Assignment of Benefits Legislation For Healthcare Providers

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I. Executive Summary

Assignment of benefits (AOB) allows insured patients to authorize their health insurers to pay their policy benefits directly to healthcare providers not participating in the health insurer's network. It is a routine and accepted insurance industry transaction. However, the largest health insurer in the country, comprised of the 41 affiliate plans of the Blue Cross Blue Shield Association (BCBSA) and representing approximately 90 million subscribers, as a matter of policy, does not typically honor assignment of benefits. Even when BCBS subscribers are willing to pay a higher premium for physician choice and choose plans that provide for out-of-network services, non-network providers are not directly compensated for providing services to subscribers, often resulting in lost revenues, increased bad debt, and collection expenses incurred when insured patients do not pay for services rendered because the health plan sent payment directly to the patient instead of the provider. The other three largest publicly traded health insurers in the country, UnitedHealthcare, Aetna, and CIGNA, which have traditionally honored assignment of benefits for their combined 46 million subscribers, continue to meet their shareholders' financial performance expectations, without negative consequences from assignment of benefits.

This study reviewed the prevalence of assignment of benefits legislative activity throughout the country and whether or not assignment of benefits has had a negative impact on consumers through increased expenditures for healthcare services or reduced access to quality care. The study also addressed the current relationship between health insurers and healthcare providers.

In order to collect the data for this study, the following organizations were contacted to determine if any research has been conducted on the potential fiscal impact of assignment of benefits on consumers and managed care networks: the American Medical Association (AMA), the American Association of Health Plans (AAHP), the Blue Cross Blue Shield Association (BCBSA), the National Academy for State Health Policy, the National Association of Insurance Commissioners (NAIC), the National Conference of State Legislatures, the National Governor's Association, and the medical societies and departments of insurance representing the fifty states. A literature search was also done.

At this time, we have not been able to establish any empirical evidence or data to support Virginia's dominant health insurer's claims that direct assignment of benefits to healthcare providers has a negative impact on insured consumer healthcare expenditures or access to quality care. Health plans' claims that direct assignment of benefits "causes harm" to consumers have not been substantiated. Health plans' abilities to provide adequate cost-effective networks have not been weakened. Actuaries in states with direct assignment of benefits but without an inclusion of a "no balance billing" requirement for out-of-network healthcare providers have not seen a correlation between assignment of benefits and increased health insurance premiums or overall healthcare expenditures. These states include Alaska, Florida, Georgia, Illinois, Louisiana, Maine, Tennessee, and Texas. The general consensus of conversations with representatives of the departments of insurance and medical societies in these states is that direct assignment of benefits has enhanced insured patients' choice of healthcare providers as well as access to services. Managed care networks have not deteriorated due to an exodus of providers electing non-participatory status.

From a Virginia perspective, Anthem's dominance of the health insurance industry represents a

70% market share in the Commonwealth, covering approximately 2.8 million subscribers. Prior to 1983, most BCBS plans in Virginia honored their subscribers' assignment of health plan benefits. As Blue Cross plans began competing for increased market dominance, Blue Cross of Virginia revised its policy on assignment of benefits to prohibit subscribers from assigning their benefits to non-participating providers in order to increase provider participation in its networks. In 1984, Delegate Thomas W. Moss, Jr., sponsored a bill that would have required all Blue Cross plans in Virginia to honor their subscribers' assignment of benefits. Blue Cross Blue Shield of Southwestern Virginia supported the assignment of benefits bill, stating that assignment of benefits favored consumer choice and did not prevent the Roanoke plan from negotiating favorable reimbursement contracts with providers, which ensured an adequate network. An official from the Roanoke plan said at the time, "No carrier should be able to usurp the consumer's right to assign benefits he has paid for, either directly or through his group health coverage plan. To attempt to remove this freedom under the banner of cost containment is especially false; benefit levels are the same regardless of assignment of benefits." Assignment of benefits was not mandated during the 1984 General Assembly session. Eventual consolidation of several non-profit BCBS plans in Virginia led to the formation of Trigon, which converted to investor ownership in 1997. During 2000, the current Virginia statute for direct assignment of health plan benefits, which applies only to dentists and oral surgeons, was passed. Anthem BCBS acquired Trigon in 2002, culminating in Anthem's recent merger with Wellpoint Health Networks Inc., creating the largest private health insurer in the country with 28 million subscribers.

A preliminary review of The Commonwealth of Virginia Health Benefits Program's annual reports from 2000 through 2003 indicates that direct assignment of benefits to dentists and oral surgeons has not increased costs as a percentage of total healthcare claims paid. During the four-year period, dental claims represented between 6.4% (2003) and 6.8% (2001) of the total expenditures for health benefits provided to active state employees and non-Medicare eligible retirees. For the four-year period, increases in overall spending for dental claims (43%) were more than the increases in physician services (39%) but less than increases in hospital inpatient services (52%), hospital outpatient services (50%), or prescription drugs (52%). It is assumed that the increase in employees utilizing dental care benefits through the State's health plan is proportionate with the total increase in enrollees utilizing medical care benefits, which increased 10% between 2000 and 2003, from 80,180 to 88,361 enrollees. A fiscal impact study conducted during 2004 indicated that healthcare expenditures for state employees and non-Medicare eligible retirees would increase dramatically if assignment of benefits was mandated in Virginia. The study implied there would be a major exodus of physicians from Anthem's networks, which would dramatically increase healthcare premiums and out of pocket expenditures. States with direct assignment of benefits have not experienced deterioration in managed care networks—employers and/or their health insurers have successfully negotiated appropriate reimbursement rates with providers without jeopardizing employees' benefits or health insurers' profitability. State employees still have a choice in determining the level of benefits provided as well as access to healthcare providers.

A 2003 BCBSA study on assignment of benefits stated "health plans negotiate contractual arrangements with providers that save consumers thousands of dollars in health care costs"…"consumers with serious medical conditions save significant amounts of out-of-pocket costs due to the contracts health plans negotiate with physicians." Typically, providers in Virginia are not given the opportunity to negotiate equitable contract terms with Anthem. The unequal

bargaining position created by Anthem's "extraordinary" market power has forced many providers to enter into one-sided contracts, which threaten the doctor-patient relationship and continuity of care.

Not only is declining physician reimbursement by both public and private health insurers prompting more contract terminations and physicians exiting the marketplace or changing the scope of their practices in Virginia, it also threatens access to health services because medical practices are finding it more difficult to retain and recruit qualified physicians. Some of the Virginia locales currently experiencing physician shortages include Fredricksburg, Lynchburg, Newport News, Rappahannock, Southwest Virginia, Williamsburg, and Tidewater. The demand for many high-risk specialties (e.g., emergency medicine, neurosurgery, obstetrics/gynecology, orthopedic surgery, thoracic surgery, , trauma, etc.) and lack of adequate physician coverage in numerous communities throughout the Commonwealth is causing delays in patients receiving treatment and increasing patient transfers between hospitals. Per a recent report from Virginia's Joint Legislative Audit and Review Commission, the most critical issue threatening access to trauma care in Virginia is inadequate physician coverage.

The profitability of the largest health insurers does not indicate an industry in crisis, quite a contrast to the practice environment many physicians are experiencing in Virginia and throughout the rest of the country. While health insurers have experienced unprecedented profitability during the last five years, due to double-digit increases in health insurance premiums, which have outpaced medical costs, and declining medical cost ratios, medical practices continue to struggle with financial viability. An illustration of health plan profitability in a state with direct assignment of benefits to healthcare providers is Georgia. Wellpoint reported a 28% increase in profits during the 3rd quarter 2004—revenue increased 16% to $5.85 billion from $5.05 billion a year earlier, attributed to a 15% climb in premium revenue. The recently completed $16.4 billion merger of Wellpoint Health Networks by Anthem BCBS will provide Georgia with approximately $126.5 million for health care programs as well as a promise to not increase premiums for Georgia's 3.2 million BCBS members. Even though California does not have direct assignment of benefits to health care providers, the new Wellpoint Inc. will also provide California with $265 million to fund health care programs and guarantees that expenditures on patient care will increase but premiums for the 7 million BCBS members in California will not increase to help finance the merger. It is expected that 293 Wellpoint executives will receive as much as $356 million in compensation, which does not include millions of dollars in stock options.

Assignment of benefits is a relatively simple and effective means to help restore some balance to the relationship between healthcare providers and health insurers. Providers have the opportunity to negotiate more favorable terms with the insurers, which allows patients greater access to necessary services. Providers can choose not to participate in health plans providing inadequate reimbursement without being financially disadvantaged or causing disruption to patient care. Assignment of benefits creates an environment where insurers have an incentive to recruit and retain providers in their networks.

II. Introduction

Healthcare Consultants, LLC was engaged by Virginians for Fairness in Healthcare to determine the prevalence of assignment of benefits (AOB) legislative activity throughout the country and whether or not direct assignment of benefits to healthcare providers has had a negative impact on consumers by either increasing expenditures for health services and/or by reducing access to quality care due to erosion of managed care networks. The study also addresses the relationship between providers and insurers as consumers continue to struggle with increasing healthcare expenditures in the midst of unprecedented health insurer profitability.

