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DECEPTIVE HEALTH INSURANCE INDUSTRY PRACTICES: ARE CONSUMERS GETTING WHAT THEY PAID FOR?—PART II

HEARING

BEFORE THE

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

MARCH 31, 2009

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SENATE COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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DECEPTIVE HEALTH INSURANCE INDUSTRY PRACTICES: ARE CONSUMERS GETTING WHAT THEY PAID FOR?—PART II

TUESDAY, MARCH 31, 2009

U.S. SENATE,
COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION,
Washington, DC.

The Committee met, pursuant to notice, at 10:21 a.m. in room SR–253, Russell Senate Office Building, Hon. John D. Rockefeller IV, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

The CHAIRMAN. The hearing will come to order.

This is the second hearing that this Committee has had on so-called usual, customary, and reasonable rates, payment to the health insurance industry. Last week we heard from the New York Attorney General's Office, and I think you know those folks and who she was. And they conducted a year-long investigation into these practices. They had done that. And then they also heard from doctors and consumers. Today we are going to hear from the insurance industry.

So let me say that I am very pleased to welcome Mr. Andy Slavitt, CEO of Ingenix, and Mr. Stephen Hemsley who is the CEO of UnitedHealth Group. There are a variety of UnitedHealths, but "Group" is sort of the overall one. Before we go any further, I would like to thank you for taking the time to come. I doubt this is something you are looking forward to, but you are standing-up people. I have read your testimony very carefully. I have some questions about it. But you are here and I honor you for that and respect you for that.

Last Thursday, we heard some very strong language, and I think you were in Europe and could not be here. So we decided to bifurcate it, which has actually worked out, I think, quite well. The Consumers Union, Mr. Chuck Bell, had to say that the insurance industry reimbursed consumers for out-of-network Medicare, which is medical care, which is all we are talking about, as a rip-off. Ms. Linda Lacewell from the New York Attorney General's Office said the insurance industry practice amounted to a "fraudulent and conflict of self-interest-ridden reimbursement scheme." In my own statement, I was utterly discreet and temperate, and I merely called the practices "deceptive."

Because our witnesses today are going to take issue with these characterizations, I want them to have every chance to defend

themselves and explain why they do not think it was deceptive or whatever approach you wish to take.

Consumers and their health insurance companies have a contractual relationship. It is not casual. Consumers promise to pay a certain premium, and in return, the insurance industry promises to provide a certain level of health coverage. It is very plain, very direct, very straight-ahead.

So as we learned last Thursday, more than 100 million Americans have paid for health insurance coverage that gives them the option of going outside of their network, which is all we are talking about, outside of network. And obviously, that would be to get care. There could be a variety of reasons for that.

So let us be very clear about this. The insurers are not letting their policyholders see a non-network doctor out of the goodness of their hearts. Consumers are paying for this option through higher premiums and higher cost-sharing.

There are many reasons American consumers decide to pay the extra money for health insurance with an out-of-network option. I have been there myself. One New York consumer we heard from last week, Dr. Mary Jerome, actually could not come because she has been battling cancer for a number of years, and she just physically was not up to it. She was going to come but then she could not come. But she said that she paid this extra for out-of-network for "peace of mind"—those were her words—so that she could feel that she was getting the absolute best of health care possible.

What we learned at our first hearing was that while consumers held up their side of the bargain, it appeared from their testimony that insurance did not. The insurance industry promised to base their out-of-network payments on what they call the usual, customary, and reasonable cost of medical care in a particular area. Thanks to the New York investigation and other lawsuits, we now know that the insurance companies were not delivering what they promised. That was the conclusion that we reached.

In Erie County, New York, for example, insurance companies were reimbursing their policyholders for doctor visits at rates that were 15 to 25 percent below the local prevailing rates. A Federal judge recently concluded that the reasonable and customary data insurers used in New Jersey was 14.5 percent lower than the prevailing market rates. And the question, of course, is how does one get at these rates.

Everywhere experts have looked at this data, they have found what statisticians called a "downward skew" in the numbers. For 10 years or even longer, this skewed data was used to stick consumers with billions of dollars that the insurance industry should have been paying, and if they had been paying would have still been making a terrific profit.

The source of this skewed data was Mr. Slavitt's company Ingenix. Ingenix markets two usual and customary database products that every major player in the health insurance industry used to calculate what their reimbursement payments were going to be. I mean, there were not other folks out there. You had two sections of them, and then it sort of became one section. And it became what everybody used. It was sort of a monopoly of this wisdom of what would be fair to pay.

Now, Ingenix is a wholly owned subsidiary of Mr. Hemsley's company, UnitedHealth Group. UnitedHealth not only owns Ingenix, but it also used the skewed Ingenix data to under-reimburse its own policyholders. A direct connection. Total ownership.

Now, I am pleased that as a result of the Attorney General of New York's investigation, Ingenix and UnitedHealth have agreed to close down their database. I have read both of your statements very carefully and both talked about how everything is going to be so much better in the future because people are going to have a real understanding of, et cetera, et cetera.

But our business on this committee is about accountability. It is about making sure that things that have not worked right in the past or have not worked fairly do not happen again. And you cannot simply always look to the future. You have to sometimes prove that the past instructs why the future has to be different, and if you do not do it, maybe it will not be. In fact, it is not all fixed yet.

So I am pleased that they have done this, and I do think accountability is important. And I think people deserve to know how these practices harmed them and who was responsible for them, and that is the goal of today's meeting.

There being no Ranking Member, there being no anybody—they will come. We are a slow but sturdy group here. We welcome your statements. We will start with you, Mr. Hemsley.

STATEMENT OF STEPHEN J. HEMSLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNITEDHEALTH GROUP

Mr. HEMSLEY. Thank you, Chairman Rockefeller, Senator Hutchison, and Members of the Commerce Committee. My name is Steve Hemsley, and I am the President and the Chief Executive of UnitedHealth Group.

Our mission at UnitedHealth Group is to help people live healthier lives. Our more than 80,000 employees do this every day for more than 70 million Americans. Our businesses touch broadly on the services enabling health delivery and financing.

We appreciate the opportunity to testify before your committee about our out-of-network reimbursement practices and, most importantly, the need to provide consumers with timely and accurate health information so they can make more informed health care decisions. These topics are of critical importance as the debate about how to modernize our health care system and to contain its costs to the consumer intensifies in Washington and around the country.

Mr. Chairman, as you know, we recently announced agreements with the New York Attorney General and the American Medical Association that resolved disputes over the reimbursement of our out-of-network services based on reasonable and customary rates. In determining these rates, we have long utilized databases of physician-billed charges licensed by Ingenix, one of our subsidiaries.

There has been a good deal of commentary about our recent nationwide agreements. Some of it is accurate and some of it is not. So I am pleased with the opportunity to clarify the facts for the Committee.

First, the Ingenix databases did not set the reimbursement rates used by any health insurer. The role of the databases was solely

to collect data and then provide the data to a broad audience of users, including physicians, hospitals, researchers, insurers, who in turn independently used the information across a range of applications. Similar to other insurers, our subsidiary UnitedHealthcare used the data only when our health plan beneficiaries sought care from physicians outside of our network and where UCR protocols applied.

Second, the primary database at issue in these settlements has been in existence for more than 35 years. During this time, the database has consistently performed an essential function to our health care economy by establishing a reasonable standard for the reimbursement of physicians who do not participate in managed-care networks. This Committee knows better than most that physician reimbursement based on nothing but the doctor's bill is simply not economically tenable for consumers nor sustainable for our health care system. The databases were created with the goal of appropriately managing costs and ensuring consumers are protected.

Third, we want to make it clear that we stand behind the integrity of the Ingenix database. We also stand by the way in which our benefits businesses, UnitedHealthcare, used the data to make reimbursement decisions. Our recent agreement with the New York Attorney General did not relate to the manipulation of data, and we disagree with any suggestion or allegation of fraud. To the contrary, working with the Attorney General, we agreed to transfer the databases to an independent nonprofit entity in the hopes of increasing information transparency and public confidence in the quality of and access to the data that will be used to set future out-of-network reimbursement rates.

Finally, the agreement with the Attorney General, which is national in scope, reflects our role as a leader in health care and our desire to strengthen the all-important trust consumers have in us and affirm our ongoing commitment to transparency.

Since 2005, UnitedHealthcare's Premium Designation program has provided millions of our beneficiaries with the ability to access online costs and efficiency data for physicians and hospitals through *myuhc.com.* And for nearly 2 years, we created the Claim Estimator that provides physicians with online estimates of whether the cost of a procedure will be covered at that amount and what level the claim reimbursement will be.

Our national agreement with the New York Attorney General reflects and builds upon our longstanding commitment to reduce costs and improve care through the dissemination of information. And the new not-for-profit entity that we agreed to fund with others in our industry will establish a website to allow consumers to search for medical services by geographic area, showing the prevailing charge or range of charges. In addition, the site will alert consumers when insurers apply other policies to determine out-of-network rates, including terms in each plan document, other reimbursement policies, co-insurance, deductibles, et cetera.

These are positive steps, but we believe even more can and should be done beyond the parameters of the agreement to enhance consumers' access to health information. Meaningful and comprehensive transparency will only be achieved when parties are

equally accountable for the accuracy of the information and equal access is provided to all stakeholders. In the end, every consumer, each patient, must believe the costs for the care they receive is fair and consistent regardless of geography, insurance carrier, health care provider. At UnitedHealthcare we are eager to be part of a national discussion to modernize the health care system.

And we thank you for this opportunity to address the Committee and will be pleased to answer your questions through the course of the day.

[The prepared statement of Mr. Hemsley follows:]

PREPARED STATEMENT OF STEPHEN J. HEMSLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, UNITEDHEALTH GROUP

Chairman Rockefeller, Senator Hutchison and Members of the Commerce Committee, my name is Steve Hemsley and I am President and CEO of UnitedHealth Group. Our mission at UnitedHealth Group is to "help people live healthier lives." We do so by providing high-quality health services and products to more than 70 million people each year in partnership with over 5,000 hospitals and 600,000 doctors and thousands of other care providers across the Nation. Our businesses touch broadly on the services enabling health delivery and financing and we tailor our approach to respond to the ever-changing needs of different clients, markets and geographies in all 50 states.

We appreciate the opportunity to testify before your Committee about out-of-network reimbursement practices and, most importantly, the need to provide consumers with timely and accurate health information so they can make more informed healthcare decisions. These topics are of critical importance as the debate about how to modernize our health care system, and to contain its costs to the consumer, intensifies here in Washington and around the country.

Mr. Chairman, as you know, we recently announced agreements with the New York Attorney General and the American Medical Association that resolved disputes over reimbursement of out-of-network services based on "reasonable and customary" rates. In determining these rates, we have long utilized databases of physician charges licensed by Ingenix, one of our subsidiaries. There has been a good deal of commentary about our recent agreements—some of it accurate, some of it not. So, I am pleased with the opportunity to clarify the facts for the Committee.

