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Regulatory Oversight In Health Care

Law 360, New York (March 10, 2009) — Given the results of New York State Attorney General Andrew Cuomo's investigation into the health insurance industry and the near simultaneous settlement of a class action, the insurance industry — as well as providers — must be asking, what is next?

Cuomo had been investigating the entity known as Ingenix, a group of databases used by various insurers to determine "usual and customary" rates for out-of-network health care providers. Such rates are used to calculate reimbursements to providers.

As a subsidiary of UnitedHealth itself, Ingenix was alleged to be anything but independent from UnitedHealth and soon became the database of choice for other insurers throughout the health care industry.

The results of Cuomo's investigation include an agreement by UnitedHealth to abandon the use of Ingenix and to pay the sum of $50 million. Days later, UnitedHealth settled a class action for an additional $350 million.

A related settlement with Aetna resulted in an additional $20 million to be paid to New York State. All settlements provide for abandoning the use of Ingenix and for funding, to the tune of $100 million, the creation of an independent database to determine those "usual and customary rates" for out-of-network providers.

Cuomo is in talks with various other insurers using Ingenix databases, and further settlements are anticipated. On Feb. 18, 2009, the Wall Street journal and the Bloomberg Times reported similar settlements with CIGNA and WellPoint, each agreeing to contribute an additional $10 million to a new independent database.

The subject of out-of network reimbursements is the concern of not just the providers, but also the insureds who are generally faced with the nearly impossible task of knowing their own liability to out-of-network providers.

The new database to be funded by the carriers through these settlements will publish "usual and customary rates" for viewing by insureds in advance of treatments.

This will give insureds a sense of costs before they are actually incurred and will obviously allow for greater transparency throughout the process. It will also allow those same insureds an opportunity to gauge the reasonableness of their own physicians' charges.

But Cuomo's New York State investigations are not the only concerns for the health insurance industry: it faces scrutiny from the Federal government as well.

On January 12, 2009, the Centers for Medicare & Medicaid Services (CMS) imposed sanctions upon WellPoint with regard to WellPoint's Medicare Advantage (MA) and Part D contracts.

The sanctions included the suspension of WellPoint's enrollment of Medicare beneficiaries as well as its Medicare marketing activities, effective immediately, on the basis that WellPoint's conduct posed "a serious threat to the health and safety of Medicare beneficiaries."

Much like the Cuomo investigations, a spike in customer complaints had directed the focus upon WellPoint's failure to comply with CMS' "administration requirements."

In the case of WellPoint, a sharp increase in prescription drug denials had been tied to an issue in its information systems. Other issues included excess premium charges, improper disenrollments, overcharging of insureds' cost-sharing obligations, and the like.

On February 20, 2009, CMS acted again, this time against WellCare Health Plans Inc. ("WellCare"), and suspended further enrollments of new customers in Medicare-backed drug and medical plans. The action against WellCare arose as a result of complaints which were three times the national average.

In an era of self-regulation, some industry leaders may have come to expect "business-as-usual" approaches to enforcement. As we have seen in the general economy, however, it appears that lax enforcement may be a thing of the past.

The Obama Administration has pointed to the many failures of self-regulation in the economy. Local administrations like Cuomo's in New York are but a few examples of a shift in methodology and a greater emphasis on compliance and enforcement.

In actions brought by the state of California, for example, several of the largest managed health care companies recently resolved thousands of rescission cases.

While issues differ, there is a distinct increase in the number of actions designed to protect the interests of the consumer, including actions brought by both state regulators and private plaintiffs in the form of class action and individual lawsuits.

The looming increase in consumer and government scrutiny points to greater litigation. This trend comes at a time when legal fees and court costs may be the least of the problems facing health care insurers.

At this very moment, the industry stands at the doorstep of potentially massive restructuring sponsored by an administration that is committed to health care reform. Just as significantly, it is also mired in a badly battered economy.

It is precisely these two factors which make the next few years critical to determining the future direction of the industry. The last thing the industry needs is to lose its focus upon those imminent fiscal and health care crises.

The distraction of dealing with the ancient history which is at the core of all litigation, is a threat to that focus.

The true cost of litigation in today's environment, therefore, is far greater than ever. It requires an even more concerted effort at containment, including far greater efforts at early resolution. Alternative dispute resolution is an indispensable tool in that effort.

Past matters resolved through mediation, for example, provide templates for quick, efficient and fair resolution of otherwise thorny, time-consuming litigation.

One recent matter involved claims for reimbursement by a hospital from an HMO for dozens of patients. Each patient fit into potentially multiple categories of coverage, varying types of claims, varying degrees of timeliness in claims submission and, of course, with claim amounts that all differed.

Entering the information on a spreadsheet took the mediator less than 30 minutes, and the resulting visual clarification allowed the parties to resolve all claims in less than two hours.

The parties can focus on a case in the collaborative environment of mediation or within the formal confines of trial. It is their choice. It would be difficult, however, to imagine the scenario of the foregoing spreadsheet in a trial proceeding ... yet that is what led to nearly immediate resolution.

In another case with fewer claims but equally complex conditions, the mediator again laid out a spreadsheet, called the parties before the mediation commenced, and resolved all issues on the phone in less than 30 minutes, relieving the parties of even driving to the mediation.

More impressive than the size of the claims (each exceeding $100,000) was the conservation of human and financial resources in reaching their resolution.

It is hard to imagine the foregoing resolutions in the course of the litigation process. Litigation is inherently inefficient, and it forces a diversion of resources to deal with those inefficiencies.

Mediation and arbitration, on the other hand, redirects those efforts toward resolution in a more controlled and effective process. That process will make available otherwise restricted resources that are sorely needed to address the challenges facing this industry and the nation as a whole.

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