the basis for determining rates that are supposed to reflect the market, but at the same time is obligated through other subsidiaries to reimburse consumers or their physicians a percentage of those rates. The insurer’s financial interest to maximize profits creates an incentive to manipulate the data so as to reduce these “market” rates, thereby reducing the rate of reimbursement.

The six-month investigation, as of February 2008, suggested that the Ingenix databases systematically reduce the rate at which insurers paid consumers or their physicians for out-of-network care. Because the care was out of network, consumers were obligated to pay the difference to their physicians. Physicians who chose for whatever reason not to balance bill their patients ended up receiving lower payments for their services than they should have.

As a result, the OAG expanded the investigation industry-wide and issued subpoenas to more than a dozen of the largest health insurers in New York and the nation, including UnitedHealth Group, Aetna (NYSE:AET), CIGNA (NYSE:CI), and Wellpoint/Empire BlueCross BlueShield (NYSE:WLP), and provided notice of the Attorney General’s intent to file suit against Ingenix, UnitedHealth Group, and additional United subsidiaries.

“As time went on, my healthcare provider put me on a payment plan to avoid going into collection status on [my family’s] numerous accounts with them. . . . If they did not allow this, these debts would have been sent to a collection agency AND reported as delinquencies on my credit report. . . . I could have been in jeopardy of losing my job.”

Consumer complaint to OAG, June 2008

II.

THE BURDEN OF HEALTH CARE COSTS ON WORKING FAMILIES

“Almost 50 percent of the American public say the cost of health care is their number one concern.”

The National Coalition on Health Care,
Facts on Health Care Costs (2008)⁷

A. THE EXTENT OF INSURANCE COVERAGE

For most people, health insurance is a lifeline. In an era of rapidly rising health care costs, health insurance can literally mean the difference between life and death.⁸ For this reason, most Americans choose to carry health insurance if they are able to do so.

In 2006-07, approximately 174 million of 298 million Americans (58 percent) had employer-based or individually-purchased health insurance coverage. Another almost 79 million (28 percent) had some form of government program coverage such as Medicaid or Medicare. New York is similar to the rest of the nation in this respect. Fifty-six percent of New Yorkers have employer or individual health insurance and 30 percent have government program coverage. Table 1 details the extent of coverage nationally and in New York.⁹

Table 1
Health Insurance Coverage – 2006-2007

	United States		New York	
Employer	159,311,384	53%	9,915,597	52%
Individual	14,541,782	5%	672,495	4%
Medicaid	39,296,423	13%	3,641,829	19%
Medicare	36,155,452	12%	2,166,402	11%
Other Public	3,253,122	1%	59,349	0%
Uninsured	45,657,193	15%	2,590,364	14%