- First, the Ingenix databases did not set the reimbursement rates used by any health insurer. The role of the databases was to solely collect data and then provide the data to a broad audience of users, including physicians, hospitals, researchers and insurers, who in turn independently used the information across a range of applications. Similar to other insurers, our subsidiary UnitedHealthcare, used the data only when our health plan beneficiaries sought care from physicians outside of our network and UCR protocols applied.
- Second, the primary database at issue in these settlements has been in existence for more than 30 years. During this time, the database has performed an essential function in our health care economy by setting a reasonable standard for the reimbursement of physicians who do not participate in managed care networks. This Committee knows better than most that physician reimbursement based on nothing but the doctor's bill is simply not economically tenable for consumers nor our health care system. The databases were created with the goals of appropriately managing costs and ensuring that consumers are protected from exorbitant medical bills.
- Third, we want to make clear that we stand behind the integrity of the Ingenix data. In addition, we stand by the way in which our insurance business, UnitedHealthcare, used the data to make reimbursement decisions. Our recent agreement with the New York Attorney General did not relate to the manipulation of data or other similar misconduct. To the contrary, working with the Attorney General, we agreed to transfer the databases to an independent, nonprofit entity in the hopes of increasing information transparency and public confidence in the quality of and access to the data that will be used to set future out-of-network reimbursement rates.
- Finally, the agreement with the Attorney General reflects our role as a leader in health care and our desire to strengthen the all important trust of consumers, and affirms our ongoing commitment to transparency.

Mr. Chairman, to understand the problems facing consumers and health plans with respect to payment for out-of-network services, one must first understand the critical role that physician networks perform in restraining health care costs. Our extensive network—one of the largest physician networks in the country—provides consumers with many options to obtain the highest quality medical care at an affordable cost. But our network also provides beneficiaries with another important benefit. It gives them visibility and certainty about the cost of health services before they seek care due, in large part, to in-network physician discounts. Unfortunately, the same is not true when consumers seek care out-of-network with doctors who have not agreed to discount his or her services.

This scenario is obviously not good for consumers. But, it's also not good for our health care system—nor our broader economy—when the costs of a routine, identical medical procedure can vary widely within the same geographic region and between private and public insurance, such as Medicare.

UnitedHealth Group has led the way in developing innovative programs that aim to provide valuable, easy-to-use health information to consumers and health care providers, among others. Since 2005, UnitedHealthcare's "Premium Designation" program has provided millions of our beneficiaries with the ability to access online cost and efficiency data for physicians and hospitals through *myuhc.com*.

In addition, nearly 2 years ago we created the "Claim Estimator" that provides physicians with an online estimate of whether the cost of a procedure will be covered. at what amount and what level the claim reimbursement will be.

Our agreement with the New York Attorney General reflects and builds upon our longstanding commitment to reduce costs and improve care through the dissemination of information. The new not-for-profit entity that we agreed to fund with others in our industry will establish a Website to allow consumers to search for medical services by geographic area showing the prevailing charge or range of charges. In addition, the site will alert consumers when insurers apply other policies to determine out-of-network rates, including terms in each plan document, other reimbursement policies. co-insurance and deductibles.

These are positive steps, but we believe even more can, and should be done beyond the parameters of the agreement, to enhance consumer access to health information. Consumers should be able find information online not only about how much they will be reimbursed by their insurer but also the cost of a medical visit or procedure at the time care is delivered. Meaningful and comprehensive transparency will only be achieved when all parties are equally accountable for the accuracy of the information and equal access is provided to all stakeholders. In the end, every consumer—each patient—must believe the costs for the care they receive are fair and consistent regardless of geography, insurance company, or health care provider.

At UnitedHealth Group, we are eager to be part of the national discussion to modernize our health care system. Thank you for this opportunity to address the Committee and we will be pleased to answer any questions that you may have.

The CHAIRMAN. Thank you, Mr. Hemsley.

Mr. Slavitt?

STATEMENT OF ANDY SLAVITT, CHIEF EXECUTIVE OFFICER, INGENIX

Mr. SLAVITT. Thank you, Chairman Rockefeller and Members of the Committee for the invitation to be here today. I am Andy Slavitt. I am the CEO of Ingenix.

I appreciate the opportunity to be here to discuss the challenges consumers face when they seek care from out-of-network providers. Two of our database products, MDR and PHCS, are sometimes used in the out-of-network reimbursement process.

I want to convey three points in my testimony today.

First, Ingenix stands behind the integrity of these databases and the databases used in this process. We would be pleased to, naturally, answer any questions you have about that.

Second, the agreement we reached with the New York State Attorney General to transfer ownership of the two database products to a nonprofit will increase public trust in these databases.

Third, this nonprofit that we and others have funded has the opportunity now to shine a brighter light for consumers both on what physicians charge and on how they will be reimbursed by their insurance companies before they receive treatment. This is the kind of consumer advancement that deserves broad support.

Advances like this are consistent with our everyday work at Ingenix. Since 1996, our job has been to put information to work for people to improve the quality and the safety of their care and to reduce their costs. Ingenix works for over 250,000 clients: physician practices, academic researchers, hospitals, health plans, employers, State and Federal agencies, and pharmaceutical and biotech companies. Whenever people use information, our job is to make sure it is accurate, transparent, and understandable, that it is handled in a way that is private and secure, and that it can be put to use to improve the quality and the cost of the health care people receive.

Here are some examples. We recently helped the State of Michigan decrease the number of children with lead poisoning 35 percent by working with their data. We helped increase organ donations in this country 11 percent by creating an information exchange for donors. We work with the FDA to protect patients from potentially harmful side effects by using data to monitor the safety of new treatments, and we provide tools for over 100 million Americans to help them find the best health care provider for their needs.

Now, the agreement that we reached that we announced with the New York Attorney General concerned two database products which have been in use since the 1970s to provide the health care system with benchmarks on what physicians charge. Thousands of doctors license these benchmarks to assist in setting their fee schedules. And commercial health care payers license these benchmarks to help them make decisions about how to reimburse out-of-network benefits under what they call a reasonable and customary standard in their insurance policies. Health plans use many different methods to reimburse out-of-network claims. Our clients use these database products on occasions when they prefer a market basis for reimbursement rather than a more static and typically lower reimbursement method such as Medicare.

Ingenix's role in all of these activities have been a limited, but important one: to collect, organize, and keep current the charges that physicians bill for their services. We do not set reimbursement rates. Rather, like information companies in many industries, we gather information from disparate sources, we validate it, and we publish it.

Now, under the agreement we reached with the New York State Attorney General, we will soon transfer the databases to an independent nonprofit. During the Attorney General's review, his office raised a concern that Ingenix's ownership of the databases presented an inherent conflict of interest. We do not want this concern to hamper the ability of the health care system to get access to this information.

We would like to make clear, however, that there is an important difference between an inherent conflict and the actual practice of bias. The latter is something neither I nor my employees nor our parent company would ever tolerate. Ingenix is a business that has

always prided itself on our reputation for integrity and innovation. Our 8,000 employees are scientists, doctors, and nurses, biostatisticians, economists, actuaries, epidemiologists. They have dedicated their careers to building a more transparent, higher-quality health care system. They are good people. I am pleased to represent them today.

Ultimately, trusted, accurate data and information technology comprise one of the keys to modernizing the health care system, particularly when combined with national quality standards and properly aligned incentives. Ultimately, we all need a system where both physicians and health plans have a venue to disclose what they charge patients so that consumers can compare and weigh the different costs and coverage implications of their decisions. We are hopeful that removing concerns over these databases will prove a meaningful step forward in creating such a system.

I want to close my statement by thanking the Committee for providing oversight on this important topic. We pledge to continue to focus our resources to make health care work better for people.

[The prepared statement of Mr. Slavitt follows:]

PREPARED STATEMENT OF ANDY SLAVITT, CHIEF EXECUTIVE OFFICER, INGENIX

Thank you, Chairman Rockefeller, Ranking Member Hutchison and Members of the Committee for the invitation to be here today. I'm Andy Slavitt, the CEO of lngenix. I appreciate the opportunity to be here to discuss the challenges consumers face when they seek care from out- of-network providers. Two of our database products, MDR and PHCS, are sometimes used in the out-of-network reimbursement process.

I want to convey three points in my testimony today:

- First, Ingenix stands behind the integrity of the databases used in this process.
- Second, the agreement we reached with the New York State Attorney General to transfer ownership of the two database products to a non-profit will increase the public trust in the databases.
- Third, this non-profit that we and others have funded has the opportunity to shine a brighter light for consumers both on what physicians charge and on how they will be reimbursed by their insurance companies before they receive treatment. This is the kind of consumer advancement that deserves broad support.

Advances like this are consistent with our every day work at Ingenix. Since 1996, our job has been to put information to work for people to improve the quality and safety of their care and reduce their costs. Ingenix works for over 250,000 clients—physician practices, academic researchers, hospitals, health plans, employers, state and Federal agencies, and pharmaceutical and biotech companies. Wherever people use information, our job is to make sure it is accurate, transparent and understandable, that it is handled in a way that is private and secure, and that it can be put to use to improve the quality and cost of the health care people receive.

Here are some examples. We recently helped the state of Michigan decrease the number of children with lead poisoning by 35 percent by working with their data; we helped increase organ donation in this country by 11 percent by creating an information exchange for donors; we work with the FDA to protect patients from potentially harmful side effects by using data to monitor the safety of new treatments; and we provide tools for over 100 million Americans to help them find the best health care provider for their needs.

The agreement we announced with the New York State Attorney General concerned database products which have been used since the 1970s to provide the health care system benchmarks on what physicians charge. Thousands of doctors license these benchmarks to assist in setting fee schedules. And commercial healthcare payers license these benchmarks to help them make decisions about how to reimburse out-of-network benefits under a "reasonable and customary" standard in their insurance policies. Health plans use many different methods to reimburse out-of-network claims. Our clients use these database products on occasions when they prefer a market basis for reimbursement, rather than a more static and typically lower reimbursement method such as Medicare.

Ingenix's role in all of these activities has been a limited, but important one: to collect, organize, and keep current the charges physicians bill for their services. We don't set reimbursement rules; rather, like information companies in many industries, we gather information from disparate sources, validate it, and publish it.

Under the agreement we reached with the New York State Attorney General, we will transfer the databases to an independent non-profit. During the Attorney General's review, his Office raised a concern that lngenix' ownership of the databases presented an inherent conflict of interest.

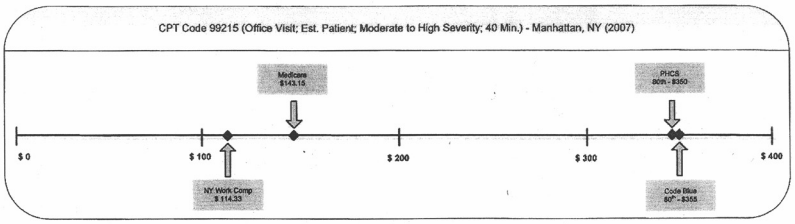
We do not want this concern to hamper the ability of the health care system to get access to this information.

We would also like to make clear that there is an important difference between an inherent conflict and the actual practice of bias; the latter is something neither I, nor my employees, nor our parent company would ever tolerate. Ingenix is a business that has always prided itself on our reputation for integrity and innovation. Our 8,000 employees are scientists, doctors and nurses, biostatisticians, economists, actuaries and epidemiologists. They have dedicated their careers to creating a more transparent, higher quality health care system.

Trusted, accurate data and information technology comprise one of the keys to modernizing the health care system, particularly when combined with national quality standards and properly aligned incentives. Ultimately, we need a system where both physicians and health plans have a venue to disclose what they charge patients, so that patients can compare and weigh the different cost and coverage implications of their decisions. We are hopeful that removal of concerns over these databases will prove a meaningful step forward in creating such a system.

I want to close my statement by thanking the Committee for providing oversight on this important topic. We pledge our assistance to continuing to focus our resources to make health care work better for people.

Exhibit 1: Methodology Comparison



The Attorney General's Office collected data for five counties but reported on only two counties.