In order to collect the data for this study, the following organizations were contacted to determine if any research has been conducted on the potential fiscal impact of assignment of benefits on consumers and managed care networks: the American Medical Association (AMA), the American Association of Health Plans (AAHP), the Blue Cross Blue Shield Association (BCBSA), the National Academy for State Health Policy, the National Association of Insurance Commissioners (NAIC), the National Conference of State Legislatures, the National Governor's Association, and the medical societies and departments of insurance representing the fifty states. A literature search was also done.

III. Overview of Assignment of Benefits to Healthcare Providers

Assignment of benefits allows insured patients to authorize their health insurers to pay their policy benefits directly to healthcare providers not participating in the health insurer's network. Out-of-network providers then receive timely payment for services rendered to insured patients while also eliminating the paperwork burden and time required of subscribers having to submit their own claims. Balance billing allows the provider an opportunity to bill the insured patient for any balance due for services rendered. Reasons providers may be out-of network with a health insurer's plans include the interval of time required for the health insurer to process credentialing for the provider or the provider has determined the health insurer's plan is an "unhealthy" contract due to reimbursement structures that do not cover the cost of doing business.

Assignment of benefits is a routine and accepted insurance industry transaction. Insured patients receive care through their chosen health plans. However, Blue Cross Blue Shield (BCBS) plans, which provide health insurance to approximately 90 million subscribers throughout the country, routinely deny their subscribers the right to assign benefits to non-participating healthcare providers as a matter of policy. Even when BCBS subscribers are willing to pay a higher premium for physician choice and choose plans that provide for out-of-network services, non-network providers are not directly compensated for providing services to subscribers, often resulting in lost revenues, increased bad debt, and collection expenses incurred when insured patients do not pay for services rendered because the health plan sent payment directly to the patient instead of the provider.

Patients receiving payment from a health insurer for services provided by out-of-network providers, sometimes months after services were delivered and without a full explanation of benefits, often do not realize the payment was intended for medical services provided by specific providers and simply cash the check. In addition, patients may ignore the need for medical care to avoid the administrative burden of dealing with outstanding bills.

Providers choosing network participation with health insurers are offered incentives to accept lower reimbursement in exchange for patient volume. Without the ability to offset increased overhead expenditures by fee adjustments, more providers are opting out of network participation with various health insurers' products not covering the cost of providing services to the plan's subscribers. However, the insurer may then deny patients access to necessary medical services provided by out-of-network providers or the patients may have to assume complete financial responsibility for services provided.

A Virginia Perspective on Assignment of Benefits: Most BCBS plans in the Commonwealth honored subscribers' assignment of benefits until 1983, when the law providing for the creation of unique territories for Blue Cross plans was repealed. As a consequence, the Blue Cross plans tried to improve market positions by vigorous competition with each other. Blue Cross of Virginia revised its policy on assignment of benefits to prohibit subscribers from assigning their benefits to non-participating providers in order to increase provider participation in its networks. In 1984, Delegate Thomas W. Moss, Jr., sponsored a bill that would have required all Blue Cross plans in Virginia to honor their subscribers' assignment of benefits. Blue Cross Blue Shield of Southwestern Virginia supported the assignment of benefits bill, stating that assignment of benefits favored consumer choice and did not prevent the Roanoke plan from negotiating favorable reimbursement contracts with providers, which ensured an adequate network. An official from the Roanoke plan said at the time, "No carrier should be able to usurp the consumer's right to assign benefits he has paid for, either directly or through his group health coverage plan. To attempt to remove this freedom under the banner of cost containment is especially false; benefit levels are the same regardless of assignment of benefits." Assignment of benefits was not mandated during the 1984 General Assembly session. Eventual consolidation of several non-profit BCBS plans in Virginia led to the formation of Trigon, which converted to investor ownership in 1997. During 2000, the current Virginia statute for assignment of health plan benefits, which applies only to dentists and oral surgeons, was passed. Anthem BCBS acquired Trigon in 2002, culminating in Anthem's recent merger with Wellpoint Health Networks Inc., creating the largest private health insurer in the country with 28 million subscribers. Anthem provides 2.8 million Virginians with health plans ranging from Medigap insurance to employer benefits. With the exception of Medicaid, Anthem is the market leader in every segment it serves in Virginia with approximately 70% of the combined HMO/PPO health plan benefits provided to privately insured citizens.

Based upon federal regulations, physicians providing services to patients seen in hospital emergency departments are not allowed to turn away patients, regardless of their insurance status. Recent examples of lost revenues due to out-of-network emergency medicine physician practices providing services to subscribers in an Anthem BCBS' plan are found in Table III.1. Anthem's payments were sent directly to the patients, who then did not remit payment to the physicians. For these three practices, the annual financial losses ranged between $300,000 and $400,000. Some emergency departments throughout the Commonwealth are now having to deal with Anthem subscribers seeking unnecessary services in order to collect payments from Anthem--the patients are "gaming the system," since they know the physicians have to see them and checks for services provided by the physicians will be sent directly to them even though they have no intent of paying the physicians.

Table III.1.Illustration of Negative Financial Impact to "Non-Par" Emergency Medicine Physicians.

Emergency Medicine Physician Groups 2002-2003	Number of Physicians in Group	Number of Annual Patients Seen by Group in Emergency Departments	Lost Revenues Due to Direct Payment Sent by Anthem BCBS to Patients
Group One	Eight (8)	36,000	> $300,000
Group Two	Seven (7)	32,000	> $300,000
Group Three	Seventeen (17)	75,000	> $400,000

The Blue Cross Blue Shield Association is a major opponent of any legislative or regulatory proposals directing assignment of benefits to healthcare providers. BCBSA asserts direct payment is a windfall for providers, disruptive to cost-efficient provider networks, and denies consumers critical network protections. During 2003, BCBSA had a study done by Reden and Anders on the potential impact of mandatory assignment of benefits to healthcare providers. The authors state "health plans negotiate contractual arrangements with providers that save consumers thousands of dollars in health care costs…"consumers with serious medical conditions save significant amounts of out-of-pocket costs due to the contracts health plans negotiate with physicians." Typically, providers in Virginia are not given the opportunity to negotiate more favorable contract terms with Anthem. The consensus amongst all medical practices interviewed is that Anthem has a "take it or leave it attitude" relative to contractual terms with providers in its networks. Anthem's "extraordinary" market power allows more aggressive negotiating with healthcare providers, resulting in reduced reimbursement rates. This unequal bargaining position has forced many providers to enter into one-sided contracts, which threaten the doctor-patient relationship and continuity of care. Studies have reported BCBS plans have been increasingly aggressive in exercising their market power by reducing provider payments, resulting in more contract terminations (Foreman, Wilson and Scheffler, 1996). Not only is declining physician reimbursement by both public and private health insurers prompting more contract terminations and physicians exiting the marketplace or changing the scope of their practices in Virginia, it also threatens access to health services because medical practices are finding it more difficult to retain and recruit qualified physicians. Some of the Virginia locales currently experiencing physician shortages include Fredricksburg, Lynchburg, Newport News, Rappahannock, Southwest Virginia, Williamsburg, and Tidewater. It is becoming increasingly more difficult to provide coverage for several medical specialties including emergency medicine, general surgery, infectious disease, internal medicine, nephrology, neurosurgery, obstetrics, ophthalmology, thoracic surgery, and trauma, etc.

BCBS asserts high-quality provider networks will be adversely affected by mandated assignment of benefits due to more physicians choosing not to participate in various health plan products. As a practical business matter, physicians should be able to contract with the networks they wish to participate in. Reimbursement rates that do not keep up with medical practice inflation are a disincentive for physicians to join or continue participation in health plans' networks. Many states have established access standards that health insurers must meet to ensure subscribers are provided adequate networks for healthcare services.

Per the 2001 policy statement from Wellmark BCBS, BCBS' public policy positions include supporting fair and equitable competition in the marketplace, such as level regulation for all

players in the health insurance and managed care market. BCBS supports customer service, which is market driven, exceeds customer expectations and enhances the development of new services and products while adapting to a changing environment. However, Virginian physicians' inability to negotiate appropriate reimbursement from health insurers does not ensure a level playing field in the health care marketplace in the midst of insurer dominance.

The recent class action lawsuit settlements against Aetna and Cigna (the third and fourth largest publicly held health insurers with 13.6 million and 9.9 million enrollees, respectively), both mandated assignment of health plan benefits to out-of-network providers. These prominent national health insurers have not argued dire financial consequences as a result of the suits—both companies have honored their subscribers' assignment of health benefits to providers for many years, as has UnitedHealthcare Group, Inc., now the second largest publicly traded health insurer with 22 million subscribers. However, since Anthem BCBS, the dominant health insurer in Virginia, prohibits its subscribers from assigning benefits to providers, other health insurers are not legally obligated to submit payment directly to their subscribers' out-of-network healthcare providers.