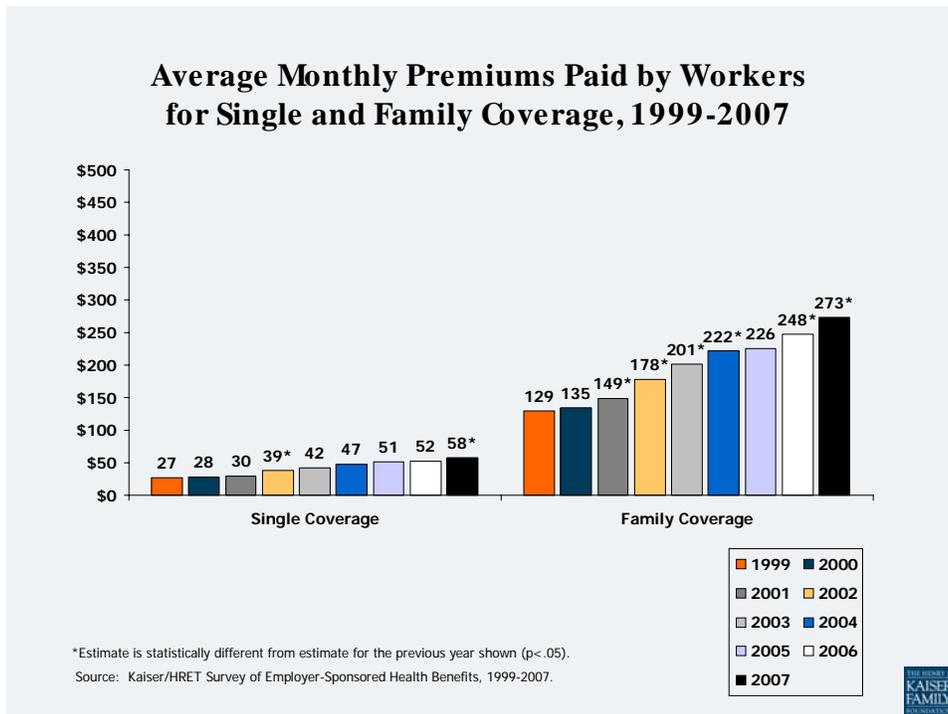
B. SPIRALING HEALTH CARE COSTS

“A survey being released today, by the Mercer consulting firm found 59 percent of companies intend to keep down rising health care costs in 2009 by raising workers’ deductibles, copays or out-of-pocket spending limits.”

Co-pays, Deductibles to Rise at Most Companies, Times Union (Sept. 4, 2008) (Associated Press)

The sums of money that families are required to contribute for employer-based health care coverage and for deductibles and co-payments have increased dramatically. The 2007 Kaiser Family Foundation/HRET (the “Kaiser Foundation”) survey of employee benefits found that the average monthly premium families paid for coverage jumped from \$129 in 1999 to \$273 in 2007, as the graph below from the Kaiser Foundation demonstrates.¹⁰

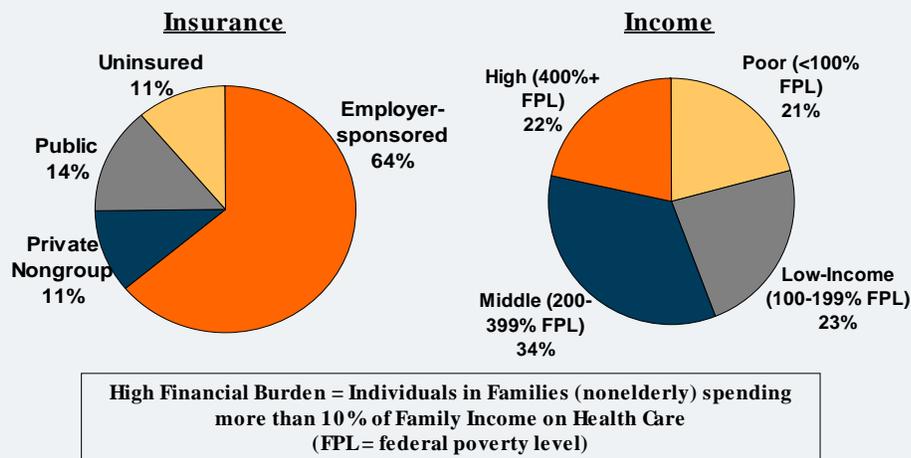
Chart 1



In addition, the cost of deductibles and co-payments has climbed steadily over the past ten years. Moreover, not all services are covered by insurance in whole or in part. As a result, some 45 million American families pay *more than ten percent of their income* for health care — and, surprisingly, 56 percent of them are classified as middle income (200 to 399 percent of the federal poverty level) or high income families (400 percent or more of the federal poverty level). Evidently, this problem affects people of every income level, as the following chart adapted from the Kaiser Foundation shows.

Chart 2

45 Million Families Spend More than 10% of Family Income on Health Care
by Insurance and Income Groups, 2004



SOURCE: Kaiser Family Foundation, based on Banthin, JS, P Cunningham, and DM Bernard. 2008. *Financial Burden of Health Care, 2001-2004*. Health Affairs 27(1).



The National Coalition on Health Care makes the following observations about the impact of health care costs on ordinary Americans:¹¹

- One in four Americans had a problem paying for medical care during the past year. Nearly 30 percent said someone in their family has delayed medical care in the past year. Most described the medical condition as “at least somewhat serious.”
- A Harvard study “found that 50 percent of all bankruptcy filings were partly the result of medical expenses. *Every 30 seconds in the United States someone files for bankruptcy in the aftermath of a serious health problem.*” (Emphasis added).
- “One half of workers in the lowest compensation jobs and one-half of workers in mid-range compensation jobs either had problems with medical bills in a 12-month period or were paying off accrued debt.”
- More than 25 percent of workers had housing problems that resulted from medical debt, “including the inability to make rent or mortgage payments and the development of bad credit ratings.”