PHCS is based on methodologies that are commonly used and well established in statistics and health care.

	Code Blue Report	PHCS	Medicare	NY Work Comp
99215 – Manhattan	$355.00	$350.00	$143.15	$114.33
99215 – Buffalo	$200.00	$182.00	$116.90	$92.00
99215 – Albany	?*	$200.00	$116.90	$87.81
99215 – Rochester	?*	$215.00	$116.90	$114.33
99215 – Syracuse	?*	$203.00	$116.90	$92.00
# of Bills – 5 Counties	1,000,000+	17,770,083	Not Applicable	Not Applicable
# of Geographic Regions – NY	Not Applicable	24	4	4
High & Low Outliers Removed	?	Yes	Not Applicable	Not Applicable
Professional Fees Reported By	CPT (no modifiers)	CPT (some modifiers)**	CPT (some modifiers)**	CPT (no modifiers)
Differentiation by training, qualifications, experience	By CPT code selection	By CPT code selection	By CPT code selection	By CPT code selection and qualifications***
Derived Charge/Relative Value Methodology	?	Yes (some)	Yes	Yes

PHCS is based on approximately 18x more data than the Code Blue Report and has 6x more geographic regions in New York than Medicare.

* The Code Blue Report states that the Attorney General's Office collected data for five counties in New York. It reported data for only two of the five counties.

** PHCS reports PC/TC modifiers. Medicare fee schedule reports PC/TC and -53 modifiers.

*** The NY Workers Compensation fee schedule reports separate fees for Chiropractors, Podiatrists, Psychiatrists, Occupational Therapists, and Physical Therapists

The CHAIRMAN. Thank you, Mr. Slavitt.

Senator Pryor, did you have any comments you wanted to make? Senator Pryor is head of our Consumer Protection, Product Safety, and Insurance Subcommittee.

Senator PRYOR. I do not, Mr. Chairman, but thank you for having this hearing. I think it is very informative and helpful. Thank you.

The CHAIRMAN. Inherent conflict of interest. I am just interested in the way that some conflicts of interest are important and others are not. I want to plumb that just a bit.

Mr. Slavitt, you are the CEO of Ingenix. Ingenix is a subsidiary which is wholly owned by UnitedHealth Group. Is that correct?

Mr. SLAVITT. That is correct.

The CHAIRMAN. Is it also correct that you will be basically out of business in about 6 months?

Mr. SLAVITT. That is not correct. May I clarify?

The CHAIRMAN. Of course.

Mr. SLAVITT. These databases represent less than 2 percent of our overall revenue.

The CHAIRMAN. Oh, no, I do not mean the other thing. I know you do lots of other things. But this aspect of your work.

Mr. SLAVITT. Yes. We will be transitioning these two databases to a not-for-profit once it has been selected.

The CHAIRMAN. Now, was that something that you were going to do anyway and there was a confluence of somehow magical convenience between the settlement with the New York State Attorney General, $350 million, $50 million of that to go to some university or some other research organization which could do what I always said you were not doing?

Mr. SLAVITT. No, we were not planning on otherwise transferring the databases.

The CHAIRMAN. And so why did you not?

Mr. SLAVITT. Well, I think——

The CHAIRMAN. You knew what was going on. You knew about the bulk material that came in to UnitedHealth Group and how a lot of that was just skimmed off the top so that there would be a low ball.

Mr. SLAVITT. With all due respect, Mr. Chairman, I do not accept the premise of that question. I would be happy to, in whatever detail you would like, talk through the statistical methods that have been alleged and what, in fact, are some other facts that I think you ought to be aware of.

And I understand that you have very deep concerns about the database and about making sure that consumers are protected when they go out of network. I share those concerns as well. I also equally care about the reputation of the work of our people and the integrity of the people that work for me on this database product. And I would like to give you an opportunity to have all of the facts available.

So while I would say we learned from the Attorney General that we were myopic in focusing only on whether or not this database had integrity and whether we were, indeed, acting appropriately, those things I have never come to question, and we have been very self-reflective in this process.

What we did learn—and you learn a lot of things going through processes like these, Mr. Chairman—is that to the outside world, this appeared to be too close for comfort. We are analytical types and we analyzed each accusation and each concern as it came in. I never once had a reason to believe that anything that was said was an indication of bias. Again, I am happy to walk through those details.

We did—however, when we learned and were made to see from the Attorney General that this looked to consumers to be something that could not be trusted, it was important for us to make sure to rectify that situation.

The CHAIRMAN. Let me continue with my question. Mr. Hemsley, as you know, the Attorney General of New York and other consumer groups had a lot of concerns about the business practices in the relationship with Ingenix. I think their concern was that Ingenix held itself out as an independent source of usual, customary, and reasonable health charge data specifically. But at the same time, Ingenix was wholly owned by you, which had a financial interest in generating low reimbursement rates. You can disagree with that, but that is clearly the conclusion of many.

Now, let me give you an example. During the New York Attorney General's investigations, they discovered a letter written in 2005, which I think we are going to distribute, to a New York consumer by UnitedHealthcare. UnitedHealthcare is another division of the UnitedHealth Group. Now, the letter informs the consumer that UnitedHealth has determined that the amount of his or her claim exceeded what is called "an allowable and reasonable standard." UnitedHealth says it reached this conclusion after consulting "independent research across the health care industry."

[The information referred to follows:]

UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare Insurance Company of New York
P.O. Box 1600 Kingston NY 12402

August 19, 2005

Mr [redacted]

Re: **Empire Plan**
Policy Number: [redacted]
Enrollee: [redacted]
Identification Number: [redacted]
Patient: Self
Mail Number: [redacted]
Total Charge: $20809.00
Account Number: [redacted]

Dear Mr [redacted]

We have received a claim for Self for services provided on 04-15-2005. The claim was evaluated according to the terms of the New York State benefits plan.

Under the terms of the plan, coverage is provided for expenses within a reasonable allowance. To determine "allowable and reasonable" expenses, we use independent research from across the health care industry. This includes over 200 million records of fees charged by health care providers for surgical and non-surgical procedures in many different geographic locations. We also consider variations in fees that may be due to complications or unusual circumstances.

Based on the information provided, the fees charged exceed the reasonable allowance and the excess amount is not covered.

There is a right to appeal this determination. There are two (2) levels of appeal available under the terms of the Empire Plan. If you wish to submit a Level II appeal, Please include any additional documentation that was not previously submitted for our review. The deadline for submitting an appeal is sixty (60) days from the date of this letter. The address for submitting an appeal is as follows:

United Healthcare Insurance Company of New York
P. O. Box 1600
Kingston, NY 12401-1600

If you have any questions or concerns, please contact one of our United Healthcare customer care professionals, toll free, at 1-877-7NYSHIP (1-877-769-7447) or write to us at the address above.

Sincerely,

J. Benson

Jeannie M Benson
Service Representative
Kingston Customer Care and Transaction Center

But here is the problem, Mr. Hemsley. This so-called independent research came from your wholly owned subsidiary Ingenix. We can find no other. The people who testified said they had never heard of anybody being called up and asked "what is going on here," "what do you think."

So, Mr. Hemsley, do you see why Attorney General Cuomo and others might be concerned about a conflict of interest?

Mr. HEMSLEY. Chairman, I think we do, and that is why we responded the way that we did. This database has been in operation for more than 35 years.

The CHAIRMAN. What does that prove? It could be that you were wrong for 35 years.

Mr. HEMSLEY. It could, Mr. Chairman. But this database has been used as a reference database only, which means it only collects raw billed charges across—served by a billion claims per year in 500 different geographic zones and is a reference database only that is used and made available to other companies for a broad set of applications, including the reimbursement of out-of-network.

The CHAIRMAN. Well, with respect——

Mr. HEMSLEY. The issue of conflict had not surfaced in the context that the Attorney General had positioned it, and when that issue of conflict presented itself, we understood the issue with respect to consumer trust and we responded accordingly. That was really at the core of our discussions with the Attorney General from the very beginning.

The CHAIRMAN. That is interesting because, as I see it, you have already acknowledged there was a conflict of interest in the relationship. And you have done that through your general counsel, UnitedHealth's general counsel, Mr. Mitch Zamoff. And he said on January 13, interestingly, of this year, "We regret that conflict of interests were inherent in these Ingenix database products." That is what he said. I doubt that was a casual statement. I bet that was vetted and gone over. I bet that was in a formal setting.

Now, let me ask you, Mr. Hemsley, do you regret there were conflicts of interest in the Ingenix database products, or do you simply deny what your general counsel said?

Mr. HEMSLEY. No, Mr. Chairman. 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.

So I would also suggest we regret the fact that there is not greater transparency with respect to charges that go outside the domain of networks where there is transparency on costs and charges and that this plays into the broader context of a health care dilemma in the country around health care affordability and the need to modernize the system so that there is greater transparency and greater information. Clearly, we regret those and we think that the steps that have been taken are very positive steps forward with respect to this aspect of cost reimbursement.

The CHAIRMAN. Mr. Hemsley, I am, I think, basically a polite person, but you are making it hard on me. I just do not see how

there can be any other interpretation of the fact that Andrew Cuomo, a not insignificant or shy Attorney General, entered into this with all four hands and feet and did a heck of a job with a heck of a staff, ran down all kinds of numbers.

And I have follow up questions, and I hope that Senator Pryor will forgive me for a second, and he can use 10 minutes too because he will have questions to ask.

Suddenly the future is rosy and this is a wonderful thing. It is in both of your statements. This is going to be so much better. There is going to be so much transparency. It is going to be so much better for the out-of-network consumer. And yet, this was said as you were about to get hit with a $350 million fine. And I have to assume that that was not sort of picked out of the air, that there was some other statement that said, you know, if you are not willing to pay that—I was not there. I am not a lawyer. But as a citizen and as somebody who has been working on health care all of my life, this is very suspicious to me, this sudden glowing view of the future, completely putting aside what I consider a very sordid past.

And I do not know why it was that you did not stop it because you knew what was going on.

Mr. HEMSLEY. Well, Mr. Chairman, the reimbursement of out-of-network services entails a billing related to entities that are not within the domain of our network. So——

The CHAIRMAN. I missed that.

Mr. HEMSLEY. That are not in the domain of our network. And therefore, consumers do not know, when they go outside the network, what those services will cost. And the usual and customary database—I think back to its original origins in the early 1970s—was built in response to establishing what costs are across 8,000 service codes established by the AMA so that there would be a reference point of actual activities in markets in geographic zones so there would be some point of reference.

So the lack of transparency is from the portion of the medical community with respect to those billed charges. Then when a consumer uses those services, there is a reimbursement mechanism that is applied, a variety of them, across this base and they may or may not make reference to that database.

So I would suggest that that database is an effort to actually bring some information to the marketplace. The dilemma was that it is not as easily or readily accessible.

So the concept brought forward with the Attorney General was to create a place where that information could come forward, come forward from a neutral party. And we participate in that and that is where our $50 million is an investment into the transition of that database to an academic center and for the use of a much broader, much more robust transparency nationwide.

The CHAIRMAN. All well and good.

I close simply by then saying that you must, therefore, reject what your General Counsel said on January 13 of this year that he regrets that conflicts of interests were inherent in this Ingenix database products. You reject that.

Mr. HEMSLEY. No, Chairman, I do not. The work with the Attorney General helped us understand the perception of the fact that

one of our businesses was involved in the development of this reference database, and it was used on an arm's-length basis by another one of our businesses, and we understand that appearance of an inherent conflict, and we responded.

The CHAIRMAN. OK. I will be back.

