Former UnitedHealth doctor Naysha Isom said she didn't agree with some diagnoses the company suggested.

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Like most doctors, Nicholas Jones prefers to diagnose patients after examining them. When he worked for UnitedHealth Group, though, the company frequently prepared him a checklist of potential diagnoses before he ever laid eyes on them.

UnitedHealth only did that with the Eugene, Ore., family physician's Medicare Advantage recipients, he said, and its software wouldn't let him move on to his next patient until he weighed in on each diagnosis.

The diagnoses were often irrelevant or wrong, Jones said. UnitedHealth sometimes suggested a hormonal condition, secondary hyperaldosteronism, that was so obscure Jones had to turn to Google for help. "I needed to look it up," he said.

The government's Medicare Advantage system, which uses private insurers to provide health benefits to seniors and disabled people, pays the companies based on how sick patients are, to cover the higher costs of sicker patients. Medicare calculates sickness scores from information supplied by doctors and submitted by the insurers. In the case of UnitedHealth, many of those doctors work directly for UnitedHealth.

More diagnoses make for higher scores—and larger payments. A Wall Street Journal analysis found sickness scores increased when patients moved from traditional Medicare to Medicare Advantage, leading to billions of dollars in extra government payments to insurers.

Patients examined by doctors working for UnitedHealth, an industry pioneer in directly employing large numbers of physicians, had some of the biggest increases in sickness scores after moving from traditional Medicare to the company's plans, according to the Journal's analysis of Medicare data between 2019 and 2022.

Sickness scores for those UnitedHealth patients increased 55%, on average, in their first year in the plans, the analysis showed. That increase was roughly equivalent to every patient getting newly diagnosed with HIV, the virus that causes AIDS, and breast cancer, the analysis showed.

That far outpaced the 7% year-over-year rise in the sickness scores of patients who stayed in traditional Medicare, according to the analysis. Across Medicare Advantage plans run by all insurers, including UnitedHealth, scores for all newly enrolled patients rose by 30% in the first year.

A spokesman for UnitedHealth said in a written statement that the company's practices lead to "more accurate diagnoses, greater availability of care and better health outcomes

and prevention, including less hospitalization, more cancer screenings and better chronic disease management." The company's approach, he said, helped to avert more serious health problems later, and to achieve Medicare Advantage's goals of improving quality and reducing costs.

In a series of articles this year, the Journal has examined the practices of Medicare Advantage companies, including UnitedHealth, the largest. Among other things, the articles showed how diagnoses added by insurers increased payments from the government.

The killing earlier this month of Brian Thompson, chief executive of UnitedHealth's insurance division, triggered widespread public venting about some of the practices of health insurers. Police said the suspect left a note saying he was taking action against the healthcare industry. UnitedHealth has said that neither the suspected gunman nor his parents were covered by the company.

Flags flew at half-mast at the headquarters of UnitedHealth's insurance division in Minnetonka, Minn., after the killing of CEO Brian Thompson. PHOTO: JERRY HOLT/STAR TRIBUNE/ASSOCIATED PRESS

In its written statement, UnitedHealth said Medicare's system of paying for diagnoses was developed by the government, not any one insurer, "to help ensure fair and accurate payments."

UnitedHealth and other Medicare Advantage insurers have said higher sickness scores among their patients reflect a sicker population with greater medical needs. UnitedHealth

has said the diagnoses it submits are accurate, and that it detects diseases sooner, benefiting patients.

Jones, the Oregon doctor, said UnitedHealth didn't suggest diagnoses for patients he treated outside Medicare Advantage, where it doesn't pay.

Traditional Medicare patients treated by UnitedHealth doctors had much lower sickness scores, the Journal's analysis showed.

A case of hyperaldosteronism—the obscure hormonal condition that sometimes appeared on Jones's checklists—could trigger about $2,000 a year in Medicare Advantage payments during the period the Journal studied. The Journal's analysis showed that doctors who didn't work for UnitedHealth seldom diagnosed that condition, which involves elevated levels of a hormone linked to high blood pressure.

Jones said he quit UnitedHealth in 2023 to start his own practice.

UnitedHealth has acquired dozens of medical groups over the past decade-and-a half. Its Optum unit now employs about 10,000 physicians, its top executive has said, making it one of the nation's largest employers of doctors. It contracts with tens of thousands more. No other national insurer has acquired and hired doctors on that scale.

Other insurers have made more limited investments. Humana runs a network of primary-care centers under the CenterWell brand, and last year Aetna parent CVS Health purchased Oak Street Health, a clinic operator that specializes in treating seniors.