III.

LACK OF TRANSPARENCY IN OUT-OF-NETWORK POLICIES

*“Sunlight is said to be the best of disinfectants,
electric light the most efficient policeman.”*

Justice Louis Brandeis, *Other
People’s Money* (1914)

A. THE FINANCIAL TRAP OF OUT-OF-NETWORK POLICIES

An in-network doctor has a contract with an insurer and has negotiated to receive a lower rate of payment. Payment is a matter between the doctor and the insurer, and the doctor cannot by law look to the patient for any shortfall for covered services.¹² An out-of-network doctor does not have a contract with an insurer; payment is a matter between the doctor and the patient. By law, the doctor may pursue the patient for the entire bill no matter how much — or how little — the insurer pays the patient.

Insurers typically charge higher premiums for policies with out-of-network benefits. Yet many people choose to pay this higher premium for the right to select their own doctor. The reason is simple: people want the freedom to make decisions about their families’ health care. Sometimes, the best or only physician they can find to treat a particular condition is not a member of their insurer’s network. Or, a job change means a change of insurer, and the family’s trusted primary care physician, pediatrician, or other specialist is now out of network. Insurers know this; they market out-of-network policies under names such as “Freedom” and “Choice.”

When an insurer fails to pay its share of an out-of-network bill in full, this has particular significance for the consumer. When health insurers fail to pay amounts for which they are

responsible for out-of-network care, they unfairly stick consumers with the bill. Because the consumer has seen an out-of-network doctor, the consumer is responsible for *the balance of the bill*. Because the doctor has no contract with the insurer, the doctor can look to the patient to pay the balance of the bill. This discourages consumers from leaving the insurers' preferred network of health care providers.

"It's as though they're holding me hostage by forcing me to go in network or get short-changed."

Consumer complaint to OAG, June 2008

Thus, out-of-network reimbursement is an issue of particular resonance for consumers. This kind of health insurance costs more money, and consumers must pay the balance of the bill irrespective of whether their insurers reimburse them in full or not. As a result, those insurers trick consumers into having to pay more for medical care than they had 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, they rob consumers of the ability to make intelligent and informed decisions about their health care.

"I'm still paying over \$20,000 of medical bills for my knee replacement of May 2005, that [my insurer] said were above reasonable costs."

Consumer complaint to OAG, February 2008

B. THE LACK OF TRANSPARENCY

“How is the usual and customary charge determined? Is it done by the insurance company or is it regulated by New York State and if so what is it based on? How does a consumer know if it is accurate or not?”

From this it seems that either my doctor is overcharging me or [my insurer] is underpaying me. How do I determine which it is?”

Consumer complaint to OAG, March 2008

During the investigation, the OAG subpoenaed a broad range of plan documents describing out-of-network policies. 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. One national insurer filled an entire page with a list of alternative ways in which it purported to calculate out-of-network rates, in language that can best be described as gobbledygook. After twenty minutes of questioning of in-house counsel about the meaning of this language, it emerged that the plan *pays the same rates for in-network and out-of-network care*. The fact that this Report can state in a single phrase how that insurer calculates out-of-network rates shows the needless obtuseness of that insurer’s page-long description. This observation leaves aside entirely the question of whether it is appropriate to charge consumers higher premiums for the right to go out-of-network and then pay the same for in-network and out-of-network care.

Another national insurer pointed to a change in policy language in approximately 2003, when the insurer stopped using the term “usual and customary” to describe its out-of-network reimbursement policies. The OAG reviewed the new language and found it vague and lacking in substance. When asked repeatedly to explain what the new language means, the head of litigation for the insurer finally replied, “I don’t know.”

