

*2009 Fall National Meeting  
Washington, DC*

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

**PUBLIC HEARING**

**USUAL, CUSTOMARY AND REASONABLE (UCR) PRACTICES**

**Thursday, September 24, 2009  
8:00 – 9:30 a.m.**

**Gaylord Convention Center—Maryland Ballroom A**

**Purpose of the Hearing**

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

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

**Agenda**

1. Opening Remarks (*5 minutes*)  
– Commissioner Kim Holland (OK) and Commissioner Sandy Praeger (KS)
2. Marty Mitchell, America's Health Insurance Plans (*12 minutes*)
3. Dr. Robert Wah, Trustee, American Medical Association (*12 minutes*)
4. Kevin Lucia, Georgetown University (*12 minutes*)
5. Bonita A. Kallestad, Mid-Minnesota Legal Assistance (*12 minutes*)
6. Ellen Kuhn, Maryland Assistant Attorney General (*12 minutes*)
7. Open Dialogue (*20 minutes*)  
– Commissioner Holland and Commissioner Praeger
8. Closing Remarks (*5 minutes*)  
– Commissioner Holland and Commissioner Praeger

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Testimony of

America's Health Insurance Plans

Before the

National Association of Insurance Commissioners'

Market Regulation and Consumer Affairs (D) Committee

And

Health Insurance and Managed Care (B) Committee

September 24, 2009

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

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

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

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

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

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

## **1. Background**

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

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

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<sup>3</sup> Id. at 2.

<sup>4</sup> Atul Gawane, *The Cost Conundrum: What A Texas Town Can Teach Us About Health Care*, *The New Yorker* (June 2009).

<sup>5</sup> Id.

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

## **2. Usual, Customary, and Reasonable Determinations**

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

The following approaches are typically used in these circumstances:

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

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

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

- *Fee schedule:* Another methodology uses a reimbursement schedule that may be fixed (e.g., no more than \$500 per hospital bed day, \$100 for an office visit) or pays out-of-network providers based on the negotiated fee schedule used for contracted providers in the same geographic region (e.g., 70 percent of the health plan's or payer's contracted rate for the same service in the same geographic region).
- *Reference to Medicare rates:* Another approach reimburses out-of-network providers based on a percentage of the Medicare published rate for the same or similar service in a specific geographic area (e.g., 150 percent of the Medicare published rate).

### **3. Impact on Consumers**

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

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

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

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

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

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

## Balance Billing – The Consumer Perspective

Ellen L. Kuhn  
Assistant Attorney General  
Maryland Office of the Attorney  
General

### What is balance billing?

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

## What do consumers think balance billing is?

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

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

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

## How consumers think the math works....

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

## Or, consumers think the math works like this....

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

## So why the confusion?

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

## Plan summaries are not clear to consumers

Example of language from a plan summary:

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

## Problems Consumers Encounter: The In-patient Setting

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

## Problems Consumers Encounter – The Medical Office

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

## Legislative Action

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

## Maryland Law – Hold Harmless

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

## Maryland Law – Balance Billing Prohibition

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

## Issues To Consider

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

## Contact Information

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## Summary of UCR Senate Hearing Report

