Consumers Union

NONPROFIT PUBLISHER OF CONSUMER REPORTS

Executive Summary: Statement of Consumers Union, April 23, 2009

Before the Subcommittee on Health Employment, Labor, and Pensions

A national health reform law is a huge opportunity to reduce the cost of health insurance for employers, employees and their families. Savings can be achieved by

Establishing a permanent insurance anti-fraud watchdog unit to work with States to prevent and detect the kind of abuses seen in the HealthNet and UnitedHealth-Ingenix case, where consumers have lost hundreds of millions of dollars over the past decade because of insurers underpaying for out-of-network costs;

Empowering consumers in the marketplace:

√Create an honest database where consumers can see beforehand what their out-of-network costs are likely to be, thus enabling some increased shopping;

√A new Office of Consumer Health Insurance Education and Information that will:

√Provide general and comparative information about insurance quality, prices, and policies using consumer-friendly formats

√Require standardization of insurance definitions and forms so consumers can easily compare policies on an "apples-to-apples' basis

√Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under typical treatment scenarios

√Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site

√Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support to community-based non-profit organizations providing one-on-one insurance counseling to consumers

√An insurance "exchange" or "connector," offering a choice of plans, that will:

√Include an optimal number of plan choices – not too few and not too many--and limit excessive variations in benefit design so that plans compete more on price and quality

√Ensure that before selecting a plan, the consumer sees the price and quality ratings of comparatble plans

√Require plans to provide year-long benefit, price, and provider network stability

√Protect against marketing abuses and punish insurers that mislead consumers

√Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, and balance-billing and co-pay problems, and to appeal coverage denials

Investigate the growing concentration (mergers) in the insurance and provider sectors and determine why, despite their purchasing power, insurers are unable to adequately slow health inflation.

Testimony of William Vaughan
Health Policy Analyst
Consumers Union
before the
Subcommittee on Health Employment, Labor, and Pensions
Committee on Education and Labor
U.S. House of Representatives
April 23, 2009

on

Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families.

Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1] We not only evaluate consumer products like cars and toasters, we rate various health care providers and insurance products, and we apply comparative effectiveness research to save consumers millions and millions of dollars in purchasing the safest, most effective brand and generic drugs.[2] Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you in big trouble.

We believe (1) a structured marketplace where consumers can shop intelligently for insurance **and** (2) increased oversight, to prevent the type of abuses revealed in the UnitedHealth-Ingenix case, can create enormous, multi-billion dollar savings in insurance for taxpayers, employers, employees and their families

The Crisis in Health Insurance: The Uninsured and the Underinsured

Our readers and our polling tell us that the high cost of health care and the insecurity in the current system are the #1 long-term consumer problem facing American families.

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[1] Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

As the Committee is painfully aware, the cost of health insurance has increased dramatically in recent years. Consumers are both paying more in premiums, and shouldering a higher burden for out-of-pocket expenses, including deductibles, co-payments and other expenses not covered by their health insurance.
According to the Kaiser Family Foundation, the cumulative growth in health insurance premiums between 1999 and 2008 was 119%, compared with cumulative inflation of 29% and cumulative wage growth of 34%. The rapid growth in overall premium levels means that both employers and workers are paying much higher amounts than they did a few years ago. The average employee contribution to company-provided health insurance has increased more than 120 percent since 2000. Too many under age 65 Americans are just another premium increase, a pink slip, an accident or an illness away from losing insurance or facing bankrupting medical costs.

The uninsured and the insured alike are facing serious financial problems because of the extraordinary high cost of American health care, which is forcing millions of Americans into the condition of being 'underinsured.' While the definition of the "underinsured" varies, quantitative definitions used by the government tend to focus on the percent of adults between 19 and 64 whose out-of-pocket health care expenses (excluding premiums) are 10 percent or more of family income.[3] The ranks of the underinsured have grown. The Commonwealth Fund estimates that 42 percent of U.S. adults were uninsured or underinsured in 2007.[4] You can be sure that with the recent loss of millions of jobs, these numbers will rise dramatically in 2008 and 2009.

Research by the *Consumer Reports National Research Center* used a series of questions to determine the percent who were underinsured based on answers to questions such as whether they considered their deductible too high, and whether they felt adequately covered for costs of surgery, doctors visits, and catastrophic medical conditions. We found that 41 percent of the adult population sampled lacked adequate health coverage. Nine percent of the underinsured (by our survey) took extraordinary measures to pay medical bills, including dipping into IRAs, 401(k)s or pension funds, selling cars, trucks or boats, or taking on home equity or second mortgage loans.

Underinsurance is a problem for two key reasons: Inadequate coverage results in the financial burden of uncovered health care. In our survey, for example, 30% of the underinsured had out-of-pocket costs of $3,000 or more for the previous 12 months.[5] Underinsurance can lead to medical debt and even bankruptcy. The second problem

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[3] Jessica Banthin, AHRQ, "Out of Pocket Burdens for Health Care, Insured, Uninsured, and Underinsured," September 23, 2008.
[4] Cathy Schoen, et.al., How Many are Underinsured? Trends Among U.S. Adults, 2003 And 2007, Health Tracking, Health Affairs – Web Exclusive, June 10, 2008. See also: Jessica S. Banthin and Didem Bernard, Changes in Financial Burdens for Health Care – National Estimates for the Population Younger than 65 Years, 1996 to 2003, JAMA, December 13, 2006.
[5] Health Care Experiences of the American Public: May 2007 Survey, Consumer Reports National Research Center Survey Research Report

posed by underinsurance is delayed or denied health care and poorer health outcomes, caused by the financial barrier to care.