A preliminary review of The Commonwealth of Virginia Health Benefits Program's annual reports from 2000 through 2003 indicates that mandating assignment of benefits to dentists and oral surgeons has not increased costs as a percentage of total healthcare claims paid. During the four-year period, dental claims represented between 6.4% (2003) and 6.8% (2001) of the total expenditures for health benefits provided to active state employees and non-Medicare eligible retirees. For the four-year period, increases in overall spending for dental claims (43%) were more than the increases in physician services (39%) but less than increases in hospital inpatient services (52%), hospital outpatient services (50%), or prescription drugs (52%). It is assumed that the increase in employees utilizing dental care benefits through the State's health plan is proportionate with the total increase in enrollees utilizing medical care benefits, which increased 10% between 2000 and 2003, from 80,180 to 88,361 enrollees. From the information presented in the annual reports, it appears Virginia's expenditures for costs attributed to average daily hospital and admissions are higher than costs experienced in other states covered by Anthem plans. The state's plan was restructured in 2004, resulting in a different premium structure with more costs shifted to employees, a three-tier prescription plan, and more preventive services provided. The annual report for 2004 has not yet been released.

IV. Assignment of Benefits Legislative Activity

Table IV.1 provides a brief summary of legislative activity pertinent to assignment of benefits, which has been addressed in numerous states.

Table IV.1. Assignment of Benefits: National Summary of Legislative Activity.

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Alaska	Yes. 2002. Statute 21.07.020 (10).	Silent.	All healthcare providers
Alabama	Yes. 1994. Statute 27-1-19 (b) Amended 2001.	No. Non-par receives same rate as par.	All healthcare providers. Interpretation of ERISA doesn't apply to HMOs.
Arkansas	Yes. Awaiting reply.	Awaiting reply.	Awaiting reply.
Colorado	Yes. Statute 10-16-317.5. 2002.	Silent.	All healthcare providers
Connecticut	Yes. 2000. HB 5126.	Silent.	Dentists and oral surgeons
Florida	Yes. 2003. Statute: 627-638. HMOs not included.	Silent.	All healthcare providers
Georgia	Yes. 1981. Statute 33-24-54. Amended 1992 and 2002. Statute: 33-24-59.3	Silent.	All healthcare providers
Hawaii	Yes. Awaiting reply.	Awaiting reply.	Awaiting reply.
Illinois	Yes. Statute 215 ILCS 5/370a. 215ILCS 5/368c. (b); 215ILCS 5/370i (c) 1999. Amended: 2000 and 2004.	Silent.	All healthcare providers
Iowa	No. 2001 Senate File 2003. BCBS Wellmark payments payable to providers are sent to patients who are expected to reimburse the provider .	Silent. 2004 Legislature opposed bill that would have prohibited balance billing.	All healthcare providers.

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Louisiana	Yes. 2001. Statute 854: Fee schedules; discounts. Yes. Act 1157: 2004 Health Care Consumer Billing and Disclosure Protection Act. Requires insurers and providers to provide adequate billing information to patients. Yes. Statute 40:2010. Assignment of Benefits. 2002. Requires BCBS to honor assignment of benefits based on state law which pre-empts federal ERISA laws.	Balance Billing Contingencies. Yes. Collaborative effort between healthcare providers and insurers. Silent.	Hospitals. Facility-based and on-call healthcare providers. Hospitals.
Maine	1999. Statute 33:2755.	Not mandated unless access standards not met.	All healthcare providers
Maryland	No. 2000. 19-710.1 Payment to healthcare providers.	Silent. Defines rates paid to out-of-network providers.	All healthcare providers.
Mississippi	No. 1992. Senate Bill 2648 did not get out of committee. Yes. Statute 43-13-305: Medicaid 1985. Amended 1991, 1993 & 2000.	Awaiting reply.	Awaiting reply. Medicaid. All healthcare providers
Missouri	Yes. Statute 376.427.1. 2003: Applies to par only.	No.	All healthcare providers
Nevada	Yes. Statute 689A.135. 1983	Silent.	All healthcare providers
New Hampshire	Yes. 2002. Amended 2003. Statute 420-B-8-n. Point of Service Plans.	Yes.	All healthcare providers

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
New Jersey	Yes. 2004.	No.	Dentists and oral surgeons
New York	Yes. Statute 3235. 1993. Amended 1994 and 2003.	Silent.	Medicare
North Carolina	No. Statute 58-3-200 (d) addresses adequate access to networks.	Yes, if inadequate access to networks.	All healthcare providers
North Dakota	No. Unsuccessful attempt.	Silent.	All healthcare providers
Oklahoma	No. BCBS prevented passage of assignment/direct pay legislation, Article 36, section 3631.1.	No.	Awaiting reply.
Oregon	Yes. .Statute 743.531 1967. Amended 1985 & 1989	No.	All healthcare providers.
Rhode Island	Yes. 2002	Silent.	Dentists and oral surgeons
South Carolina	Yes. Statute 38-71-10. 1987. No. S644 stalled for the 2004 session.	Silent. No. Non-par would have received par rates.	Hospitals. All healthcare providers
South Dakota	Yes. Statute 58-17-61. 1983 .	Silent.	Hospital Services.
Tennessee	Yes. Statute 56-7-20:1992. Amended 1992, 1997, and 2003.	Silent.	All healthcare providers-- excludes Medicaid program.
Texas	Yes. 1991. Statutes: 1204.053 & 1204.054; Art 21.24-1.	Silent. 2003 Legislature opposed bill 1313 that would have prohibited balance billing for non-par.	All healthcare providers

STATE	DIRECT ASSIGNMENT	BALANCE BILLING	COVERED PROVIDERS
Vermont	Yes. Awaiting reply	Awaiting reply.	Awaiting reply.
Virginia	Yes. 2000. Statute 38.2-34067.13	Silent	Dentists and oral surgeons
Washington	Yes. Statute 48.44.026 Payment for certain health care services. 1999	Silent.	All healthcare providers
West Virginia	No. Statute 33-11-4. 2001.	Silent.	All healthcare providers
Wyoming	Yes. Statute 26-15-136. 1993	Silent.	Hospitals, MDs, and agencies with state sponsored plans.

The American Medical Association (AMA) has supported assignment of benefits to providers for several years: D-390.995. *Our AMA will seek (1) legislation or regulation, or develop model state legislation to ensure that third party payers be required to issue payment directly to providers when the patient has signed an authorization for the assignment of benefits; and (2) legislative relief mandating that health plans notify physicians when claim payments are issued to the insured rather than the physician who has an assignment agreement. (Res. 127, A-00).*

During 2004 legislative sessions held throughout the country, nine states considered directing assignment of benefits/direct pay legislation to healthcare providers but due to BCBS opposition, only New Jersey's legislature passed an assignment of benefits bill, which applies only to dentists and oral surgeons and does not allow balance billing provisions (BCBSA, 2004).

In Alabama, assignment of benefits for health care providers was mandated in 1994 but BCBS sought exemptions based on ERISA provisions pre-empting state law—the Alabama Department of Insurance concurred so the statute does not apply to BCBS or other HMOs. In Iowa, the House and Senate overwhelmingly passed legislation directing the assignment of benefits to all healthcare providers in 2001, but the Governor vetoed the bill due to pressure from Wellmark BCBS. A subsequent compromise with Wellmark created dual endorsement of checks payable to the provider but remitted to the patient. Washington State reached a similar compromise where health plans send checks requiring dual endorsement to patients for payment of health services provided by non-participating providers.

Some states have assignment of benefits provisions limited to network providers or specific entities (e.g., hospitals) or programs (e.g., Medicare or Medicaid) while several states have bills providing assignment of benefits to all health care providers. At least four states (e.g., Connecticut, New Jersey, Rhode Island and Virginia) have direct assignment of health plan

benefits applicable only to dentists and oral surgeons.

Balance billing has not been specifically addressed by all the states with direct assignment of health plan benefits, and is often a "silent" issue. BCBS is opposed to any balance billing provisions associated with direct assignment of benefits. However, Iowa and Texas legislators recently defeated proposed legislation that would have prevented balance billing by out-of-network healthcare providers. BCBS is currently seeking legislation that will mandate par reimbursement rates to non-par providers working in par facilities in Colorado. Louisiana has passed legislation intended to prevent duplicate billing processes by healthcare providers. It was a collaborative effort by legislators, providers and health insurers to ensure adequate and correct billing information is provided patients. Contrary to BCBS' successful overturn of Alabama's mandated assignment of benefits pertinent to health plans and ERISA exemptions, Louisiana's Supreme Court determined ERISA regulations do not pre-empt state statutes for assignment of health plan benefits and consequently, BCBS must honor patients' assignment of benefits to their healthcare providers. The Court also found the anti-assignment provisions language in Blue Cross health plan contracts specifies assignment of benefits will not be honored "except as required by law."

Legislators in North Carolina and Colorado have not yet directed assignment of benefits but the health insurers must adhere to "access standards" for adequate provider networks. If the standards are not met, out-of-network providers are assigned health plan benefits and reimbursed at 100% of billed charges—patients are not financially responsible for the health insurers' inability to maintain adequate networks due to contractual terms offered to providers.

In order to understand why direct assignment of benefits is important for ensuring adequate access to healthcare services in Virginia, the current relationship between healthcare providers and health insurers, and consumers, is discussed in the next three sections of this report.

