UnitedHealth to Close Database, Pay $350M

BY MARY ELLEN SCHNEIDER
New York Bureau

As part of an agreement with New York Attorney General Andrew Cuomo, UnitedHealth Group has agreed to shut down a national billing database used by health plans to determine reimbursements to members who use out-of-network physician services.

The billing database, which is operated by the UnitedHealth Group (UHG) subsidiary Ingenix Inc., will be replaced with a new, independent database run by a qualified nonprofit organization. Under the terms of the agreement, UHG will pay $50 million to help establish the new database. The nonprofit organization will develop a public Web site where consumers can research how much they may be reimbursed for common out-of-network medical services in their area.

OFFICE OF THE N.Y. ATTORNEY GENERAL

"This agreement marks the end of that flawed system," N.Y. Attorney General Andrew Cuomo said.

Aetna, the nation's third largest insurer, also has entered into an agreement with the New York attorney general to abandon its use of the Ingenix database in favor of the new one. Aetna will contribute $20 million over 5 years for the creation of the new database.

In February 2009, Aetna reached an agreement with the New York Attorney General's office to pay $5.1 million to reimburse patients and physicians for claims involving out-of-network care. The agreement will affect underpayments made to students across the country.

The agreements follow an investigation by Mr. Cuomo's office into allegations that insurers were systematically underpaying consumers for out-of-network medical expenses by saying that physician charges were higher than the "usual, customary, and reasonable" rates as calculated by the Ingenix database. As a result, insurers would pay a percentage of the lower "usual, customary, and reasonable" rate, leaving consumers to pay their own portion plus the balance of the bill.

The investigation found that insurers were underpaying consumers for out-of-network expenses by 10%-28% for medical services across the state. "For the past 10 years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry," Mr. Cuomo said in a statement. "This agreement marks the end of that flawed system."

"We are committed to increasing the amount of useful information available in the health care marketplace so that people can make informed decisions, and this agreement is consistent with that approach and philosophy," Thomas L. Strickland, executive vice president and chief legal officer for UnitedHealth Group, said in a statement. "We are pleased that an independent not-for-profit entity will play this important role for the marketplace."

Just days after reaching an agreement with Mr. Cuomo's office, UHG also settled a lawsuit with the American Medical Association and two state medical associations over the use of the Ingenix database. The $350 million settlement is the largest monetary settlement of a class action lawsuit against a single health insurer in the United States, according to the AMA.

The suit, which has been pending since 2000, alleged that UHG had been understating the "usual, customary, and reasonable" charges in payments to physicians and in reimbursing patients for out-of-network expenses. Under the class action settlement, UHG subscribers who submitted a claim for out-of-network services and were not properly reimbursed are eligible to receive part of the settlement. Physicians also could be eligible to receive payment under the settlement if they were underpaid by UHG and did not receive the balance from the patient.

But the biggest gain for physicians under both the AMA settlement and the agreement with the New York attorney general won't be money, but the rebuilding of the trust lost between patients and physicians, said Dr. Nancy H. Nielsen, AMA president.

When UHG and other insurers refused to pay the physician's charge, they were telling patients that the charge was unreasonable, creating "a wedge between patients and physicians," said Dr. Michael H. Rosenberg, president of the Medical Society of the State of New York, which was part of the AMA's class action lawsuit.

Regardless of who calculates the usual rates, there is still a wide discrepancy between the in-network rates available to most patients and the out-of-network rates paid by some, said Robert Laszewski, president of Health Policy and Strategy Associates LLC, a Washington-based consulting firm. Increased transparency would benefit the insurance industry if it shows physicians charging out-of-network patients significantly more.

"I think the insurance industry has won," Mr. Laszewski said. ■

POLICY & PRACTICE

FDA Launches Safety Program

The Food and Drug Administration launched a pilot program aimed at ensuring the safety of drugs produced outside the United States. The agency said it plans to select 100 companies that volunteer to participate in the Secure Supply Chain pilot program. To qualify, applicants will need to maintain control over drugs and active ingredients from the time of manufacture through entry into the United States. The FDA said it's testing the practicality of a comprehensive supply chain program that could identify foreign products that fail to comply with U.S. standards. The pilot program will run for 2 years, the FDA said.