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

### Background on “Usual and Customary” Reimbursement Rates

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

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

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

### Flawed Data

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

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

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

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

### The Senate Commerce Committee Investigation

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

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

## **Significant Findings**

### **The Use of Ingenix Data Was Widespread in the Insurance Industry**

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

### **Lack of Transparency to Consumers about the Data**

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

### **Evidence that the Ingenix Data Was Faulty**

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

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

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

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COMMITTEE ON COMMERCE,  
SCIENCE, AND TRANSPORTATION

OFFICE OF OVERSIGHT AND INVESTIGATIONS

**UNDERPAYMENTS TO  
CONSUMERS BY THE  
HEALTH INSURANCE  
INDUSTRY**

**Staff Report for Chairman Rockefeller  
June 24, 2009**

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## **Executive Summary**

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

### ***Background on “Usual and Customary” Reimbursement Rates***

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

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

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

### ***Ingenix’s Flawed Data***

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

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

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

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

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

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

### *The Senate Commerce Committee Investigation*

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

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

- ***The Use of Ingenix Data Was Widespread in the Insurance Industry*** With one exception, all of the 18 insurance companies that received Chairman Rockefeller’s April 2 letter responded that they, or at least one of their affiliates or subsidiaries, purchased and used Ingenix data to pay claims for out-of-network health care or dental services. These responses demonstrate that the use of the Ingenix products was pervasive throughout the health insurance industry, not just among the largest national insurers involved in the New York settlement. They also suggest that the number of American consumers who were harmed by under-reimbursements based on the Ingenix data may be substantially higher than previously estimated.
- ***Lack of Transparency to Consumers About the Ingenix Data*** The Committee’s review of disclosure materials shows that the insurance industry failed to provide consumers accurate, understandable information about Ingenix or the way it used Ingenix data to calculate out-of-network allowances. The Committee has even found consumer disclosures that contain patently false information. A review of contracts between Ingenix and the insurance industry shows that Ingenix explicitly prohibited insurers from disclosing information about the Ingenix databases to consumers and doctors.
- ***More Evidence that the Ingenix Data Was Faulty*** In spite of Ingenix’s testimony before the Committee that it closely monitors the data it receives from insurers for completeness and accuracy, Committee staff have reviewed persuasive evidence that this statement is inaccurate. Some insurance companies improperly “scrubbed” valid charges before submitting their data to Ingenix. Committee staff have uncovered new evidence that a major contributor of data to Ingenix submitted its data in a manner that violated the Ingenix data submission guidelines and harmed consumers by skewing prevailing rates downwards.
- ***More than Two Million Federal Employees and Military Family Members Participated in Plans that Used Ingenix Data*** In response to Chairman Rockefeller’s March 31 letter, OPM informed the Committee that in 2008, approximately 911,000 out of the 4 million federal employees and retirees who received health coverage through the Federal Employees Health Benefits Program (FEHBP) were enrolled in plans that used Ingenix data to calculate out-of-network reimbursement rates. In addition, more than a million military family members were enrolled in health coverage through the TRICARE program that used Ingenix data to calculate out-of-network benefits.

## I. “Usual and Customary” Rates in the Health Insurance Industry

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

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

### A. *The “Out-of-Network” Health Care Option*

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

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

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

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

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

<sup>3</sup> *Blue Cross and Blue Shield Service Benefit Plan. A Fee-for-Service Plan (Standard and Basic Option) with a Preferred Provider Organization* (2009), 134. (Online at: [http://www.fepblue.org/benefitplans/2009-sbp/SBP2009Brochure\\_English.pdf](http://www.fepblue.org/benefitplans/2009-sbp/SBP2009Brochure_English.pdf)).

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

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

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

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

*B. The Development of “Usual and Customary” Reimbursement Rates*

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

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

<sup>5</sup> *Id.*

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

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

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

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

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

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

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

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<sup>6</sup> *Id.*, Testimony of Stephen Hemsley, President and CEO, UnitedHealth Group.

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

<sup>8</sup> *March 2009 Health Care Hearings*, Testimony of Dr. Nancy Nielsen, President, American Medical Association.

<sup>9</sup> As will be discussed further below, in 2003, HIAA and the American Association of Health Plans (AAHP) merged to form America’s Health Insurance Plans (AHIP).

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

<sup>11</sup> *United HealthCare Buys HIAA Pricing System*, Bestwire (Oct. 22, 1998) (“Both systems [PHCS and

separate product lines, although the company appears to have consolidated the two databases in 2001.<sup>12</sup>

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

## II. **Ingenix’s Close Ties with the Health Insurance Industry**

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

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

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

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

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

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

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

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

<sup>15</sup> Master Services and License Agreement Between Ingenix, Inc. and [Insurer] (July 7, 1999) (hereinafter “Exhibit A”).

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

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

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

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

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

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<sup>16</sup> *Id.* (“Customer shall have no right to allow any person or entity who is not a party to this Agreement to access the Software or Data directly or indirectly in any way, at Customer’s site or via remote communication methods.”)

<sup>17</sup> Prevailing Healthcare Charges System (PHCS) Product Schedule Agreement Between Ingenix, Inc., and [Insurer] (May 1, 2005) (hereinafter “Exhibit B”).

<sup>18</sup> *Id.*

<sup>19</sup> *March 2009 Health Care Hearings*, Testimony of Dr. Nancy Nielsen.

<sup>20</sup> Exhibit B.

## *B. Data Contribution Agreements Between Ingenix and Insurers*

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

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

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

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

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

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

<sup>22</sup> Exhibit B.

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

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

data to Ingenix, Mr. Slavitt responded that, “we run a number of analyses to check and make sure” that the data is accurate and complete.”<sup>26</sup>

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

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

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

*C. How Ingenix Products Were Used to Determine Reimbursements*

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

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

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

<sup>26</sup> *March 2009 Health Care Hearings*, Testimony of Andy Slavitt, CEO, Ingenix, Inc.

<sup>27</sup> *See Davekos v. Liberty Mutual*, 2008 Mass.App. Div. 32, 2009, WL 241613 (Mass. App. Div.).

