

PERSONAL JOURNAL.

THE WALL STREET JOURNAL.

HEALTH COSTS

TUESDAY, APRIL 22, 2003 R7

A Matter of Definition

Health insurers say they reimburse patients based on 'usual and customary' charges. But what exactly does that mean?

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A S A PILOT for American Airlines, Clifford Wilson decided more than a decade ago that he could afford the most expensive type of health insurance -- one that would allow him and his family to see any doctor they wanted if they paid 20% of their medical bills.

But when his wife was diagnosed with breast cancer and began very expensive treatment, Mr. Wilson soon learned that his insurance company's definition of 20% was very different from his own.

Under Mr. Wilson's health plan, UnitedHealth Group Inc. pays 80% of medical bills -- but only 80% of what it thinks should be charged, or the "usual, customary and reasonable charges." Patients are responsible for the rest, which can amount to much more than 20%.

Over the course of Mr. Wilson's wife's treatments, her doctors billed the insurer \$98,000. But UnitedHealth lowered that amount by about \$35,000, saying a more "reasonable" amount would have been \$63,000. That left the Wilsons wholly accountable to doctors for the \$35,000 reduction, on top of the 20% of the remaining balance.

Mr. Wilson's misconceptions about his health-insurance policy is a common one. His policy -- as do most patients' -- spells out that patients will be reimbursed according to "usual and customary" or "reasonable" charges. But policies don't say how much that amount might differ from what doctors will actually charge. Nor do health insurers offer a complete list of prices they consider "customary." For Mr. Wilson, who has had his policy for 16 years, the issue never troubled him until the numbers started getting bigger because of his wife's illness.

Preventive Medicine for Medical Bills

Insurers sometimes pay a far smaller share of a bill than patients expect because they deem a doctor's charges to be above usual, customary or reasonable fees. It's easier to avoid surprises before you get service than to remedy them later. Some tips:

- **Try to see a participating in-network physician.** Fees will already have been cleared with your insurer.
- **If you prefer to go out of network,** have the doctor estimate what he or she will charge before you get the service.
- **Call your insurance company** with the physician's estimate. The insurer should be able to tell you whether the charge is within its "usual and customary" range, and if not, how much higher it is.
- **If the fee is high,** be frank with your physician about your ability to pay. The American Medical Association says doctors have an obligation to compassionately consider the patient's ability to pay.
- **Negotiate, but don't haggle.** You aren't buying a used car. One approach grounded in reality: Ask if the physician will accept an in-network rate.
- **If you must go out of network** for a procedure because an in-network specialist is not easily available, try using this fact as a bargaining chip with the insurer. The insurer may be willing to adjust your portion of the bill.
- **If you get the service before** you consider price and then get stuck with a huge bill, you can try asking your physician to lower the bill and asking the insurance company to pay more. But physicians sometimes are restricted from discounting fees because of state laws or contracts with insurers.

What's Reasonable?

Many people choose the type of insurance Mr. Wilson used, called indemnity insurance, which gives patients freedom in choosing doctors and hospitals, but holds them responsible for a portion of the bill. Also, people in preferred-provider organizations, or PPOs, have the option to see doctors outside the participating network. But they are then typically responsible for 20% to 30% of their bills. About 70% of the nation's insured population is in one of these two types of plans, according to Mercer Human Resource Consulting in New York.

Most of the country's large health insurers that administer such plans use a

tool, called the Prevailing Healthcare Charges System, to determine usual-and-customary charges. It's a giant database containing 2.8 billion entries of what doctors charge for thousands of different procedures in more than 400 areas of the country. From that database, health insurers determine what a specific doctor should charge for a given procedure in a particular area. When a doctor charges more than that, health insurers automatically chop the bill down to a "reasonable" size before reimbursing the patient or the doctor.

UnitedHealth of Minnetonka, Minn., the largest insurer in the U.S., with 17 million members, owns the database. It licenses its use to major insurers, including

Aetna Inc., Hartford, Conn., and Cigna Corp., Philadelphia, the country's No. 2 and 3 health insurers with 14 million and 13 million members, respectively.