Senator Pryor?

STATEMENT OF HON. MARK PRYOR, U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Thank you, Mr. Chairman.

Mr. Slavitt, let me start with you, if I may, and that is during your testimony, I did not count how many times, but I lost track after five or six times of you using the word "transparency" in your statement. Are you saying that your system has been transparent?

Mr. SLAVITT. I am saying that—no, I am not saying that it has been transparent enough to the consumer, and I think this has been an awfully confusing process for the consumer. I think our clients, both physicians and health plans, would consider that a failure, a very difficult area of health care, no doubt, but a failure.

I think our notion has been to try to make essentially a good thing happen, which is, as you well know, the health care industry sometimes gets criticized for not pooling its information together to create one version of truth or to combine information across a variety of sources to people. So our hope and our goal has been to take sources from many different health plans so that every health plan does not have its own reasonable and customary rate based on much less information and put it all in one place and make it available. And we have made it available through various products to doctors, to health plans, and to consumers. I think, obviously, it has not succeeded as well as we hope it will in the future.

Senator PRYOR. So let me ask. Your company is a wholly-owned subsidiary of UnitedHealth Group. As I understand it, that is not generally made known or made clear to policyholders and even doctors. We had a couple of folks in last week to testify to us, and they said they had tried to figure out how these reasonable and customary charges were calculated, and they were basically stonewalled and could not get an answer.

So basically today before the Committee, you are telling us that your operation has not been transparent and has not worked in a way that it should for consumers. Is that fair to say?

Mr. SLAVITT. Senator, what I am saying is that we go through a very thorough process of ensuring that the data we present to people is as accurate as possible. We take in a lot of information. We go through a very thorough verification process, which I would be glad to outline to you. We publish information much in the same way a company like A.C. Nielsen or companies in other industries publish information. We certify the information that comes in. We run tests. We ensure that nothing happens in the course of that process that are biased, and we turn that information over to various people to use it. It includes health plans, including one of our sister companies. It includes other health plans. It includes physicians. And what I am testifying today is all of that was done properly.

Senator PRYOR. Well, let me ask this. There is some disclaimer language I want to focus on, and it is a document that you have, I think the Committee has. You may have it in front of you, but if not, we will make sure you have it. Basically it says, "The database is provided for informational purposes only and Ingenix disclaims any endorsement, approval, or recommendation of data in the database." Now, to me, that sounds like you are not standing behind the data in your database. And to me, it sounds like you are not standing by the integrity of your own database, although in your testimony a few minutes ago, you said you are.

[The information referred to follows:]

"Client is responsible for decisions made and actions taken based on the database. The database is designed and intended for use by professionals experienced in the use and limitations of claims processing, and it is client's responsibility to ascertain the suitability of the database for client's purposes. The database is provided for informational purposes only and Ingenix disclaims any endorsement, approval or recommendation of data in the database."

*Disclaimer included with MDR and PHCS database products.

Mr. SLAVITT. Sure.

Senator PRYOR. So explain that for me.

Mr. SLAVITT. No, I understand why you are asking the question.

Our clients, many, many health plans, write policies and their own policy language and refer to our database in that policy language. We are explicit about what the database is and what it is not. However, we cannot warrant that if a health plan says something about our database that is not, in fact, true, that therefore they are using it in a reasonable and customary way.

What we can warrant is that our database that lists, for example, what a doctor visit costs in a certain location for a certain service for a certain price is, in fact, derived the way we indicate that it is derived.

Senator PRYOR. So in other words, just a minute ago in answering my question, you said that you publish information like A.C. Nielsen and others, and you go through this rigorous testing and this examination and this process that you go through, and you are like other database or information providers. But that is not true because A.C. Nielsen and others actually can get inside their numbers. They can verify the accuracy of the numbers. But you did not at Ingenix. Is that fair?

Mr. SLAVITT. No. With all due respect, to the contrary. We run a very thorough process. And I think on Thursday in this room, you heard some facts, and I think there are other facts that would be useful to hear. For example, I think you heard that high values are removed from the database, and the other half of that statement is that about 5 percent on average of the data that comes into this billion-record database is excluded as being outliers.

So what is an outlier? An outlier is a number that comes in that does not make any sense. In plain terms, if a bill for a certain service is $75 week in, week out, year in, year out from a doctor, and you get a record that comes in at .075 or $7,500 or $75,000, which happens, naturally we exclude it. And as a matter of fact—and this is important—we exclude four times as many low values as we do high values.

Why that other part of the sentence has never been talked about I am not exactly sure. But criticism after criticism has not entirely told the entire story about these methods and these processes. The processes that we use we always go back and test to see whether or not what we did created a bias or a downward skew, to use your expression, of the information, and it does not.

Senator PRYOR. Mr. Hemsley, let me ask. And I am really out of time here, but with the Chairman's indulgence, let me ask you. You mentioned in your opening statement that the database did not set rates.

Mr. HEMSLEY. Yes, sir.

Senator PRYOR. Well, who did set the rate then?

Mr. HEMSLEY. The individual user, if they are using it for reimbursement purposes——

Senator PRYOR. So in other words——

Mr. HEMSLEY.—the database itself——

Senator PRYOR.—UnitedHealthcare would set the rate.

Mr. HEMSLEY. Whatever insurer would use it as a point of reference. It is a static database that collects billed charges from across the country with about 100 contributors to it, and it merely takes those data points in and sorts them by service code, AMA service code, 8,000 service codes, along 500 geographic areas, and then presents it in terms of percentile terms as a reference point.

Senator PRYOR. So it is up to the individual insurance company to set the rate.

Mr. HEMSLEY. Yes, sir.

Senator PRYOR. And you also mentioned that the primary database in question has been in existence for 35 years, but I want not to parse words with you but when you say the primary database, the truth is it has changed a lot in the last 35 years. Is there not a different ownership structure with this database than there used to be?

Mr. HEMSLEY. The original database was created and put in a trade association of health benefit purveyors and operated until that trade association merged with another in the late 1990s, at which point in time we took responsibility for that database and have operated it since.

Senator PRYOR. And would you agree with me that by virtue of the change of ownership and the change in the structure of the database, then it does open the door for this inherent conflict of in-

terest that we have talked about and also may add to the lack of transparency with the database?

Mr. HEMSLEY. As I think we said before, it does create the appearance of a conflict, and that is why we responded as we did with the Attorney General.

Your other question was?

Senator PRYOR. Does it—this conflict of interest and also this lack of transparency.

Mr. HEMSLEY. The use of the reimbursement and the reference to the database, et cetera is set forth in plan language, plan documentation, et cetera, all reviewed by regulators and passed by regulators. I do suggest, as I had responded to the Chairman, that we wish we had done more with respect to being more aggressive in terms of the relationship between the businesses, yes.

Senator PRYOR. In other words—I am sorry, Mr. Chairman—if I am John Q. Policyholder with UnitedHealthcare and I have a policy with UnitedHealthcare, and when I get my insurance and it says, you know, something to the effect of if it is an in-network service, United pays for 90 percent, but if it is out-of-network you pay for 50 percent, the truth is that in most cases you are not paying 50 percent. You are paying 48 percent, 45 percent, 40 percent, 35 percent, something like that, but you are paying less than 50 percent because of the way this deal was structured.

Mr. HEMSLEY. No, Senator, I would not agree with that. We generally pay much higher, and I will use the case of Dr. Jerome, the witness. Ultimately, this was a self-funded case, so it was sponsored by her employer. We paid 86 cents on the dollar for the services she received at Sloan-Kettering, very costly, but also a very high-quality institution. 86 cents on the dollar.

Senator PRYOR. Mr. Chairman, thank you.

The CHAIRMAN. Thank you.

Senator McCaskill?

STATEMENT OF HON. CLAIRE MCCASKILL, U.S. SENATOR FROM MISSOURI

Senator MCCASKILL. I am a little confused. You all settled a lawsuit and a complaint—an investigation by the Attorney General's Office for hundreds and hundreds and hundreds of millions of dollars. I think between the agreement with Cuomo and the agreement in New Jersey, are we not talking about a half a billion dollars that you all are paying?

Mr. HEMSLEY. Yes, Senator.

Senator MCCASKILL. And Mr. Slavitt, you are maintaining there is absolutely nothing wrong with this data?

Mr. SLAVITT. Yes, Senator.

Senator MCCASKILL. Do your shareholders know that you have settled this amount for a half a billion dollars when you have done nothing wrong?

Mr. SLAVITT. Maybe I could put a context to that. The discussions with the Attorney General have been around the issue of conflict and a better positioning of that database, which really is essential for the health care system, and to position that database in a center that would have no business interests associated at all. And to help transition that and to deal with the root issue of lack

of transparency on out-of-network bills and charges from the provider community and the solution with the Attorney General and the investment associated with that to bring that capability to bear nationwide as an industry utility is what our discussions with the Attorney General have been about.

Our resolution with the American Medical Association really relates to a conflict that has been in place with them for nearly a decade, and we are interested in cultivating a much more constructive relationship with the medical community at large. About 85 percent of the health care community, about 5,000 hospitals, 6,000 physicians, and so forth, are part of our network infrastructure. We procure about $100 billion in health care services a year through that, and we are not interested in having a contentious relationship with that very vital aspect of the health care——

Senator MCCASKILL. I guess my concern, Mr. Hemsley and Mr. Slavitt, is that I anticipated, after the hearing last week, that your testimony today would be "we did not do this right," not just it did not look good, but "we did not do it right." Now, you are admitting, Mr. Hemsley, that it did not look good. But what I am not hearing is any acknowledgement that you did not do it right.

Let me ask you, Mr. Slavitt. If you were so busy throwing out the low price outliers, then why were you able to market this information to insurance companies by saying for every dollar you spend on our data, you will save $16? How is it that if this data is so accurate that you would advertise that by using this data, you are going to save $16 for every dollar you spend, if you were so busy throwing out the low outliers?

Mr. SLAVITT. Senator, we market this data to physicians and health plans and researchers and governments. The data and the analytical processes are overseen by Ph.D.s who are people that have very deep ethical training, very deep analytical training——

Senator MCCASKILL. I am not asking about the training of the people who did it. I am asking you about the marketing of for every dollar you spend, you are going to save $16. If this is just accurate data, how can you market that they would save that kind of money over what they had been paying?

Mr. SLAVITT. First of all, Senator, I need to see the document. I am not familiar with——

Senator MCCASKILL. It is in the complaint that you settled. It is in the complaint. It is on page 32 of the complaint, 130. "In marketing PHCS, UnitedHealthcare promised and continues to promise that PHCS users will achieve substantial cost savings, including a 16–to–1 return on investment."

Mr. SLAVITT. Right. So, Senator, if I may?

Senator MCCASKILL. Yes.

Mr. SLAVITT. For a health plan to decide that they would like to pay less or would like our rates to be lower, the easiest thing in the world for them to do is to say I do not want to pay at the 80th percentile. I want to pay at the 70th percentile. The thing that I find hard to believe is that they would come to us and suggest that we should cook the data.

Now, promising our clients who buy our software, if they use data and they use data well, that they will be able to run their business better and operate better, whether it is on the physician

side or on the health plan side, is not something that I am embarrassed about.

Senator MCCASKILL. Well, I guess the point is that your marketing was we are going to help you not pay.

Mr. SLAVITT. No. Excuse me. I am sorry. I did not mean to interrupt you.

Senator MCCASKILL. Well, that is certainly what it—if I were an insurance company and I got a flyer from your company and it says for every dollar you spend for our data, I am going to save you $16, that means I am going to be paying out less money in claims.

