Insurance Fraud Scheme Investigated in N.Y.

Head of state task force alleges 'Ingenix is nothing more than a conduit for rigged information.'

BY MARY ELLEN SCHNEIDER
New York Bureau

Following a 6-month initial investigation, New York Attorney General Andrew Cuomo announced plans to file suit against UnitedHealth Group and four of its subsidiaries for allegedly systematically underpaying consumers for their out-of-network medical expenses.

The attorney general claimed that UnitedHealth Group used faulty data from one of its subsidiaries, the billing information company Ingenix Inc., which resulted in the underestimation of "usual, customary, and reasonable" rates for a range of out-of-network medical expenses and then provided unreasonably low reimbursement to consumers.

The investigation is ongoing and the attorney general's office has issued subpoenas to 16 other health insurance companies who use the Ingenix database. The subpoenas will seek documents that show how the companies calculate reasonable and customary rates, as well as copies of member complaints and appeals, and communications with Ingenix.

The investigation has national implications since five of the nation's largest health insurance companies rely on data from Ingenix, according to the attorney general.

UnitedHealth Group has denied that there are problems with the reference data used by Ingenix, which is "rigorously developed, geographically specific, comprehensive and organized using a transparent methodology," according to a company statement. The insurer says it is in discussions with attorney general's office and plans to cooperate fully.

Ingenix owns a database of billing information that many health insurers use to determine how much to reimburse consumers who go out of network for their care. But the attorney general's preliminary investigation found that the Ingenix data are provided by insurers that have a vested interest in keeping the rates low and that there is no auditing of the data that come in, Linda Lacewell, head of the attorney general's Health Care Industry Task Force, said at a press conference held to announce the industry-wide investigation.

The database also doesn't take into account whether a service was provided by a physician or a non–physician provider, a factor that would affect the price, Ms. Lacewell said.

"Our investigation has revealed that Ingenix is nothing more than a conduit for rigged information that is defrauding consumers of their right to fair payment," she said at the press conference.

The attorney general says UnitedHealth used faulty data from Ingenix, resulting in the underestimation of rates for a range of out-of-network medical expenses.

About 70% of insured Americans pay higher premiums for the right to go out of their insurer's network for care.

In exchange, the insurer typically promises to pay about 80% of the usual, customary, and reasonable rate. The consumer then is responsible for the balance of the bill.

But the attorney general says UnitedHealth Group subscribers haven't been getting what they paid for when going out of network. For example, for a 15-minute office visit in which most physicians charged $200, United told subscribers that the typical cost was $77 and agreed to pay only $62, leaving consumers to pay the remainder of the $138 bill.

"This is not news to us," Dr. Nancy H. Nielsen, president-elect of the American Medical Association, commented at the press conference.

In fact, the charges made by the attorney general are the same as those made by the AMA in an ongoing class action lawsuit it filed against UnitedHealth Group in 2000, which alleges that the insurer has been understating their calculation of usual, customary, and reasonable charges in payments to physicians and when reimbursing patients for out-of-network services.

While consumers are the ones responsible for paying the balance of these bills, it also can create a contentious situation for the physician, Dr. Robert B. Goldberg, president of the Medical Society of the State of New York, said at the press conference.

When patients receive an underpayment from their insurers, it's usually the physician's bill that they challenge, he said, since the information from the insurer makes it appear that the doctor has overcharged for the service. ■

Aetna, AMA Clash Over Medicare Payments

BY JANE ANDERSON
Contributing Writer

Aetna Inc. said in January that it is working with the American Medical Association and state medical societies to resolve issues involving nonparticipating physicians after the AMA complained that the insurer was paying those physicians just 125% of Medicare rates and then telling patients they didn't need to pay the rest.

In a letter sent to Aetna, Dr. Michael Maves, AMA's chief executive officer and senior vice president, noted that Aetna's policy—implemented last June—fails to take into account different practice costs that are reflected by physicians' billed charges.

"It is simply arbitrary and capricious for Aetna to deem 125% of Medicare to be a fair payment across the board," Dr. Maves wrote in his letter to Dr. Troyen Brennan, Aetna's chief medical officer.

Dr. Maves also said in the letter that physicians nationwide are reporting receiving Aetna Explanation of Benefits (EOB) forms stating that the patient has no obligation to pay the nonparticipating physician the difference between the physician's charge and the amount Aetna has paid.

This practice, Dr. Maves said, potentially violates the 2003 settlement agreement with Aetna in Multidistrict Litigation 1334, the large class action lawsuit in which physicians sued large managed care companies, including Aetna, over business practices.

However, Dr. Brennan said in an interview that the settlement in that case "clearly differentiates between HMO-based plans and traditional plans." It requires Aetna to tell members in traditional plans that they can be balance-billed by nonparticipating physicians, but it treats HMO plans differently, he said.

HMO members receive an EOB stating that Aetna does not contract with a nonparticipating provider, and that the provider might not accept Aetna's payment as payment in full for services, Dr. Brennan said.

"In the notice, we inform the member that we 'seek to ensure that they do not pay this provider any amount above any applicable copayment, coinsurance, or deductible at the in-network (referred) benefit level,' and if they receive a bill for the difference, they should send the bill to us," Dr. Brennan said.

Aetna believes it has complied with the 2003 settlement agreement "in all respects," but is in discussions with the AMA and state medical societies about the issues involved, Dr. Brennan said. However, "no substantive discussions have occurred as of yet with the AMA," said AMA spokesman Robert Mills.

Meanwhile, nonparticipating physicians are being placed in an awkward situation, said Dr. Alan Schorr, a Langhorne, Pa.–based endocrinologist who does not participate with Aetna. Some of his patients have received the Aetna EOBs.

"This puts the patient and physician into adversarial roles," said Dr. Schorr, who added that, although Aetna might believe that 125% of Medicare represents fair reimbursement, "the patient has to have some sense of responsibility."

But the EOBs from Aetna state that the patient has no responsibility to pay the difference between 125% of Medicare rates and the actual charges, Dr. Schorr said in an interview, and patients therefore don't want to pay the difference. "We've had comments made to our office manager along the lines of 'Just write off the difference—you make enough anyway,' " he said.

Aetna "is trying to force physicians back into the [network] fold," Dr. Schorr said, adding that he had complained to the AMA and to the Pennsylvania Medical Society about Aetna's practice. "What we're looking at, in my opinion, is restraint of trade. They're trying to ratchet down physicians' fees," he said. ■

"Do you think Brad Pitt is happy?"

More Free Drug Samples Go to Insured Patients

Poor and uninsured Americans are less likely than wealthy or insured Americans to receive free drug samples, according to a study by physicians from Cambridge Health Alliance and Harvard Medical School.

The investigators found that, in 2003, 12% of Americans received at least one free drug sample (Am. J. Public Health 2008;98:284-9).

More people who were continuously insured received a free sample than people who were uninsured for all or part of the year, and the poorest third were less likely to receive free samples than were those with incomes at 400% of the federal poverty level or more.

"We know that many doctors try to get free samples to needy patients," said study senior author Dr. David Himmelstein in a statement.

"We found that such efforts do not counter society-wide factors that determine access to care and selectively direct free samples to the affluent. Our findings strongly suggest that free drug samples serve as a marketing tool, not as a safety net," he said.

But Ken Johnson, senior vice president at the Pharmaceutical Research and Manufacturers of America, said in a statement that free samples help millions of Americans, regardless of income, and "offer an option for those who have difficulty affording their medicines.

—Jane Anderson