The key breakdowns of the health coverage marketplace that have fueled the growth in the underinsured included the increase in high deductible coverage, annual caps in coverage, lifetime benefit limits, limited benefits, pre-existing condition exclusions, higher co-pays, out-of-network charges, barebones policies, and a flawed individual health insurance market.

Real Examples of People with Insurance Market Problems

Last summer, Consumers Union traveled around the country and collected over 5,000 'stories' documenting why our nation needs fundamental health care reform. Appendix 1 is a tiny sample of those stories from **some of your constituents**, focusing on the particular problems of high cost, inadequate benefits, pre-existing condition exclusions, and administrative hassles in the individual insurance market.

Solutions

We hope that this year Congress will enact reform legislation to ensure that a comprehensive package of benefits is always available and affordable for every American. That legislation will mean a number of big changes, including insurance reform: no pre-existing conditions and no waiting periods.

Assuming you enact that kind of reform, it will probably include some form of annual open enrollment period in some type of 'marketplace' or 'connector' where private and--we hope--a public plan could compete for consumers.

It is in that marketplace of enrollment that we ask you to provide critical consumer reforms which will lower costs and save money for America's employers, employees, their families, and taxpayers.

Why Consumers Need Help Shopping for Insurance

The honest, sad truth is that most of us are terrible shoppers when it comes to insurance. The proof is all around you.

> --In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[6]
>
> --In the somewhat structured Medigap market where there is a choice of plans A-L, some people spend up to 16 times the cost of an identical policy.[7]

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[6] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.

--In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available.[8]

--In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[9]

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[10] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc., ad nauseum.

If Congress wants an efficient marketplace that can help hold down costs, you need to provide a structure to that marketplace.

We recommend the following in any legislation you enact:

Empower Consumers in a New Health Insurance Marketplace

■ **A new Office of Consumer Health Insurance Education and Information that will:**

√Provide general and comparative information about insurance issues and policies using consumer-friendly formats.

We need a Medicare Compare-type website (with some improvements) applied to all health insurance sectors where policies can be compared on price and quality. Extending this comparison site to all insurance would help stop the waste in the Medigap market where seniors are talked into buying a standard policy that may be up to 1600 percent of the cost of the low-cost plan in their state.

√Require standardization of insurance definitions and forms so consumers can easily compare policies on an "apples-to-apples' basis.

This is key. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. In our May magazine article, we describe a policy in

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[7] See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.
[8] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[9] SeniorJournal.com, March 29, 2009.
[10] HHS Office of Disease Prevention and Health Promotion

which the fine-print excluded the first day of hospitalization—usually or often the most expensive day when lab and surgical suite costs are incurred.

NAIC could be charged with developing these definitions, backed up by the Secretary if they fail to act.

√Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under typical treatment scenarios.

See Appendix II for how much policies can vary--to the surprise and shock of consumers.

The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[11]

√Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly on a Web site.

The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

√Institute and operate quality rating programs of insurance products and services.

This would be similar to the Medicare Part D website, with its '5 star' system.

√Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to consumers.

These programs need to be greatly expanded if you want the marketplace/ connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public. Instead of roughly a $1 per Medicare beneficiary for the SHIPs, the new program should be funded at roughly the level that employers provide for insurance counseling. We understand that can range from $5 to $10 or more per employee.

■ **An insurance "exchange" or "connector," offering a choice of plans, that will:**

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[11]Op. cit., p. 68.

√Like Medigap, include an optimal number of plan choices—not too few and not too many.
√Limit excessive variations in benefit design so that plans compete more on price and quality.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[12] Fewer offerings of meaningful choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[13]. The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and fail to make rational, advantageous economic changes during the open enrollment period.

It is shocking that CMS allowed roughly 1400 Part C plans with less than 10 members to continue to clutter the marketplace. What a waste of time and money for all concerned. Reform legislation should set some guidance on preventing the proliferation of many plans with tiny differences that just serve to confuse a consumer's ability to shop on price and quality.

We hope you will enact a core benefit package which all Americans will always have. If people want to buy additional coverage, there would be identical packages of extra coverage (as in the Medigap program) that many different companies could offer for sale.

Consumers would have to be shown the pricing and quality ratings of those different packages before purchase. (Chairman Stark's AmeriCare bill includes much of this concept.[14])

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[12] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

[13] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

[14] HR 193, Sec. 2266(c)(2) SIMPLIFICATION OF BENEFITS-
`(A) IN GENERAL- Each AmeriCare supplemental policy shall only offer benefits consistent with the standards, promulgated by the Secretary, that provide--
`(i) limitations on the groups or packages of benefits, including a core group of basic benefits and not to exceed 9 other different benefit packages, that may be offered under an AmeriCare supplemental policy;
`(ii) that a person may not issue an AmeriCare supplemental policy without offering such a policy with only the core-group of basic benefits and without providing an outline of coverage in a standard form approved by the Secretary;
`(iii) uniform language and definitions to be used with respect to such benefits; and
`(iv) uniform format to be used in the policy with respect to such benefits.
`(B) INNOVATION- The Secretary may approve the offering of new or innovative and cost-effective benefit packages in addition to those provided under subparagraph (A).