No insurer in its documents disclosed that a major health insurer (UnitedHealth Group) operates the databases used to calculate out-of-network reimbursement rates, which presents a potential conflict of interest. Many plans falsely represented that out-of-network rates were based on data supplied by “HIAA” (the Health Insurance Association of America), a trade association that has not existed since 2003. Other documents were apparently updated to state instead that the data is supplied by “AHIP” (America’s Health Insurance Plans), a successor trade association formed through a merger of HIAA and another association. The problem with both of these references is that HIAA has not supplied the data for several years and AHIP has never supplied the data. Reference to HIAA and AHIP also masks the conflict of interest inherent in UnitedHealth Group’s operation of the databases.

Many health insurers in their materials evinced a lack of focus on consumers and a lack of literacy. The lack of transparency and accuracy in these materials creates a financial trap for the consumer. The consumer has paid more for the right to select a doctor outside the insurer’s preferred network. Now the time comes for the consumer to exercise that right. 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 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. No one’s interests here are advanced, except perhaps when next time, the consumer decides to stay in network for fear of what bills may accrue for out-of-network care. The interests advanced in that event are those of the insurer, whether by accident or design.

IV.

THE INGENIX DATABASES UNDER-REIMBURSE CONSUMERS

Investigation conducted since February 2008 has led us to conclude that the conflict of interest problems described in this Report are not hypothetical; they are real, because the Ingenix databases in fact under-reimburse consumers.

During the past several months, in an effort to determine the level of accuracy of the Ingenix databases, we collected and analyzed millions of health care bills from a variety of sources, including a range of insurers operating within the State of New York. In particular, as relevant here, we collected over a million bills to insurers for certain ordinary doctors' office visits both simple and complex within the following counties: Albany, Erie (Buffalo), New York (Manhattan), Monroe (Rochester), and Onondaga (Syracuse), for the period of 2004 through 2007. The doctors' visits were billed under the following codes ("Current Procedurals Terminology" or "CPT Codes"):

CODE	DESCRIPTION
99212	Minor problems of an established patient making a visit to the doctor's office.
99213	Problems of low to moderate severity of an established patient making a visit to the doctor's office.
99214	Problems of moderate to high severity of an established patient making a visit to the doctor's office.
99215	Problems of moderate to high severity of an established patient making a visit to the doctor's office; problems are usually more complex than 99214.
99245	Problems of moderate to high severity of a new or established patient who may be hospitalized; problems are usually highly complex .

These bills were made to the very same insurers under investigation for their use of the Ingenix databases. From these bills, we were able to derive how much health care providers

actually charged in the market for the relevant office visits during the relevant time period. In this way, we created our own model database (the “Model Database”) for these services in these New York State counties.¹³ We also obtained comparable rate information from Ingenix. This enabled us to compare the rate Ingenix databases (the “Ingenix Database”) indicate should be paid with the rate that doctors’ own bills to insurers indicate should be paid.

Our analysis¹⁵ showed that insurers systematically under-reimburse New Yorkers for doctor’s office visits. Statewide, consumers were underpaid by up to 28 percent. Regional disparities across the State exist. For example, in New York County (Manhattan), underpayments were typically 10 to 20 percent, as this table shows:

Table 2

MANHATTAN UNDERPAYMENTS (2007)

BILLING CODE	RATE PER MODEL DATABASE	RATE PER INGENIX	DIFFERENCE (DOLLARS)	DIFFERENCE (PERCENT)
99211	\$125	\$100	\$25	20
99212	\$150	\$125	\$25	17
99213	\$185	\$160	\$25	14
99214	\$250	\$225	\$25	10
99215	\$355	\$350	\$5	1
99245	\$550	\$550	\$0	0

Even worse, in Erie County, a much poorer region, underpayments were much higher, ranging from 17 to 28 percent, as this table shows:

Table 3

ERIE COUNTY UNDERPAYMENTS (2007)

BILLING CODE	RATE PER MODEL DATABASE ¹⁶	RATE PER INGENIX ¹⁷	DIFFERENCE (DOLLARS)	DIFFERENCE (PERCENT)
99211	\$45	\$36-\$37	\$8-\$9	18-20
99212	\$68	\$53-\$61	\$7-\$15	10-22
99213	\$84	\$70-\$78	\$6-\$14	7-17
99214	\$130	\$105-\$122	\$8-\$25	6-19
99215	\$200	\$145-\$182	\$18-\$55	9-28
99245	\$373	\$276-\$340	\$33-\$97	9-26