Mr. SLAVITT. I am sorry. I respectfully disagree with the statement that that means that we are going to have them not pay. What our clients want to do——

Senator MCCASKILL. Pay less.

Mr. SLAVITT. What our clients want to do is pay accurately, and when they license our database, what they are saying they want to do is pay at something that approximates a market rate as opposed to what they could do, which is pay at a Medicare rate or create a schedule of their own. They actually pay something like 30 percent more when they use our product than if they were to, in fact, use something closer to their in-network rate or double what they would if they used the Medicare rate.

So the links that you are making I do not think are—appropriately imply that we are finding ways for them to inappropriately pay less, with all due respect.

Senator MCCASKILL. Well, I think the problem here is that there appears to be a disconnect in terms of owning some responsibility for what clearly the company decided was wrong. I mean, you cannot tell me in this day and age with the kind of shareholder scrutiny there is that any company would already have agreed to pay out a half a billion dollars in settlement for something that just had an appearance of a problem. Usually cases get settled because you are afraid you are going to get nailed if they go to court, and they do not get settled otherwise.

And it seems to me that—I am just disappointed. I think this is why the health care reform—you know, there is such a lack of confidence in so many institutions right now, Congress being among them, but certainly health insurance is one of the places where most people that I work for think they are getting a raw deal.

And I am just disappointed that there is not more of an acknowledgement today that the way you all did this was wrong, that the information and the way you disseminated it was not done correctly, and that consumers were getting the short end of the stick. If you had come here today and said those things, I would feel much better going forward. As it is, I think we need to be vigilant and stay on you like white on rice.

Mr. HEMSLEY. Well, Senator, we are here because we are interested in consumer confidence. We are interested in making sure that all of this is understood. We made a business decision and we made a decision about the transference of the database to a neutral site and to invest in a greater transparency that would benefit the health care domain in total and consumers and physicians alike. We also made a business decision to resolve a conflict with the

medical community at large, which is very important to our business, and that conflict had been in place for some time.

Once we had made a decision to transfer the database, we were also interested in resolving the conflict with the medical community. It is very important that we maintain a relationship with them. We procure a great number of services through them. In the era that we are moving forward, in terms of health reform, I think it is more important than ever to have an appropriate and smooth relationship with the health community, and we made a decision that to resolve this conflict, which had been longstanding, was a very good business decision in that context.

Senator MCCASKILL. And I appreciate it, Mr. Hemsley, and I know you are trying to do what is best for your company.

One final question, Mr. Chairman. Are you saying that the Attorney General's inquiry into your business was, in your mind, a separate and distinct issue from the lawsuit that had been ongoing for 7 or 8 years before the Attorney General ever opened a book on you?

Mr. HEMSLEY. I am suggesting that the Attorney General really focused on the issue of the positioning of the database and the appearance of conflict with that reference database and our activities in other aspects of our business in health benefits. And his interest was in resolving that, and that is what our solution with the Attorney General——

Senator MCCASKILL. But were the issues not the same, Mr. Hemsley, in the lawsuit and the information that the Attorney General uncovered? Were the issues not the same?

Mr. HEMSLEY. No, Senator. I think the issue in the litigation was about the validity of the database, and we stand behind the validity of the database and the appropriate support of that database.

Senator MCCASKILL. So the lawsuit was about the validity of the database which you stand by, and the Attorney General's inquiry was on conflict of interest. So you decided to settle the conflict of interest and, in turn, just decided to settle the validity of the database lawsuit at the same time? And these are not related?

Mr. HEMSLEY. To put, in essence, the entire matter and to move forward in a much more constructive way, absolutely.

Senator MCCASKILL. Thank you.

Mr. SLAVITT. May I?

Senator MCCASKILL. It is up to the Chairman.

The CHAIRMAN. Please.

Mr. SLAVITT. Senator, of course, 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.

But we would not have signed an agreement that contained accusations of fraud in it because we simply do not agree with it, and we did not sign an agreement that had fraud in it.

Senator MCCASKILL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator McCaskill.

Senator Warner?

Senator WARNER. Mr. Chairman, since I missed the last hearing, I think I am going to pass at this point and listen a little bit more.

The CHAIRMAN. OK.

Then Senator Klobuchar?

STATEMENT OF HON. AMY KLOBUCHAR, U.S. SENATOR FROM MINNESOTA

Senator KLOBUCHAR. Thank you very much, Mr. Chairman. I thank both of you for being here.

Just to sort of set the stage here, Mr. Hemsley, there was a lawsuit or two legal actions. They were settled, as Senator McCaskill pointed out, for half a billion dollars. But the key part of this, just from my perspective, is part of this with the Attorney General of New York was that there was $50 million devoted to a website to move forward to post and figure out a way to accurately depict these rates, out-of-network rates.

And just to clarify here the record, your company settled, but there are other companies that have not settled who are being sued. Is this correct?

Mr. HEMSLEY. That is correct. The context of it was the development of a concept that we had actually brought forward with the Attorney General about the establishment of a more universal site so that charges could be transparent when they were in an out-of-network setting and to use the database, which is by far the most robust database in the industry, as a source for this. We adopted that on a national basis for our business, and I believe the other carriers are in the process of considering that right now.

Senator KLOBUCHAR. So will other carriers, even if they have not settled—will their customers be able to access this? It is going to be a public database?

Mr. HEMSLEY. It will be a public database.

Senator KLOBUCHAR. OK. And what other changes do you think would make it easier for patients to understand the true costs? You know, retail clinics often post prices in their office, things like that. As we move forward here, when people are looking at out-of-network costs—and I can tell you I am devoted trying to get people covered as much as possible, but if they want to go out-of-network, what are some other ways they can assess the cost?

Mr. HEMSLEY. For our network and the vast majority—I mean, we are talking about a very small percentage of services that are really rendered out of network. So the vast majority of services that are rendered in-network we have information about the service itself and about the physicians and so forth that assess and report on quality on their service efficiency and also do this in the context of natural groupings of services because the services themselves are very technical in terms of AMA service codes, and so they are then grouped into more natural, plain English. And that is what we use and we would use that as a model I think. I think it is the most advanced of its kind across the industry. We would use that as a model for this site.

Senator KLOBUCHAR. And I will say I have some statistics. We will maybe ask you the questions in writing about how patients can do better bargaining when they have the information, those kinds of things.

But I have to tell you I just do not think this is the way we want to go. I do not think you do either in terms of having individual

patients trying to negotiate rates. There is no way the patients win in this circumstance. And to me, the answer is to, of course, leverage patients by having them together in a major group to take on the costs.

And I just want to move to another area that Mr. Slavitt had raised. Where I look at where can we really save money in the system—and I know the President is devoted to this as well, and that is this issue of geographic variation in the Medicare reimbursements. Mayo Clinic just announced that they lost $765 million last year because of the Medicare reimbursements. Yet, they have the highest quality and lowest cost of health care around. In fact, a Dartmouth study came out—I mentioned this last week—that showed if every hospital in the country followed their protocol, we would save $500 billion every 4 years in taxpayer money on Medicare.

And so could you comment as we look to this health care reform about how we can account better for these geographic differences where some areas of the country are incredibly inefficient in how they deliver health care? Miami, Florida, $15,000 for the same package of Medicare services that is $7,000 in the Twin Cities. That is a fact. So how can we fix this where you have these wildly disparate health systems? And to me, that is going to be a lot of the answer of how we save costs in this area, Mr. Hemsley.

Mr. HEMSLEY. Yes, Senator. I think what you reference to—and our company has been supportive of that as well—is that in a major area, if you think about reform broadly, you can think about it in terms of four zones, in terms of health policy, appropriate use of resources, appropriate alignment of the health care economy, and citizen responsibility for health.

In the area of appropriate resource use, there is significant variation of care. It is well established. There are evidence-based medicine protocols. They are generally established by the specialty societies. We use those protocols as a basis for setting the evaluation framework for our premium networks, and we believe that if the evidence-based medicine was consistently complied with across the spectrum of care, that you would get meaningfully better, more efficient use of resources. And that is very much what our business is engaged in.

Senator KLOBUCHAR. Thank you very much. I just want to correct the record. It is $50 billion—$50 billion—every 4 years that we can save. So thank you.

Mr. Slavitt, did you want to add anything on the Medicare issue?

Mr. SLAVITT. No, I think Mr. Hemsley covered it.

Senator KLOBUCHAR. OK. Thank you very much.

The CHAIRMAN. Thank you, Senator.

Senator Begich?

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you, Mr. Chairman.

I appreciate you all being here today. I apologize I missed the first portion of your presentation, but just remind me. Maybe, Mr. Hemsley, you could do this, or either one of you.

In the settlement that was done, the amount of money in the settlement—besides setting up the nonprofit and setting up the new system, what are the chunks of the money? How does that go? Just so I kind of get the basis——

Mr. HEMSLEY. In developing the recommendation with the Attorney General and recognizing that there would be costs to establish a transparent, robust database for these purposes, we have indicated that we would make investments over a period of time—I forget the period—of $50 million and anticipated that others in the insurance domain would make investments of that. So that is what the $50 million is about.

Senator BEGICH. To set up the system.

Mr. HEMSLEY. Transfer the database, which is an industry——

Senator BEGICH. Owned and operated.

Mr. HEMSLEY.—essential service.

Senator BEGICH. I understand.

Mr. HEMSLEY. And to make sure that service is transferred to a new setting, fully operational, and then also to get more proactive in terms of developing the kinds of transparencies that everybody in the health care community is looking for, whether that be portals, whatever venues may come forward. So those would be investments for those purposes.

Senator BEGICH. And then in that, was there—I could not ask this to the last week's panel, but maybe you could answer this. I ran out of time last week. But are there operating dollars to continue to flow to operate that facility? In other words, I understand the setup costs and so forth, but what ensures the continual operation for the staffing and the data collection and all that it takes to keep that going?

Mr. HEMSLEY. The database itself should be self-sustaining so long as it is used broadly in the industry, and we have committed, as it pertains to reference for usual and customary rate purposes, that we would continue to use it. So it should be a sustaining entity.

Senator BEGICH. But the nonprofit has to operate—how will the nonprofit fund itself and continue to operate?

Mr. HEMSLEY. License fees——

Senator BEGICH. To the insurers who then would pay a fee to put the data in there and collect it and manage it.

Mr. HEMSLEY. Yes, sir.

Senator BEGICH. OK. That is the question I had.

The second one is do you think—I asked this of last week's panel. I mean, the settlement was kind of regional. You know, I come from Alaska. So I think almost three-quarters of our business is Blue Cross. Probably Aetna is our secondary. Do you think this settlement should be codified into the health care reform? When I say settlement, I mean the elements of this independent type of nonprofit that collects the data for the whole country from Alaska to Florida and everywhere in between.

Mr. HEMSLEY. We are approaching it on a national basis. We will do this on a national basis.

Senator BEGICH. But do you think it should be part of the health care reform in the sense of codifying it to make sure that it does not have to be a settlement issue in the future if there are other

issues that come up down the road? Maybe the nonprofit starts not doing what they should be doing? Should it be part of the health care reform, or do you think satisfies it? Do you think all the insurance companies are going to participate?

Mr. HEMSLEY. I cannot speak for the other insurance companies. I would broadly suggest that I think that standards applied in the health care community would be a positive thing in a number of areas. And I think——

Senator BEGICH. This specifically. I am going to kind of drill down here.

Mr. HEMSLEY. I believe that this database is the standard in the industry, so I would agree with that.

