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Dispute Between Insurer and Hospital Has Patients Rattled

By RICHARD PÉREZ-PEÑA

Insurance companies fight with hospitals and doctors over money — that much is a given. But a dispute between Oxford Health Plans and a hospital in Queens has raised hostilities to a rare pitch, and could threaten the hospital's financial health.

This spring, Oxford told hundreds of doctors and thousands of its subscribers that it would no longer pay for medical care at Jamaica Hospital Medical Center, and gave them a month to make new arrangements. It told some doctors that they, too, would no longer be allowed to participate in the Oxford plans, and it told many patients that they needed to find new doctors.

That disruption was put on hold, at least temporarily, after Jamaica sued the insurer. But doctors say that the dispute has already interrupted medical care and scared away patients, and that if Oxford carries out its threat, it will cause an exodus of patients and doctors from a hospital that is barely getting by financially.

The trouble began in 2004 when Oxford agreed to a new contract that increased the rates it paid the hospital, then continued to pay the old rates for more than a year, according to both Jamaica and the New York State Department of Health.

That cost the hospital tens of millions of dollars, but the loss is minor compared with the harm that an abrupt cancellation of its contract would cause, said David P. Rosen, president of Jamaica and its parent company, MediSys Health

Network. "What Oxford did was use a nuclear weapon" in what ought to have been a minor skirmish, he said.

Jamaica officials say the crux of the dispute is that Oxford is illegally punishing the hospital for refusing to strong-arm doctors into accepting Oxford's rates.

Whatever the merits of the dispute, Oxford's attempt to cut off a hospital on short notice marks a rare degree of escalation in the continuing struggle between a thriving health insurance industry and a troubled hospital industry.

Hospitals and insurers sometimes decide to stop doing business with each other, but it is usually a careful parting carried out over several months. Hospital executives say it is also highly unusual for an insurer to go to such lengths to persuade a hospital to help it gain leverage over a group of doctors.

Calls to Oxford were referred to its parent company, UnitedHealth Group, which bought Oxford in 2004. UnitedHealth declined to address specifics because the dispute is in court.

"We are committed to extending our relationship with Jamaica Hospital by implementing a multiyear contract," Debora M. Spano, a UnitedHealth spokeswoman, said in a statement. "We are working with the New York Department of Health to assure a continued relationship with Jamaica Hospital and to alleviate any disruption our members might face."

Kenneth E. Raske, president of the Greater New York Hospital Association, a trade group, said: "I field complaints from hospitals about insurers every day. But I have never seen anything like this."

If Oxford's tactics succeed, he said, then every financially troubled hospital is at the mercy of any major insurer that does not want to honor its contract.

Jamaica officials noted that the Oxford moves they object to happened after the July 2004 takeover by UnitedHealth, one of the nation's largest and most profitable health insurers.

It is hard to estimate how much business the hospital would lose in an abrupt separation from Oxford, which accounts for 8 percent of its revenue. Some Oxford customers would change insurers and remain with Jamaica, while others would stay with Oxford and go to other hospitals. If doctors shifted their business to other hospitals, they would take both Oxford and non-Oxford patients with them.

But even a small loss could be critical. Jamaica Hospital, on the Van Wyck Expressway near Jamaica Avenue, serves a largely poor population with many immigrants and a large number of uninsured patients. It is generally considered well managed, but has had serious losses in recent years. Officials say it merely broke even in 2005.

A quick cutoff by Oxford "doesn't mean we're going to close, and it doesn't mean we're going to file for bankruptcy," Mr. Rosen said. "But this could be the tipping point in terms of cutting vital services."

In interviews and court papers, Michael D. Brown, a lawyer for Jamaica, as well as Mr. Rosen and other MediSys officials, gave the following account of the dispute; UnitedHealth and Oxford declined to respond because of the litigation.

In 2004, MediSys and Oxford negotiated new contracts to set the rates the insurer would pay to two MediSys hospitals, Flushing Hospital Medical Center and Jamaica. Oxford drafted the contracts, and MediSys signed them and returned them to Oxford. In each case, based on custom and verbal understanding with Oxford, it was expected that the insurer would sign right away, and that the contract would go into effect the following month.

But after a few months, MediSys realized that Oxford was still paying the old, lower rates, and it complained to the insurer. At that point, Oxford raised a new and unexpected subject: the anesthesiologists at Flushing Hospital.

Those doctors are not Flushing employees, but an independent partnership with an exclusive contract to provide anesthesia services at the hospital — a typical arrangement. The anesthesiology group does not have an agreement with Oxford to be part of its network of doctors. When Oxford members have surgery at Flushing, the anesthesiologists bill the insurance company for their full fees, not the lower rates Oxford would negotiate with in-network doctors.

In late 2004 and early 2005, when MediSys protested that Oxford was not abiding by its new contracts, Oxford responded by asking the hospitals to pressure the Flushing anesthesiologists to join Oxford's network. MediSys rebuffed that request, saying it was up to the anesthesia group to make its own insurance arrangements.

After several months, Oxford relented and began paying Flushing the new rates. But with Jamaica, it would not.

Oxford signed the contract with Jamaica on April 25, 2005 — almost four months after hospital officials thought the contract had gone into effect. But even then, Oxford did not start paying Jamaica the new rates.

When repeated protests produced nothing, Jamaica officials raised the possibility this year of canceling the contract, but Oxford talked them out of it.

On March 27, Mr. Brown received Oxford's first written response to Jamaica's complaints — an e-mail message from a senior vice president at Oxford. The message, included in Jamaica's court papers, was an offer to pay the new rates, both in the future and retroactively, on the condition that the Flushing anesthesia group make a deal with Oxford. MediSys continued to insist that it could not compel those doctors to join Oxford's network.

In early April, doctors and patients received letters from Oxford informing them that as of May 2, Jamaica would no longer be an Oxford provider. Doctors who had admitting privileges at other hospitals were told that they would have to take their patients elsewhere. Doctors who had privileges only at Jamaica were told that they would no longer be paid to treat Oxford members, and their patients were told to find new doctors.

Dr. Alan R. Roth, a family practitioner with many patients at Jamaica Hospital, said he had hundreds of Oxford patients who received such letters.

"A lot of these are low-income, elderly people who have heart disease and diabetes and arthritis, people who see a lot of different specialists, and they were panicked," he said. "And all of a sudden, they're told they can't go to all those docs at Jamaica they're used to seeing, who coordinate care with me."

He said that major surgery for two patients was postponed while he scrambled to make arrangements at other hospitals. Doctors said they were inundated by calls from patients requesting their medical records so they could change doctors.

Dr. Gina M. Basello, another family practitioner at Jamaica, told of a woman in her 60's with chronic hepatitis C.

"She came in one day hysterically crying, completely distraught, saying she got this letter from Oxford that I could no longer be her doctor," Dr. Basello said. "Later, she missed appointments because she didn't think she could keep coming to me, and with someone who has serious chronic disease, that is not what you want to see happening."

Jamaica complained to the state, and in April, it sued Oxford in State Supreme Court in Queens. Oxford agreed to keep doing business with Jamaica through Aug. 1.

So far, Jamaica and the state say, Oxford has not made any retroactive payments. But Robert Kenny, a spokesman for the state Health Department, said: "As of this

month, Oxford began paying the higher rates. We've communicated to Oxford that they must do so."

But Mr. Rosen said that because of the lag in billing, he did not know yet whether Oxford was paying the new rates.

Marilynn K. Yee/The New York Times

Oxford subscribers, patients of Dr. Alan R. Roth and Dr. Gina M. Basello, received letters saying Jamaica Hospital care would not be covered.

modernhealthcare

October 2, 2006

Cover Story

Written by Laura B. Benko

The big squeeze

Insurers point to slower growth in premiums in past few years to show progress, but providers say they're paying the price

Health plans were quick to pat themselves on the proverbial back last week after the release of a report indicating that insurance premium increases have continued to slow nationwide for a third consecutive year.

America's Health Insurance Plans immediately issued a news release attributing the slowdown to its members' "cutting-edge" cost-control efforts, such as tiered prescription-drug formularies, pay-for-performance initiatives, and disease-management and prevention programs.

"Our community has reinvented cost-containment strategies and is deploying a new generation of tools and techniques to stretch healthcare dollars and mitigate the burden of rising medical costs," AHIP President and Chief Executive Officer Karen Ignagni said in the news release.

The other half of the story

But for doctors and hospital, there's far more to the story. Providers argue that large insurers, many emboldened by a spate of recent megamergers, have been able to ease up on premiums predominantly because they've been clamping down even more on reimbursements. "These `savings' are coming off the backs of providers," said Martin Wasserman, executive director of the Maryland State Medical Society. "So let's not celebrate yet."

"Insurers are using their market dominance to hold hospitals hostage," added Gary Gaube, president and CEO of 150-bed Landmark Medical Center in Woonsocket, R.I., which is wrangling over reimbursement rates with Blue Cross and Blue Shield of Rhode Island.

According to the report released by the Kaiser Family Foundation and the Health Research & Educational Trust, premiums rose 7.7% in 2006, the slowest annual rate increase since 1999. Although still about twice the rate of general inflation, the figure marks the third straight year that premium hikes have decelerated since soaring 13.9% in 2003, and its the second straight year of increases in the single digits (See chart).

And the gradual slowdown is expected to continue -- at least in the near future. According to a separate survey released last week by consulting firm Towers Perrin, large employers anticipate their healthcare costs will slow again in 2007 to 6% from the 7% increase they reported last year.

Industry insiders said insurers are taking a harder line on reimbursement rates, largely to appease frustrated employers, many of which have been cutting back or dropping their healthcare benefits after years of double-digit premium increases.

"Employers are putting pressure on insurers to demonstrate their ability to hold down costs, and clearly a lot of that is being driven through tougher negotiations with providers," said Henry Loubet, chief strategy officer for insurance broker Keenan & Associates and former CEO of UnitedHealth Group's Western operations. He pointed to a study released last month by the federal Agency for Healthcare Research and Quality, which found that hospitalizations are the single most expensive component of healthcare, consuming 33% of every dollar spent on medical care.

But hospitals argue that some insurers have become so stingy in recent years that it has put them in financial jeopardy at a time when they are caring for more uninsured patients, seeing smaller rate increases from government payers and having to invest in new technology and facility upgrades. About one-third of the nation's hospitals -- most of them stand-alone community facilities -- lose money each year.

Insurers "are always going to try to give you as small (a reimbursement) increase as possible with as little pain to themselves as possible; that's to be expected," said Russ Weaver, director of managed care for 199-bed Huguley Memorial Medical Center, Burleson, Texas, which is locked in a contract dispute with Aetna. "But what's worrying is that there's a growing segment (of insurers) that aren't going to budge an inch, no matter what." Weaver said Aetna has been paying Huguley so little that even the hospital's proposed increase -- which the insurer has rejected -- would still leave it at 40% below going rates in the area. "When an insurer's rates won't even cover your costs, you know something is going on," he said.

The contract was set to expire Sept. 30. Aetna spokeswoman Rachelle Cunningham said the insurer stopped negotiating with Huguley in August after the hospital issued a formal termination notice. "It's unfortunate, but we believe the rates we offered were fair and in line with comparable facilities," Cunningham said, adding that Aetna contracts with 85 other hospitals in the Dallas-Fort Worth area.

Indeed, data from the Bureau of Labor Statistics indicate that the balance of power may be shifting once again in insurers' favor, after a number of years in which large hospital systems seemed to hold the upper hand at the negotiating table. According to the bureau's Producer Price Index for general medical and surgical hospitals, annual rate increases from private insurers began to climb rapidly in 2000 after being stuck below 2.5% in the mid- to late '90s. But after hitting a 10-year high of 8% in 2003, the rate hikes slipped to 7.1% in 2004 and 4.3% in 2005, and were averaging 4.4% through August 2006. (The PPI includes payers' negotiated rates plus any portion expected to be paid by the member.)