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition.[15]

√Require information on price and quality to be presented in user-friendly formats

Medicare law requires a pharmacist to tell consumers if there is a lower-priced generic available in their plan. A similar concept in the insurance market might be scored by CBO as driving savings. That is, before you enroll in a plan, you must be told if there is an insurer with equal or better quality ratings offering the same standard structured package.

√Require plans to provide year-long benefit, price, and provider network stability

In Medicare Part D, we saw plans advertise certain drug costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√Protect against marketing abuses and punish insurers that mislead consumers

We urge stronger penalties against sales abuses. We assume that any reform bill will include the best possible risk adjustment so as to reduce insurers constant efforts to avoid the least healthy individuals (e.g., rewarding sales forces for signing up healthy individuals). This would have the added benefit of encouraging development of best practices for efficient treatment of these complex cases—which is a key part of controlling costs over time.

√Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, balance-billing and co-pay problems, and to appeal coverage denials

We urge you to require the standardization and simplification of grievance and appeals processes, so that it is easier for consumers to get what they are paying for.

Many are worrying that comparative effectiveness research (CER) may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service. The key to this is ensuring that the nation's insurers have honest, usable

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[15] Center for Budget and Policy Priorities, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," by Sarah Lueck, March 31, 2009.

appeals processes in place. This legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER. .

Do More to Fight Fraud in Insurance

American consumers need a better system to prevent, detect, and correct insurance fraud and abuse.

We are surprised that there has not been more outrage over the recent court findings and discoveries of the New York Attorney General that for at least a decade American consumers have been ripped off by a combination of health insurers and subsidiary data collection firm practices.

In the midst of this escalating crisis of out-of-pocket costs, consumers have also been forced to contend with a gravely-flawed out-of-network reimbursement system. According to a recent investigation by New York Attorney General Andrew Cuomo, and recent settlements with some the nation's largest insurance carriers, it now appears that consumers may have been underpaid for their out-of-network reimbursements by hundreds of millions of dollars. Senate Commerce Committee Chairman has said "billions of dollars."[16] The databases used to calculate out-of-network reimbursements are riddled with serious data quality problems and massive financial conflicts of interest.

Over the last several years, Consumers Union has become increasingly concerned about consumer problems in obtaining fair, appropriate and timely reimbursement for out-of-network health services. These problems came to our attention as a result of consumer complaints, concerns expressed by physicians and employers, reports in the news media, and litigation. In particular, in New York state, we were aware that the American Medical Association, the Medical Society of the State of New York, other state medical societies, New York State United Teachers, Civil Service Employees Association (CSEA), other public employee unions and other consumer plaintiffs had sued UnitedHealth Group in 2000, alleging that they were being systematically shortchanged regarding out-of-network payments.

We were therefore very pleased when Attorney General Andrew Cuomo initiated a national investigation of problems relating to out-of-network charges in February, 2008. The methods used by insurance companies to calculate "usual, customary and reasonable" rates (also known as UCR rates) have long been obscure and mysterious to consumers. It was not easy for consumers to verify the basis of the alleged UCR rates, or to contest perceived underpayments. Companies are supposed to disclose the details of how they calculate these charges upon request. But in practice many consumers found it difficult to find out how the charges are calculated, and what they are based on. Over 110 million Americans – roughly one in three consumers – are covered by health insurance plans which provide an out-of-network option, such as Preferred Provider

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[16] Senate Commerce Committee, Opening Statement at hearing of March 31, 2009.

Organizations (PPOs) and Point of Service (POS) plans This includes approximately 70% of consumers who have employer-sponsored health coverage.

Consumers and employers often pay higher premiums to participate in an out-of-network insurance plan, because it gives patients greater flexibility in seeking care from doctors, specialists and providers who are not in a closed health plan network. In most out-of-network plans, the insurer agrees to pay a fixed percentage of the "usual, customary and reasonable" rate for the service (typically 80% of the rate), which is supposed to be a fair reflection of the market rate for that service in a geographic area. Because the health plan does not have a contract with the out-of-network doctor or provider, the consumer is financially responsible for paying the balance of the bill – whatever the insurance company doesn't pay. By law, the provider may pursue the consumer for the entire amount of the payment, regardless of how little or how much the insurer reimburses the consumer.

Even if UCR charges were calculated accurately, consumers could still experience "sticker shock" when they get the medical bills for out-of-network care. Why? They may not understand that the insurance company didn't agree to pay 80% of the doctor's bill – they only agreed to pay 80% of the "usual and customary" rate, which is a kind of average of charges in a geographic area.

For example, suppose a patient went to visit the doctor for a physical, and was charged $200. Eighty percent of $200 is $160. But if an impartial and accurate calculation of "usual and customary rate" shows that what other comparable doctors charge for physicals is an average of $160, the insurance company would only pay $128, or 80% of $160. The consumer would be responsible for paying the balance of $72.