V. Healthcare Expenditures

On average, national private health insurance premiums rose 11.2% in 2004, lower than the 13.9% increase in 2003 but still the fourth consecutive year of double-digit increases (Kaiser Family Foundation and the Health Research and Education trust, Employer Trust, Employer Health Benefits Survey, 2004). During 2004, premiums rose most substantially at HMOs with an average increase of 12.0%, down from the average of 15% in 2003. Between 2001 and 2004, the average annual cost of health insurance increased by 59%. Although most employers kept the same level of benefits, more costs were passed on to employees via increased premium contributions, deductibles, co-payments, prescription costs, etc. During 2005, employers' health insurance premiums are expected to increase an average of 11.3% (Hewitt Associates, Lincolnshire, Ill.).

Per the 2004 Kaiser Family Foundation and Health Research and Educational Trust Employer Benefit Survey. The national average for annual premiums for family coverage and single coverage were $9,950 and $3,695, respectively. Table V.1 illustrates average annual health plan premiums for Employer Health Plans during 2004.

Table V.1 Employer-Sponsored Health Insurance: Average Annual Premiums: 2004.

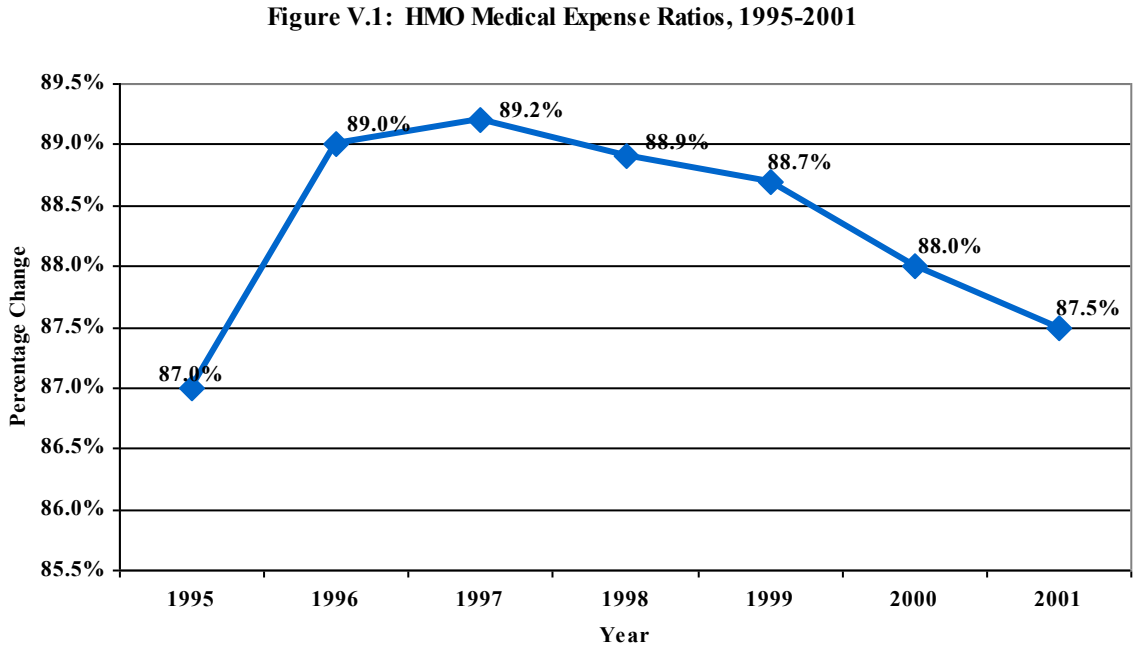
	ALL REGIONS	NORTHEAST	MIDWEST	SOUTH	WEST
Single Coverage					
Conventional	$3,820	$4,041	$3.919	$3,485	$3.977
HMO	$3,458	$3,542	$3,661	$3,470	$3,217
PPO	$3,808	$3,971	$3,832	$3,701	$3,899
POS	$3,627	$3,756	$3,536	$3,514	$3,698
All Plans	$3,695	$3,789	$3,769	$3,627	$3,629
Family Coverage (4 members)	ALL REGIONS	NORTHEAST	MIDWEST	SOUTH	WEST
Conventional	$9,602	$10,256	$9,627	$8,675	$10,286
HMO	$9,504	$9,848	$9,945	$9,621	$8,777
PPO	$10,217	$11,010	$10,428	$9,761	$10,317
POS	$9,813	$10,347	$10,366	$9,293	$9,411
All Plans	$9,950	$10,449	$10,280	$9,625	$9,629

Source: Kaiser Family Foundation and Health Research and Educational Trust: Employer Health Benefits, 2004.

Health plan premiums vary by geographic region. Overall, HMO premiums were less in the West while PPO premiums were highest in the Northeast. Premiums representing the average of all plans for family coverage were highest in the Northeast, followed by the Midwest. Mandated benefits by individual states also cause regional variation in health plan premium expense.

Revenues from health plan premiums paid to health insurers are divided into two categories—the medical expense ratio is the portion of revenue spent on medical claims while administrative costs include all operating expenditures and profits of the plans. Figure V.1 illustrates average HMO medical expense ratios between 1995 and 2001. At year-end 2003, medical expense ratios continued their decline for several proprietary health insurers doing business in Virginia (i.e., Anthem--80.8%; Aetna—78.3%, Cigna—86.9%, Coventry--80.9%; UnitedHealth—80.0%, and Wellpoint—80.5%, etc.). The Abell Foundation reported a significant portion of the profit margins of investor-owned Blues plans result from lower payment rates to health care providers (Schramm, 2001). In addition, Abell determined medical expense ratios associated with for-profit BCBS plans are about five to ten percentage points lower than those of nonprofit BCBS plans and that BCBS plans medical expense ratios in Virginia are significantly lower than that of some other health insurers in that market**.**

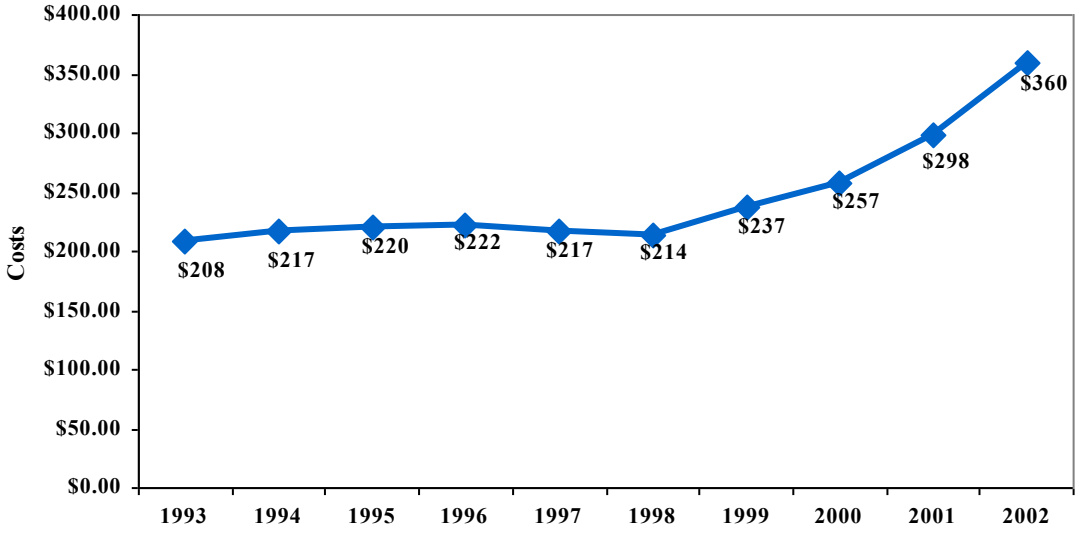
Figure V.1. Average HMO Medical Expense Ratios, 1995-2001.



Source: InterStudy Publications, The InterStudy Competitive Edge 12.2, Part II: HMO Industry Report, October 2002, Figure 7, p. 51.

Administrative costs per health plan subscriber have continued to increase during the last four years, contributing to the excessive profitability reported by many health insurers. Figure V.2 illustrates the average health insurer administrative costs per subscriber for the period between 1986 and 2002.

Figure V.2. Private Health Insurance Administrative Costs per Person Covered, 1986-2002



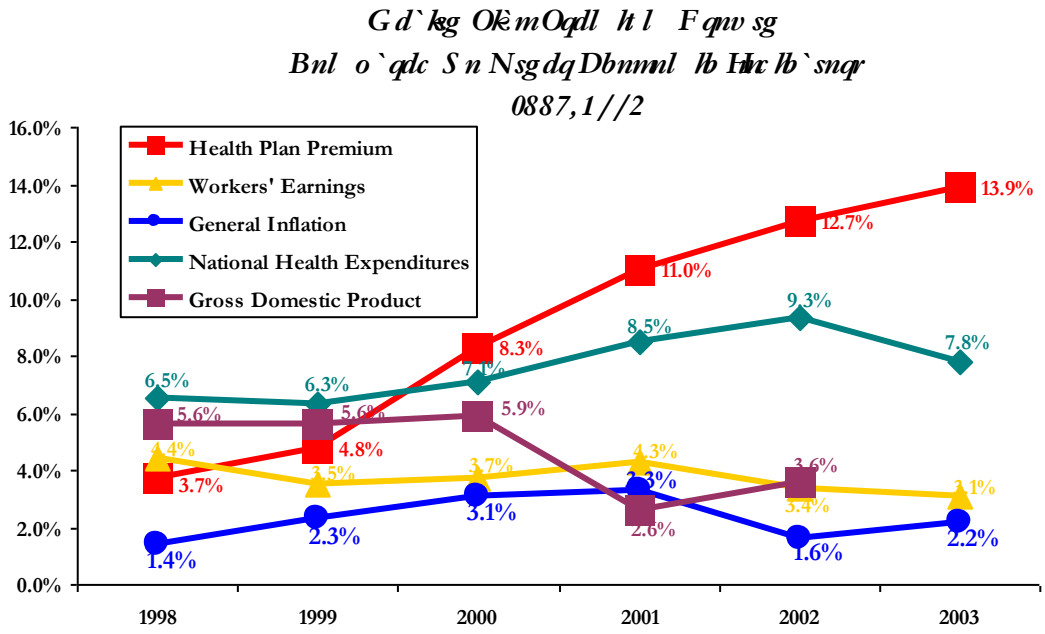
Source: Centers for Medicare and Medicaid Service, Office of the Actuary, National Health Statistics Group

A correlation between direct assignment of benefits to out-of-network providers and increased health insurance premiums has not been established. According to the most recent Families-USA survey illustrating a four-year average premium increase for all states, premium increases in some of the states with mandated assignment of benefits were higher than the national average while others were lower. However, it is difficult to make an exact comparison of premium increases in different states due to variation in health plan products, insurance regulations, and how enrollment in the various plans is determined.