Butting heads

Growing tensions between insurers and providers have been bubbling to the surface in a number of highly public contract disputes.

Landmark, for example, upped the ante in its months-long battle with the Rhode Island Blues by staging a rally outside the insurer's headquarters in July and more recently, recruiting the public support of Gov. Donald Carcieri. The hospital says the state's dominant insurer has refused to adjust reimbursement rates to reflect more accurately the rising cost of providing these important services. Landmark's contract with the Blues was set to expire Sept. 30.

"We've done a really good job of responding to our market's needs, and yet we find ourselves unable to penetrate with Blue Cross as other systems have done," said Landmark Chairman John St. Sauveur. "We have tertiary services, too, but they want to continue to see us as a community hospital."

However, Rhode Island Blues spokeswoman Kim Keough contends that the insurer has offered Landmark a "fair and equitable" reimbursement rate and that the hospital is simply "trying to lay its financial problems at our feet."

"As a nation, we're all facing a crisis of rising healthcare costs, and a good part of that is related to hospital reimbursement rates," Keough said. "It would be easy for us to give every hospital exactly what they're asking, but unfortunately those costs would be put on the backs of our members through higher premiums. We feel we have a fiduciary duty to our subscribers."

Maryland's CareFirst Blue Cross and Blue Shield used a similar argument this year when it opted to cut physicians' rates by as much as 20% in some areas. In a letter dated May 1, the insurer told doctors it had lost several large accounts to competitors who paid providers lower rates and therefore could offer lower premiums. "We believe CareFirst and CareFirst BlueChoice members should not have to pay providers higher fees than those paid by members of other commercial health plans," wrote Bruce Edwards, CareFirst's senior vice president of networks management.

Yet such calls for cost savings ring hollow with many providers when large insurers, including many of the nation's not-for-profit Blues plans, are posting record profits, boosting their reserves and paying executives hefty salaries and perks (Aug. 7, p. 6). The Rhode Island Blues, for example, holds $326 million in reserves and is expected to post $60 million to $70 million in operating profits this year. "It's very hard for me to be sympathetic," said David Rosen, president and CEO of 588-bed Jamaica (N.Y.) Hospital Medical Center, of insurers' calls for fiscal responsibility. "Sure, it's a noble thing to say, but I'm not seeing where they're enduring any pain," he said.

Jamaica is suing Oxford Health Plans for $50 million in punitive damages for harm allegedly caused to the hospital during a contract dispute that began in 2004, after the insurer was acquired by UnitedHealth. According to Rosen, Oxford agreed to higher rates that December, but continued to pay Jamaica at the old rate for more than a year. In the meantime, Rosen alleged Oxford tried to strong-arm Jamaica into coercing a private group of anesthesiologists at a sister facility to join Oxford's network.

When Jamaica didn't comply, Oxford sent out letters informing members that the hospital would be dropped from its network, Rosen said. After Jamaica filed suit in April, Oxford agreed to honor the new rates until 2008 and reprocessed all claims the hospital submitted after Feb. 1, 2005. But the dispute is "hardly resolved," said Rosen, arguing that the agreement didn't compensate for the extensive disruption caused to the hospital. "This is not curtailing healthcare expenses; this is stealing money," he said, noting that UnitedHealth earned $3.3 billion in net profits in 2005.

Oxford spokeswoman Maria Gordon-Shydlo said the allegations are without merit. The insurer in August filed a motion to dismiss the lawsuit.

Critics all around

Insurers, however, aren't the only ones turning a critical eye on some hospitals' demands for higher reimbursements. A number of consumer groups and labor unions, including the California Nurses Association, have criticized the hospital industry for profiting from huge markups in charges to patients.

American Hospital Association data show that in 2004, hospitals' total profits climbed 16.4% to $26.3 billion while their net profit margin expanded to 5.2% from 4.8% in 2003. And according to *Modern Healthcare*'s 30th annual Hospital Systems Survey, that growth continued for multihospital systems in 2005, thanks to continued success curbing operating expenses and an emphasis on leveraging their size for savings (June 12, p. 24).

"High hospital charges are a direct contributor to skyrocketing increases in healthcare costs that result in more people losing their coverage, more employers eliminating benefits ? and the ongoing implosion of our healthcare system," said CNA President Deborah Burger. She cited a study released in December 2005 by the CNA's Institute for Health & Socio-Economic Policy, which found that the nation's hospitals had set their gross charges at an average of 244% of their costs in 2004, an increase from 232% the year before.

(On a related note, California Gov. Arnold Schwarzenegger vetoed, as expected by policymakers, a controversial single-payer bill designed to expand healthcare coverage to all of the state's 36 million residents. The legislation, strongly endorsed by the CNA, narrowly passed the state Assembly and Senate last month.)

Labor leaders in Ohio even lent their support to insurance giant WellPoint during its protracted contract dispute with its most expensive network provider, Dayton-based Premier Health Partners. In an open letter issued last year, AFL-CIO's regional labor council said Premier's request for a 45% increase over three years was "unacceptable" given that the health system held $900 million in reserves, and called the dispute "an issue between Premier and those of us who live and work in this community." In December 2005, after more than a year of trying to rally public support in its favor, Premier ultimately acquiesced, accepting a 17% rate increase over four years.

But with more Americans going uninsured, even some business groups are seeing it hospitals' way. The Westchester County (N.Y.) Association, for example, blames insurers for what it called "horrific" reimbursement practices that contributed to the closure of two regional hospitals and financially hobbled others -- making the local climate bad for business. The 600-member business group is working with the Northern Metropolitan Hospital Association on a legislative initiative that would force insurers to return some profits to "rebalance the marketplace" and support providers' capital-intensive improvements in technology and patient services.

"Here we have hospitals and doctors who are in real trouble, and then we have the paper-pushers walking away with carloads of money and not wanting to help the industry where they make all that money," said WCA President Bill Mooney. "There's something very wrong with this picture."

-- *with Cinda Becker*

modernhealthcare

October 23, 2006

McGuire's billion-dollar exit

Investor's are sad to see UnitedHealth chief go

By: Laura B. Benko

The mounting stock-options backdating scandal at UnitedHealth Group, which resulted in last week's stunning ouster of longtime leader William McGuire, is playing differently on Wall Street than it is at hospitals and doctors' offices.

How these groups are reacting reflects how they've fared as Minnetonka, Minn.-based UnitedHealth has morphed over the years from a struggling regional health plan into an insurance empire with 28.3 million members and expected 2006 revenue of $72 billion. Much of the financial community mourned the departure of McGuire, a former physician who has been widely revered as a healthcare visionary. But for many providers, the management shake-up -- and the public scrutiny that's accompanied it -- was long overdue at a company they say has unfairly enriched itself and its executives by squeezing reimbursements, delaying payments and pressuring doctors and hospitals to cut back on care.

"We've been complaining for years now about this type of corporate culture that's allowed them to operate with very flexible ethics," said David Rosen, president and chief executive officer of 588-bed Jamaica (N.Y.) Hospital Medical Center. "We've been really, really unhappy with their abuse of power, and it's refreshing in a way that someone else is finally taking a look at this, even if it's from a different (i.e., option-backdating) perspective."

Jamaica is suing UnitedHealth's Oxford Health Plans unit over a contract dispute that began in 2004. According to the lawsuit, Oxford agreed to pay higher rates that December, but delayed signing the contract and continued to pay Jamaica the old rate for several months. Then the insurer allegedly backdated the contract to prevent Jamaica from opting out of the agreement, an action Rosen says Oxford officials have admitted to in court papers.

UnitedHealth spokesman Tyler Mason said he could neither confirm nor deny that the contract was backdated. But he emphasized that "there is absolutely no link between the options issue and reimbursements, and it would be completely misleading to draw any comparisons between the two."

McGuire announced his resignation as UnitedHealth's chairman and CEO last week after an internal probe concluded many of the stock options bestowed upon him and other

executives over the past 12 years were surreptitiously timed to maximize their value. President and Chief Operating Officer Stephen Hemsley will take over as CEO on Dec. 1. Richard Burke, a company director, was named nonexecutive chairman. UnitedHealth also dismissed its general counsel and the head of its board's compensation committee, and said five other directors would be forced out over the next three years in what amounted to a sweeping overhaul of its governance practices and leadership ranks.

At the end of 2005, McGuire held $1.6 billion in exercisable stock options. The 58-year-old executive agreed to have all of the options issued to him between 1994 and 2002 re-priced to each year's highest share price, cutting what analysts estimate will be about $100 million from his holdings.

UnitedHealth still faces investigations by the Securities and Exchange Commission, the Internal Revenue Service and the Justice Department, as well as two shareholder lawsuits. Last week, Sens. Chuck Grassley (RIowa) and Max Baucus (D-Mont.) also sent letters to UnitedHealth officials questioning the appropriateness of McGuire's severance package, which, if left in place, could amount to $1.1 billion in stock options and other benefits, including an annual pension of $5.1 million. Mason said the company is still reviewing the terms of McGuire's compensation.

Sheryl Skolnick, an analyst with CRT Capital Group, said she was "outraged" by the com-pany's apparent lack of internal controls. But she added that McGuire's resignation would be a "big loss" for the healthcare industry, which she says has benefited greatly from McGuire's influence on advancing evidence-based medicine, information technology and accessibility.

But news of McGuire's resignation was received quite differently by providers and patient-rights groups, many of whom contend UnitedHealth's robust earnings growth and generous executive-pay packages have come at the expense of better care.

"His replacement was well-deserved," said Brent Mulgrew, executive director of the Ohio State Medical Association. "It offends me personally how much money McGuire alone has taken out the healthcare delivery system. ... And it reinforces my belief that, to a significant number of people in the payer community, healthcare is merely about moving money from one place to another, and often into their individual pockets."

The revelations of McGuire's controversial gains are particularly galling, some providers say, because they come at a time when insurers have been clamping down at the negotiating table (Oct. 2, p. 6). "When we're trying to get an extra dollar or an extra couple of dollars for a procedure, seeing these kinds of pay packages makes us twinge," said Peter Bastone, president and CEO of 272-bed Mission Hospital, Mission Viejo, Calif.

And UnitedHealth has been a particularly hardball player, says Robert Seligson, president of the Physicians Advocacy Institute, which represents the state medical associations involved in a long-running class-action lawsuit that accused the nation's largest health

insurers of systematically shortchanging physicians. While seven other insurers reached multimillion-dollar settlements with physicians over the past three years, UnitedHealth remained one of just two holdouts. The lawsuit was ultimately dismissed June 19 by a federal judge in Miami, but the plaintiffs have appealed.

Seligson, however, says he's optimistic that the increased scrutiny UnitedHealth now faces will prompt the company's new leadership to take a more conciliatory stance toward providers. "We're hoping it'll be a new day," Seligson said, adding that the institute sent Hemsley a letter last week asking him to "begin to repair the years of damaged relationships."

Others, though, aren't so optimistic. Many industry observers said they viewed Hemsley's promotion to CEO as a sign that UnitedHealth plans to stay the course that boosted its stock price nearly 8,500% over McGuire's 15year tenure as CEO. "They may not dole out the same options packages in the future, but their main goal as a for-profit company will always be to make more money than the year before," said Robert Hayes, president of the Medicare Rights Center, New York. "So if we're waiting for UnitedHealth -- or Aetna or Humana, for that matter -to lead the charge toward a fairer healthcare system, we're in trouble."

STAR TRIBUNE

Newspaper of the Twin Cities

Minneapolis – St. Paul, Minnesota

June 25, 2006

Where cost and care collide

Did UnitedHealth's profits come at the expense of patient health?