The key problem with the out-of-network reimbursement system is that the UCR rates were not calculated in a fair and impartial way. For the last ten years or so, the primary databases that are used by insurers to determine "usual, customary and reasonable" rates have been owned by Ingenix, a wholly-owned subsidiary of UnitedHealth Group. Ingenix operates a very large repository of commercial medical billing data, and prepares billing schedules that are used to calculate the market price of provider health services. In 1998, Ingenix purchased the Prevailing Healthcare Charges System (PHCS), a database that was first developed by the Health Insurance Association of America, an insurance industry trade association started in 1974. Also in 1997, Ingenix purchased Medical Data Research and a customized Fee Analyzer from Medicode, a Utah-based health care company.

Thanks to the Attorney General's investigation, however, we now know that there were serious problems with the Ingenix database that appear to have consistently led to patients paying more, and insurers paying less. In January, 2009, Attorney General Cuomo announced key findings from his office's investigation regarding the out-of-network reimbursement system:

- According to an independent analysis of over 1 million billing records in New York state, the Ingenix databases understate the market rate for physician visits by rates ranging from 10 to 28 percent across New York state. Consumers got much less than the promised UCR rate, so that instead of getting reimbursed for 80% of the UCR charge, they effectively got 70%, 60% or less. Given the very large number of consumers in out-of-network plans – 110 million nationally -- **this translates into hundreds of millions of dollars in losses (perhaps more) over the last ten years for consumers around the country.**

- UnitedHealth has a serious financial conflict of interest in owning and operating the Ingenix databases in connection with determining reimbursement rates. Ingenix is not an independent database – it is wholly-owned by UnitedHealth Group, Inc. It receives billing data from many insurers and in turn furnishes data back to them, including to its own parent company, UnitedHealth. UnitedHealth had a financial incentive to understate the UCR rates it provided to its own affiliates, and other health insurers also had an incentive to manipulate the data they submit to Ingenix so as to depress reimbursement rates.

- In general, there is no easy way for consumers to find out what the UCR rates are before visiting a medical provider. The Attorney General characterized Ingenix as a "black box" for consumers, who could not easily find out what level of reimbursement they would receive when selecting a provider. When they received a bill for out-of-network services, consumers weren't sure if the insurance company was underpaying them, or whether the physician was overcharging them.

- As an example of the lack of transparency, when UnitedHealth members complained their medical costs were unfairly high, the United hid its connection to Ingenix by claiming the UCR rate was the product of "independent research."

- The Ingenix database had a range of serious data problems, including faulty data collection, outdated information, improper pooling of dissimilar charges, and failure to conduct regular audits of the billing data submitted by insurers.

As a result of the Attorney General's investigation, on January 13, UnitedHealth agreed to close the two databases operated by Ingenix, and pay $50 million to a qualified nonprofit organization that will establish a new, independent database to help determine fair out-of-network reimbursement rates for consumers throughout the U.S.

As a central result of his investigation, Attorney General Cuomo concluded that:

> *"...the structure of the out-of-network reimbursement system is broken. The system that is meant to reimburse consumers fairly as a reflection of the market is instead wholly owned and operated by the [insurance] industry. The determination of out-of-network rates is an industry-wide problem and accordingly needs an industry-wide solution.*

> *Consumers require an independent database to reflect true market-rate information, rather than a database owned and operated by an insurance company. A viable alternative that provides rates fairly reflecting the market based on reliable data should be set up to solve this problem... Consumers should be able to find out the rate of reimbursement before they decide to go out of network, and they should be able to find out the purchase price before they shop for insurance policies or for out-of-network care."*

While UnitedHealth did not acknowledge any wrongdoing in the settlement, its agreement with the New York Attorney General ended the role of Ingenix in calculating UCR charges, and created a new national framework for a fair solution. In fact, in a press release announcing the settlement, Thomas L. Strickland, Executive Vice President and Chief Legal Officer of UnitedHealth Group, expressed strong support for a nonprofit database to maintain a national repository of medical billing information:

> "We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy. We are pleased that a not-for-profit entity will play this important role for the marketplace."

Shortly after settling with the Attorney General's office, UnitedHealth also settled the lawsuit brought by the AMA and Medical Society of the State of New York, other physician groups, unions and consumer plaintiffs for $350 million, the largest insurance cash settlement in US history. As sought by MSSNY and the other physician groups, United also agreed to reform the way that out-of-network charges were calculated.

Since January, nine other insurers with operations in New York State, including huge national insurers such as Wellpoint, Aetna and Cigna, have also agreed to stop using data furnished by Ingenix, and to contribute funds in support of the new nonprofit database. The leaders of other insurance companies have also expressed support for a new nonprofit database to increase transparency and reduce conflicts of interest, and pledged to use the database when it becomes available. Two insurance companies agreed to also reprocess claims from consumers who believe they were underpaid for their out-of-network charges.

All told, the Attorney General has now collected over $94 million to support the new independent database, which will be based at a university in New York.

Implications of the New York State Investigation

From a consumer point of view, Attorney General Cuomo's intervention has been extremely helpful for consumers in New York and across the U.S. This investigation squarely exposed the problems resulting in underpayment of consumers and physicians, and created a sweeping new framework for a national solution. The plan set out in the agreements reached by Attorney General Cuomo will help bring comprehensive, sweeping reform to the out-of-network reimbursement system.

The investigation has exposed a swamp of financial shenanigans, and now reached a critical juncture. Consumers Union is calling for coordinated action by state and federal policymakers and regulators to help to consolidate the investigation's gains, and ensure that the new database for calculating out-of-network charges will be broadly used across the entire marketplace.