Patients of the medical groups operated by UnitedHealth have unusually high sickness scores compared with those of other doctors' practices, the Journal's analysis found.

UnitedHealth's doctors, in addition to treating those in the company's Medicare Advantage plans, treat people covered by other insurers and traditional Medicare.

Patients who both saw UnitedHealth doctors and were enrolled in UnitedHealth plans had the highest average sickness scores in the Journal's analysis of claims from 2019 to 2022. Those higher sickness scores triggered about $4.6 billion more in Medicare payments than UnitedHealth would have received if those patients' scores had been in line with the average for the company's other Medicare Advantage patients.

"The system is not primarily about taking care of the patient," said Dr. Emilie Scott, who worked for a UnitedHealth-owned practice in California before leaving in 2016. "It's, how do you get the money to flow?"

The Journal analysis is based on billions of Medicare records obtained under a research agreement with the federal government. The Journal also examined internal documents from medical practices owned by or under contract with UnitedHealth.

UnitedHealth said its sickness scores trend higher partly because its plans "serve some of the sickest and most vulnerable populations," and that research showed under-diagnosing

in traditional Medicare led to some of the differences in sickness scores between the two parts of the program. The company said it had performed well in Medicare's audits of the accuracy of diagnoses it submits for payment.

The company said revenue accrued from additional diagnoses "are not simply earnings for the company but are instead used to invest in medical benefits" and reduce out-of-pocket costs for members, among other things. It has said that its insurance unit, UnitedHealthcare, operates separately from its Optum health-services arm.

INVESTIGATING MEDICARE

- Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated
- The One-Hour Nurse Visits That Let Insurers Collect $15 Billion From Medicare
- Medicare's Opioid Limits Didn't Protect This Doctor's Patients From Deadly Overdose
- The Sickest Patients Are Fleeing Private Medicare Plans—Costing Taxpayers Billions
- Insurers Collected Billions From Medicare for Veterans Who Cost Them Almost Nothing

A spokeswoman for the Centers for Medicare and Medicaid Services declined to comment on the Journal's analysis, but said the agency is studying relationships between Medicare Advantage insurers and medical providers. She said Medicare Advantage insurers are required to ensure the accuracy of diagnoses they submit, and that the agency had overhauled the list of diagnoses that trigger extra payments.

The Journal reported in July that Medicare Advantage insurers added diagnoses to patients' health records that no doctor treated. The insurers collected $50 billion in payments from 2019 through 2021 for those diagnoses, the Journal reported.

Recording diagnoses

When Dr. Naysha Isom started working at a UnitedHealth medical group in the Las Vegas area in 2019, she said, she got two days of training on how to record diagnoses. At the training, a UnitedHealth employee suggested that Isom, who had practiced for more than a decade, should consider diagnoses she had never made before.

Isom said she was told that signs of bruising could be recorded as senile purpura, a condition that generated payments in Medicare Advantage but generally didn't require treatment. Isom saw no point, since the finding didn't change patients' care: "OK, wear some sunscreen. Maybe stop bumping the wall."

After she decided not to diagnose peripheral artery disease, a narrowing of blood vessels, based on a screening test she distrusted, she said, a supervisor pressed her to reconsider. UnitedHealth didn't require her to make diagnoses, she said.

“You’re just encouraged to, because obviously, if you don’t, they come bothering you,” said Isom, who left UnitedHealth to start her own practice in 2022.

UnitedHealth’s doctors in the Journal’s analysis diagnosed the bruising condition, which triggered extra payments of about $1,900 a year at the time, 28 times more often with patients in UnitedHealth Medicare Advantage plans than those in traditional Medicare.

Diagnosis Gap

UnitedHealth doctors diagnosed some diseases that trigger extra payments at higher rates for Medicare Advantage patients than for recipients of traditional Medicare.

Diagnoses per 10,000 patients

UnitedHealth plan
Other Medicare Advantage plan
Traditional Medicare
Age-related bruising
732
397
26
Obstructed leg arteries
403
194
5
Secondary hyperaldosteronism
318
183
8
Alcohol dependence
205
166
6
Malnutrition
165
81
8

The bruising condition, senile purpura, “is a completely benign condition” for patients, said G. Michael Harper, a geriatrician at the University of California, San Francisco. “There’s nothing you have to do for them.”