Senator BEGICH. OK. Same thing? Would you agree with that, or additional comments?

Mr. SLAVITT. I have opinions probably on a lot of things, including reform-related. I do not have an opinion as to whether this should be codified in reform.

I do think that the Committee is right to focus on ways to encourage both health plans and physicians to disclose their charges in advance to consumers in an easy way. Mr. Hemsley mentioned bundling services, which is an even more friendly way to do that. But the more that—and I think most of my clients, who are physicians and health plans, would agree with that, that more transparency will be better. We will have fewer situations like the ones that frustrate the Committee and certainly us as well.

Senator BEGICH. Let me end with just one last question because my time is about out, and maybe this could be data either one of you could get. But I would be curious, over the last—you know, maybe to the insurance company, but specifically to both of you—over the last half a dozen years, do you have some data that can show me your consumer complaints, as well as your physician complaints and/or organization complaints, and kind of what volume and what types of complaints that have come to you in regards to the charges and so forth? Is that something that either one of you or both of you could provide?

Mr. SLAVITT. We will get with our team and we will get something out.

Senator BEGICH. OK. Both? Thank you very much. My staff will follow up with you. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Udall?

STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO

Senator UDALL. Thank you, Chairman Rockefeller. Once again, I appreciate you bringing us back to this important issue.

The lawsuit and the settlement that resulted hurt consumers in a significant way. And my first question is boring in on New Mexico, but I think this is true for the rest of the country. I mean, I am wondering are my New Mexico residents—have they been as under-reimbursed as consumers in New York, as was proven out in these hearings that we have had? That is the first question. Do you have any, Mr. Hemsley, on——

Mr. HEMSLEY. Well, as I said, the context of our resolution with the American Medical Association and the medical community at large is to resolve the conflict between our entities that has been longstanding. It was important to us that if the conflict resolution involved funds, that those funds be used to return to both consumers and care providers and to establish a fair basis to do that. And our resolution is nationwide in context. It covers all States. It covers all consumers, all providers.

Senator UDALL. But you are talking about going forward.

Mr. HEMSLEY. No, sir. This is——

Senator UDALL. You are going to make whole the consumers from the past. You are going to make them whole. Is that what you are telling us?

Mr. HEMSLEY. I do not know what process will be used, but there will be an effort to distribute these funds to consumers and providers on a national basis.

Senator UDALL. Well, that is fine, but do you think there is enough in the settlement to make everyone whole that is out there?

Mr. HEMSLEY. The settlement is a very significant settlement, as Dr. Nielsen indicated last week, supported by the AMA, and very, very significant in its scope.

Senator UDALL. Yes, well, it is but it basically dealt with the State of New York, did it not?

Mr. HEMSLEY. No, no. It was nationwide.

Senator UDALL. This is nationwide. And so you believe that consumers in Minnesota, New Mexico, Virginia are going to benefit from this and be made whole as a result of this settlement.

Mr. HEMSLEY. It is my understanding that these proceeds will be used and distributed——

Senator UDALL. Well, I know they are going to be distributed. My point is that in many of these lawsuits where you have a big settlement like this, the funds that go into the overall settlement fund to pay out are many times less than the consumers were hurt.

So I am asking you, first of all, from your view as you know it as to what happened on a nationwide basis, do you believe the funds are adequate and do you believe consumers across the Nation are going to be made whole in this process?

Mr. HEMSLEY. I cannot respond to that from the perspective that we do not believe that there are any issues with the integrity of the database as a reference database. We do not know how others may have used that database for reimbursement purposes.

Our solution with the American Medical Association was to resolve a conflict with them, and I believe that those proceeds were very significant with respect to a response to that and has been embraced by the American Medical Association in that context. Yes.

Senator UDALL. Well, I just hope that this committee is going to continue to look into this and continue to follow up and to bore in on what has happened in all of our states in this particular circumstance and find out if in reality, consumers are going to be made whole. My sense is that probably if you had a state-by-state basis, that that would not be the case. But we appreciate having you here today, and I hope we stay involved in this and make sure that the settlement is going to make our consumers whole.

Thank you, Chairman Rockefeller.

The CHAIRMAN. Count on that.

Senator Warner?

STATEMENT OF HON. MARK WARNER, U.S. SENATOR FROM VIRGINIA

Senator WARNER. Thank you, Mr. Chairman, and again, I appreciate the chance to hear some of my colleagues since I missed the setup for this last week.

What I have believed for some time is that—and this case I think reflects this—as we move toward getting better data and whether actions from the stimulus program, in terms of health care IT or the over $1 billion finally in terms of comparative effectiveness research, we have seen here in this circumstance that there is data out there, maybe not always used to the benefit of the consumers.

This is an area that has not been a problem because of lack of technology. We have had the technology to be able to do this for more than a decade. I believe it has been an issue of a lack of will and many all across the health care system may not want to, one, share this data or, two, be willing to—in effect, fear that more transparency might curtail people's ability to practice medicine in an old-fashioned way.

And I guess what I would like to hear from the witnesses is—I heard Mr. Hemsley say we need national standards. I would agree with that. I think that is going to have to be defined at a national basis and not kind of bottom-up-driven. If we wait for the market to arrive at these national standards in terms of how we share this data or create these health care IT standards, then we will be waiting decades more.

I guess I would—in light of your experience and rightfully or wrongfully being called out for this and a half a billion dollar settlement, how would you see the ability to create, one, those national standards?

Two, how would—following up on Senator Klobuchar's comments about the questions about differential results based upon geographic disparity in this country, how can we best use the over $1 billion we have got in comparative effectiveness research to make sure that we can drive down on that type of disparity, and not just geographic, but the host of others?

And three, I personally believe we need to look at disparity in reimbursement rates based upon whether—you know, if a doc does not want to change and meet these standards or a provider does not want to meet these national standards, maybe we reimburse him at 95 cents on the dollar versus if they do meet these new national standards, $1.03.

There was—I am sure you saw, Mr. Chairman—just this week an indication out that we have got such a long way to go that only 9 percent of our hospitals at this point in this country have any kind of major electronic medical records system, comprehensive.

So having perhaps not efficiently or effectively or appropriately used the data that you have been collecting and being called to task on that, what guidance would you give us, gentlemen, in terms of, one, how we use this effectiveness research dollars out of the stimulus; two, how we set these national standards in terms of

health care IT; and three, how do we make sure that this data, beyond being forced through adjudication, gets out into the marketplace in a better way?

Mr. HEMSLEY. I will frame a few themes, and then maybe Andy, who is more facile with the details.

Our businesses, as we introduced this morning—we serve 70 million Americans. We are connected to about 85 percent of the care delivery community in this country. And our business is all about the use of information and technology expertise in care management, national networks, et cetera to really enhance care and to make it more affordable and accessible for consumers. And we believe we do that in the context of our business, and I think our many decades of success and so forth offer a model in terms of how information can be used. You are correct. There is information in the marketplace. We use it across our business in a standard way.

I think the multiple parties across the health care community can be brought together to use standards. Evidence-based medicine is not a new concept. It is well established in the community. Specialty groups have optimal care protocols, et cetera. The work done at Dartmouth suggests that adherence to evidence-based medicine and compensating the care community for adherence to evidence-based medicine is well established and we think very positive.

And there are meaningful disparities in the marketplace. I will just use one example. In the State of New York, a regular delivery would have billed charges of about $6,000. Those charges in our experience have been submitted as high as $40,000. And Medicare pays $1,917. And those are very significant disparities across the economics of health care, all in one market, and those need to be dealt with as well.

Senator WARNER. Let me just finish. My understanding, at least, is that while you have some amount of established protocols within certain specialties, that the evolution of or the growth of evidence-based medicine across a variety of specialties and having those protocols adopted as a basis for fixed reimbursement rates really has not come to pass yet.

Mr. HEMSLEY. We do have premium networks where we do have pay-for-performance and have identified those practices that adhere to evidence-based medicine on a consistent basis and we do compensate them on a premium for that basis.

Mr. SLAVITT. Senator, our Nation's commitment right now, led by the President and this Congress, to help information technology has a lot of promise. It is very exciting and the opportunity to close health disparities across this country if we put in place, I think, the three components that are in the stimulus properly. You know, an EMR in every pot or an access point for every physician so that people can access the best information that is out there, health information exchanges or the ability on a national basis to get the information about any patient to a doctor at the right time, and then as you referenced, Senator, comparative effectiveness research or a commitment to pursuing and finding treatments that are most effective at treating people.

I would offer you that there are three things that I would encourage us to do as a nation.

One is aggregate data and do everything we can to encourage people to aggregate data in a way that is safe and secure so it stays where it needs to stay until called upon. That is possible, given today's technologies.

Two, use very, very low-cost means of distributing technology, web-based technology, to doctors that is instantly updatable so that doctors can become customers. Doctors do not feel like customers of EMRs, which is why they do not typically use them. So doctors have to get low-cost EMRs with a lot of competing vendors that is networked together and can be instantly updatable.

And then finally, there are about 30 conditions that we believe evidence-based medicine standards have broad agreement. Those should be adopted nationally, and then we should be continuing to research the rest of it. We should have our scientists, our physicians, and others in this country that can pursue that knowledge base, update that as we pursue it.

Senator WARNER. Well, a piece of that, I believe, as well—and I guess this goes into how we get this connection between the various EMRs—you have got to have an interoperability. Again, I would encourage you, in light of some of the review and some of the settlements you have entered into recently, the more you can be advocates across that interoperability and recognize that if there is not this willingness to meet this national standard, if there is not this willingness to share some of your proprietary databases, one, it is going to end up being forced.

Two, at least as a former Governor, hearing numbers of hospitals and providers say they understood the importance of EMR and health care IT, but they had just invested in a legacy system. And candidly, my sympathy for investments in legacy systems at some point, if we continue to have that as an excuse, we are never going to get to a universal national, truly interoperable system in terms of health care IT. And I would again encourage you to be more proactive in sharing and leading this area.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warner.

Mr. Hemsley, could you pull your microphone a little bit closer? Good. It is important to hear you. Mr. Slavitt is very audible. You are a little bit less audible.

I am going to continue on this because I love talking about the future. But I was one who voted to go to war in Iraq. I did not actually. I voted to give the President authority to go to the United Nations, but it turned out to be different. I went on television, because I have been on the Intelligence Committee for a long, long time and still am, as we did our weapons of mass destruction studies and discovered that the whole thing was a fraud and there was no connection between any weapons that the President was using to speak to the Congress to influence American public opinion, and that there was no relationship between Al-Qaeda and Iraq with respect to the 9/11 tragedy.

So what we did in the Intelligence Committee—the natural instinct is always to look forward to the future. This is particularly advantageous for you too because it is where you can be most comfortable. I do not, frankly, know how you sleep at night based upon all these previous years. But nevertheless, in order to not repeat

what I think you folks have done, although you are very smooth and your testimony is very glib, you are contradicting yourselves in many places and that does not go unnoticed by this committee or its investigators. We harbor a little bit of attention on the past to make sure that this never happens again.

Mr. Slavitt, this is rather crudely put, but my great grandfather would have really taken you in as an immediate partner in the Standard Oil Company. I mean, he would have really liked the way you do business or the way that you do business in hiring him to collect all of this information which was used generally by the insurance community.

Now, Mr. Slavitt, in your testimony, you say that Ingenix's role was to gather data about physicians' charges, validate the information that you collected, and then publish it. Insurance companies like UnitedHealth, Aetna, CIGNA, et cetera would then use your products to set their out-of-network reimbursement rates. That is correct?