Figure V.3 compares national health plan premium growth to other economic indicators (i.e., workers' earnings, general inflation, national health expenditures and gross domestic product) between 1998 and 2003. Per a report released by the Center for Studying Health System Change (HSC) and the Employee Benefit Research Institute (EBRI), the 5.7 percent increase in healthcare spending for the first six months of 2004 was less than the previous five years, but still double the growth in the overall economy. During 2002 and 2003, health plan premiums rose 7.9 and 6.3 times, respectively, as fast as general inflation; 3.7 and 4.5 times, respectively, as fast as workers' earnings; and 1.37 and 1.78 times, respectively, as fast as national health expenditures.

Harvard economist David Cutler estimates that if medical costs rise 5% above inflation for each of the next four years, at least 3 million more US residents will be without coverage. If health plan premiums continue to rise about 10% a year, today's average premium could double in just over seven years. Wages, however, are only expected to grow at about 3% a year.

Figure V.3. Health Plan Premium Growth Compared to Economic Indicators, 1998-2003.

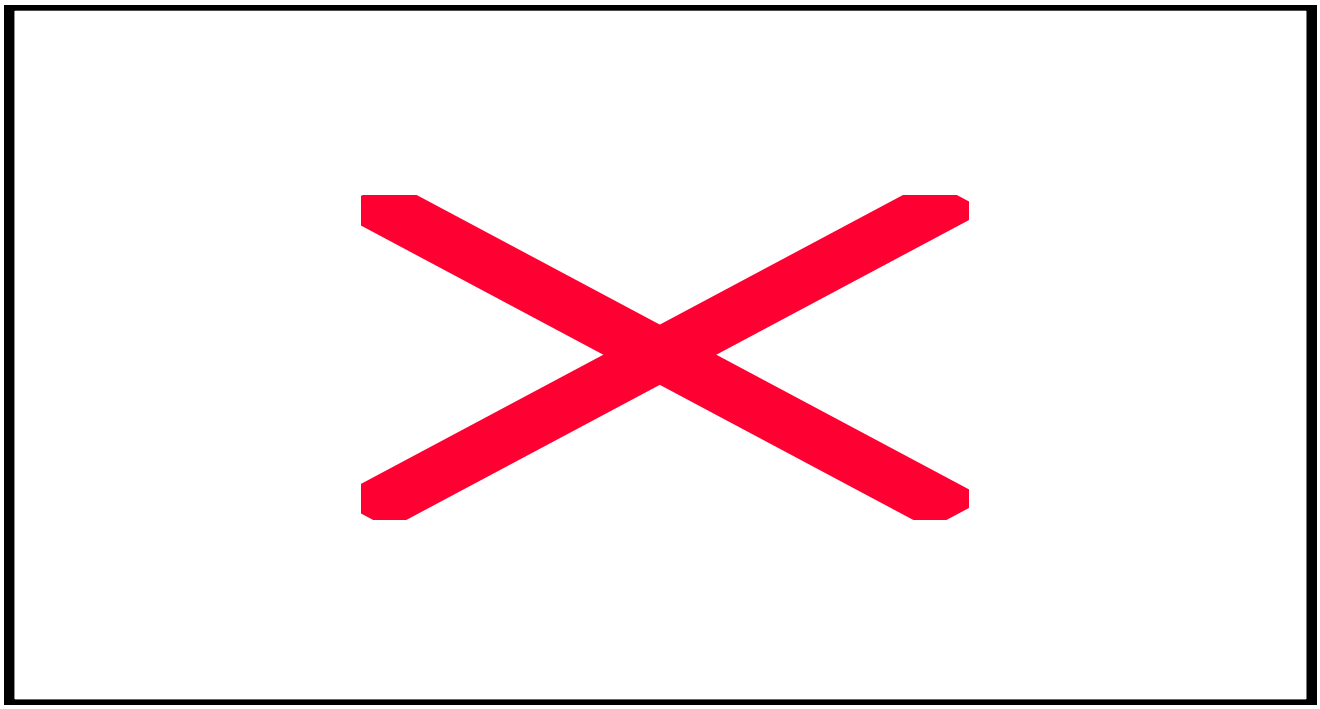


Sources: Kaiser Family Foundation, 2003: Bureau National Statistics: CMS

Per capita healthcare cost trends indicate spending on physician services has not increased at the same rate in recent years as hospital and pharmaceutical spending. Typically, cost trends are utilized to determine increases in health insurance premiums. However, between 2000 and 2003, health insurers have consistently raised annual premium prices above the rate of costs with premium yields at least 1.5 to 2.0 percentage points above cost trends since 2000 (Robinson, 2004).

Even though national health care costs declined during 2003 to 7.4 percent, the 13.9 percent increase in health plan premiums indicates health insurers are not experiencing vigorous price competition (Robinson, 2004) and that health insurers' administrative costs and profits have accelerated as benefit growth has decelerated (Grossman and Ginsburg, 2004). A study by the Center for Studying Health System Change (HSC) reported the four spending categories associated with total health care costs per privately insured person rose 7.4 percent in 2003. For the third consecutive year, spending on physician services was the slowest-growing category with a 5.1 percent increase, down from 6.5 percent in 2002. Total hospital spending increased by eight (8) percent, compared to 5.2 percent in 2002. The increase in hospital spending is indicative of favorable payment rate increases negotiated between hospitals and health insurers during 2002 and 2003. The New York Times reported that recent hospital mergers have created "powerful networks" that have "the upper hand in negotiations with health insurers." Figure V.4 illustrates the annual per capita percentage change in health care spending between 1994 and 2003.

Figure V.4. Annual Per Capita Changes in Healthcare Spending, 1994-2003.



Source: Center for Studying Health System Change, June 2004

Per the Center for Medicare and Medicaid Services (CMS), spending for physicians' services during 2002 represented 22% of total health care expenditures while overall hospital spending represented 32% of total healthcare expenditures, an increase of eight (8) percent compared to 5.2 percent in 2001, indicative of better payment rates from health insurers due to greater negotiating leverage created from recent hospital mergers and consolidation.

