UNDERPAYMENTS TO CONSUMERS BY THE HEALTH INSURANCE INDUSTRY

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.