This regional disparity is troubling because upstate New Yorkers can least afford to take on additional health care costs. Within Erie County, the City of Buffalo currently ranks as the country's third poorest city and an estimated 30% of the residents live below the poverty line. The City's median household income is approximately \$30,000, the seventh-lowest among large cities.¹⁸

These underpayments have a real impact in terms of dollar losses. Ordinary doctor's office visits are the most frequent health care charge. Underpayments of up to 10 to 20 percent in Manhattan alone translate to millions of dollars per year in underpayments. When extrapolated across the State and the country, it is fair to say that the Ingenix databases have caused Americans to be under-reimbursed to the tune of at least hundreds of millions of dollars over the past ten years.

The most money in New York state is due in Manhattan because many more people live there, have the option to go out-of-network, and generate more claims. But the people of Erie County individually suffer the highest degree of underpayment. Given the economic disparity between Manhattan and Erie County, it is troubling to see that upstate residents are being disproportionately saddled with the costs of health care that should be borne by insurers. While the total underpayments is less in dollar terms outside of Manhattan, as a proportion, the losses are higher in upstate New York where residents are generally much less able to afford the loss.

All told, these results suggest the need for continued investigation into the impact of the use of Ingenix on health insurer payment problems — as well as a broadened focus on payment reductions for reasons other than use of the Ingenix data. In order to bring more understanding to these issues, the OAG is collecting the same data for all counties statewide for a range of medical services, not confined to ordinary doctor's visits.

V.

REFORM IS NEEDED

“Criticism may not be agreeable, but it is necessary. It fulfills the same function as pain in the human body. It calls attention to an unhealthy state of things.”

Winston Churchill, House of Commons speech (quoted in William Manchester, *The Last Lion: Winston Spencer Churchill, Visions of Glory 1874-1932*, at 348 (1983))

In February 2008, the OAG announced that the database used by most of the industry to determine reimbursement rates for out-of-network services was tainted by a serious conflict of interest. The database is operated by a subsidiary of an insurer, which has a financial interest to skew the rates downward so as to save the insurer money. In addition, we noted that Ingenix, which operates the database, makes little to no effort to determine whether the data it receives has integrity, is what it purports to be, and is sufficient for the intended purpose. Moreover, the statistical methodologies and protocols applied to the collected data are deficient and tend to skew the rates downward.

The investigation conducted to date leads us to conclude that the out-of-network reimbursement system is broken. This critically ill system needs serious and immediate attention. The cure is simple to state: an independent and fair database and transparent pricing information. For the cure to work, the entire industry must participate. This is an industry-wide problem that needs an industry-wide solution. The fault cannot be laid on Ingenix alone. All industry members have benefited unfairly at the expense of consumers over the past ten years, and they continue to benefit unfairly from a rigged system day after day. They must all agree to stop using the conflicted database and use instead independent and fair data. And they must be

more clear about how they determine payment to consumers. Working families deserve no less, and all in the industry will benefit from greater accuracy, transparency and fairness in out-of-network reimbursement.

ENDNOTES

¹ For more information, visit http://www.ag.ny.gov/bureaus/health_care/HIT2/reimbursement_rates.html.

² Kaiser Family Foundation, Employer Health Benefits Survey 2008 (pp. 46 & 64) (158 million Americans have health insurance through their employers; 58 percent of covered workers are in preferred provider organization (“PPO”) or point of service (“POS”) plans), available at <http://ehbs.kff.org/pdf/7790.pdf> (last visited Jan. 11, 2009); U.S. Bureau of Labor Statistics, “Definitions of Health Insurance Terms” (p. 3) (PPO and POS plans include out-of-network option), available at <http://stats.bls.gov/ncs/ebs/sp/healthterms.pdf#search=%22pos%20health%20insurance%20plan%20definition%22> (last visited Jan. 11, 2009).

³ Wellpoint’s subsidiary, Empire BlueCross BlueShield, the largest insurer in the State of New York, uses the Ingenix databases to determine reimbursement rates.

⁴ For information on the Attorney General’s doctor ranking initiative, visit http://www.ag.ny.gov/bureaus/health_care/HIT2/doctor_ranking.html.