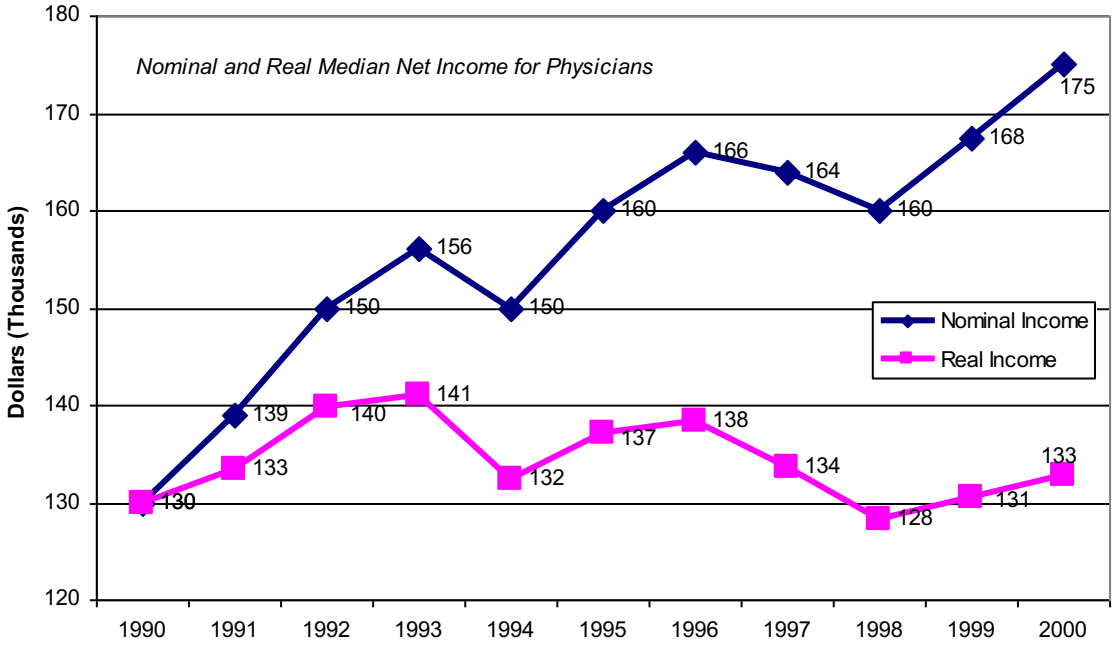
VI. Trend of Physician Income

While health plan premiums and health insurer profits continue to escalate, physician reimbursement has remained relatively flat or decreased. Physicians have received very little of the substantial resources generated by increased health plan premiums. "Real" practice revenues fell by 1.5% per year between 1998 and 2000 while health plan premiums increased by double-digits (AMA Patient Care Survey, 2001; The Lewin Group, June 2003). The median "real income" of all U.S. physicians increased an average of 0.2% per year from $130,000 in 1990 to $132,800 in 2000 (American Medical Association, 2003). Financial pressures from increasing professional liability insurance premiums has emerged as a crisis for many physician specialties including obstetrics/gynecology, orthopaedics, neuro-surgery, trauma, emergency medicine, etc., In order to offset reductions in Medicare and commercial reimbursements, many physicians are increasing their workloads while also dealing with increased administrative burdens related to health insurers and federal regulatory compliance. The combination of lower payments and rising costs are making it more difficult for physicians to cross-subsidize care provided to Medicaid and

uninsured patients, again jeopardizing access to care. Physicians are also seeking other ways to increase medical revenues to offset increasing practice costs (e.g., ambulatory surgical centers, professional service agreements with hospitals to subsidize the expense of providing care in the hospital setting, increased utilization of physician extenders, etc.).

A candid reminder of physicians' inability to negotiate appropriate reimbursement for professional services was found on The Medical Society of Virginia's website in January 2004, "Unlike other professions, we as physicians are not able to raise our prices to meet the increasing cost of delivering care to our patients…." The AMA's Report on Competition in Health Insurance (Second Edition: January 2003) validated that "physicians have little, if any, bargaining power with health plans." Figure VI.1 illustrates nominal and real median income for physicians between 1990 and 2000.

Figure VI.1. Nominal and Real Median Income for Physicians Between 1990 and 2000.

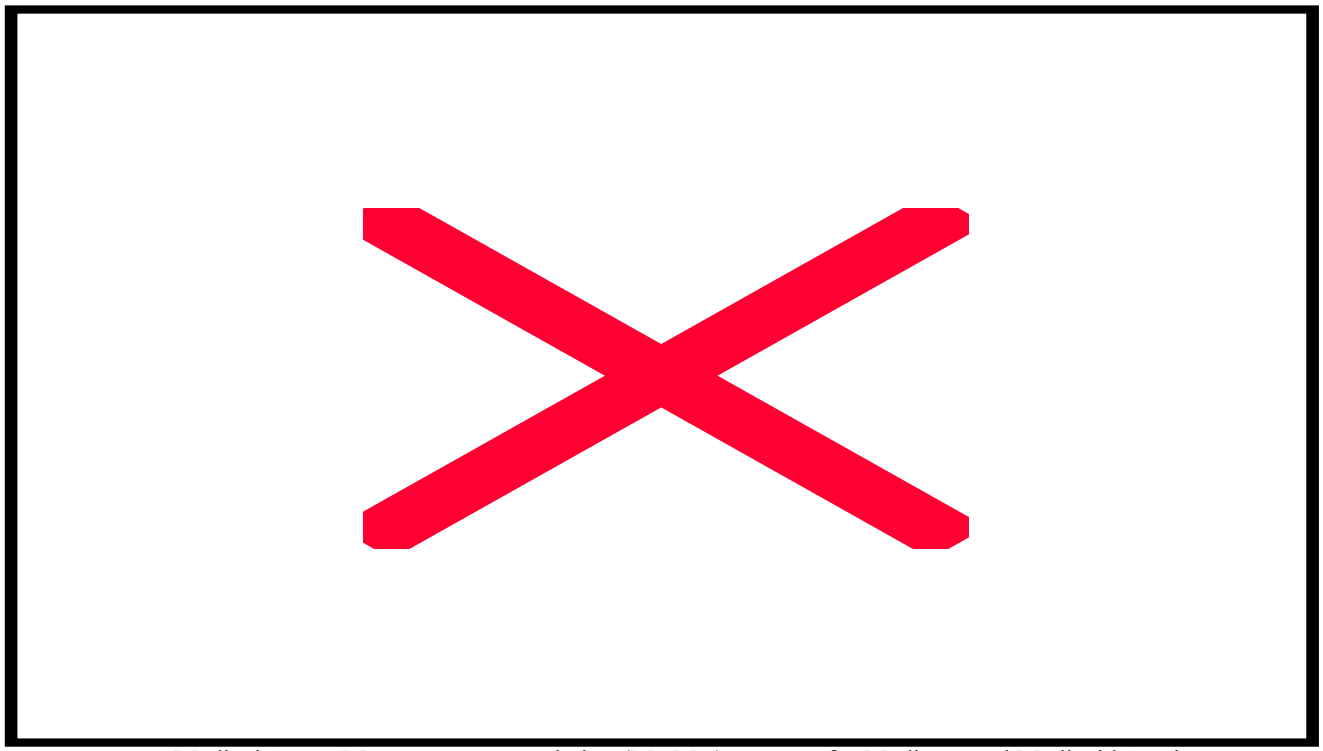


Sources: 1991-1999 AMA Physician Socioeconomic Statistics, 2001 AMA Patient Care Survey and Income Adjusted using Bureau of Labor Statistics CPI for all urban consumers (not seasonally adjusted).

Medicare's Fee Schedule (MFS) for physicians fell 14% behind practice cost inflation from 1991 through 2003 (AMA letter to Congress, June 2003). Based upon data provided by the Medical Group Management Association (MGMA), medical practice costs have outpaced Medicare reimbursement by an average of 2.7 percent annually during the last ten years, with practice costs increasing by more than 3.8 percent per year while Medicare reimbursements increased by only 1.1 percent. Since most national health insurers benchmark their fee schedules according to

Medicare reimbursement, healthcare services for non-Medicare populations are also being negatively impacted. Physician practices are struggling to offset rising costs and declining reimbursement through staff reductions, postponement of technology investments, and limited expansion of their practices—all indicators of declining access to care. Figure VI.2 compares medical practice costs, the Medicare Economic Index and Medicare Updates.

Figure VI.2. Comparison of MGMA Practice Costs, the Medicare Economic Index and Medicare Updates:



Sources: Medical Group Management Association (MGMA), Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and Medicare Payment Advisory Commission (MedPAC). Estimates for 2003-2006 operating costs and 2005-2005\6 MEI are 5-year average.

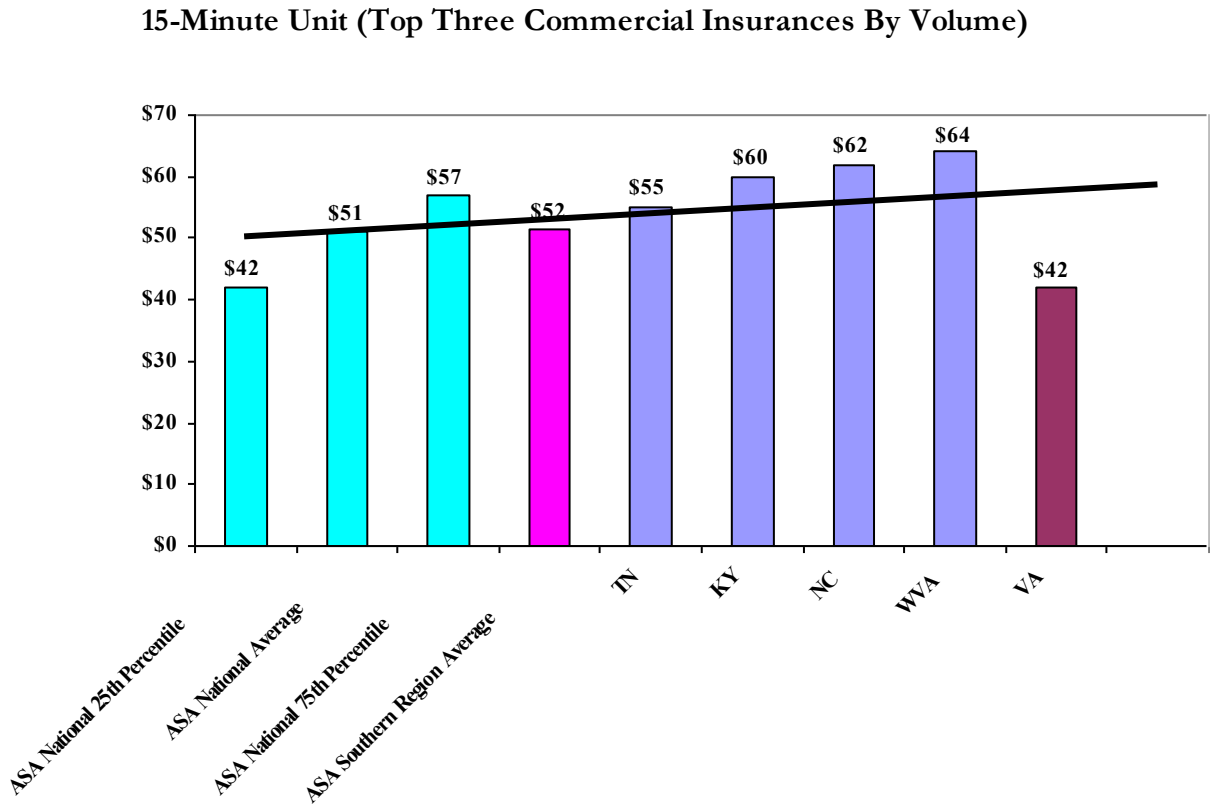
Through consolidation, health plan insurers have secured significant leverage in determining the delivery of healthcare services in this country. Only ten health insurers now cover over one-half of commercially insured Americans. The primary obligation of publicly traded health insurers is to their shareholders, not to patients enrolled in their plans. With the recent finalized merger of Wellpoint and Anthem, it is reasonable to assume that issues specific to healthcare delivery and physician shortages in Virginia will not be driving Wellpoint/Anthem's corporate policies.