David Phelps, Star Tribune

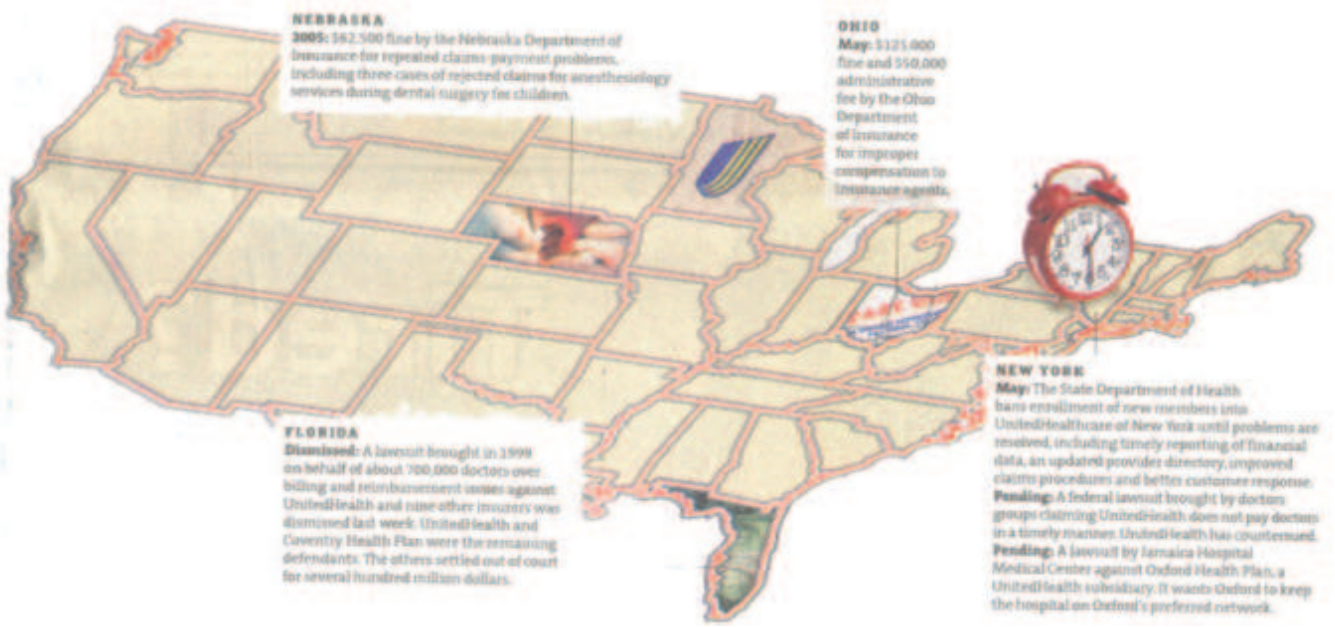
The 4-year-old had an abnormally small head, a condition known as microcephaly, so the child's doctor requested an enclosed bed to prevent the child from rolling off and being injured. The insurer said no.

The 42-year-old woman had shed 200 pounds after bariatric surgery, leaving her with flaps of excess skin that her doctor wanted to remove to prevent infection. The insurer denied the request.

The 3-year-old had dental surgery under general anesthesia. The insurer refused to pay for the anesthesia, despite a state law that required coverage for children that age.

NATIONAL REACH, NATIONAL HEADACHES

UnitedHealth Group has been disciplined or sued in three states in recent months, while notching a court victory in a fourth.



In each instance, state regulators said the insurer acted improperly.

In each instance the insurer was part of UnitedHealth Group, the Minnetonka-based health care giant and the second-largest health insurer in the nation.

Disputes between insurers, physicians, patients and state regulators are hardly unusual, and tracking the number of cases filed against UnitedHealth Group or its rivals is difficult. Each state has its own insurance regulator and the National Association of Insurance Commissioners doesn't compile complaints, lawsuits and enforcement actions against insurers.

A recent report by AthenaHealth Inc., in collaboration with the journal Physicians Practice, found that UnitedHealth had a higher denial rate for claims than five other national insurers: Humana, Champus/Tricare, Cigna, Medicare and Wellpoint.

UnitedHealth also took longer on average than five other national insurers -- Humana, Aetna, Medicare, Cigna and Wellpoint -- to pay physicians for services, according to claims data from 7,000 health care providers analyzed by AthenaHealth, a company that sells financial software for doctors. Overall, the report ranked UnitedHealth third among the seven national insurers for performance.

The wide-ranging federal probe of compensation practices at UnitedHealth, where CEO William McGuire had stock options worth an estimated $1.6 billion at the end of 2005, is serving as fresh fuel for critics who contend that patients suffer when insurers strive to satisfy Wall Street with healthy profits and management with huge paydays.

When insurers cut expenses to raise profits, "the policyholder, in the end, is affected," said Tim Wagner, director of the Nebraska Department of Insurance, who said his department has seen a sharp rise in complaints against UnitedHealth in recent years.

UnitedHealth, which covers 26 million members and expects revenue of $70 billion this year, said the legal and regulatory actions against it are relatively minor in the scope of its everyday activity.

"We do hundreds of millions of transactions," said Mark Lindsay, UnitedHealth's vice president of communications and strategy. "The regulatory and litigation environment is remarkably clear given the controversial nature of things that go on in health care."

Part of that controversy is rising health care costs and the inherent tension between those who sell medical services -- doctors and hospitals -- and those who buy it: insurers.

Lindsay said conflict is inevitable in a health care system that's going through big changes. For example, he said, some in the medical profession resent a push by insurers to make them start providing consumers with information about cost and quality.

Others agree. "Plans are redefining what they are," said Jeremy Delinsky, a policy director for AthenaHealth. "They don't want to be just claims processors. They're using data for new products to drive patients to providers who do great work at a reasonable cost. ... UnitedHealth is pretty good relative to the other national payers."

A string of lawsuits

In UnitedHealth's case, conflict has taken different faces in different places.

• UnitedHealth and subsidiary Oxford Health Plans are tangled in litigation in New York City, where Oxford is trying to remove a Queens hospital from its coverage network. The hospital, with a patient mix that is largely low-income immigrants and minorities, is suing to remain in the insurer's network.

• In late May, the New York State Department of Health barred UnitedHealthcare of New York, another subsidiary, from enrolling new members until it addresses numerous alleged regulatory deficiencies, including updating financial reports, adding staffing to improve customer relations and responding faster to claims disputes.

"We take this matter seriously and are concerned about the length of time it's taken UnitedHealth to address these matters," said department spokesman Robert Kenny.

• Earlier in the spring, United Healthcare of Ohio agreed to pay a $125,000 fine and $50,000 in administrative costs to the Ohio Department of Insurance as part of a department investigation into what it called "bid-rigging and inappropriate compensation" between Ohio-licensed insurers and agents.

Department director Ann Womer Benjamin called the fine "fairly significant" although UnitedHealth did not admit or deny the allegation that it paid commissions to agents working under contract with other public bodies to select it for insurance coverage. Anthem Blue Cross and Blue Shield was part of the same consent order and paid a $25,000 fine.

• Last week, a federal judge in Florida dismissed a huge class-action lawsuit alleging that UnitedHealth and another insurer, Coventry Health Care, manipulated their reimbursement software in order to downgrade and deny insurance claims made by physicians.

The attorney for the doctors in the Florida case noted that seven insurers had settled earlier for several hundred million dollars. Those insurers are likely to have better relations with providers in the future, said Archie Lamb, the plaintiff's attorney, adding that UnitedHealth "can expect an onslaught of litigation for their systemic mistreatment of physicians."

UnitedHealth's Lindsay called the case "a red herring" by doctors trying to place the blame of rising health care costs on insurers. He said the dismissal order was "a profound repudiation" of the doctors' claims.

• In a similar lawsuit in New York state, the American Medical Association, the Medical Society of the State of New York and the Missouri State Medical Association are alleging that UnitedHealth used inappropriate data to justify its reimbursement rates for medical procedures. United has countersued the AMA on antitrust issues.

Despite these cases, Lindsay said UnitedHealth believes that physicians generally are on board with the way the company does business.

"We have 500,000 doctors in our network. You tell me whether or not doctors are antagonized," Lindsay said.

Complaints on the rise

In Nebraska, where UnitedHealth had been doing business since the early 1980s, consumer complaints to the state Department of Insurance surged beginning about five years ago. Patients were being denied coverage. Claims reimbursements were slow in coming.

"The company had a sterling reputation in the state, and then we began to get an unusual number of consumer complaints related to a number of issues," Wagner said. "In terms of volume of complaints, it far exceeded our norms."

Glenn Fosdick, chief executive of the state's largest hospital, the Nebraska Medical Center in Omaha, said dealings with UnitedHealth can be more complex than those with other insurers. He said that in some cases it took nearly four times longer to get a doctor credentialed with UnitedHealth than it did with other insurers. An uncredentialed doctor cannot bill an insurer for services.

"It's critically important for providers today to work with insurers that pay on a timely basis," Fosdick said. "Historically UnitedHealth has been a very poor performer. You have to question if that is by corporate intent."

Officials in the Nebraska medical community acknowledge that UnitedHealth has recently improved its patient and doctor responsiveness in the state but say the insurer still lags behind its competitors.

In New York City, UnitedHealth and its Oxford subsidiary are in the midst of an ugly public brawl with the 400-bed Jamaica Hospital Medical Center. A simmering, two-year dispute over reimbursement rates and anesthesiologists who provide services outside of the Oxford reimbursement network led Oxford to threaten to pull all coverage for the hospital's doctors and patients.

Losing Oxford's business would be devastating to the hospital, officials said.

The dispute began in summer 2004, after Oxford was acquired by UnitedHealth, said David Rosen, the hospital's chief executive. Jamaica Hospital signed a new contract that required Oxford to pay higher rates to the hospital and its physicians, but Oxford continued to pay old rates. When the hospital complained, Oxford demanded that its lower reimbursement rates also apply to anesthesiologists at another hospital managed by the company that manages Jamaica. The anesthesiologists in question are an independent group that sets its own prices for work.

After Oxford sent a letter to Jamaica's patients and doctors earlier in the spring advising them they soon would need to find new doctors and hospitals, the hospital sued Oxford to stay in its network.

"It was extremely disruptive," said Dr. Alan Roth, a family practitioner for 20 years. "I had elderly patients who were all upset. 'What am I supposed to do?' they said."

Forest Burke, general counsel for UnitedHealth, called the case "a routine contract dispute with one hospital out of 4,000 in our network."

Rosen, a 36-year veteran of the hospital business, likened Oxford's threat to cancel a three-year contract to using "a nuclear weapon" in a matter that should be negotiable.

"I've worked with Oxford for 10 years and I have not seen conduct like this before," Rosen said. "This is not just a local curiosity. It's much bigger than that. We're looking at a corporate culture that allows this kind of behavior."

David Phelps • 612-673-7269

ASSOCIATED PRESS

November 15, 2006

AP Centerpiece: Health insurance contract negotiations grow increasingly nasty

By THERESA AGOVINO
AP

NEW YORK (AP) - Tension typically defines contract negotiations between health insurers and health care providers, but the haggling has taken an ugly turn lately.

Two hospitals in New York sued UnitedHealth Group Inc. for fraud earlier this year. An ad by HCA Inc.-owned hospitals in Las Vegas warned patients' health could be jeopardized if its properties are dropped from the Sierra Health Services Inc. network. A UnitedHealth executive's home was vandalized in Denver during negotiations with HCA. A Blue Cross Blue Shield of Georgia ad accused a Piedmont Healthcare official of lying.

Experts say the spate of acrimonious, public disputes signal years of rising health care costs are taking a toll on all those involved. Hospitals accuse health plans of skimping on payments to boost their earnings, while health plans say they are under pressure from clients to lower costs, and that providers balk at tying payment to performance.

"As costs go up, the pain threshold is starting to be met," said Les Funtleyder, an analyst at Miller, Tabak & Co. "Maybe we are just reaching some kind of a tipping point."