An internal presentation to doctors at a UnitedHealth-owned medical group in Southern California, reviewed by the Journal, listed doctors and the average Medicare sickness score for their patients. Doctors with the highest averages were highlighted in green, and those with the lowest, in red. The presentation showed that as of July 2022, the average sickness score among those practices’ patients was 55% higher than the average among traditional Medicare recipients.

Under Medicare rules, each condition that triggers extra payments has to be diagnosed annually. UnitedHealth doctors said patients whose records showed past diagnoses that hadn't been re-documented were frequently called in for office visits, and the company's software would spool out lists of potential diagnoses.

The list UnitedHealth sent one doctor included a potential diagnosis of a lower-leg amputation, citing prior records, even though the patient wasn't missing a limb. The company told another doctor it suspected a patient had heart failure "based on prevalence of this condition in our patient population."

Jones, the former UnitedHealth doctor in Oregon, said the suggestions included diagnoses based on scant evidence, such as long-term insulin use for patients who had received the drug only once during a long-ago hospital stay. For patients regularly taking aspirin, he said, the technology would propose a clotting disorder.

To finish a visit, he had to check a box to confirm or rule out each possible diagnosis—or defer it for later. At first, he said, the checklists were optional, but then they became mandatory. He usually rejected the hyperaldosteronism diagnoses, he said, if he didn't see any testing or treatment for the condition.

The design of the system, he said, could lead to good-faith errors as doctors clicked through all the boxes. "The system is made to have these happy little accidents that end up resulting in a lot of money from taxpayers," he said.

Bonus pay

A December 2023 compensation plan for one UnitedHealth-owned practice offered doctors bonuses of up to $37.50 a year for each of their Medicare Advantage patients if they confirmed or ruled out more than 90% of the suggested diagnoses. That means a doctor seeing 800 Medicare Advantage patients in a year could see a bonus of as much as $30,000 a year.

Tom Lin, a former UnitedHealth physician in Oregon, said it was easier to say yes than no, particularly with diagnoses that another doctor had previously confirmed and placed in the patient record.

"You didn't have time to rule it out," he said, given the volume of patients each day. He said he did his best to remove from patients' charts diagnoses that he questioned such as secondary hyperaldosteronism, which UnitedHealth often suggested for heart-failure patients, "because I had no idea what the hell they were talking about."

Shweta Bansal, a nephrologist at UT Health San Antonio who studies that disease, said "the treatment of heart failure is the same" regardless of whether secondary hyperaldosteronism is diagnosed.

High Scores

Patients of medical groups owned by UnitedHealth had higher sickness scores than those receiving treatment from many other medical groups.

Average 2021 sickness score of Medicare Advantage recipients, by medical group

Note: Comparison group includes large primary-care focused practices identified in the Medicare Data on Provider Practice and Specialty database; limited to practices with 1,000 Medicare Advantage recipients in the analysis.

UnitedHealth said a company study found that patients of medical providers under its Optum umbrella had better outcomes than patients in traditional Medicare, including an 18% lower risk of inpatient hospital admissions and an 11% lower risk of emergency department visits. The company said its model improved management of chronic diseases, including diabetes.

Like other Medicare Advantage companies, UnitedHealth also contracts with outside doctors in ways that can increase their payments when they diagnose more conditions. That includes arrangements where doctors receive a portion of the Medicare payments insurers get for their patients. Other Medicare Advantage insurers also suggest diagnoses to independent doctors examining their patients.

In some contracts with independent doctors reviewed by the Journal, UnitedHealth linked bonuses to sickness scores and quality ratings derived partly from patient surveys. For patients with sickness scores 20% higher than average and good quality ratings, doctors could get an extra $40 per patient each month, one contract shows. Scores 50% above average and top quality ratings could yield $65 per patient a month. For a doctor with 100 patients covered by the contract, that would amount to a $78,000 annual bonus.

Andy Pasternak, an independent family doctor in Reno, Nev., has lower-than-average sickness scores across his practice, records show. He said he gets a per-patient bonus of $2 a month, or $2,256 annually, for the 94 Medicare Advantage patients covered by his contract with UnitedHealth.

Dr. Andy Pasternak, an independent family doctor in Reno, Nev., treats Medicare Advantage patients under a contract with UnitedHealth. PHOTO: ALEJANDRA RUBIO FOR WSJ

Pasternak said UnitedHealth offered to send nurses to visit those patients to diagnose them more fully. The company would pay him $250 for each patient their nurses examined, he said.

"That's more than I get paid for treating my own patients," he said. He said the focus on diagnosing has soured him on Medicare Advantage, and made him grateful when patients younger than 65 come to his office.