Health insurers say the usual-and-customary system protects them from overpaying doctors whose bills are out of whack with their peers. Indeed, a spokesman for UnitedHealth says its employer clients "demand" the use of such systems "to support their efforts to offer affordable coverage for their employees." If there wasn't a way to cap doctors' fees at a "reasonable" level, the spokesman says, employers wouldn't be able to afford to pay for out-of-network services for their workers. According to Mercer, health-care costs per employee skyrocketed 57% to \$5,646 a year in 2002 from \$3,594 in 1997.

Each health insurer sets usual-and-customary charges by, for example, setting the 90th percentile of charges as a limit. For instance, the database will tell health insurers that for a normal vaginal delivery of a baby in Manhattan, 90% of doctors' bills amount to \$7,500 or less. Thus, a health insurer licensing the data from UnitedHealth that chooses to set the usual-and-customary payment at the 90th percentile wouldn't cover any portion above that amount.

'Unusual and Cruel'?

Doctors, meanwhile, gripe that insurers' usual-and-customary database should actually be called "unusual and cruel."

The American Medical Association and Mr. Wilson filed lawsuits against UnitedHealth beginning in March 2000, and the cases are now in the U.S. District Court for the Southern District of New York. The suits allege that the database doesn't accurately measure usual-and-customary charges, but instead includes fees that are discounted and often dismisses fees from high-charging doctors. In addition, the suits contend, the database doesn't take into account that some doctors are more highly skilled and experienced than others. These things, among others, cause the UnitedHealth database to understate true usual-and-customary prices, says D. Brian Hufford, an attorney with Pomerantz Haudek Block Grossman & Gross in New York, who represents both the AMA and patients like Mr. Wilson.

UnitedHealth says in a statement that "the allegations of the plaintiffs are baseless." Further, the insurer says that Mr. Wilson's employer, American Airlines, a unit of AMR Corp., Fort Worth, Texas, set the rules for how employees and their doctors would be reimbursed. And so the

insurer shouldn't be liable.

Mr. Wilson also sued American Airlines in the same court charging the same thing as in the UnitedHealth suit. A spokesman for American Airlines says the carrier declines to comment because of the litigation.

Get Specific

So, short of suing, what can patients do to ensure that they won't be saddled with larger-than-expected out-of-pocket expenses?

Generally, patients don't learn about what their insurer will and won't pay until after the service has been performed. But patients should be more proactive.

For instance, no patients with a PPO plan should have an out-of-network procedure, such as surgery, without first calling the insurer and asking exactly how much they will be liable for. In many cases, the phone representative may just say: "You're responsible for 20% of usual and customary." But patients need to press for actual dollar figures. Patients with indemnity plans also should find out exactly how much they will be required to pay before treatment.

According to Cigna, members can call ahead and get the precise dollar amount that Cigna considers to be usual and customary for a given procedure. Cigna's only requirement is that a patient get the "CPT" code from his or her doctor. Doctors use the code in billing to represent a specific procedure. Aetna will sometimes require that the patient find out first what the doctor will bill, and then an Aetna representative will tell the patient whether that bill is in the range of its usual-and-customary pricing, and if it's above, by how much.

UnitedHealth, meanwhile, says patients can obtain such information easily on the UnitedHealth Web site (www.myuhc.com3). However, the site only provides average prices for a given area -- which is not the same as the usual-and-customary rates that the company uses when reducing reimbursements. And the average prices for some procedures aren't available. A UnitedHealth spokesman says members who call the company with a CPT code can receive some usual-and-customary information.

Coding Errors

Patients also should question their doctors directly. That may be tough for patients undergoing serious treatment, who don't want to risk angering their doctor by questioning his or her bills. But it's crucial information. And many procedures for doctors are routine, so an office admin-

istrator is likely to answer the question, "What is the doctor's routine charge for this service?" It's preferable to get that in writing, including the CPT codes.