Last year, the cost of covering an employee's health care rose 6.1 percent, the 8th consecutive year of increases, according to Mercer Health & Benefits LLC.

High cost has squeezed demand for health insurance, so plans are under pressure to lower premiums to win business.

Plans forced to price more competitively must control costs to grow profits for shareholders, said Phillip Seligman, an equity analyst at Standard & Poor's. Hospitals represent a prime target because they account for the largest percentage of costs, he said.

Declaring a winner in these brawls is difficult. A health plan that covers a large percentage of an area's population will use that as an advantage over a hospital that needs those patients. But a hospital that controls most of a city's market can call the shots with health plans.

"It isn't clear whose power is growing in the market. Maybe these showdowns are an attempt to sort it out," said Paul Ginsburg, president of Center for Studying Health System Change, a nonpartisan policy research organization.

Wellpoint Inc. Chief Financial Officer David Colby said health plans have the advantage because there are more tools to compare hospital quality - a powerful bargaining chip. He said Wellpoint's stance isn't a ploy to increase profits.

"You are not guaranteed a rate increase. We want to tie increases to quality because that is beneficial to our members," Colby said.

Linking rate increases to quality measures was a sticking point between Blue Cross Blue Shield of Georgia, which is owned by Wellpoint, and Piedmont Healthcare. The contract was ultimately settled to include quality measures, but two of Piedmont's hospitals and its doctor group were out of the BCBS network for a month.

"We felt we had to take a stand for what is right. These insurance companies are big conglomerates that are becoming very profitable on the care we provide," said Piedmont spokeswoman Nina Montanaro said.

Hospitals aren't exempt from allegations that their demands for higher rates are designed to bolster their finances. Several of the recent battles involved HCA, which is slated to go private in a leveraged buyout. Some analysts suggested HCA needs to increase its cash flow to pare down the debt resulting from the deal. HCA spokesman Ed Fishbough denied that speculation.

HCA and UnitedHealth reached a nationwide agreement earlier this month, ending nasty disputes that banished hospitals in Denver, Southern Florida and Tampa, Fla. from the insurer's network for nearly two months.

HCA is still battling over rates with Sierra in Las Vegas for a contract that expires in December. Sierra has said the potential loss of HCA hospitals will hurt its 2007 earnings, but that it shouldn't be a problem by 2008. HCA said it will be able to replace the 28 percent of its business it derives from Sierra.

Jonathon Bunker, president and COO of Sierra, said HCA is seeking four times the rate increase given to other hospitals, and if it conceded to that demand other institutions would demand similar deals, forcing premiums hikes.

Bunker assailed HCA's ad, which he said falsely told patients they might need to leave the state for lifesaving treatments. He said only pediatric cardiology is not offered elsewhere and that other area hospitals were working to lure such specialists.

"What has taken us by surprise is how vindictive they have been in attacking us," Bunker said.

HCA countered the old contract has been in place for 17 years and the amount Sierra pays doesn't cover expenses.

"The disruption in the community will be great" if Sierra excludes HCA because there are not a lot of empty beds in the area, said Amy Stevens, system vice president of four HCA hospitals in Las Vegas.

Disruption is an issue in a $50 million lawsuit filed against UnitedHealth by Flushing Hospital Medical Center and Jamaica Hospital Medical Center, which are part of the same network in New York.

The suit claims UnitedHealth repeatedly and erroneously told members that Flushing wasn't in its network and Oxford Health, a unit of UnitedHealth, mirrored such behavior regarding Jamaica Hospital, costing them business. The suit also claims Oxford postponed signing contracts with both hospitals to avoid paying them higher negotiated fees.

David Rosen, president and CEO of both hospitals, said Oxford backdated the Jamaica contract to prevent him from terminating it, and accused Unitedhealth of having an unethical culture which puts profits and executive salaries above patient care. Recently, UnitedHealth acknowledged stock options awarded to its CEO may have been backdated, which increased their worth.

UnitedHealth spokesman Tyler Mason said the company will fight the suit and denied the company was unethical. Mason said the contract dating issue was a misunderstanding and the hospitals were compensated for any shortfall that resulted from payments at old rates.

Mason added that Oxford's belief that Jamaica was leaving the network moved it tell members and doctors that it had left the stable. Letters were subsequently sent to members and providers, saying Jamaica remained in the network. Maria Gordon Shydlo, another UnitedHealth spokesperson, said the Flushing allegations are false.

Meanwhile, employers and patients sit on the sidelines of the disputes, attempting to figure out how they'll be affected.

"They (the health plans) couch this as 'we are trying to lower costs', but we don't know if they are just trying to get more from the health care system," said Joe Hodas, spokesman of Frontier Airlines Holdings Inc. The Denver-based airline will drop UnitedHealth next year, in part because HCA's hospitals had been banned from its network while negotiations were going on.

The ultimate losers may be the patients, who have to adapt to changing networks of hospitals and doctors, experts said.

"The poor consumer is being told to do a better job researching their health care and then find out the facility they want isn't in their network," said Jane DuBose, health plan analyst for HealthLeaders-InterStudy, a health plan research company. "Our health care model still leaves the consumer at the bottom of the heap."

ASSOCIATED PRESS

December 1, 2006

Health Hearings

New York - The state assembly is holding a hearing on health care and consolidating hospitals in New York State today. The President of a hospital group in the city says health insurance companies are a key reason why healthcare in New York is declining. David Rosen is President of MediSys Health Network, which includes three hospitals. He is to testify today that Health Maintenance Organizations are the "800 pound gorilla" being ignored in the healthcare discussion. Rosen says HMOs routinely deny claims they are supposed to pay. He says for the 8th year in row New York State hospitals have lost money totaling 2 billion dollars, however in 2005 HMOs reported profits of more than 1 billion dollars. Rosen says money paid by policy holders into the healthcare pipeline is being kept by insurance companies rather then being forwarded to hospitals and healthcare providers.

HealthLeaders Media

May 2007

Throwing Stones at the Big Boys

People tell me major health insurers are "rackets" more often than you might think. Usually this stuff comes from certifiable crackpots. But my ears perked up when I heard about a lawsuit between a hospital system and the nation's second-largest insurer.

When I spoke with David Rosen, who for 30 years has been president and CEO of MediSys Health Network, he was calm, collected and tired from a tussle he never wanted. Rosen says Oxford Health Plans, a unit of the nation's second-largest health insurer, United Health Group, should be punished under the Racketeer Influenced and Corrupt Organization Act—the same law associated with convicting organized crime figures.

In its federal lawsuit, MediSys says United Health Group has implemented a "rogue business plan on a national level" that "contributed to UHG's profits, which, in turn, have been utilized in attempts to justify outlandish compensation to [former United CEO William] McGuire, other UHG senior executives and managers of its business groups."

How did a dispute over a couple of local hospital payer contracts lead to a federal RICO suit? MediSys, an urban system in the New York boroughs of Queens and Brooklyn with 1,200 acute beds and three hospitals, among other holdings, services a working class population. Rosen alleges that United bullies dozens of smaller hospital systems like his across the country that compete for business with large academic medical centers, while treating AMCs comparatively well.

The lawsuit, filed in the U.S. District Court, Eastern District of New York, centers on provider contracts that came up for renewal at different times in 2004 for Jamaica Hospital and Flushing Hospital. It accuses Oxford of telling its members falsely that Jamaica and Flushing were out-of-network providers while MediSys and Oxford disputed the implementation of two signed contracts over a period of years. Meanwhile, United continued to pay the hospitals under old lower rates and selectively told patients they would be responsible for a larger portion of their bill should they choose to have procedures done at a MediSys facility, the suit contends. Rosen says this behavior was motivated by Oxford's desire to coerce MediSys into cajoling an independent, fee-for-service anesthesiology group into accepting Oxford's network terms.

Rosen says “it’s lonely out there being the only guy throwing stones,” and that he never wanted to file a lawsuit. Another MediSys facility, Brookdale University Hospital and Medical Center in Brooklyn, has since filed a lawsuit of its own against Health Insurance Plan of Greater New York alleging the managed care organization conspired with physicians to improperly deny coverage to patients. However the UHG case turns out, Rosen says he’s surprised that Oxford chose to escalate to this level instead of simply executing the signed contracts and paying the hospitals retroactively. “But frankly, now we’ve reached the point where they can’t come in here and settle very easily.”

—Philip Betbeze

MODERN PHYSICIAN

Aug 6, 2007

Hospitalists' role at center of racketeering lawsuit

Perhaps it was inevitable, but a prominent company that is part of the fastest growing specialty in medicine finds itself in the middle of a coverage disagreement between a hospital and an insurer.


Russell Holman, M.D.

The charge is racketeering, and hospitalists—those site-based specialists touted for improving hospital quality, lowering costs and taking the pressure off overburdened primary-care physicians—have been caught in the crossfire.

Brookdale University Hospital and Medical Center, a 960-bed facility in New York, names the Health Insurance Plan of Greater New York and privately held Cogent Healthcare, a Nashville-based provider of hospitalists programs, in a Racketeer Influenced and Corrupt Organizations Act lawsuit filed in U.S. District Court in New York in April. Brookdale, part of the three-hospital MediSys Health Network, accuses the health plan and hospitalist company of using "a pattern of racketeering activity" to deny coverage to HIP members.

Cogent was "a Trojan horse," brought into the hospital by HIP to improperly unleash its hospitalists to conduct utilization review rather than care for patients, says David Rosen, president and chief executive officer of Brookdale and MediSys.

If Cogent were merely acting as an employment agency placing hospitalists in hospitals, "that would be fine because their loyalty would be to their patients," Rosen says. "If they are functioning as utilization review, their loyalty is not to patients, which implicates the proscription against the corporate practice of medicine."

Still in the discovery process, the lawsuit nevertheless raises questions regarding just who commands the loyalty of hospitalists, who are proliferating faster than emergency

room doctors and will soon dwarf by number nearly every other specialty, according to the Society of Hospital Medicine. Barely 10 years old, the practice of hospital medicine has grown to 20,000 today and is expected to reach 30,000 by 2010, eventually topping out at 40,000, says Larry Wellikson, M.D., CEO of the society.

"The hospitalist movement has so much momentum," Wellikson says. "We like to think of ourselves as the iPod of healthcare." By that he says he means the specialty has advanced by leaps and bounds technologically while costs have come down. "That's why insurers love us as well as hospitals and surgeons because of the opportunity to get better care for less money. This is an evolution in healthcare," he adds.

Still, a study by research company Thomson Healthcare found mixed results when measuring the impact hospitalists have had on hospital care, finding that hospitals using them may experience shorter lengths of stay and improved mortality rates. But there was no indication that hospitalists markedly lowered costs, improved patient safety or reduced complications.

Rosen himself says MediSys hospitals have employed hospitalists for many years to ease the transition and improve efficiencies. Many patients admitted to the hospitals through the emergency room don't have their own physicians, and "it's important to have people prepared to take cases on duty and make judgments early on," he says. "We want people who are highly skilled and know how to maximize efficiencies in the hospital."

But that's not how it worked with Cogent, Rosen says. According to a news release, HIP "convinced Brookdale to implement a 'hospitalist utilization monitoring program' using HIP's 'consultant' Cogent to provide doctors and nurses purportedly 'specially trained' to deal with hospital practices and procedures."

The complaint alleges that HIP and Cogent conspired to use the "licenses of physicians to allow nonphysicians to make adverse determinations regarding coverage of hospital care for HIP members, as evidenced by such irrelevant and unbelievable justifications for denying coverage that they could not have been made by a licensed physician," the news release says. The denials resulted in losses for Brookdale of one dollar out of every five that HIP should have paid it for care provided to HIP members, Rosen charges.

HIP declined to be interviewed for this story but in a written statement says, “Hospitalists have been very effective in improving the quality of patient care through enhanced coordination in other parts of the country. HIP is pleased to bring this effective strategy, based on patient advocacy, to the New York metropolitan area.”