CMS IDs Protected Drug Classes

The Centers for Medicare and Medicaid Services tried to guarantee that Medicare beneficiaries with certain conditions—including HIV infection, some cancers, and mental illness—may confidently enroll in Medicare Part D prescription plans. In June 2005, the CMS directed that Part D formularies include nearly all drugs in six classes: antidepressants, antipsychotics, anticonvulsants, immunosuppressants, antiretrovirals, and antineoplastics. A new CMS rule notified Part D plans that they must continue to provide coverage of these drugs through 2010, consistent with the policy already in place. For 2011 and beyond, the CMS may propose further steps to ensure availability of drugs in the six specified classes, the agency said.

Mixed Grades on Tobacco Control

Smoking in workplaces and public spaces has been banned in 23 states, but the pace of adoption of those lifesaving prohibitions has slowed, according to the American Lung Association's annual State of Tobacco Control report. Only two states passed such laws in 2008, compared with five in 2007 and six states and Washington, D.C., in 2006. Similarly, only three states and Washington, D.C., increased tobacco taxes in 2008. New York tops the list at $2.75 in taxes per pack, whereas South Carolina exacts only 7 cents per pack. In 2008, Arizona, Nebraska, and Washington state increased Medicaid beneficiaries' access to smoking cessation benefits—important because the Medicaid population smokes at a rate that's 50% higher than the national average, according to the association. The group's state-by-state report card on tobacco-control measures is available at its Web site.

Jump in Singulair Psych Reports

Surging reports of aggressive and suicidal behavior associated with the asthma drug Singulair (montelukast) contributed to another high number of serious adverse events reported to the FDA in the second quarter of 2008, according to the nonprofit Institute for Safe Medicine Practices. The group said that a sevenfold increase in Singulair reports (to 644) was driven by the FDA's announcement in March 2008 that it was taking a closer look at the drug's side effects. For all drugs, 22,980 reports of drug-related serious injuries included 2,968 deaths. Digoxin accounted for 650 deaths, and the institute's analysis linked most of those to the recalled Digitek brand. After digoxin, the smoking-cessation drug Chantix (varenicline) accounted for the greatest number of reports: 910 cases of serious injury or death.

School Embraces Medical Home

A family practice residency program at the University of Kansas, Wichita, will establish a patient-centered medical home model of care, making it one of the first residency programs in the nation to offer training in a medical home environment, the university said. The transformation of the Smoky Hill Family Medicine Residency Program in Salina, Kan., will be supported in part by a $49,500 grant from the United Methodist Health Ministry Fund. The program is to focus on electronic health records and other health information technology, increased support for patients, better chronic disease management, scheduling innovations, and alternatives to routine office visits. "The adoption of the medical home model at the residency level is particularly important because the office practices [that] physicians learn in residency—good or bad—tend to translate into their 'real life' practice upon graduation," Dr. Rick Kellerman, professor and chair of family and community medicine, said in a statement.

Group Pushes Swipable Cards

The Medical Group Management Association has launched an effort to persuade providers and health insurers to adopt standardized, machine-readable insurance cards by next January. The initiative, dubbed Project SwipeIT, would save an estimated $1 billion annually that is currently spent on "wasteful, redundant administrative tasks," said Dr. William F. Jessee, MGMA president. For example, because most people's health insurance cards have no machine-readable elements, providers usually photocopy the cards and then manually enter the information into their computers, a process that's prone to error. Many cards also feature photos, illustrations, and shading that make legible photocopying difficult. Machine-readable cards would automatically enter patient information correctly and cost-effectively, according to the MGMA. The organization has developed a Web site to promote the initiative at www.SwipeIT.org.

—Jane Anderson