Mr. SLAVITT. That is correct, Mr. Chairman.

The CHAIRMAN. My understanding is that the way Ingenix obtained physician charge data was through what you called a voluntary data distribution program. Correct?

Mr. SLAVITT. Yes, Mr. Chairman.

The CHAIRMAN. Insurers would gather up the charge data and then send it to Ingenix to be used in your databases. Is that correct?

Mr. SLAVITT. Yes, Mr. Chairman.

The CHAIRMAN. And under Ingenix's protocols, insurers were supposed to send all of their charge data. Correct?

Mr. SLAVITT. Yes, Mr. Chairman.

The CHAIRMAN. They were even supposed to submit a form—life is complicated, but they were supposed to submit a form certifying they were sending all of their data.

Mr. SLAVITT. That is correct.

The CHAIRMAN. But we know now that they were not sending all of their data to you. We know that. They would scrub the data—you have sort of pushed that aside during your testimony so far this morning—before they sent it to Ingenix. For example, Aetna would skim off 20 percent of the charges before they sent the data to your company, your wholly owned company. And other insurance companies had similar practices. The data you were getting was biased in favor of the insurance companies. I would stipulate that. If I were a lawyer, I would probably say that better.

Mr. Slavitt, does the fact that you were receiving only partial, prescreened sets of data from your contributors not raise doubts about the accuracy of your data-based products? I mean, it does in your statement here. You say that you really cannot be responsible for it.

Mr. SLAVITT. Senator, if we were, indeed, only getting partial data and, indeed, selective data, that would absolutely give this committee and it would have given me reason to be concerned. As a matter of fact, when we receive our data, we run a number of analyses, in addition to the certification which requires a signature which states that the data is both accurate and complete—we run

a number of analyses to check and make sure that that, indeed, has happened.

Routinely—I would estimate five or six times a year—we find that for whatever reason the data that comes in is not complete. When we find that to be the case, we do one of three things. We either call the company and request a resubmission and get one. If we do not get one satisfactorily, we conduct our own audit, and if we are still not satisfied, we do not include the data in the database.

The CHAIRMAN. Mr. Slavitt, does the fact—let me go on to Massachusetts.

There was recently a public trial in Massachusetts. During this trial, a senior Ingenix executive admitted under oath that Ingenix did not audit the data they were getting from the insurance companies. In other words, Ingenix did not go back to the insurance companies, did not ask them to prove that they were sending all of their charge data.

Now, auditing is widely accepted. When you own the whole deal, I would think that you would be interested in doing that to make sure that you were right. You did not have to worry about competition, so perhaps you decided you did not need to.

Why did you not perform regular audits to make sure that the data you were getting was complete and accurate?

Mr. SLAVITT. Senator, our procedures had us go through an audit process with data submitters when the analysis of the data indicated that there was a reason to do an audit.

The CHAIRMAN. What do you mean a reason to do an audit? I mean, this is something you do automatically. You do not have a reason to do an audit. I do not have a reason to take an exam if I am going to college. I have to take it.

Mr. SLAVITT. Well, I guess it depends on how we were to define an audit, and I do not mean that fliply. But if a submitter of data we knew had, say, 1 million members, we understand using national averages and using past experience and using all sorts of methods how many bills that would be likely to create. So each time that the data was submitted, we would run tests, and if it appeared to us that we were getting data which would indicate that there is no possible way that that represented 1 million members, we had tests, routines that our statisticians deployed that would indicate that to us, in which case we would stop the presses and we would pursue that and we would pursue that vigorously.

The CHAIRMAN. Well, why was it that the court found that the data was incomplete?

Mr. SLAVITT. I need to refamiliarize myself with that Massachusetts case, but I think what I heard you say was that someone from my company said that we do not routinely perform audits. Is that what you said?

The CHAIRMAN. That is what he said.

Mr. SLAVITT. That is what he said?

So in the context of do we perform an annual audit——

The CHAIRMAN. The name was Carla Ghee.

Mr. SLAVITT. Yes.

We do not perform, for example, an annual audit of our clients and go through their processes, go through their systems, and so

on and so forth. That could be something that this new entity, nonprofit, chooses to do, and that might be a prudent step. I could not argue that the more safeguards and the more processes and so forth that we go through will be of benefit.

The CHAIRMAN. Good.

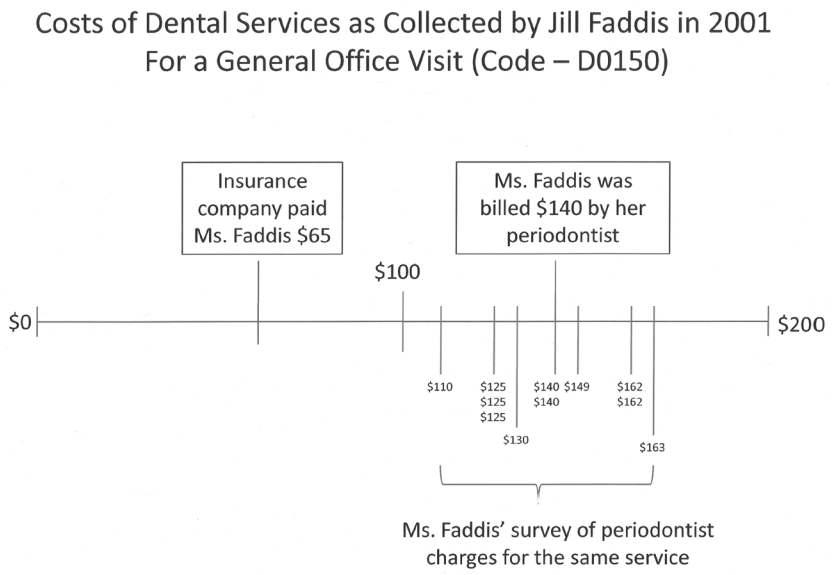
At our hearing on Thursday, Dr. Nielsen, the first woman chairperson of the American Medical Association—naturally, she is from West Virginia, so she has to be good—was critical of the fact that Ingenix considered only the medical service delivered to the patient and did not consider the expertise or qualifications of the health care provider.

On Thursday, we discussed a hypothetical case, but today I would like to talk about an actual case. It involves general practice dentists and periodontists. Periodontists are dentists with additional specialized training to treat advanced gum disease. The problem was that both dentists and periodontists often used the same billing code, in this case, D0150, to bill an office visit. But it appears that on average periodontists charge more for their office visits than general dentists and with reason.

The case I want to talk about involves a consumer named Jill Faddis who lived at that time near Seattle, Washington. In 2001, her husband was charged $140 for an appointment with a local periodontist, but the insurance company, in this case Aetna, told them that the usual and customary rate for that service was $65. Ms. Faddis took out her Yellow Pages—this is a woman of force, life force—and called every periodontist in her area. She found that periodontists billed between $110 and $160 for the service that her husband had received.

We have a chart. I have it. Do you have it? It is very interesting. It is extremely interesting. Does the press have it? OK.

[The information referred to follows:]



But here is what she also discovered. Ingenix automatically invalidated the high periodontist charges because they were so much higher than the fees dentists charged for their services. These were valid charges. They represented the prevailing rate periodontists charged for their services in this area, but Ingenix threw them all out of the data set. They threw them out. The result of this practice was that Ingenix and Aetna were reimbursing customers half of what the prevailing charge was in this area for periodontist services.

My staff spoke with Ms. Faddis yesterday. The end of the story was that she and her husband were stuck paying $75 out of their pockets they did not owe.

Now, that is not a lot of money, but if you are going through today's economy or if you come from many places in this country, that is a tremendous amount of money. And when it is repeated thousands of times, obviously it gets worse.

So this practice saved the insurance company money, but it was frustrating and costly for Ms. Faddis. She was left feeling that either her insurance company or her periodontist had ripped her off. That is what she told us.

So, Mr. Slavitt, can you explain why Ingenix scrubbed the valid medical charges from your database, number one?

Mr. Hemsley, can you understand why these kinds of practices make consumers and doctors so angry?

Mr. SLAVITT. So, thank you for sharing that. I think I followed it. I may need to—at some point want to get more familiar with that situation. But let me speak to a couple of the points that I think you are getting at here, which are important questions.

One of those questions is why does the database use the same code for two different specialists who might use the same service or, in fact, that can be applied to a physician assistant and a physician doing the same service. That is, indeed, how it works. This is the same system that CMS uses.

The system was designed by the AMA. The AMA designed a system that is based on the service rendered, not where it is performed or who performed it. It is called CPT, as you well know. It is a very detailed system. So it incorporates—the reason there are so many codes is because it allows the physician to code it based upon the level and intensity of the resources that they apply.

What it allows physicians to do, because I think this ends up working both ways, is as physicians have gotten busier and busier and busier and have less and less time to see patients, they can send a physician assistant, who is very qualified for a lot of tasks, to see a patient for 15 minutes, code the visit, and not degrade what they receive.

The CHAIRMAN. Now, you are not talking about the example that I used. You are making up your own example. Right?

Mr. SLAVITT. Yes. Two points I am trying to make. One is that we use the same system that everybody uses to reimburse. Otherwise, it would be apples to oranges. So we use a system that was designed by the AMA itself. So, therefore, a periodontist and a dentist who performed the same service, if they coded it the same way, would, indeed, come the same way. We did not make that decision. We are following that accepted guideline that——

The CHAIRMAN. So, in other words, if the AMA did it—and I have not been a great fan of the AMA in the past, nor have they been of me. I am becoming warmer now that I see a brighter future for them. And she testified very strongly against both of you and what you are doing. Very strongly.

Because the AMA was doing it, why does it make it the right thing for you to do? Do you not know it is wrong?

Mr. SLAVITT. Well, what I am trying to explain is why we made the decision that we made. I believe——

The CHAIRMAN. No. I understand you are saying that.

Mr. SLAVITT. I believe it was the right decision. I believe other people——

The CHAIRMAN. You believe AMA was right.

Mr. SLAVITT. I believe that adding yet—with 8,000 codes and 500 geographies, adding a third dimension of complexity to the data would get the sample sizes so small as to be a lot less meaningful. That is what I believe. But a reasonable person could conclude something different, and I respect that. I understand that.

But I do not want that to be tied with an intent to perpetrate some sort of fraud because I think it can happen as often on the lower side as on the higher side. It is an attempt to use the data in the way that it is commonly used in the industry so that it can serve a function for the industry.

The CHAIRMAN. Well, you are sort of emphasizing, in your previous testimony today, that you do four times as much on the cutting off of the low side than the high side. Boy, you are going to have to really prove that to me. And I would like to get a whole bunch of paperwork from you showing that.

Mr. SLAVITT. OK.

The CHAIRMAN. All right. Mr. Hemsley. It is hard to say. We are all so accustomed to Hemsley.

In our hearing on Thursday, we had a witness from the New York Attorney General's Office. Her name was Linda Lacewell. You must be familiar with her. One of the things we discussed with her was the results of her investigation into reimbursements for rates out-of-network for out-of-network doctor visits in Erie County, New York.

I would like to show you another table that Ms. Lacewell and I discussed at the hearing on Thursday. Take a moment to look at it. You will understand it right away.

[The information referred to follows:]

Payments for Doctor Visits

Erie County, NY (2007)

Doctor Office Visit Codes	Ingenix "usual and customary" Reimbursement Rate	NYAG Estimate of Prevailing Cost	Difference (%)
99211	$36–$37	$45	18–20%
99212	$53–$61	$68	10–22%
99213	$70–$78	$84	7–17%
99214	$105–$122	$130	6–19%
99215	$145–$182	$200	9–28%
99245	$276–$340	$373	9–26%

Source: State of New York, Office of the Attorney General, *Health Care Report: The Consumer Reimbursement System is Code Blue* (Jan. 13 2009), 20.