In some cases, doctors' administrative errors are part of the problem. Medical codes can be so complicated that some-

Insurers say the system protects them from overpaying doctors whose bills are out of whack

times doctors simply get it wrong. And "the patient bears the brunt of their mistakes," says Abbie Leibowitz, the former chief medical officer at Aetna, now executive vice president and chief medical officer of Health Advocate, a West Conshohocken, Pa., company he started with several other former Aetna executives that helps patients maneuver through their health-insurance troubles.

Dr. Leibowitz describes a recent case in which a patient was billed for \$37,000 because a brain surgery's price tag was deemed above usual and customary. It turned out that the doctor had put the wrong codes on his bill. "You know how people say 'It's not brain surgery'? Well, this guy got the brain surgery right, and got the coding wrong," says Dr. Leibowitz. "His error almost cost the patient \$37,000." After straightening out the coding, Health Advocate got the insurer to pay an extra \$20,000, and the doctor wrote off the difference.

Unfortunately, it's extremely difficult for a patient to figure out whether a doctor has correctly coded a procedure. Indeed, doctors and health insurers battle constantly about the proper way to code certain procedures. Such disputes are the subject of even more litigation.

Dr. Leibowitz's suggestion: Patients "should ask their doctor to help them understand what their plan typically pays for the service and then question the health insurer about how they calculated" the usual-and-customary rate. But, he warns, "you never really know in advance how the doctor is going to bill for what they do, so this is always nothing more than a rough estimate." And for patients with PPOs, he suggests going to doctors within your network if you can. But what can be done when a patient's medical issue is beyond what an insurer considers usual and customary and the charges reflect that?

Looking to a Third Party

Patients can challenge decisions through the standard appeals process, which begins with the insurer but can work its way up to state appeals boards. They also can ask doctors to reduce charges if they are out of line with what the health insurer says peers are charging. Doctor-administered drugs, like some chemotherapy and other injectable drugs, often have huge profit margins for doctors. Doctors argue they need such margins to cover losses in other parts of their practice, but individual patients may be able to persuade them to reduce those charges if insurers refuse to pay up.

Patients also can turn to third parties to help them work through the differences. Firms such as Health Advocate are hired by employers to help their employees work through a host of disputes.

Jane Cooper, president and chief executive of Patient Care in New Orleans, says it's much more effective to negotiate with physicians about lowering their fees before a service is provided. But the company, which charges patients \$15 a month for a year's subscription to its advocacy services, also helps patients

who are dealing with bills after the service is provided and the bills start piling up.

In some cases, doctors can be convinced to accept an in-network rate for a patient who is going out of the participating network, says Maura Carley, a former HMO executive and now president of Healthcare Navigation LLC, a Darien, Conn., company that handles patient problems with health insurers. But if a consumer ends up worrying only after the bills come, he or she "needs to try to get a handle on whether the insurance payment was low, the doctor charges high, or both." She suggests trying to negotiate with both the doctor to lower the fee and the insurer to increase the payment. Healthcare Navigation charges range from \$80 an hour for routine issues to \$175 for work on appeals cases.

'Inappropriate' Claims

Mr. Wilson's wife was five months pregnant when she discovered the cancerous lump in her breast in 1997. A local doctor in Allentown, Pa., told her to terminate the pregnancy so that she could begin cancer treatments. But when she

went to Memorial Sloan-Kettering Cancer Center in New York City for a second opinion, a specialist in both oncology and obstetrics told her she could safely continue the pregnancy while getting cancer treatments. Her baby was born healthy. And Mrs. Wilson survived for nearly four years after the birth her child.

After such a feat, Mr. Wilson scoffs at the thought that Sloan-Kettering's charges aren't reasonable compared with other doctors, as UnitedHealth maintains.

Sloan-Kettering is so accustomed to having patients get this type of notice from health plans that it sends insurers a form letter that calls the insurers' claims of exceeding reasonable and customary "inappropriate." The letter says that patients at Sloan-Kettering have cases that are more serious than at other hospitals. "In addition, most of our physicians are board certified in both oncology and their specific area of expertise ... their preparation to practice" at Sloan-Kettering "requires many years of training beyond the standard ... the care delivered at this institution is not equivalent to that provided in 'customary' medical situations."