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 Virginia billed between 780 and 2,080 percent of the Medicare fee for that service in 2008.*

VARIOUS OUT-OF-NETWORK PHYSICIAN CLAIMS FILED IN THE STATE OF VIRGINIA 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	$ 6,486.05	$ 312.60	2,075%
29881	Minimally invasive knee meniscus surgery	$ 7,598.00	$ 553.26	1,373%
47562	Laparoscopic gallbladder removal	$ 8,500.00	$ 703.69	1,208%
63075	Surgical removal of all/or part of the intervertebral disc inc. spiny growths	$ 12,628.50	$ 1,175.42	1,074%
58150	Total abdominal hysterectomy	$ 9,000.00	$ 872.26	1,032%
22612	Lower back spinal fusion	$ 13,957.00	$ 1,367.56	1,021%
66984	Cataract surgery with insertion of artificial lens	$ 6,037.00	$ 604.84	998%
99215	Outpatient office visits of moderate to high severity requiring 2 out of 3: comprehensive history, comprehensive exam and high complexity medical decision-making	$ 1,125.00	$ 117.29	959%
27130	Total hip replacement	$ 11,170.00	$ 1,256.31	889%
15738	Lower extremity flap	$ 11,743.00	$ 1,509.78	778%

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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.