



Protecting consumers from the extraordinarily high charges from some out-of-network physicians is an important policy issue in an era when our nation is facing major economic and health care systems challenges. A recent survey of America's Health Insurance Plan (AHIP) members collected data on various out-of-network physician billed charge amounts for claims submitted in 2008. As demonstrated in the below table, out-of-network physicians in South Carolina billed between 560 and 1,510 percent of the Medicare fee for that service in 2008.

VARIOUS OUT-OF-NETWORK PHYSICIAN CLAIMS FILED IN THE STATE OF SOUTH CAROLINA IN 2008

| CPT Code | Service Description | Amount Billed | Medicare Fee | Amount Billed as % of Medicare Fee |
|----------|---|---------------|--------------|------------------------------------|
| 19120 | Benign breast lesion removal | \$ 5,633.27 | \$ 372.06 | 1,514% |
| 27130 | Total hip replacement | \$ 15,714.00 | \$ 1,209.91 | 1,299% |
| 66984 | Cataract surgery with insertion of artificial lens | \$ 7,277.82 | \$ 590.83 | 1,232% |
| 29881 | Minimally invasive knee meniscus surgery | \$ 5,760.00 | \$ 532.73 | 1,081% |
| 43239 | Upper GI endoscopic visual diagnostic exam with biopsy | \$ 3,214.63 | \$ 301.53 | 1,066% |
| 47562 | Laparoscopic gallbladder removal | \$ 5,280.00 | \$ 588.85 | 897% |
| 99244 | Outpatient office consults of moderate to high severity requiring a comprehensive history, comprehensive exam and moderate complexity medical decision-making | \$ 1,385.00 | \$ 168.22 | 823% |
| 45380 | Colonoscopy with biopsy | \$ 3,059.65 | \$ 410.21 | 746% |
| 99215 | Outpatient office visits of moderate to high severity requiring 2 out of 3: comprehensive history, comprehensive exam and high complexity medical decision-making | \$ 800.00 | \$ 114.53 | 699% |
| 22612 | Lower back spinal fusion | \$ 7,376.00 | \$ 1,312.65 | 562% |

August 2009

Overview of Survey Methodology: In May 2009, America's Health Insurance Plans (AHIP) asked Dyckman & Associates (Dyckman) to collect and analyze results of a survey of member plans in order to identify the highest 2008 billed charges by non-participating physicians in the 30 most populous states for certain CPT (Current Procedural Terminology) codes representing various categories of physician services. Surveys were returned to Dyckman from ten plans: national plans that operate in most surveyed states, and regional plans that operate in one or a few states. Tables were provided to AHIP in a format that did not identify survey respondents or associate data with a specific plan. Dyckman used a conservative approach to the data that excluded high charge outliers that may reflect billing or coding errors.



The Value of Provider Networks and the Role of Out-of-Network Provider Charges in Rising Health Care Costs

Protecting consumers from runaway charges billed by some out-of-network physicians is an important policy issue at a time of major economic challenges and a national debate surrounding health care reforms.

One tool that health insurance plans use to improve quality and make health care more affordable for consumers is the establishment of provider networks.

- By selectively contracting with credentialed providers, health plans ensure consumers affordable access to a wide choice of high-quality doctors and hospitals. Nationally, it is estimated that close to 90 percent of providers participate in networks.
- Consumers see measurable savings when they visit contracted providers because in-network physicians are generally prohibited from charging patients the difference between billed charges and a negotiated rate. Also, consumers who receive services from in-network providers typically have lower cost-sharing obligations. Over the decades, this has saved consumers billions of dollars in out-of-pocket costs and premiums.

Some out-of-network providers are charging exorbitant prices – several hundred or even over a thousand percent of the Medicare reimbursement for the same service in the same area.

- Recent examples: \$4,500 for an office visit when Medicare would have paid \$134; \$14,400 for removal of a gallbladder when Medicare would have paid \$656; and \$40,000 for a total hip replacement when Medicare would have paid \$1,558.
- Attached is state-specific data, along with information on how it was compiled.

Consumers who are charged exorbitant fees by out-of-network providers incur additional costs because the protection against balance billing generally does not extend to services provided out-of-network. This detracts from the ability of health plans to offer affordable access to out-of-network providers for those consumers who want the advantages of a network, but also maintain the option to go out-of-network if they choose.