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 Tennessee billed between 590 and 1,630 percent of the Medicare fee for that service in 2008.*

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

CPT Code	Service Description	Amount Billed	Medicare Fee	Amount Billed as % of Medicare Fee
43239	Upper GI endoscopic visual diagnostic exam with biopsy	$ 4,900.18	$ 299.82	1,634%
29881	Minimally invasive knee meniscus surgery	$ 8,000.00	$ 539.09	1,484%
66984	Cataract surgery with insertion of artificial lens	$ 6,520.00	$ 589.81	1,105%
63075	Surgical removal of all/or part of the intervertebral disc inc. spiny growths	$ 10,500.00	$ 1,150.52	913%
27130	Total hip replacement	$ 10,688.00	$ 1,229.22	869%
45380	Colonoscopy with biopsy	$ 3,430.52	$ 408.58	840%
99215	Outpatient office visits of moderate to high severity requiring 2 out of 3: comprehensive history, comprehensive exam and high complexity medical decision-making	$ 824.00	$ 114.36	721%
22612	Lower back spinal fusion	$ 8,500.00	$ 1,338.73	635%
47562	Laparoscopic gallbladder removal	$ 3,522.00	$ 596.93	590%
19120	Benign breast lesion removal	$ 2,199.00	$ 374.81	587%

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.