⁵ http://www.ag.ny.gov/media_center/2007/sep/sep07a_07.html.

⁶ Ingenix produces schedules for services in geographic areas at various percentiles of the database. For example, a rate of \$100 for a medical office visit in Manhattan listed at the 80th percentile means that 80 percent of those claims in the database are billed at the rate of \$100 or below. Ingenix licenses these schedules to insurers, which rely on them to find the “usual and customary rates” by which they reimburse consumers or their physicians for out-of-network care.

⁷ The National Coalition on Health Care, *Health Insurance Costs*, http://www.nchc.org/documents/cost_fact_sheet_2008.pdf (last visited Sept. 9, 2008) (citing Wall St. J.-NBC Poll on America’s Economic Mood, Wall St. J., Aug. 2, 2007).

⁸ See, e.g., Remarks of Mark Cronin, American Cancer Society Vice President for the Lakes Region, Press Release: *Attorney General Cuomo Announces Agreement with Excellus and CareCore to Ensure Cancer Patients Get Timely Critical Care Services* (June 4, 2008) (remarking that delays in access to health care “could literally cost a patient his or her life”), available at http://www.ag.ny.gov/bureaus/health_care/HIT2/radiology.html.

⁹ Kaiser Family Foundation, *New York: Health Insurance Coverage of the Total Population, States (2006-2007), U.S. (2007), Facts*, <http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3&sub=39&yr=85&typ=1> (last visited Jan. 8, 2009); see also United States

Census Bureau, *Health Insurance Coverage Status and Type of Coverage by State, All People: 1999-2007*, <http://www.census.gov/hhes/www/hlthins/historic/hihist4.xls> (last visited Oct. 9, 2008).

¹⁰ Kaiser Family Foundation and Health Research & Educational Trust, *Survey of Employer-Sponsored Health Benefits, 1999-2007*, <http://www.kff.org/insurance/7672/upload/7693.pdf> (2007) (last visited Jan. 8, 2009). See also J.S. Banthin, P. Cunningham, and D.M. Bernard, *Financial Burden of Health Care, 2001-2004*. *Health Affairs* 27(1)(2008). Where we have included charts from other materials, we have in some instances edited the titles in non-material respects to improve clarity. These edits were made to Charts 1 and 2.

¹¹ The National Coalition on Health Care, *Health Insurance Costs* (2008), http://www.nchc.org/documents/cost_fact_sheet_2008.pdf and <http://www.nchc.org/documents/Costs-Workers-2009.pdf> (last visited Jan. 8, 2009).

¹² N.Y.C.R.R. tit. 10, ch. II, §98-1.5(b)(6)(ii)(2005); N.Y.C.R.R. tit. 11, ch. IV §101.4(a)(2) (2008). See also Non-Network Hospital Emergency Treatment, Op. N.Y. Ins. Dep't (July 10, 2008), OGC Op. No. 08-07-04, <http://www.ins.state.ny.us/ogco2008/rg080704.htm> (last visited Jan. 8, 2009) (noting that when the procedure involves emergency services, the provider may not balance bill for out-of-network services if the patient is in an HMO, citing N.Y. Ins. L. §4303(a)(2) and N.Y.C.R.R. tit. 10, ch. II, §98-1.13(a)(2005)).

¹³ While the Model Database is sufficient for the purpose of conducting the analysis described in this report, a database actually used to determine reimbursement to consumers would need to be more rigorous to account for the complexities of a range of health care charges by various health care providers in relevant geographic areas around the country.

¹⁴ We subpoenaed data from the Prevailing Healthcare Charges System, which is the primary Ingenix database.

¹⁵ The analysis reflected compares the Model Database and Ingenix rates listed at the 80th percentile. See endnote 6 regarding the use of percentiles.

¹⁶ The Ingenix rates for Erie County vary depending on the first three digits of the zip code of where services were provided within the county. The rates per the model database included here are blended rates for Erie County.

¹⁷ The Ingenix rates for Erie County vary depending on the first three digits of the zip code of where services were provided within the county.

¹⁸ United States Census Bureau, *Income, Earnings, and Poverty Data from the 2007 American Community Survey* 13, 25 (Aug. 2008).