For its part, Cogent said in a written statement that it “is disappointed” that Brookdale included the company as a defendant in what amounts to a reimbursement dispute between the hospital and HIP. The company denies that it makes any coverage or payment decisions “pursuant to the express terms of its agreement with HIP.” Although officials also admit that the “client arrangement with HIP is unique in that the company’s client is a health plan, as opposed to the usual case where Cogent is invited by a hospital or health system into their facilities to provide hospitalist program expertise and support.” Like HIP, Cogent notes in the statement that Brookdale is “a struggling hospital at odds with a significant payer.”

Just how unusual the arrangement between Cogent and HIP might be is revealed in a survey conducted by the hospitalist society in 2005-06. More than one-third—34% of all hospitalists—are employed by hospitals or hospital corporations, based on the responses of 396 hospital medicine groups representing 2,550 hospitalists.

Another 20% are employed by academic institutions, 19% by hospitalist-only groups or management companies like Cogent, and 12% by local hospitalist-only groups. The remainder is employed by multispecialty or primary-care medical groups. Health insurance companies were not even on the radar.

Russell Holman, M.D., Cogent’s chief operating officer and also president of the Society of Hospital Medicine, says with this possible exception, “Cogent never works for insurance companies.” Indeed at Brookdale, the physicians employed by Cogent had previously worked for a long time for a New York medical group.

Cogent’s business model varies so that sometimes it employs hospitalists directly, and other times the company may have a joint venture relationship or be employed by a hospital. Commonly, Cogent employs the doctors and manages “the infrastructure around the doctors to provide a comprehensive program for caring for hospitalized patients,” Holman says.

Regardless of the model, the hospitalists’ first loyalty is to the patient, Holman says. “There are multiple stakeholders involved in the care of hospitalized patients. You have the physicians who work for us, the hospital itself, referring physicians from the

community and outlying areas and other physicians working within the hospital, but most importantly you have patients," Holman says. "I think if we were to conduct a survey, patients would be the absolute first starting point, and then you would look at other stakeholders along the way. That's what it all boils down to."

Wellikson, who says he had heard Cogent was sued but knew no other details, says he doubts the lawsuit will do anything to slow the specialty's momentum. Even Rosen says he doesn't believe the lawsuit casts dispersions on the specialty itself. "There is nothing wrong with being a hospitalist," Rosen says. "What you have here are these guys who were really not hospitalists. They were utilization review people. That's what our argument is. We're making the allegation, but there is a lot to be learned once we get into discovery."

The New York Times

February 16, 2007

OP-ED COLUMNIST

The Health Care Racket

By PAUL KRUGMAN

Is the health insurance business a racket? Yes, literally — or so say two New York hospitals, which have filed a racketeering lawsuit against UnitedHealth Group and several of its affiliates.

I don't know how the case will turn out. But whatever happens in court, the lawsuit illustrates perfectly the dysfunctional nature of our health insurance system, a system in which resources that could have been used to pay for medical care are instead wasted in a zero-sum struggle over who ends up with the bill.

The two hospitals accuse UnitedHealth of operating a "rogue business plan" designed to avoid paying clients' medical bills. For example, the suit alleges that patients were falsely told that Flushing Hospital was "not a network provider" so UnitedHealth did not pay the full network rate. UnitedHealth has already settled charges of misleading clients about providers' status brought by New York's attorney general: the company paid restitution to plan members, while attributing the problem to computer errors.

The legal outcome will presumably turn on whether there was deception as well as denial — on whether it can be proved that UnitedHealth deliberately misled plan members. But it's a fact that insurers spend a lot of money looking for ways to reject insurance claims. And health care providers, in turn, spend billions on "denial management," employing specialist firms — including Ingenix, a subsidiary of, yes, UnitedHealth — to fight the insurers.

So it's an arms race between insurers, who deploy software and manpower trying to find claims they can reject, and doctors and hospitals, who deploy their own forces in an effort to outsmart or challenge the insurers. And the cost of this arms race ends up being borne by the public, in the form of higher health care prices and higher insurance premiums.

Of course, rejecting claims is a clumsy way to deny coverage. The best way for an insurer to avoid paying medical bills is to avoid selling insurance to people who really need it. An insurance company can accomplish this in two ways, through marketing that targets the healthy, and through underwriting: rejecting the sick or charging them higher premiums.

Like denial management, however, marketing and underwriting cost a lot of money. McKinsey & Company, the consulting firm, recently released an important report dissecting the reasons America spends so much more on health care than other wealthy nations. One major factor is that we spend $98 billion a year in excess administrative costs, with more than half of the total accounted for by marketing and underwriting — costs that don't exist in single-payer systems.

And this is just part of the story. McKinsey's estimate of excess administrative costs counts only the costs of insurers. It doesn't, as the report concedes, include other "important consequences of the multipayor system," like the extra costs imposed on providers. The sums doctors pay to denial management specialists are just one example.

Incidentally, while insurers are very good at saying no to doctors, hospitals and patients, they're not very good at saying no to more powerful players. Drug companies, in particular, charge much higher prices in the United States than they do in countries like Canada, where the government health care system does the bargaining. McKinsey estimates that the United States pays $66 billion a year in excess drug costs, and overpays for medical devices like knee and hip implants, too.

To put these numbers in perspective: McKinsey estimates the cost of providing full medical care to all of America's uninsured at $77 billion a year. Either eliminating the excess administrative costs of private health insurers, or paying what the rest of the world pays for drugs and medical devices, would by itself more or less pay the cost of covering all the uninsured. And that doesn't count the many other costs imposed by the fragmentation of our health care system.

Which brings us back to the racketeering lawsuit. If UnitedHealth can be shown to have broken the law — and let's just say that this company, which is America's second-largest health insurer, has a reputation for playing even rougher than its competitors — by all means, let's see justice done. But the larger problem isn't the behavior of any individual company. It's the ugly incentives provided by a system in which giving care is punished, while denying it is rewarded.

Business Insurance
AMERICAS / EUROPE

February 08 11:23:00, 2007

Hospitals sue UnitedHealth over claims practices

By Douglas McLeod

NEW YORK—A civil racketeering lawsuit filed by two New York hospitals charges that UnitedHealth Group Inc. and several of its affiliates systematically defrauded hospitals and UnitedHealth members with alleged schemes to deny legitimate claims.

New York-based Jamaica Hospital Medical Center Inc. and Flushing Hospital Medical Center Inc. filed the suit in U.S. District Court in Brooklyn, naming Minneapolis-based UnitedHealth, several top UnitedHealth officers, Oxford Health Plan (NY) Inc. and other UnitedHealth units.

The complaint alleges that UnitedHealth has pursued a fraudulent plan to boost its own profits by deceiving members of its health plans and shortchanging health care providers.

UnitedHealth plans have repeatedly provided members with inaccurate information about participating providers, and have shifted costs to members and providers by falsely claiming that participating providers are "out of network," the suit charges.

The two hospitals also charge that UnitedHealth plans "distorted" the utilization review process, delaying reviews while hospitals treated members but later denying payments and depriving the hospitals of an effective right of appeal.

A UnitedHealth spokesman said the hospitals' charges are without merit. The spokesman added that similar charges brought by the hospitals in a New York state court have been ordered arbitrated. David P. Rosen, the hospitals' president and chief executive officer, countered that the racketeering suit's allegations go beyond those in the state court case and are not subject to arbitration provisions of the hospitals' UnitedHealth contracts.

United Healthcare Insurance Co. of New York, a UnitedHealth unit named in the lawsuit, recently settled charges by the New York Attorney General that it misled members about the providers participating in one of its plans. United Healthcare said computer errors caused providers to be included in its directories mistakenly over a five-year period. The company agreed to several business reforms and to pay restitution to plan members.

ASSOCIATED PRESS

February 6, 2007

2 Hospitals Allege RICO Violations by UnitedHealth in Contract Negotiations

By JOSHUA FREED, AP Business Writer

MINNEAPOLIS (AP) - Two New York hospitals said they sued insurer UnitedHealth Group Inc. on Tuesday alleging "a pattern of racketeering activity."

The lawsuit by Flushing Hospital Medical Center and Jamaica Hospital Medical Center was brought under the Racketeer Influenced and Corrupt Organizations law and filed in federal court in the Eastern District of New York, according to Idan Sims, a spokesman for the hospitals. It claims at least $50 million in punitive damages, along with millions more in actual damages.

The same hospitals sued under a similar set of facts last year in state court in New York. Both lawsuits claim UnitedHealth cost them business by repeatedly telling patients that Flushing was not in its network and that Oxford Health, which was bought by UnitedHealth, did the same thing to patients at Jamaica Hospital.

The dispute stems from contract negotiations between the insurers and the hospitals. The lawsuit also claims Oxford postponed signing contracts with both hospitals to avoid paying them higher negotiated fees.

The new lawsuit claims that UnitedHealth also has been providing inaccurate information about whether other providers are in its network, including a 2003 case related to a health plan for New York civil service employees, and similar allegations by the Nebraska Department of Insurance.

"This behavior persists to this day. And the consequence of that is the patients pay more for the services that they purchased in their health care coverage," said David Rosen, chief executive of Flushing and Jamaica hospitals and their parent company, MediSys Health Network.

He said that UnitedHealth last month denied a patient's appeal for in-network coverage for a surgical procedure at Flushing and billed the patient for $1,100 more than she should have had to pay.

"It's $1,100 on the case I just described, and $1,000 on the next case. These are things that are inappropriately enriching the company," he said.

Rosen said the federal case would supercede the state case, which he said was headed for arbitration.

Tyler Mason, a spokesman for Minnetonka-based UnitedHealth, pointed out that both hospitals ultimately remained in the network. He said he had not seen the new lawsuit, but said the company believes arbitration is the best way to work out the dispute.

ASSOCIATED PRESS

April 18, 2007

Fed up with claims denials, hospital accuses HMO of racketeering

By DAVID B. CARUSO, AP

NEW YORK (AP) - A hospital network tired of having its bills challenged by HMOs has decided to play rough. Its members are suing two of the region's largest health insurers, claiming each tried to weasel out of paying for millions of dollars in patient care.

In the latest suit, filed last week, the Brooklyn-based Brookdale University Hospital and Medical Center accused the 1.3 million-member Health Insurance Plan of Greater New York of engaging in an illegal conspiracy to routinely reject valid claims.

Brookdale's chief executive, David Rosen, said the managed care company refused to pay for more than 1 of every 5 days its patients spent at the hospital last year. Often, those rejections were on the grounds that the treatment was not medically necessary.

The lawsuit said many of those denials were baseless, and it cited the example of one patient who spent 11 days at Brookdale after having surgery for a malignant brain tumor.

The gravely ill woman suffered from brain swelling and organ failure and was fed through a tube during her hospital stay. But, according to the lawsuit, the HMO ultimately refused to pay for her final eight days of care, saying "the patient was medically stable."

Brookdale's lawsuit said the HMO's actions amount to civil racketeering, and cost the hospital at least $8 million.

Health Insurance Plan executives denied any wrongdoing, and issued a statement calling the federal suit "profoundly dishonest and defamatory" - an effort by Brookdale to "distract attention from its own financial distress and possible mismanagement."

"Brookdale believes that it should be free of any oversight or review and is willing to make baseless allegations to get its way," the statement said. "HIP will resist these tactics and will not sacrifice requiring appropriate care simply because Brookdale wants to increase its revenue."

The lawsuit is similar to one filed last spring by two of Brookdale's sister hospitals in Queens against another big insurer, UnitedHealth Group Inc.

In that case, Jamaica Hospital Medical Center and Flushing Hospital Medical Center claimed they had been shortchanged by millions of dollars by UnitedHealth's managed care subsidiary, Oxford Health. The suit said Oxford had promised to increase its payment rates to the hospitals after a contract negotiation, but continued to pay the old rates for more than a year.