<sup>28</sup> *Id.*

<sup>29</sup> Ingenix employs the American Medical Association’s proprietary “Current Procedural Terminology” (CPT) coding system to describe the services rendered.

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

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

#### *D. Health Insurers Acknowledge Their Conflict of Interest with Ingenix*

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

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

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

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

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

<sup>31</sup> *Id.*

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

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

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

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

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

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

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

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

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<sup>32</sup> *UnitedHealth Settles New York Reimbursement Probe*, Reuters (Jan. 13, 2009).

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

<sup>34</sup> *March 2009 Health Care Hearings*, Testimony of Stephen Hemsley.

<sup>35</sup> *Id.*, Testimony of Andy Slavitt, CEO, Ingenix, Inc.

<sup>36</sup> Senate Commerce Committee Staff Telephone Conversation with Jill Faddis (March 30, 2009); *See*

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

#### *A. Private Legal Actions*

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

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

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

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Exhibit C, at 18.

<sup>37</sup> *American Medical Association, et al. v. United Healthcare Corporation, et al.*, S.D.N.Y. (No. 00 Civ. 2800).

<sup>38</sup> *AMA Alleges HMO Uses Faulty Data In Reimbursements*, Wall Street Journal (Mar. 16, 2000).

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

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

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

<sup>42</sup> *McCoy v. Health Net, Inc.*, 569 F.Supp.2d 448, 468 (D.N.J. 2008).

settlement determined that the Ingenix database products suffered from “serious flaws” due to the way they collected and “scrubbed” medical claims data.<sup>43</sup>

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

### *B. The New York Attorney General’s Investigation*

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

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

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

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<sup>43</sup> *Id.*

<sup>44</sup> *Davekos v. Liberty Mutual*, 2008 Mass.App. Div. 32, 2009, WL 241613 (Mass. App. Div.).

<sup>45</sup> *Id.*

<sup>46</sup> Attorney General of New York, *Cuomo Announces Industry-Wide Investigation into Health Insurers’ Fraudulent Reimbursement Scheme* (Feb. 13, 2008) (Online at [http://www.oag.state.ny.us/media\\_center/2008/feb/feb13a\\_08.html](http://www.oag.state.ny.us/media_center/2008/feb/feb13a_08.html)).

<sup>47</sup> See Part II.D above.

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

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

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

#### **IV. The Senate Commerce Committee Investigation**

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

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

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

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

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

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

<sup>51</sup> *March 2009 Health Care Hearings*, Testimony of Chuck Bell, Programs Director, Consumers Union.

insurance market in the United States.<sup>52</sup> These letters asked the companies for the following information:

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

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

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

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

#### *A. The Use of Ingenix Database Products Was Widespread*

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

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

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

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

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

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

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

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

#### *B. The Deliberate Lack of Transparency in Disclosure Materials*

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

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

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

Health Plan’s payment for covered out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable, and customary. This means a fee that:

- i. Does not exceed most Charges which providers in the same area charge for that Service; and
- ii. Does not exceed the usual Charges made by the provider for that Service; and
- iii. Is in accord with standard coding guidelines and consistent with accepted healthcare reimbursement payment practices.

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

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

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

#### Step 1: We Review the Data

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

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

<sup>57</sup> Aetna, *How Aetna Pays Claims for Out-Of-Network Benefits*, (2009).

Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code....

Step 2: We calculate the portion we pay

For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code. If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use “derived charge data” instead. “Derived charge data” is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed.

Step 3: We refer to your health plan

We pay our portion of the Plan allowance as listed in your health plan. You pay your portion (called “coinsurance”) and any deductible. Sometimes what we pay is less than what your provider charges. In that case, your provider may require you to pay the difference. This is true even if you have reached your plan’s out-of-pocket maximum...

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

*C. The Continuing False Attribution of Data to HIAA*

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

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

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

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

*D. New Evidence of Ingenix Data “Scrubbing”*

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

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

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

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

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

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

<sup>59</sup> *March 2009 Health Care Hearings*, Testimony of Andy Slavitt.

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

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

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

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

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

*F. Regulatory Mandates to Use Ingenix Data*

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

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<sup>60</sup> Exhibit C.

<sup>61</sup> NJ Admin. Code 11:21-7.13(a).

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at 11:21-713(a)(1).

<sup>64</sup> New Jersey Law also requires insurance companies providing individual health insurance to use the

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

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

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

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

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

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

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

<sup>65</sup> 28 California Code of Regulations 1300.1(a)(3)(B).

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

#### *H. Ingenix Was Used in Other Health Insurance Products*

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

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

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