First, regulators need to hold insurance companies accountable to their contractual promises, on an ongoing basis. Consumers clearly have the right to expect that their health insurance policies will pay the bills that they are legally obligated to pay. We rely on the promises our insurance companies make in their contracts, and we expect the provisions of those contracts to be enforced by regulators and the courts. If your policy says it will pay you 80% of the "usual and customary" charge for a medical service, it should pay that amount.

To enforce this principle in New York state, Attorney General Cuomo used his authority under New York's General Business Law §349 and §350, which prohibits deceptive acts and practices against consumers, to bring the insurance industry into compliance in New York state, as well as sections of the insurance law and the common law. Other states have similar laws, and they should be appropriately used when needed to prevent egregious consumer rip-offs.

Everyone can easily agree that insurance companies should not engage in deceptive or unfair practices against consumers. But the reality is that it takes sustained effort and political will to achieve the vigorous, comprehensive enforcement of state and federal insurance and consumer protection laws and regulations. In this case, the technical nature of the subject matter, and the obscure, veiled nature of the Ingenix database, resulted in a persisting rip-off that unfortunately took far too many years to rein in.

This case raises very troubling questions about why financial rip-offs persist in the marketplace for many years without effective intervention at the state or federal level. Why didn't the alarms go off earlier about unfair practices that created very large financial losses for consumers? Since this rip-off was occurring all across the Nation, why didn't a Federal agency or official step in to stop it and help consumers?

As part of health care reform, we hope you will create a national office charged with working with and assisting State regulators, to monitor and investigate health insurance issues such as this. In addition, perhaps a way can be found to extend the qui tam or Lincoln law whistleblower provisions to abuses such as this. In addition, the insurance "hotline" idea we proposed earlier in this testimony could serve as a locus for citizen complaints that could help ensure timely investigations.

Second, in any reform bill, consumers should be able to obtain up-to-date information on usual and customary charges through a national, free web site, and have a good fix on what their potential reimbursements will be when they visit physicians and other health care providers.

Third, by arranging for some of the largest health insurers in the country to support the

new database, Attorney General Cuomo has paved the way for a comprehensive national resolution of these issues. We would note, however, that there are many other health insurance companies who used data from the Ingenix databases, including state-based and regional health plans in the South, Midwest and Western states, who do not have operations in New York state. These companies were not reached by the investigation or the agreements, so they have not necessarily halted their use of the Ingenix database, or notified consumers of its shortcomings. We therefore encourage Congress to investigate the nature and extent of the use of the Ingenix databases by other health insurance companies throughout the U.S., and solutions for halting this practice and securing restitution for consumers.

Is There Too Much Market Concentration Among Insurers, and If So, Why Are They Failing to Control Costs So Badly?

For decades, the health delivery marketplace has been inflating roughly twice as fast as the rest of the economy, creating special burdens for American businesses and taxpayers, and raising rates of un-insurance, under-insurance, personal bankruptcy and increased morbidity and even mortality for uninsured consumers.

Recently, there have been rumors of possible further mergers among some of the nation's largest health insurers.

We believe it would be useful for Congress—perhaps with several Committees working together—to investigate the level of market concentration in the health insurance versus health provider sectors to determine if there are steps that should be taken in health reform to bring us a system which is better at reducing the Cost of Health Insurance for Employers, Employees and their Families.

A Congressional investigation could address the following kinds of questions:

It is often thought that a large buyer can demand discounts and be able to control costs better than many small purchasers. At the same time, it is usually feared that a monopolist will collect excessive profits from their market dominance. There are reports that in a sixth of our large metropolitan areas, a single insurer/purchaser has enrolled 70 percent or more of the local consumer-patient population. It would seem that in such a situation, the insurer could both control costs and reap windfall or oligopolistic profits. Obviously the insurers are not doing a good job controlling costs, but are they collecting higher than expected profits? That is, do we have the worst of both worlds: higher profits being added to failure to control costs?

But at the same time that insurers have been consolidating, there are reports that in many markets, hospital and physician practices have been merging and have formed a dominant countervailing force. Has the consolidation of providers been a contributing factor in the crippling rate of health inflation? Yet while oligopolistic or even monopolistic behavior among providers is a source of concern, so is quality of care. And there is strong data that smaller hospitals, which do limited numbers of procedures, often have a difficult time

delivering quality outcomes. In general, consumers needing complex treatments are well-advised to seek out hospitals and practices which do large volumes of such treatments (centers of excellence) and which coordinate care. From a quality, medical education, and research point of view, a larger health care provider can often be a good thing.

The March 2009 Medicare Payment Advisory Commission report to Congress provides a remarkable chart showing that an eighth of the nation's larger hospitals which deliver the highest quality care have, on average, positive Medicare margins and are below average cost hospitals. The other seven-eighths of the hospitals have poorer quality and higher costs. It is MedPAC's thesis that while Medicare is paying approximately 100% of the costs of an efficient provider, the private insurers (who have become relatively consolidated and may be planning further consolidation) are paying about 132 percent of cost at most hospitals. Basically, MedPAC is saying that the private insurers, despite their growing consolidation, have become toothless buyers, and are often turning a blind eye to the unacceptable rate of medical inflation.