The case, also filed in federal court in Brooklyn, is still pending. A UnitedHealth spokeswoman did not return phone messages Wednesday.

Rosen, who is the CEO of all three hospitals, said state regulators have not acted aggressively enough on industry malfeasance, leaving it up to medical centers to fight on their own.

"We're saying, this can't go on, and if I can't get attention at the regulatory level, what am I supposed to do?" he said.

Brookdale's new lawsuit also accused a group of doctors affiliated with a national health care company, Cogent Healthcare Inc., of secretly aiding Health Insurance Plan's attempts to slash valid claims.

The suit said the doctors, who were brought to the hospital at the HMO's request, were given incentives to write patient records in a way that would make it easier for the insurer to reject claims later.

Cogent said its doctors had nothing to do with HIP's coverage or payment decisions. "We believe the accusations against us are without merit and we intend to defend our company vigorously," said spokeswoman Anne S. Hancock.

CRAIN'S HEALTH pulse
A daily newsletter on the business of health care

Friday, September 7, 2007

United Settlement Has Critics

For Dave Rosen, the multistate settlement with UnitedHealthcare is a vindication of sorts. Mr. Rosen, chief executive of Jamaica and Brookdale hospitals, has two lawsuits pending against United: one an appeal in state court, the other a RICO suit filed in federal court.

"The United settlement reflects many of the same charges in our federal racketeering lawsuit," says Mr. Rosen, who has long insisted that claims-processing issues at United were a national, not a local, issue. "But this settlement doesn't scratch the surface."

Mr. Rosen contends that United systematically boosted earnings by not paying out claims because of its "problem ridden MIS system."

A United spokesman says that while a state court ruled that arbitration is the proper venue for Mr. Rosen's disputes with United—the decision that Jamaica is appealing—"we are continually trying to talk with them."

The spokesman adds that United expects past issues to be resolved through a new national improvement plan.

Yesterday, United agreed to pay New York $4 million to settle claims-processing problems. The settlement has no direct impact on Mr. Rosen's lawsuits.

New York state will receive the biggest share of the $13 million that United agreed to pay to 36 states and Washington, D.C. Some $320,000 of the New York settlement is from a separate agreement, because the insurer violated the state's prompt-payment statute and claim-appeal rules.

THE ASSOCIATED PRESS

December 19, 2007

N.Y. Hospital Accuses UnitedHealth Unit of Age Discrimination

MINNEAPOLIS (AP) - A UnitedHealth Group Inc. subsidiary engages in age discrimination against people enrolled in Medicare Advantage, a New York hospital alleged Wednesday.

Jamaica Hospital Medical Center in Queens released data it said shows a pattern of age discrimination by Oxford Health Plans in its denials of coverage for acute rehabilitation and traumatic brain injury patients.

UnitedHealth spokeswoman Kathleen Harrington called the accusations "preposterous" and said the company follows Medicare guidelines, which she said sometimes require that acute rehabilitation take place in non-hospital settings.

Jamaica Hospital said that from Jan. 1, 2006, to Aug. 2, 2007, of 58 Oxford-insured patients who were referred by medical professionals for acute rehabilitation or traumatic brain injury rehabilitation, 46 were denied coverage, an 80 percent denial rate.

"Our data clearly shows a pattern of age discrimination by Oxford that can be characterized as 'elder abuse,'" David P. Rosen, chief executive of the hospital and its parent company, MediSys Health Network, said in a statement.

Rosen said Oxford rarely denied coverage for younger patients for those services. He said the only difference was age.

Many of the patients included in that data belong to Oxford's Medicare Advantage program and were frequently denied coverage for required medical treatment that would have been automatically covered under traditional Medicare, the hospital said. Under Medicare Advantage programs, the government pays insurance companies for taking on the risk of covering elderly patients' health needs.

But Harrington said it's a mistake to apply the standards of commercial plans to the Medicare plan in question. She said for Medicare to cover rehabilitation in a hospital, the patient has to meet certain criteria - "a number of different faculties have to be impaired," she said, and if they're not then Medicare requires the rehabilitation take place in a community facility or even in the home.

The hospital has not filed a lawsuit or complaint with regulators.

On the Net:

Jamaica Hospital Medical Center: http://www.jamaicahospital.org
UnitedHealth Group: http://www.unitedhealthgroup.com

Senior With Fractured Back Battles Insurance Company

Hospital Says Medicare Advantage Plan Would Not Authorize Woman's Care

To view video go to: http://www.youtube.com/watch?v=H8erunWFyT4

By CHRIS CUOMO, JAY SHAYLOR AND JONANN BRADY

NEW YORK, Dec. 21, 2007—

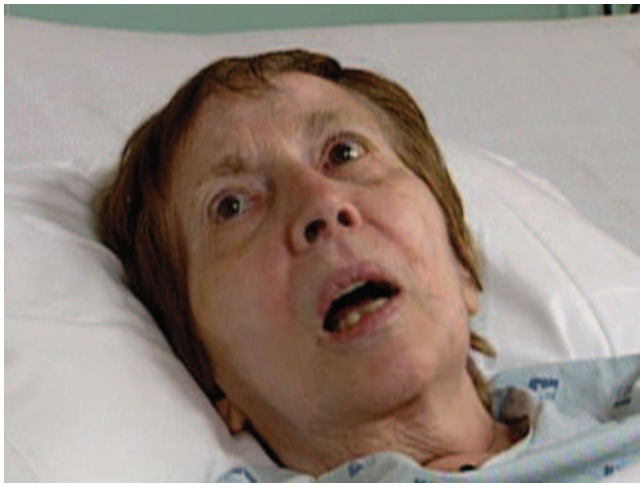
Seventy-seven-year-old Angela Dispenza considers herself fiercely independent. She lives in a modest home with her 83-year-old sister in Queens, N.Y., where she tends her garden and walks to mass each Sunday. She says she loves to spend time in her neighborhood.

The one place she does not like being is in the hospital.

But this summer, the usually active senior citizen found herself on a stretcher in the emergency room at nearby Jamaica Hospital after falling at home.

"I don't want to be here," Dispenza said of her hospital stay. "I've got a house to take care of [and] bills."

Dispenza's family says after the fall, she could not care for herself, much less her home.



After her insurance company wouldn't authorize hospital treatment for her fractured spine, 77-year-old Angela Dispenza thought she'd be left at home to "stay in my bed and die." (ABC News)

After her pain became too much to handle, she was brought to the hospital, where doctors diagnosed Dispenza with a fractured spine.

Multiple physicians confirmed the finding and recommended that Dispenza be admitted to the hospital for pain management and further treatment. But when hospital staff asked Dispenza's insurance company, Oxford, to authorize her admission to the hospital, the company refused.

Hospital workers say they tried repeatedly to explain to representatives from Oxford why Dispenza needed to be admitted.

Lisa Schneider, the director of social work at Jamaica Hospital, said the insurance company told staff members that "she's not for admission," and "that she did not need to be in the hospital."

Medicare Advantage

Schneider says she was surprised by the difficulty staff members had getting Dispenza's care approved, because she is a senior citizen.

That's because most seniors in the United States are enrolled in the government-run health care system called Medicare. As part of the program, seniors are typically treated immediately by hospitals and doctors when they need care.

Medicare does not require patients to receive "pre-authorization" before being treated. The government negotiates the rates at which it will reimburse medical providers for the medical care in advance, and pays providers once the care is provided.

While Dispenza had the option to enroll in the government-run Medicare system when she reached retirement age, several years ago she and her sister opted to enroll in a new version of the program called Medicare Advantage, which is run by private insurance companies.

Originally called Medicare Choice, the program was conceived during the Clinton administration as a way to reduce the escalating cost of Medicare. Supporters argued private insurers could provide medical services to seniors more efficiently than Washington, and could reduce the amount of money the government spent on the program. The program remained small through most of the 1990s.

During the Bush administration's push to add prescription drug coverage to Medicare during 2002 and 2003, the program renamed Medicare Advantage was overhauled. To entice insurers to create Medicare Advantage plans and enroll seniors, the annual government payments to participating insurers were increased. Almost immediately, analysts say, insurance companies saw a potential financial windfall and began creating new plans and signing up seniors.

As of November 2007, nearly 9 million seniors or 1 in 5 of those enrolled in Medicare have opted for a Medicare Advantage plan.

But as enrollment has swelled and new plans created, critics have become more vocal in their complaints about how Medicare Advantage works.

David P. Rosen, the president and CEO of Jamaica Hospital, said he believes the program is short-changing seniors like Dispenza.

Rosen said this is especially true in areas where the hospital must receive "pre-authorization" from a senior's Medicare Advantage plan before treating a patient.

"We see frequent evidence of denial of care that would have been a no-brainer under the conventional Medicare program," Rosen said.

Government audits and other reports appear to back up Rosen's concerns. ABC News reviewed hundreds of audit reports created by the Centers for Medicare and Medicaid Services. The audits showed Medicare Advantage providers with backlogs of unanswered patient complaints, plans that improperly denied claims, and concerns about marketing practices which do not follow government guidelines.

'Not Medically Necessary'

In Dispenza's case, her Medicare Advantage plan which is run by United Healthcare's subsidiary, Oxford denied a series of pre-authorization requests by Jamaica hospital staff.

Despite Oxford's refusal to authorize payment for the care, Jamaica Hospital says it had no choice but to treat Dispenza, because of the condition she was in. To send her home, Rosen said, would have been tantamount to malpractice. So doctors admitted Dispenza to an in-patient room after she arrived in the emergency room, and began providing her pain medication.

Staff members say even after Dispenza was admitted, they continued to call the insurer to ask Oxford to authorize her stay. Without the authorization, the hospital says, Oxford will not pay for any of the care it provides, even if doctors believe it is necessary.

In a wide-ranging interview with "Good Morning America's" Chris Cuomo, staff members who cared for Dispenza said no matter what evidence supporting the need for Dispenza's care the hospital provided to Oxford, requests for authorization were denied.

ABC News reviewed medical records, voice mail recordings and letters sent by Oxford that support the staff members' claims.

Schneider said she was especially disheartened by Oxford's refusal to pay for acute, or in-patient rehabilitation, a type of intensive physical therapy offered in the hospital, even though Dispenza's doctors said it provided the best chance for her to walk again.

Nicole Barone, a social worker who worked with Dispenza, says the type of rehabilitation the hospital requested did not seem unusual for the injuries Dispenza sustained.

Yet, Barone says the case manager at Oxford, who had never met Dispenza, told her the senior was not a candidate for rehabilitation and would be better off living in long-term care facility than living at home.

"She said that I should go in and speak to the family regarding whether they wanted to privately pay for her to go into a nursing home," Barone said.

Barone said she was told Oxford would not cover nursing home expenses.

Frustrated by her interactions with the case manager, Barone asked her supervisor, Schneider, for assistance.

"We had basically begged them, give us a week," Schneider said. "Try her for a week. If she doesn't work for a week, then what are you gonna do? You're not gonna pay us, anyway? We're going to be in the same boat we're in now."

But Schneider said the company told hospital staff "no."

"Absolutely not," Schneider said.

ABC News obtained a copy of a letter Oxford sent to Dispenza in August 2007. The letter said acute rehabilitation was "not medically necessary" for her.

Good Business?

Critics of the program including Jamaica's CEO, Rosen say denying care for Medicare Advantage patients is not good medicine. But, Rosen said, it is good business for insurance companies.

"They're making a lot of money," Rosen said. "All you need to do is look at their financials."

Last year, Oxford's parent company, United Healthcare, made more than $4 billion. Analysts say some of that profit came from the strength of the company's Medicare Advantage products, which are paid for by the federal government.

In fact, Democrats in Congress have now begun investigating the rates Washington pays to insurance companies. Recent reports by several government agencies including the Congressional Budget Office show Medicare Advantage plans actually cost the government an average of 12 percent more each year to run than traditional Medicare, even though the program was designed to save tax dollars.