The first column contains the various billing codes that cover doctor office visits, and the second column presents the range of usual and customary reimbursements, as calculated by Ingenix.

Now, let me explain the third and fourth columns. Ms. Lacewell and her staff went back and independently collected doctor visit claims data for Erie County. They just went to work. They have a large staff. It was New York. They could do it. Most states cannot. Our state could not. My state could not. They hired a health care economist to analyze the data and develop rates that could be directly compared to the Ingenix data.

The results of this analysis are presented in the third and the fourth columns. What they show is that the insurance industry reimbursement rates, as calculated by Ingenix, were anywhere from 10 to 25 percent lower than what doctors were actually charging their patients in this area. This is solid information. You all quickly settled for $350 million. There must have been something there.

Mr. SLAVITT. We were not shown this report prior to settlement.

The CHAIRMAN. Well, it does make any difference to me whether you were shown it. They had done their homework, and if you did not see them, then I am so sorry. But you sure settled.

So here is what this table means for real doctors and consumers in Erie County. If a doctor in Buffalo is charging $84 for an office visit but the insurance company is only paying $74 for the visit, consumers get stuck with a $10 balance. Now, they should not be paying that. You should or he should. Now, it is not a lot of money, but it is not the amount of money that counts here because it is just added up and added up and added up because people have to keep going to doctors.

It sort of takes me back to this earlier statement that you made that you do not stand—it is for informational purposes, a database "for informational purposes only, and Ingenix disclaims any endorsement, approval, or recommendation." That is an extraordinary thing to say for a group that has the whole business. It is an extraordinary thing to say, but you say it. You do not stand by what you produce.

So, Mr. Slavitt and Mr. Hemsley, do you dispute the New York Attorney General's findings that insurance companies were underreimbursing consumers for doctor visits in Erie County, New York? Do you dispute that?

Mr. HEMSLEY. We do not agree with the findings——

The CHAIRMAN. You do dispute it.

Mr. HEMSLEY. We do. If you take a look at what they reviewed, they reviewed five counties. They reviewed six codes. They reviewed a million claims over 4 years. That compares to—our comparable database is updated four times a year. It has 18 million claims, 8,000 codes. On average, that database would suggest reimbursements that would be two to four times Medicare and one and a half times normal network charges. So we do not agree with the conclusions of the Code Blue Report.

The CHAIRMAN. OK. I think I need to explain to you why practices like this make people so angry. Mr. Hemsley, according to *Forbes* magazine, you are one of the 400 top paid executives in the United States. Your company, UnitedHealth Group, reported $3 billion in profits last year. This is not a good time to be talking

about this. I admit that. $10 per doctor visit probably does not cause you to lose a lot of sleep, but it is causing a lot of people, 100 million people around the country, to lose a lot of sleep and a lot of money and a lot of opportunities for their families.

I have no doubt that your company would have remained profitable if you had been doing the proper reimbursement, as we on this committee understand it, as the New York Attorney General understands it, as you evidently, to some degree, understood it when you took the $350 million settlement because I suspect there was an alternative that was standing in the shadows that you did not want.

Why did you allow this to happen?

Mr. HEMSLEY. Mr. Chairman, we operate the database in a consistent fashion to high standards of performance. The database is used for reference purposes only, and we do not believe that there are—we stand behind the database. We do not believe——

The CHAIRMAN. You do not stand behind the database.

Mr. HEMSLEY. We do stand behind it.

The CHAIRMAN. He does not. Mr. Slavitt does not.

Mr. HEMSLEY. The database, in terms of the integrity of the collection of data and the presentation of that data, as it is intended to be presented—we believe that database is valid.

The CHAIRMAN. Evidently.

All right. I am going to make some closing statements. I think this is profoundly troubling testimony from both of you. So let me say this.

I would like to review what we know and what we do not know about the insurance industry's—how they reimburse consumers for out-of-network services.

First of all, we know that for a long time alert doctors and consumers knew that something was wrong about the way the industry was calculating usual and customary. But they did not have the resources to find out what was really going on. Ms. Lacewell from the New York Attorney General's Office described it last week and said that the insurance industry's practices were hidden in a black box. It took the combined efforts of the AMA—this is evidently a new AMA than the one that you said this is what we should be doing before—and it took the Attorney General's Office to open this box. What they found was what they had suspected all along, that consumers were being reimbursed at rates that were significantly below the prevailing rates. You declined to acknowledge that, but frankly, that does not bother me because I am satisfied that it is true.

Armed with this information, the New York Attorney General was able to force insurance companies operating in New York to change their practices. You had not done so before. You had been in business for a long time before. You had complete control in your case of what was available for setting the payment.

Because many of the country's largest insurance companies, including UnitedHealthcare, CIGNA, Aetna, and WellPoint, do business in New York, Attorney General Cuomo's work had a national scope. That has been discussed.

But there are still a number of questions that have not been answered. For example, there are hundreds of thousands of Federal

workers who have health insurance coverage with an out-of-network option. I will be sending a letter today to the Inspector General of the Office of Personnel Management asking him to investigate how many Federal workers' out-of-network reimbursements may have been reduced by the use of Ingenix's databases.

Another thing we do not know is how widely the Ingenix databases were used by insurance companies that do not operate in New York. According to our review, Attorney General Cuomo's settlements have forced 7 out of the top 25 health insurance companies to change their practices. It is a good beginning, but it is not an ending.

Over the next few days, this committee will be sending letters to the rest of the top 25 companies asking them if they use the Ingenix data to determine reimbursement rates. These letters will also ask these companies if they intend to change their practices in light of the Attorney General's investigation.

We are continuing this investigation because the American consumers deserve to know what they are getting when they pay their health insurance premiums.

This committee has to be and will be henceforth all about accountability. Whether it is NASA, whether it is NOAA, whether it is aviation, whether it is transportation, we are going to be all about accountability.

And just like I made that vote, as soon as I found out as a member of the Intelligence Committee that everything the President said was false, every single thing he said in his March 23, or whatever it was, speech back in 2003 which sent us to war and got the Nation behind him—when I found out, because intelligence is not owned by the intelligence committees—it is owned by the Government and made available as the Government decides to make it available, a situation not unlike us here. But as soon as I found out that I had been wrong, I happened to be going on *Meet the Press,* and I said I was wrong.

Now, a lot of people refused to say they were wrong. Either they did not want to. They felt that somehow that would show that they were flip-floppers. I would just say they were ignoring reality.

Now, I am going to close this hearing, and I need to tell you that I am very unhappy and we are going to continue this. But I also need to tell you that I am very proud of both of you for coming down here and taking what I think is well-deserved abuse because you have done it smoothly. Your testimony was remarkably smooth, talking always about the future. It was interesting to me that some of our members talked about the future because they had missed the first meeting. So it is always easier to talk about a better future. But I am one who believes that unless you do the accountability business firmly, you do not really know what the future might be because the future describes itself. So I thank you both and I really do.

This hearing is adjourned.

[Whereupon, at 12:13 p.m., the hearing was adjourned.]

A P P E N D I X

RESPONSE TO WRITTEN QUESTION SUBMITTED BY HON. MARK PRYOR TO STEPHEN J. HEMSLEY

Question. I understand that United Healthcare and/or companies owned by UnitedHealth Group provide health plans through both the Medicare Advantage Program and the Federal Employees Health Benefits Program (FEHBP). Can you please provide the committee with information concerning each health plan offered by United Healthcare or a company owned by UnitedHealth Group in 2008 through Medicare Advantage or FEHBP, which used data from Ingenix to determine reimbursements for medical care provided by out-of-network providers? For each plan specify how out-of-network reimbursements were calculated. Please also include the same relevant information for any plans offered under the Federal Employee Dental and Vision Benefits Enhancement Act.

I would also appreciate your providing the committee with information concerning how these plans may have changed the calculation for out-of-network reimbursements following the settlement that was reached with the New York Attorney General.

Answer. UnitedHealth Group companies use the lngenix data bases to make reimbursement decisions for only a very small percentage of claims administered across our business. The vast majority of claims we receive are from care providers and facilities which are in our networks. For out of network claims, we use several methodologies in addition to a "reasonable and customary" standard to determine reimbursement amounts. Less than 4 percent of claims we receive are processed using the Ingenix data bases.

Our 2008 experience in the Medicare Advantage Program, the Federal Employee Dental and Vision Benefits Enhancement Act, and the Federal Employees Health Benefits Program (FEHBP) are consistent with the overall experience described above.

Medicare Advantage Programs

UnitedHealth Group companies served approximately 1.7 million members in Medicare Advantage programs in 2008. None of these members had a benefit structure which used data from the Ingenix PHCS or MDR data bases in connection with out-of-network reimbursements. These programs use methodologies and rates published by the Centers for Medicare and Medicaid Services (CMS) for reimbursement of out-of-network services.

Federal Employee Dental and Vision Benefits Enhancement Act

UnitedHealth Group companies also provided vision benefits to around 200,000 members in 2008 through plans offered under the Federal Employee Dental and Vision Benefits Enhancement Act. None of these members had a benefit structure which used data from the lngenix PHCS or MDR data bases in connection with out-of-network reimbursements. The vision plans reimburse out-of-network services at a fixed fee that is not based on PHCS or MDR.

FEHBP Plans

In 2008, UnitedHealth Group companies provided medical benefit coverage to approximately 300,000 members through the Federal Employees Health Benefits Program. None of these members had a benefit structure which used data from the lngenix PHCS or MDR data bases in connection with out-of-network reimbursements.

The majority of these members were enrolled in health maintenance organization (HMO) offerings which provide no coverage for non-emergency out-of-network services.

Approximately 2 percent of United FEHBP members were enrolled in preferred provider organization (PPO) offerings in 2008. These offerings did provide coverage for out-of-network services; out-of-network allowed amounts for professional medical

services were calculated based on a percentage above the Medicare fee schedule, not the Ingenix data bases.

UnitedHealth Group companies also provided vision benefit coverage to approximately 150,000 members through FEHBP plans. None of these members had a benefit structure which used data from the lngenix PHCS or MDR data bases in connection with out-of-network reimbursements. The vision plans reimburse out-of-network services at a flat fee that is not based on PHCS or MDR.

United Health Group companies provided dental benefit coverage to approximately 200,000 members through FEHBP plans. Some of these members had a benefit structure which used data from the Ingenix PHCS database in connection with out-of-network reimbursements. These dental plans reference the 85th percentile of the PHCS database in determining allowed amounts.

Since our agreement with the New York Attorney General, UnitedHealth Group companies have been determining "reasonable and customary" reimbursements in the out-of-network setting in accordance with that agreement. Once the not-for-profit entity is named by the New York Attorney General and issues a new database for use in "reasonable and customary" determinations, UnitedHealth Group companies will apply that database in all settings to which it is applicable and which require a "reasonable and customary" determination.

Members of United medical plans—including FEHBP enrollees—whose dental claims were administered under a reasonable and customary standard using the lngenix data bases are covered by the class action settlement discussed at the hearing. The settlement is supported by the American Medical Association and state medical societies, among others.

Under the settlement, which is subject to court approval, eligible members will receive notice from a court-approved settlement administrator which will contain instructions about how to submit a claim for a portion of the settlement funds.

Thank you for the opportunity to provide this information.