This raises a fundamental question: if large private buyers who feel a need to maintain a broad network of health care providers cannot control costs, what is the alternative? As we consider health care reform, doesn't this argue for a public plan option (like Medicare) that can set rates at the approximate level of cost that an efficient provider can deliver quality care?

If the current situation does not argue for a public plan option, then why are these large insurers not doing a better job in controlling health care inflation, and what hope is there that they will do a better job in the future? What kinds of amendments would Congress need to make to ensure that the private payers can hold inflation down to at least Medicare's past rates of growth?

Conclusion

We thank you again for this opportunity to testify. The American health care system can be fixed, but consumers need tools to help drive the system toward quality and cost savings. And we need strong regulators who prevent future gross abuses like those revealed in the UnitedHealth-Ingenix case. The reforms we have suggested are keys to this goal.

Appendix I
Examples of why America needs comprehensive health care reform, collected in 2008 during Consumer Union's tour of the United States

This is a small sample of the 5000-plus stories we collected. The sample concentrates on cost, pre-existing condition exclusion, and poor coverage problems in the individual market, along with examples of what it means to be uninsured because one cannot afford a policy. All of these individuals are willing to be contacted upon request for further discussion.

Kristin from Beaverton, OR-1 Wu

I am a single mom who has been out of work for almost a year. I started working 2 months ago and was diagnosed with Interstitial Cystitis last week. I went to fill my prescription of "Elmiron" and to my horror found out that AFTER my insurance discount, I will still have to pay $283/mo. for my medication. I also take buproprion and effexor xr. This means that I will be paying $420/mo for medication alone. I already pay almost $400 for my insurance. I live on $1000/mo after paying my mortgage (which I currently can't do anything about due to the market) payment. Now I will live on $200???? Yet, because I took a contract position until the end of the year, I make too much money for any assistance programs. I am very frustrated with the system and I'm tired of being taken advantage of for insurance and medication that I need. Maybe I would be better off not working and getting assistance. This is a serious problem with our society! Sometimes not working and depending on assistance is the ONLY way to get our medications...what else can I do?

Melinda from Lakewood, OH-10 Kucinich

I'm a 46 year old self-employed woman. I have not had health insurance since 2002 or 2003. As a company of one/an individual, I am denied more favorable underwriting/rates/cost savings and benefits afforded to companies of 2 or more. I have pre-existing conditions. From 2003 through 2007, I estimate I paid (out of pocket) an average of $7,000 per year in medical expenses. Most of these payments have been made using funds saved for retirement. The last "best" proposal I received for individual health insurance included a $10,000 deductible and an annual premium of over $5,000. Most of my $7,000 in annual medical expenses would be considered uncovered and would not count towards meeting my deductible. From my perspective, I would need to receive benefits in excess of $22,000 before I would "break even". If I work, I can make very good money, often grossing in excess of $75,000 per year. As far as I know, this income would exclude me from participation in any existing or proposed program supporting guaranteed access to health care. I have never benefited from government supported programs. No scholarships or loans, worker's comp, unemployment or Social Security. I have always planned on providing for myself - including paying for my health care during both my working and retirement years. I do not expect a "free ride". I want guaranteed access to competitively priced health care/insurance and I am willing to pay for it. I just need help leveling the playing field. No denial of coverage. No exorbitant premiums. No limited benefits - just because I am an individual with pre-existing conditions.

Keith from Lakewood, OH-10 Kucinich

"My wife and I are retired, more by reason of lost employment than anything else. We are not yet eligible for Medicare. When our coverage under COBRA was soon to end, I searched high and low for affordable health insurance. I called agents. I searched over the internet. I called insurance companies directly. What I found is that, because I have high blood pressure (which has been under control for years) and she has Type 2 diabetes (also under control), we are unable to buy a private policy for anything less than $3000 a month, for each of us! And even at that price, I couldn't get a firm commitment without paying three months premiums in advance. That's $18,000! As a result, my wife was forced to find another job (she's an RN, and therefore much more employable than I am) just for the health insurance. So instead of traveling the US in our RV, as we had hoped, she's working the night shift at a local hospital, and I'm picking up odd jobs as I can while we wait for Medicare."

Neil from Pepper Pike, OH-11 Fudge

"Due to pre-existing conditions, I have been relegated to few choices for insurance coverage, and all at extremely high costs. Premiums for my wife and myself, with $1000 deductibles, have been exceeding $24,000 per year for many years! I have not been able to find insurers willing to cover us at a reasonable cost. Regulated, universal coverage is the only answer to provide health coverage for all persons without bankrupting so many."

Jamie from Clio, MI-5 Kildee

"With the faltering economy my small cell phone business of 12 years is slowly sinking. I had Blue Cross Blue Shield of Michigan. In 1999 it cost $450.00 a month to cover myself, my husband and our three daughters. When I could no longer afford the coverage it was up to $1600.00 per month for my husband and I and only two of our college age daughters. Same coverage, an 80/20 split, so there were some 'out of pocket' expenses too. I have also been unable to maintain my term life insurance policy of 10 years I still can't believe after 12 years in business that I wouldn't be able to pay my bills. It is very heart wrenching. Especially when we had to cut our daughters off while they were still in college."