'Stay in My Bed And Die'

Barone said after Oxford refused to authorize Dispenza's treatment, the hospital was told to send her home. Dispenza was in too much pain to ride in a regular car, Barone said, so she was sent home in the back of an ambulance.

Barone was asked to tell Dispenza about Oxford's decision. "She said, 'well, I guess I'm just gonna stay in my bed, then, and die.'"

After a week at home, Dispenza was back in the emergency room after a therapist visiting her discovered she had developed bed sores. Jamaica Hospital says it admitted Dispenza again without Oxford's pre-authorization.

In an interview with Chris Cuomo, Dispenza said she was frustrated by the repeated denials from Oxford.

"How dare you do these things to me!" Dispenza told Cuomo when asked what she would say to Oxford. "I was paying every year. Every year. I never failed to pay. That's why they took me in."

Dispenza told Cuomo she just wanted to leave the hospital walking.

ABC News asked Oxford and its parent company United Healthcare to respond to Dispenza's situation on camera. The company refused and directed ABC News to the insurance industry's trade group, America's Health Insurance Plans.

In an interview with Cuomo, the group's spokesperson, Susan Pisano, said seniors who are enrolled in Medicare Advantage, receive better care than those enrolled in traditional Medicare.

"One thing you get if you join the Medicare Advantage plan is better benefits, get broader benefits, you get lower out-of-pocket costs," Pisano said.

While seniors may get broader benefits, however, the program does have a trade-off: Medicare Advantage plans decide what care seniors get.

Pisano told Cuomo that insurance companies' decisions about whether or not someone is admitted to the hospital is "not just a question of money."

"People should be admitted to a hospital when they need to be admitted to a hospital," Pisano said. "But if they shouldn't be there, then a hospital brings risks with it that shouldn't you shouldn't have to confront unnecessarily."

"Do you think that happens a lot that somebody goes to the hospital and doesn't really need to be there?" Cuomo asked.

Pisano asked if Cuomo was talking about a particular patient.

"No, literally, I could be talking about hundreds of patients," Cuomo said. "The insurance companies will not talk to me about the specific cases. How are you supposed to get answers?"

"Well, I think, culturally, it's not something that companies are attuned to, talking about specific, you know, private patient issues publicly," Pisano said.

Rehabilitation

Even though United Healthcare refused to authorize payment for in-patient rehabilitation for Dispenza, the hospital provided it to her this fall, anyway. Rosen said the hospital had both a moral and legal obligation to assist her, even without insurance company approval.

Cuomo also filed an appeal on behalf of Dispenza, after she designated him her authorized representative to the insurer. The appeal was written on ABC News stationary and detailed the care the insurance company apparently refused to authorize.

United Healthcare responded to the appeal a month after it was sent.

The company's response did not directly answer the questions in the appeal, nor did it explain if the company was wrong to refuse authorization for Dispenza's care.

The letter did, however, state that Dispenza was not responsible for any payment beyond her usual co-payments for the care she received. United Healthcare said in the letter the payment issue was between the company and the hospital.

Going Home

Dispenza said she is lucky, because she received in-patient rehabilitation from Jamaica Hospital, despite Oxford's refusal to authorize her treatment.

After several weeks of rehabilitation, Dispenza is now getting around with the aid of a walker. She was recently discharged from the hospital and is now home with her sister and her garden.

TRANSCRIPT

Jamaica Hospital Medical Center Battles Health Insurer On Behalf Of Patient

CHRIS CUOMO, co-host: But first, for all the politicking going on in Iowa, one of the most important issues on the table is getting little attention. Senior citizens in Iowa and all around the country are being bombarded with pitches for something called Medicare Advantage. Now, this is a privately run controversial alternative to traditional Medicare. It promises big savings and better benefits, but there are serious concerns, which we learned through one woman's experience in our latest installment of GMA Gets Answers.

Ms. ANGELA DISPENZA (Medicare Advantage Patient): I don't like staying in the bed.

CUOMO: For a fiercely independent woman like 77-year-old Angela Dispenza, being stuck here is unbearable.

Ms. DISPENZA: I don't want to be here. I got--you know, I got a house to take care, bills.

CUOMO: But over the summer, this usually active widow from Queens, New York slipped and fell. Instead of tending her garden or walking to mass, Angela lay in bed, writhing in pain. She was rushed to the emergency room at Jamaica Hospital.

Ms. LISA SCHNEIDER (Director of Social Work, Jamaica Hospital): She had a fracture in her back.
CUOMO: Broken back.

Ms. SCHNEIDER: Yeah.

CUOMO: No question?

Ms. SCHNEIDER: No question.
CUOMO: But when hospital staff asked Angela's insurance company, Oxford, to admit her, the company said no. Did you tell the woman from the HMO that she had a broken back?

(Ms. Schneider nods yes)

CUOMO: And what was their response?

Ms. SCHNEIDER: That she's not--that she's not for admission; that she did not need to be in the hospital.

CUOMO: Usually when seniors visit a hospital, they're treated immediately as part of Medicare, but Angela isn't enrolled in traditional Medicare. Like more than 8,000,000 other seniors, she opted for an alternative program called Medicare Advantage, run by insurance companies. David Rosen is Jamaica Hospital's CEO. He says the program is short changing seniors like Angela.

Mr. DAVID P. ROSEN (President, CEO, Jamaica Hospital): We see frequent evidence of denial of care that would have been a no-brainer under the conventional Medicare program.

CUOMO: And, government audits show the problems are widespread. Backlogs of patient complaints; improperly denied claims and unethical marketing practices. In Angela's case, Oxford denied a series of requests by Jamaica's staff, including rehabilitation in the hospital. Doctors said it was Angela's best chance to walk again, but Oxford said inpatient rehab was not medically necessary.

Unusual thing to request in a situation like this, rehabilitation?

Ms. NICOLE BARONE (Social Worker, Jamaica Hospital): Of course not.

Ms. SCHNEIDER: We had--we had basically begged them. Give us a week; try her for a week. If she doesn't work for a week then what are you going to do? You're not going to pay us anyway, we're going to be in the same boat we're in right now. Just try her for a week--no.

CUOMO: No.

Ms. SCHNEIDER: No.

CUOMO: Surprised by what the HMO said?

Ms. SCHNEIDER: Stunned.

CUOMO: Critics like Rosen say denying care for Medicare Advantage patients isn't good medicine, but it is good business for insurance companies.
Mr. ROSEN: They're making a lot of money.

CUOMO: Last year, Oxford's parent company, United Healthcare, made more than $4 billion. Some of that profit came from you because Oxford and other companies are paid by Washington to run Medicare Advantage, even though government reports show it can cost as much as 20 percent more than the traditional program. Despite the higher price tag, critics say for some patients it's hard to see the advantage.

In Angela's case, rather than keeping her in the hospital for rehab, Oxford sent her home in the back of an ambulance.

Ms. BARONE: She said, well, I guess I'm just going to stay in my bed, then, and die.

CUOMO: A week later she was back at Jamaica Hospital with bed sores. That's when we met Angela.

What would you say to the insurance company?

Ms. DISPENZA: How dare you do these things to me? I was paying every year--every year. I never failed to pay. That's why they took me in.

CUOMO: And now you just want to get back—

Ms. DISPENZA: Get out of here.

CUOMO: Get up and get home.

Ms. DISPENZA: Yes.

CUOMO: But on your own two feet.

Ms. DISPENZA: Exactly.

CUOMO: We asked Oxford United Healthcare to sit down with us on camera, but the company declined. And like many other times when we've tried to get answers, we were directed to the insurance industry's trade group and its spokesperson, Susan Pisano.

Ms. SUSAN PISANO (Spokesperson, Insurance Industry): One thing you get if you join the Medicare Advantage plan is better benefits. You get broader benefits;you get lower out-of-pocket costs.

CUOMO: But, while seniors may get broader benefits, here is the tradeoff. Medicare Advantage plans decide what care they get.

You know you have these protracted discussions about whether or not somebody even gets into the hospital.
Ms. PISANO: It's not just a question of money.

CUOMO: What is it?

Ms. PISANO: People should be admitted to a hospital when they need to be admitted to a hospital.

CUOMO: Yes—

Ms. PISANO: But if they shouldn't be there, then a hospital brings risks with it that shouldn't--you shouldn't have to confront unnecessarily.

CUOMO: You think that happens a lot, that somebody goes to the hospital and doesn't really need to be there?

Ms. PISANO: OK, can I ask you, are we talking about a particular patient now?

CUOMO: No. Literally, I could be talking about hundreds of patients.

Ms. PISANO: No, OK. All right.

CUOMO: The insurance companies will not talk to me about the specific cases. How are you supposed to get answers?

Ms. PISANO: Well, I think that, culturally, it's not something that companies are attuned to, talking about specific, you know, private patient issues publicly.

CUOMO: When they're bad--when they're good, they'll talk to you about them all day long.

Like Joe Cameron, a favorite example for the industry. While Oxford United Healthcare wouldn't talk to us, it did point us to this former Texas insurance salesman. Cameron says he survived a massive heart attack in 2002, thanks to United Healthcare's Medicare Advantage plan, which paid for a quadruple bypass and several months of rehab.

Mr. JOE CAMERON (Medicare Advantage Plan User): My bill was $1,300,000. My co-pay was $1,700. That's an excellent coverage plan.

CUOMO: What United Healthcare didn't tell us is Cameron has been flying around the country to lobby in favor of the program. And Cameron says the insurance companies paid his travel expenses, including United Healthcare, the same company that sent Angela Dispenza a denial of coverage letter while she was still lying in Jamaica Hospital.

CUOMO: Your name, your identification number—

Now, that letter said Angela could appeal the decision. So, with her permission, GMA did just that. And a month later we got a response. The letter didn't say if Oxford was wrong to deny Angela's care or even who would pay her bills, but it did say that the issue was not for Angela, that it was between Oxford and Jamaica Hospital. Lucky for Angela, Jamaica Hospital gave her inpatient rehab, providing the same treatment Oxford called not medically necessary. And look at her now. Angela is back on her feet, walking. And she can't wait to go home.

Ms. DISPENZA: I'll be dancing. I'll be dancing.

CUOMO: She will be dancing and she is beautiful. Again, Angela was lucky here because she got the rehabilitation and the insurance company said she won't be billed for it. But Jamaica Hospital says it still hasn't been paid by Oxford and doesn't think it will be. In fact, the hospital's parent company is suing Oxford in federal court over issues just like this one.

And Kate, you know, we talked to a lot of experts who say patients aren't as lucky as Angela very often, that they get turned away by the hospital and this is something people have to think about.

KATE SNOW, co-host: Well, let's point out what the difference is in Angela's case--that letterhead from ABC News.

CUOMO: Maybe. Maybe. This hospital, to be frank, Jamaica Hospital, was lobbying very actively on her behalf.

SNOW: So, it could be partly that, too.

CUOMO: It could. It could. But we like to get involved In these things because you see someone like Angela and it takes your heart and it hurts it because you want to—

SNOW: But, you wonder how many other patients out there could use a letter from someone like you to go after the system.

CUOMO: That's exactly right. That's exactly right and that's why we do the stories, because the more people know about it, the more we pay attention, the more people there are to help people like Angela.

The New York Times
ON THE WEB

February 19, 2008
PATIENT MONEY | OUT OF NETWORK

Health Plans Put Onus on Insured

By REED ABELSON

Let the patient beware. Going outside your insurer's network of preferred doctors or hospitals could be even more hazardous to your financial health than you suspected.

The broad investigation that New York's attorney general announced last week, questioning the "reasonable and customary" calculations on which insurers base reimbursements for out-of-network medical services, raised the lid on a particularly confusing part of the nation's health care system.