In a letter to the Federal Trade Commission from the Congress of the United States, Representative Pete Stark expressed: "Dominant health insurers, particularly those that are for-profit have the potential, if not the incentive, to use their market power to establish highly favorable bargaining positions with providers, increase premiums to employers and individuals, and generate higher profits."

As Virginia's dominant health insurer, Anthem is one of the most influential forces in the state's health care economy and plays a considerable role in the political community and public policy arenas. Per a comment from the Milbank Quarterly report (2003), "Before Anthem's acquisition of Trigon, BCBS was very conscious of how it was viewed from a political standpoint by the public, the press, and the regulators, and that this constrained its behavior to some extent. Several people thought that BCBS was still trying to craft workable solutions to public policy and regulatory issues in Virginia"….."But due to Anthem's dominance, two cynics maintained that BCBS in Virginia did not really care what people think because they don't have to," …."BCBS liked to be perceived as caring about the community but the feeling was not genuine."

An example of low reimbursement rates paid to physicians by health insurers in Virginia is illustrated in Figure VI.3, which compares anesthesia rates nationally and in surrounding states. Other categories of medical practices (e.g., emergency medicine, general surgery, obstetrics, orthopaedic surgery, thoracic surgery, etc.) are also experiencing lower reimbursement rates than neighboring states.

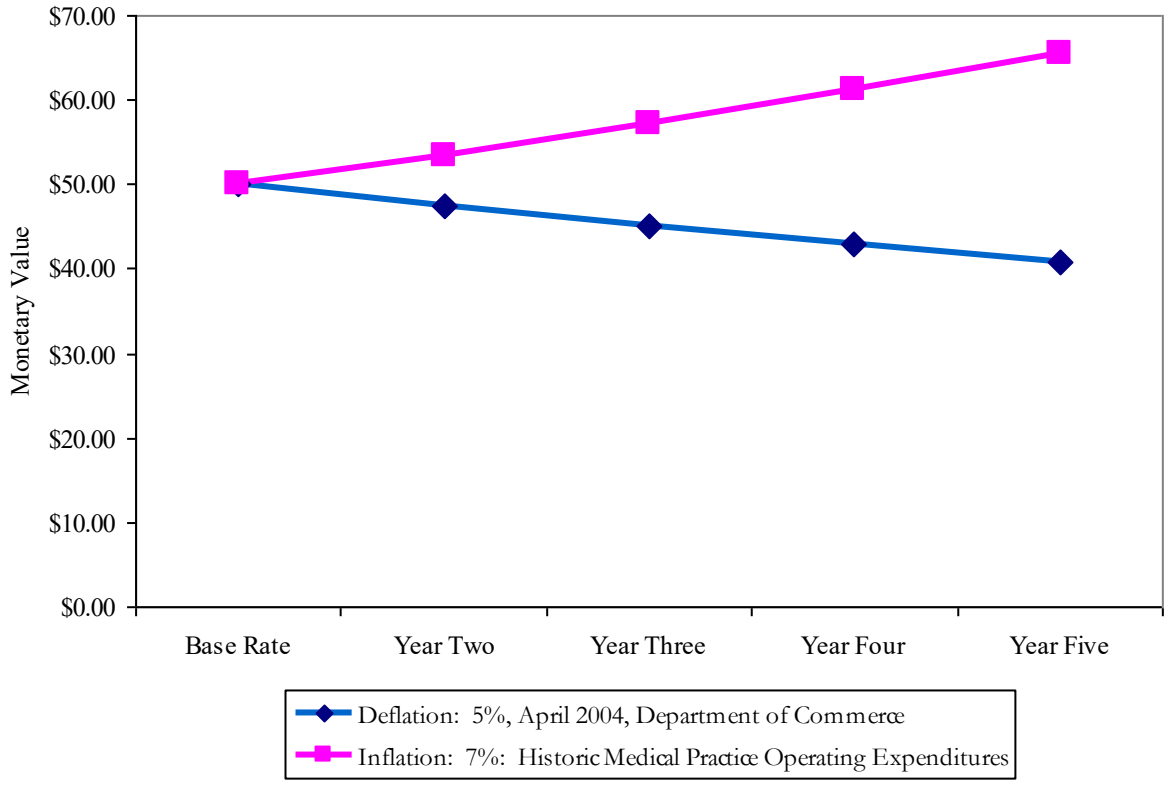
Figure VI.3. Comparison of Anesthesia Reimbursement Rates in Virginia



Based on the 2003 ASA survey, average commercial reimbursement per 15-minute anesthesia unit in Virginia is $42.00, which places it in the nation's lowest 25th percentile for anesthesia reimbursement. Reimbursement rates are higher in the states surrounding Virginia, making it

more difficult to recruit anesthesiologists to the Commonwealth. In addition, some health insurers are presenting contractual agreements to anesthesia practices with a five-year flat fee. Figure VI.3 presents the inflationary and deflationary value associated with a flat fee and medical practice inflation.

Figure VI.3: Anesthesia Reimbursement: Monetary Value of Flat Fee for Five Years.



The AMA met with the Federal Trade Commission (FTC) and members of Congress to address the inability of physicians to negotiate appropriate reimbursement from health insurers while the health insurers continue to consolidate and command extraordinary market power and report record profits. The AMA's position on collective bargaining for physicians includes the following:

- AMA: H-160.966 Market Forces on Medical Practice. "The ratcheting down of physician payment rates will not produce appreciable reductions in the rate of health care cost increases, since payment for physicians' services constitutes only about 1/5 of spending for health care: however; it may well reduce access to care as more physicians leave the area, retire, or in other ways change their practices."

- Collective Bargaining/Antitrust Relief: "Self-employed MDs lack the ability to negotiate with managed care plans or be involved in key decisions that affect the well being of their patients and the quality of care of their professional practices or training institutions. There have been several recent examples of unprofessional and egregious health plan tactics in contract negotiations and employment issues."
- H-385.976 Physician Collective Negotiations—"the AMA will seek amendments to the National Labor Relations Act and other appropriate federal antitrust to allow physicians to negotiate collectively with payors who have market power. "(Res. 95, A-90; Reaffirmed by BOT Rep. 33, A-96; Reaffirmation A-97).

VII. Largest Publicly Traded Health Insurers' Financial Performance

Weiss Ratings, Inc. reported the nation's HMOs experienced a $3 billion profit for the first quarter of 2004, which was a 33 percent increase of $742 million over the same period during 2003. The HMOS nearly doubled their profits to $10.2 billion during 2003, an 86% increase over the $5.5 billion profit reported for 2002, which represented an 81% increase from the $3 billion profit reported in 2001. The gains have been attributed to ongoing double-digit premium increases and cost-cutting measures, including decreased reimbursement to providers. Regarding the earnings, Melissa Gannon, a Weiss Rating, Inc. vice president, commented "The industry's soaring profits continue to irk both consumers and businesses who are shouldering skyrocketing healthcare costs without any perceived improvement in benefits."

The Hartford Courant reported the S&P Managed Health Index for 2004 increased 43% and is ranked eighth-best among 132 industry groups in the Standard & Poors (S&P) 500 index, as health insurers' profits surged due to a continuing decrease in medical costs (12/02/04). While health insurance premiums increased an average of 11.2% in 2004 (Kaiser Family Foundation), it is expected that medical costs will have increased approximately 8% at year-end (Strunk and Ginsburg). From an investor perspective, Robinson reported the health industry has remained extremely attractive during the last four years. With the exception of Aetna and CIGNA, which both endured setbacks and loss of market share (mainly to BCBS plans), Wellpoint, Anthem and United share prices consistently appreciated by double-digits, compared to the S & P 500 index for the broader market, which declined 10.1% in 2000, 13.0% in 2001, and 23.4% in 2002, followed by an increase of 26.4% in 2003.