Carolyn from Media, PA-7 Sestak

"After my COBRA coverage ended, I applied for health insurance as an individual. I decided to work for myself and I am 53 years old. A couple of companies rejected me but finally I received coverage but with exclusions for depression, migraines, and high cholesterol and a high deductible. All of these conditions are treated with medication. Originally, the rate was about $350, which I thought was reasonable. Unfortunately, after just 4 years my rate is now over $512. My agent tells me the plan has closed which means that my premiums will continue to skyrocket since no new members will be added to the pool. I applied for insurance again and was rejected for the same reasons. I see these conditions as somewhat common and assume that only someone in perfect health can receive an individual health plan. On the other hand, someone with cancer can obtain insurance as long as they are employed (typically). Since I have many years before I am eligible for Medicare, this situation is a big concern. I do not understand why individuals cannot have guaranteed access like employed people since the insurance company's overall risk is still spread. But, I suppose the rate they would charge would be astronomical. I wish there was some organization that individuals could join and gain coverage as part of a large pool. One other issue is the treatment of these costs at tax time. My total costs run about $10,000 which is a large percentage of income. If costs do skyrocket, I might have to lower my standard of living. The overall health care situation in this country is astonishing given our supposed wealth as a nation. We claim to have the best health care but this is not borne out by surveys and studies. Certain politicians scare the populace with terms such as ""socialized medicine"" and drown out other voices of reason. Shame on us."

Keith from Hilton Head, SC – 2 Wilson

I am a currently partially retired but still practicing physician. I am still under 65 and have a high deductible ($5200) Blue Cross Policy (SC). The premiun went up $250 per month this year. This represented an almost 50% increase. We had made no claims on the policy during the last 3-4 years we have had it. I contacted BC and was told that the rate increase was approved by the State of SC Insurance Commission. I contacted them and have received no acceptable answer. This is just one of the outrageous examples of the appalling state of the US Health Care System. I am currently working as a Physician in New Zealand where good care is delivered at a third of the cost of the US and actually medical professionals are reimbursed as well or even better than in the US. It is not difficult to figure where the wastes are!!

June from Spokane, WA – 5 McMorris-Rodgers

I just retired early at 60, I have RA and have struggled for years to support myself on what I earn. My pension income covers all my expenses but I am unable to get an insurance company to take me because of my 'pre-existing' condition. I am exploring all possibilities for health care but make just enough monthly to disqualify me for state programs. Medication is soooo expensive with no co-pay. I have five more years before I qualify for medicare.

Jean from Marietta, GA – 6 Price

I own a small business and cannot find affordable health care coverage. I pay way too much money for a high deductible policy and every year on my birthday I get hit with another huge increase in premium. Because I am the only empolyee of my business I don't have enough people to make up a group policy so I pay what I think is about the highest rates that are out there. I am in excellent health and had hoped the current administration would have created a health care plan to allow small business owners like myself to pool together to get a better rate. I find it unfair that I have to pay such high rates simply because I am not part of a larger group. I am in excellent health so the insurance company is making 100% profit on me.

Eileen from Roswell, GA – 6 Price

A few years ago, when we had group coverage, I had my first colonoscopy. A BENIGN polyp was removed during that procedure. We subsequently had to sign up for individual insurance. We applied to Golden Rule (who required our payment information before even accepting our application). Once the acceptance letter arrived, I found that they had disallowed any further colonoscopy procedures...and any disease that has to do with my colon, and various other organs, as a preexisting condition! I called the Georgia insurance commissioner's office to see if that was even legal. They told me that a preexisting condition is anything you have now or have ever had... so it is perfectly legal for them to deny me coverage.

Nancy from Atlanta, GA – 6 Price

"I work for a small employer and pay about $90 every two weeks totaling $2,136 a year. Then add what my employer pays for me and it is probably $4,000 a year. Our current plan has a $2,000 deductible, meaning any tests we get we pay for until we hit $2,000. And so, most of us skip needed tests because we cannot afford it. So, we are paying lots into the plan and getting nothing back. What is wrong with this picture, everything. Americans deserve affordable healthcare and preventative tests so we do not become seriously ill. I spend most of my disposable income on healthcare costs, energy and food with little left for anything else, including a well needed vacation. We need a united movement to demand Washington wake up and start to take care of us and they get taken care of with our tax money. This has impacted our national economy and our Government has become Wall Street vs Main street. No one seems to care about our lack of adequate care and the costs to individuals and business. The healthcare industry has bought our government and sold the citizens of the USA as the cost. Help us start the fight to come up with a system we can all be proud of and afford."

Rick from Canton, GA – 6 Price

I am unemployed and just lost my insurance on Jan 1, 2009. I am 59 and have a few health and mental health issues. First of all, I had prostate cancer that was diagnosed in the end of 2006 and treated in early 2007. All went exceptionally well, I am glad to say. However, I need Prostate-Specific Antigen (PSA) tests every quarter to make sure that it doesn't come back; then, I will need the tests twice a year and eventually once a year as time goes on. I do not know how I am going to pay for an urologist or the blood work until I begin working and receive a salary and insurance. Oh, wait - it is a preexisting condition! Unless I get hired by a large enough company, and it doesn't exclude pre-existing conditions, I'll have to wait a year to have my post-cancer visits covered or anything else tied in with the treatment.