For consumers, the issues go beyond whether insurers are underpaying for 15-minute visits to out-of-network doctors. The uncertainties can extend to the vast array of tests, services and even hospitalizations they may encounter on their medical journey — and the puzzle of determining which ones will be considered in network, out of network or paid for at all.

Of the estimated 54 million Americans who are covered by their employers' health plans, about three of four are in plans that give them the option of going out of network. And while most people covered under such plans probably understand that out-of-network services will cost them more, they may be startled to find out just how much more they may end up spending.

"There's a lot of confusion," said Tom Billet, an executive at the benefits consulting firm Watson Wyatt.

For starters, many people may assume that their insurer will reimburse them for a fixed percentage, perhaps 60 or 80 percent, of whatever the

medical bills turn out to be. But the calculation is actually much more complicated, experts say.

To determine how much of the medical bill they will pay, insurers calculate the so-called reasonable and customary charge for a given procedure or medical service and then pay a percentage of that amount, which is frequently much less than the doctor's or hospital's actual bill.

Through the insurer's calculations, for example, a $100 charge for a doctor's office visit may be assigned a "reasonable and customary" value of $60. And so the insurer, paying 80 percent of that amount, reimburses the patient only $48. The remaining $52 comes from the patient's pocket.

Ingenix, the company that provides the information insurers use to calculate those reimbursements, defends the accuracy of its data. Ingenix, owned by one of the nation's largest health insurers, UnitedHealth Group, says its data is based on the actual billed charges that it gathers from insurers nationwide.

But some consumers have started questioning those methods — like Errol Reiter, a 59-year-old consultant in a small Oregon city, Medford, who is suing his insurer, Aetna, in small-claims court.

Mr. Reiter has been insured by Aetna for the last 10 years and said he had generally "just grinned and bore it" when his benefit statements showed the insurer was paying only a fraction of his actual out-of-network medical bills. But then he had an opportunity to compare benefits statements for two exams he had — one in network and the other out — to which Aetna assigned the same medical code.

The in-network exam was conducted by a nurse-practitioner in Medford in April 2006. Aetna paid $92.70 for the visit, and Mr. Reiter owed nothing. Last July, he went to a doctor at the Mayo Clinic in Scottsdale, Ariz., who is not under contract with his insurer.

The Mayo doctor charged him $149.80. What surprised Mr. Reiter was that Aetna calculated the prevailing charge for that exam as just $90. He found it odd that Aetna would say that an exam conducted by a well-regarded doctor at the prestigious Mayo Clinic, in a metropolitan market, had a lower prevailing value than the exam conducted at a contracted discount rate by a nurse-practitioner in his small home city.

Under Mr. Reiter's plan, Aetna was responsible for 80 percent of the $90 value it assigned to the Mayo exam, or $72. In that instance, because Mr. Reiter had not yet met his annual deductible, Aetna paid nothing.

Mr. Reiter, who has for years received his medical care at Mayo when possible, says he believes there has been a longstanding pattern on Aetna's part to not pay its fair share of his out-of-network care.

Aetna declined to comment on Mr. Reiter's case.

Mr. Billet, the benefits consultant, said that the employers who subsidize health insurance typically do not pay much attention to out-of-network claims because they are such a small fraction of a company's overall medical bills — perhaps only 5 to 10 percent of the claims, even among people who have plans giving them the option of going out of network. And so employees themselves must be extra vigilant.

When people do seek out-of-network care, it is typically because their doctors refer them or because the patients themselves want to go to a doctor or hospital they think has special expertise in a particular illness, said Kevin Flynn, the president of Healthcare Advocates, a Philadelphia-based company that works with consumers when they have a billing dispute with their insurance companies.

Someone will go to Memorial Sloan-Kettering Cancer Center for treatment, for example, only to find that what that hospital charges is much higher than the insurer deems is usual. "Then they get sticker shock," Mr. Flynn said.

In some cases, patients may feel they have no choice but to go outside a network. Last October, Stacey Herzlinger, a 29-year-old police officer in Northern Virginia, was at a conference in Orlando, Fla., when she had severe stomach pain. Ms. Herzlinger called her in-network doctor back home, and was told to go to an Orlando emergency room, where she was examined and received medication — and a bill several weeks later for $3,168. The hospital said her health plan, UnitedHealth, would not pay because she had gone out of network.

“It was excuse after excuse after excuse why they weren’t paying,” said Ms. Herzlinger, who has hired Mr. Flynn to work with her on getting reimbursed.

While not commenting on the specifics of Ms. Herzlinger’s case, UnitedHealth says that emergency-room visits are typically covered under its plans and that it works with customers to resolve any concerns they have with their bills.

Even if someone does go to a doctor or hospital within the plan’s network, not everyone who becomes involved in the case may be in network. The anesthesiologist during an operation, for example, may not be under contract with the insurer. So the bill for anesthesia may be deemed an out-of-network claim, cautioned Mary Beth Senkewicz, a deputy insurance commissioner for Florida. “You really need to check” beforehand, she said, to avoid being hit with a substantial bill.

And there have even been cases in which, because one doctor involved in the care was not under contract with the insurer, other services are labeled as out of network even though the providers are part of the insurer’s network.

UnitedHealth is involved in a lawsuit brought by some New York hospitals, saying it improperly classified claims as out of network. In one example, a doctor not in UnitedHealth’s network sent a patient to Flushing Hospital in Queens for a breast biopsy. Although the hospital and the doctor performing the procedure were both under contract with

the insurer, the patient was billed $1,110 as if she had gone out of network.

Although UnitedHealth declined to comment on the litigation, it said its current policy would be to consider care at an in-network hospital as covered, even if the referring doctor was out of network.

But Dr. Robert Goldberg, the president of the Medical Society of the State of New York, a professional organization for physicians and a frequent adversary of the insurance companies, said patients needed to be aware that seeing a doctor out of network could create financial havoc, depending on the insurer's stance.

"Each policy and plan may be different," he said, "and may vary from admission to admission."

The New York Times
ON THE WEB

December 11, 2008

Hospital Officials Worry As Paterson Signals Need For More Medicaid Cuts

By ANEMONA HARTOCOLLIS

Heart attack victims would be revived, and broken bones would be put in casts. But pregnant women might not be able to get prenatal checkups at convenient times, treatment for children's asthma might be cut and diabetes diagnoses for adults could be delayed.

These are among the doomsday predictions of public and private hospital executives across New York City as Gov. David A. Paterson prepares to release a budget next week that he has warned will include severe cuts to the state Medicaid program that reimburses hospitals and doctors for services to low-income patients.

In the worst case, officials say, hospitals could face bankruptcies, service cuts and layoffs within a matter of months if Medicaid cuts being proposed by Governor Paterson go into effect.

"I'm never going to argue that you can't be more efficient or that you can't remodel the care, but I guarantee you the cuts are going to be more of an across-the-board cut," said Stanley Brezenoff, chief executive of Continuum Health Partners, which runs five New York hospitals, including Beth Israel. "There's no scalpel in any of this; it's all whack, whack, whack."

The governor plans to announce his latest budget on Tuesday, and has already signaled that it could contain cuts to the state's health care system far deeper than the $572 million reduction in Medicaid spending statewide that he proposed in November, which is supposed to get the state through March.

Since the November proposal, there have been further drops in tax revenue, with a yawning budget gap now projected at $14 billion to $15 billion.

Kenneth E. Raske, president of the Greater New York Hospital Association, said the governor warned his executive committee and hospital union leaders at a meeting last week: “Your worst fears will be realized.” He said he was so taken aback by the governor’s comment that he wrote it down.

On Tuesday, Joe Baker, the governor’s health policy adviser, told a health policy forum at the Rockefeller Institute in Albany that the new budget would be “tougher than you think.”

Beyond fueling the expected complaints from those on the receiving end of large budget reductions, the impending health care cuts have set up a broader philosophical discussion between the Paterson administration and the hospital industry.

State officials say that New York has been relatively inefficient in its Medicaid spending, steering money toward expensive hospital treatment of problems that could be better handled in doctors’ offices.

New York State spends more on Medicaid than any other state, $2,283 per capita per year, twice the national average of $1,026, a state Health Department spokeswoman said.

Dr. Richard F. Daines, the state health commissioner, said the new budget would lay out a plan to pay more to primary care and clinic doctors, while shifting that money away from hospitals, which in theory would see fewer patients because of better preventive care.

At the health forum, Mr. Baker said, “It’s not about curtailing generosity, it’s about whether or not we’re getting real value for the money that we’re spending.”

Hospital executives say that they are not opposed to making that shift, but that cutting Medicaid is counterproductive if the goal is to promote primary care.

“There is a fundamental dilemma or contradiction here on the state level between their stated health care policy reform agenda, which is all about robust primary and preventive care and better disease management, and the inevitable outcome of these cuts,” Alan D. Aviles, president of the city’s Health and Hospitals Corporation, said. The corporation runs the city’s 11 public hospitals, which get about 65 percent of their income from Medicaid.

“I don’t know whether the executive proposal will find a way to balance those problems, or whether the deficit will be so overwhelming it’s going to trump everything else and it’s only going to be about cost-cutting,” Mr. Aviles said.

Hospital executives say that they cannot cut essential services like the emergency room and neonatal intensive care, even if they lose money, and that cutting acute inpatient care does not make sense because it is reimbursed at or above actual costs.

But spending on community-based clinics, which generally lose money and are subsidized by other services, can be cut through measures like reductions in hours, longer times between appointments and reductions in the number of specialists on staff.

At Jamaica Hospital Medical Center, in a part of Queens near Kennedy Airport heavily populated by immigrants, David P. Rosen, the chief executive, said the proposed Medicaid cuts could force the hospital to shrink or close its outpatient clinics, which get about 400,000 visits a year, sending many of those patients to an already bursting emergency room.

Jamaica’s E.R., Mr. Rosen said, handles 110,000 visits a year — or about 300 patients a day — and accounts for 90 percent of admissions to the 287-bed hospital.

Dr. Linda Brady, the chief executive of Kingsbrook Jewish Medical Center in Brooklyn, said that the economic downturn combined with the anticipated Medicaid cuts had led Kingsbrook to submit a plan to the state for closing a community clinic and that the hospital was considering shutting down other services “that are not mission critical.” Last year Kingsbrook closed three clinics that it acquired when nearby St. Mary’s Hospital closed in 2005.

While Medicaid costs are high in New York, much of that money has gone to long-term care for the elderly, the disabled and people with multiple medical problems. Mr. Brezenoff said there has been little growth in spending for women and children, who make up the bulk of the Medicaid population, and are most vulnerable to cuts.

New York’s private nonprofit hospitals showed operating surpluses in 2006 and 2007, according to the association, but are breaking even “at best” this year because of declining investment income and frozen credit markets, Mr. Raske said. Even before the state cuts take effect, some New York City hospitals are considering filing for Chapter 11 bankruptcy, he added, declining to say which ones for fear of damaging their reputations.

The hospital industry employs 400,000 people statewide and had been immune from the layoffs plaguing other industries until recently; in the last national unemployment report, “the only sector that actually had a net increase was health care,” Mr. Raske said.

“For all practical purposes, that trend is dead now in New York and around the country,” he said. “Those statistics are going to go the way of the American bison.”

He said the cuts would hurt the economy of many small communities. “We employ a lot more people than Wall Street,” Mr. Raske added. “We are the Main Street employer.”

Because the federal government matches most Medicaid spending in New York, any cuts by the state will be doubled, and multiplied again by

the reduction in payments from Medicaid managed-care plans, Mr. Raske said. He said that Medicaid cuts affected not only poor people who qualify for the program, but everyone.

“The average hospital has probably 30 percent Medicaid,” Mr. Raske said. “Even if you’re on Park Avenue and you think this doesn’t affect you, well, it will. It affects everybody. It goes into the bottom line of every hospital. We don’t have Medicaid nurses. We don’t have Medicaid CT scans.”

Danny Hakim contributed reporting.