An illustration of health plan profitability in a state with mandated assignment of benefits to healthcare providers is Georgia. Wellpoint reported a 28% increase in profits during the 3rd quarter 2004—revenue increased 16% to $5.85 billion from $5.05 billion a year earlier, attributed to a 15% climb in premium revenue. The recently completed $16.4 billion merger of Wellpoint Health Networks by Anthem will provide Georgia with approximately $126.5 million for health care programs as well as a promise to not increase premiums for Georgia's 3.2 million BCBS members. Even though California does not have mandated assignment of benefits to health care providers, the new Wellpoint Inc. will also provide California with $265 million to fund health care programs and guarantees that expenditures on patient care will increase but premiums for the 7 million BCBS members in California will not increase to help finance the merger. It is expected that 293 Wellpoint executives will receive as much as $356 million in compensation, which does not include millions of dollars in stock options.

The profitability of the largest health insurers does not indicate an industry in crisis, quite a contrast to the practice environment many physicians are currently dealing with in Virginia and throughout the country. Additional information on various financial performance indicators for some national publicly traded health insurers doing business in Virginia includes the following:

•**The Blue Cross and Blue Shield Association** reported the combined earnings of its 41 independent Blue Cross Blue Shield affiliates increased 32% to $3.7 billion for the 2nd quarter of 2004, compared to $2.7 billion for the same period last year. The increase comes after a 53% increase in 2003 profits to $6.1 billion, compared to a 43% increase to $4.0 billion profit reported for 2002 and the $2.8 billion profit reported for 2001. At year-end 2003, the 41 plans held a combined $31.9 billion in reserves, up 30% from $24.5 billion from 2002. Total enrollment in the plans climbed 4% in 2003 to 88.8 million members, the highest level in 23 years.

•**Anthem** reported record results for 1st quarter 2004, which increased 54% to $295.6 million, compared to a $191.7 million profit for the same period last year. Anthem's chairman, president and chief executive commented, "We remain confident in our ability to continue this momentum, and look forward to the additional opportunities that our pending merger with WellPoint Health Networks will bring."

Anthem's annual net income during 2003 increased 41% to $774 million while enrollment increased by 8% to 874,000 members. Second-quarter earnings during 2003 represented a 67% increase due to Anthem's acquisition of Richmond, VA.based Trigon Healthcare during 2002. Anthem's medical cost ratio decreased from 84.8% in 2000 to 80.8 percent in 2003. Anthem experienced the same rate of profitability between 2000 and 2002 when its annual performance goal was projected at only 15 percent. The press reported in 2001 that Wall Street's expectations had been exceeded by Trigon every quarter since it's conversion to for-profit status (Milbank Quarterly, 2003). Per a Securities and Exchange Commission filing, Anthem's rapid growth between 2000 and 2002 earned Larry Glasscock, Anthem's Chairman, an incentive bonus of $42.5 million. During 2003, Glasscock's combined salary and bonus was $3.3 million. Anthem's four other top executives were also rewarded for the company's substantial three-year performance. The executive vice president and chief legal and administrative officer, David R. Frick, received $1.3 million in compensation and bonus plus a $16.1 million performance award; executive vice president and chief financial and accounting officer, Michael L. Smith, received $1.4 million in compensation and bonus plus a $16.1 million performance award; the president of Anthem Midwest, Keith R. Faller, received $1.45 million in compensation and bonus plus a $11.9 million award; and the president of Anthem Southeast, Thomas G. Snead, Jr. received $4.8 million in compensation and bonus plus a $4.4 million award. The executives, including Glasscock, must stay with Anthem until 2005 to fully collect on the performance awards, which will be equally comprised of cash and stock. William J. Ryan, a Maine banker who chairs Anthem's Board of Directors compensation committee commented, "the company has performed in an extraordinary way, and it would be unfair for the executives not to be paid in an extraordinary way."

•**WellPoint** reported 2004 first-quarter profit rose 53% to $295.2 million, up from $193.1 million for the same period last year. Overall, all of 2003 net income increased 33% to $935.2 million, up from $703.10 million during 2002. Wellpoint's medical cost ratio remained consistent between 2000 and 2003, ranging between 81.5% and 80.5%. Per filings with the Securities and

Exchange Commission, WellPoint's Chairman and CEO, Leonard Schaeffer, stands to receive a total of $335 million when the WellPoint/Anthem merger is completed. Based on annual cash compensation only, Schaeffer was also one of the ten highest paid CEOs of S&P 500 companies in 2002 (i.e., $7,077,413). Schaeffer explained the pressure created by having to keep Wellpoint's investors happy: 'there is no question that the pressure for economic performance and thus accountability to investors is very real….Stock analysts who follow companies want them to perform to their calculated profit estimates every quarter. Having said that, though…there was almost no change in how we behaved [following conversion]. We were [already] one of the most profitable plans in the United States. However, when we became publicly held, and listed on the stock exchange, for the first time ever there were incredible pressures for achieving our goals for quarterly earnings." (Iglehart, p.135).

•**Aetna,** the country's third largest proprietary health insurer with membership of 13.6 million enrollees, posted a steep rise in profit for 3rd quarter 2004, up from $215.9 million for the same period last year to $1.29 billion. For all of 2003, Aetna reported net income of $933.8 million. Aetna's medical cost ratio decreased from 89.8% in 2001 to 78.3% in 2003. Aetna's CEO, John W. Rowe received $10.6 million in compensation during 2003, which does not include $7.6 million in gains made from stock options.

•**CIGNA**, the country's fourth largest proprietary health insurer by membership—approximately 9.9 million enrollees at the end of 3rd quarter 2004, has projected 2004 consolidated income will be between $580 million to $610 million for its healthcare operations. CIGNA's net income for 3rd quarter 2004 was $320 million, up 64% from $195 million for the same period last year. CIGNA's medical cost ratio has remained fairly consistent at approximately 87% during the last four years.

•**Coventry Health Care** reported a 72% increase ($69.7 million) in net earnings for 2003, compared to 2002, due to higher premiums and increased membership. Its medical loss ratio decreased from 86.99% in 1998 to 80.9% in 2003. It is expected Coventry will become the country's eighth-largest health insurer with approximately 4 million enrollees if its acquisition of First Health Group Corp. receives regulatory approval during the first quarter of 2005.

•**UnitedHealth Group, Inc**., now the second largest proprietary health insurer with 22 million enrollees behind the newly created Wellpoint, Inc with approximately 28 million enrollees, posted a 37% increase in first-quarter net income for 2004. During 2003, United Health Group had $28.8 billion in revenue and record earnings of $2.9 billion. United's medical loss ratio decreased from 84.9% in 2000 to 80.0% in 2003. UnitedHealth Group Inc.'s Chairman and CEO, Dr. William McGuire, was the highest paid corporate executive in Minnesota last year. He received $94.2 million in compensation, ten times higher than his 2002 compensation. UnitedHealth's proxy statement also reported the compensation packages of the four other highest-paid executives in the company. The president and chief operating officer of UnitedHealth Group Inc. received $39.2 million, the CEO of UnitedHealthcare $10.7 million, the CEO of Uniprise, $9.3 million, and general counsel, $7.5 million.

Conclusion

At this time, we have not been able to establish any empirical evidence or data to support Anthem's claims that direct assignment of benefits to healthcare providers has a negative impact on insured consumer expenditures or access to quality care. Health plans' claims that mandated assignment of benefits will "cause harm" to consumers have not been substantiated. Health plans' abilities to provide adequate cost-effective networks have not been weakened. Managed care networks have not deteriorated due to an exodus of providers electing non-participatory status. A correlation between assignment of benefits and increased health insurance premiums and overall healthcare expenditures has not been established.

The practice environment in Virginia is making it more difficult to retain and recruit qualified physicians who are attracted to surrounding states with more favorable reimbursement. For many medical practices located in Virginia, the "cost of doing business" is no longer a viable option—increasing operating expenditures (i.e., medical malpractice premiums, health plan premiums, personnel, technology, regulatory mandates, etc.), are exceeding revenues even though physicians' work loads and the utilization of physician extenders have increased, prompting many physicians to exit the marketplace via early retirement, relocation or by reducing the types of services provided. The demand for many high-risk specialists (e.g., neurosurgery, obstetrics/gynecology, orthopedic surgery, thoracic surgery, emergency medicine, trauma, etc.) and lack of adequate physician coverage in numerous communities throughout the Commonwealth is causing delays in patients receiving treatment and increasing patient transfers between hospitals. Per a recent report from Virginia's Joint Legislative Audit and Review Commission, the most critical issue threatening access to trauma care in Virginia is inadequate physician coverage.

During the last five years, health insurers have experienced unprecedented profitability due to double-digit premium increases and declining medical expense ratios. Three of the four major health insurers in this country—United Healthcare, Aetna and Cigna, representing approximately 46 million subscribers, have not experienced negative financial consequences due to honoring assignment of benefits to healthcare providers. Blue Cross Blue Shield plans, which provide health plan benefits to approximately 90 million subscribers, and are typically the dominant private insurer in most markets, are the only insurers to deny their subscribers the right to assign benefits as a matter of policy.

Assignment of benefits is a relatively simple and effective means to help restore some balance to the relationship between healthcare providers and insurers in the Commonwealth of Virginia. Providers would have the opportunity to negotiate more favorable terms with the insurers, allowing patients greater access to necessary services. Providers could choose not to participate in plans providing inadequate reimbursement without being financially disadvantaged or causing disruption to patient care. Assignment of benefits creates an environment where insurers have an incentive to recruit and retain providers in their networks.

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