Bruce from Cloverport, KY – 2 Guthrie

I am a 57 year old man in bad health. My wife is 6 years younger than I am. Health insurance is so expensive that I will have to work until I am 71, so my wife can be covered under Medicare.

Michael from Iowa City, IA-2 Loebsack

"I wanted to switch to a healthcare policy with the highest deductible in order to lower my premiums. My individual policy was with Wellmark of Iowa and I also got my current policy with Wellmark. In order to get virtually the same policy, except with a higher deductible, they called me and said that I would have to agree to waive coverage for mental health, anything to do with my eyes, and anything to do with my G.I. tract. Their request for the waivers surprised me because I had had very little problems with those things. I agree to sign the waivers in order to save money because of the lower premiums that come with the high deductible policy."

Joel from Brooklyn, NY-11 Clarke

"I am among the uninsured. I cannot afford health insurance. I am a published, prizewinning novelist and I have been, among other things, in chronic pain for about seven years, in both knees. I also have other health problems I cannot see to, even though I know that this is dangerous, especially at the age of 61. I make enough money not to qualify for Medicaid, or even New York State's budget/help-out plan, but I am far from being able to afford health insurance at anything approaching the current rate. I'm in trouble and do not know if there is anything I can do about it. How's that for a story?"

Jan from Lebanon, CT-2 Courtney

"My husband and I were squeezed out of our jobs as we approached the age of 60. We moved to a less expensive area, and are now self employed. At age 62 we spend as much on our monthly health care premiums as we used to spend on our mortgage. Together we pay over $1300/mo. for premiums and the copays we are responsible for are higher. Having health insurance tied to employment does not make sense in the present atmosphere of job insecurity. We feel caught in a financial bind until we reach Medicare age."

Grace from Danielson, CT-2 Courtney

"I work for a healthcare services company. In short I do provide necessary services to disabled and elderly clients who would not otherwise be able to remain in their homes. They all have Social Security or Disability income that provides for doctor visits and medications and emergency surgeries when necessary. I have no health insurance from the company for whom I work. In 2006 I had to have an incisional hernia surgery. I waited until it had started to strangle itself. I received help through a federal program to pay my hospital bill. But there was no program to pay for my anesthesia bill or my doctor bill. The total bill was somewhere between $10,000 and $12,000 with about $7600 being paid on the hospital bill. The doctor has been real good to me and not pushed the issue. The anesthesia bill went to collection and is now registered with the credit reporting agencies. There is nothing I can do about this. This is a non-profit company. My weekly hours are less than 40 and I live in Connecticut which is the 2nd or 3rd most expensive state to live in. Every penny I make is tied up in survival. My rent has gone up $50 since the operation. My gas for the car (I pay all but a $50 stipend) has tripled, my electric bill has nearly doubled and my grocery bill has tripled. I am 58 years old and am having a hard time finding a good paying job. I got a $.25 raise in February and already the groceries and a recent raise in the electric bill have eaten that raise and next year's as well. I could very easily be homeless by this time next year. If it were not for help with heating oil I would already be there. Not because I don't work for a living but because what I make is less than an existence at this point. I suspect my electric will be shut off in May due to my inability to pay. If I become seriously ill I have nothing to help me with expenses or medical bills. I make nearly $20,000 per year. Unless something is done to change this I am going under. I need help for a lot of things but I have no where to turn. According to the State of Connecticut I make too much money. Once upon a time I could have done well on this but not now."

Appendix II

...and out-of-pocket expenses can vary widely	**Massachusetts plan**	**California plan**
With its lower premium and deductible, the California plan at right would seem the better deal. But because California, unlike Massachusetts, allows the sale of plans with large coverage gaps, a patient there will pay far more than a Massachusetts patient for the same breast cancer treatments, as the breakdown below shows.	**Monthly premium for any 55-year-old:** $399 **Annual deductible:** $2,200 **Co-pays:** $25 office visit, $250 outpatient surgery after deductible, $10 for generic drugs, $25 for nonpreferred generic and brand name, $45 for nonpreferred brand name **Co-insurance:** 20% for some services **Out-of-pocket maximum:** $5,000, includes deductible, co-insurance, and all co-payments **Exclusions and limits:** Cap of 24 mental-health visits,$3,000 cap on equipment **Lifetime benefits:** Unlimited	**Monthly premium for a healthy 55-year-old:** $246 **Annual deductible:** $1,000 **Co-pays:** $25 preventive care office visits **Co-insurance:** 20% for most covered services **Out-of-pocket maximum:** $2,500, includes hospital and surgical co-insurance only **Exclusions and limits:** Prescription drugs, most mental-health care, and wigs for chemotherapy patients not covered. Outpatient care not covered until out-of-pocket maximum satisfied from hospital/surgical co-insurance **Lifetime benefits:** $5 million

Service and total cost	**Patient pays**	**Patient pays**
Hospital	$0	$705
Surgery	981	1,136
Office visits and procedures	1,833	2,010
Prescription drugs	1,108	5,985
Laboratory and imaging tests	808	3,772
Chemotherapy and radiation therapy	1,987	21,113
Mental-health care	950	2,700
Prosthesis	0	350
TOTAL $104,535	**$7,668**	**$37,767**

Source: Karen Pollitz, Georgetown University Health Policy Institute, using real policies and claims data from state high-risk pool. May, 2009 issue