One UnitedHealth document reviewed by the Journal projected Pasternak could receive as much as $23,250 a year in such payments. A UnitedHealth executive in his area told him in an email his practice also would benefit from any additional diagnoses made by the nurse.

Valerie O'Meara, a former UnitedHealth nurse practitioner, said she never provided treatment for the patients she saw in doctors' offices in Washington state. "Your job is finding diagnoses, that was clear as a bell," she said. "I was like, am I finding all these things that the doctors who are taking care of these people didn't find?"

She said a Minnesota-based UnitedHealth manager urged her to make new diagnoses beyond what doctors had treated. Patients were often confused, she said, about why she, not their own doctor, was examining them. "They don't tell the patient, the nurse needs to see you to make sure your high-scoring medical problems are checked off this year."

Suspicious patient

Chris Henretta, a UnitedHealth Medicare Advantage plan member who lives in The Villages, a retirement community in central Florida, was suspicious when his primary-care doctor diagnosed him as morbidly obese during his annual exam in October.

He is a lifelong weightlifter, plays water volleyball five times a week and has an athletic build.

"I told her I didn't think I was obese," Henretta said. When she recorded morbid obesity anyway, he said, he began to "suspect my doctor may have a financial incentive to portray people as higher risk."

The diagnosis can trigger payments of about $2,400 a year to Medicare Advantage insurers.

A widely used measure to diagnose obesity, body-mass index, has been criticized for sometimes mischaracterizing muscular people as overweight. Henretta's medical record shows that even by that standard, he didn't qualify as morbidly obese. His BMI was 32.3 at the time of his October visit, nearly three points below the minimum threshold for morbid obesity.

Chris Henretta, a UnitedHealth Medicare Advantage plan member, said he was suspicious when his primary-care doctor diagnosed him as morbidly obese. PHOTO: ZACK WITTMAN FOR WSJ

Henretta said he began to 'suspect my doctor may have a financial incentive to portray people as higher risk.' PHOTO: ZACK WITTMAN FOR WSJ

Henretta's doctor at The Villages Health, a clinic that contracts with UnitedHealth, also diagnosed him with qualitative platelet disorder, a condition that affects blood clotting.

Henretta said his doctor added the diagnosis after he agreed that his blood seemed to clot slightly more slowly after he started taking baby aspirin several years earlier. His doctor had recommended the baby aspirin after he was diagnosed, in 2021, with aortic atherosclerosis—which could trigger Medicare payments of about $2,700 a year at the time.

Dr. Rachel Bercovitz, a hematologist and professor at Northwestern University's medical school, said aspirin inhibits platelet function, so Henretta's doctor is "diagnosing the intended effect of the medication" as a separate disease.

A qualitative platelet disorder diagnosis can trigger extra payments of about $2,000 a year to insurers.

The Villages Health, its top executives and Henretta's doctor didn't respond to phone calls and emails requesting comment.

Dr. Coleen Madigan used to work for a UnitedHealth medical practice in Texas. PHOTO: KAYLEE GREENLEE FOR WSJ

Dr. Coleen Madigan, who worked for a UnitedHealth medical practice in Texas for a little over a year before leaving in 2020, said one of her patients there didn't know what she was talking about when she asked when he had been diagnosed with chronic obstructive pulmonary disease, and got upset when she told him his chart included the illness.

The patient was a smoker who had bronchitis in the past, but he had never been tested to confirm COPD, Madigan said. She added a note to his record saying there wasn't documentation to support the lung disease diagnosis, she said, but it was difficult to remove completely.

During her time at UnitedHealth, Madigan, now mostly retired, said she felt "an insidious pressure" to document diagnoses. "It distracts you from focusing on the patient."

Mark Maremont contributed to this article.

HOW THE JOURNAL ANALYZED MEDICARE DATA

The Journal calculated sickness scores—which Medicare calls risk adjustment factors—for all full-year recipients of both traditional Medicare and Medicare Advantage using claims and encounter data from 2019 through 2022. The Journal got access to the data under a research agreement with the federal government.

The Journal applied Medicare's methodology for calculating scores of Medicare Advantage patients to all patients in the analysis. The analysis excluded the effect of nursing-home stays on sickness scores. It also excluded Medicare Advantage members in atypical plan types.

The Journal looked at UnitedHealth Group's filings to state insurance regulators to identify medical groups it reported owning as of the end of 2018. The Journal excluded groups without primary-care doctors, based on Medicare's classification of provider specialties, and urgent-care providers. The Journal identified large, primary-care-focused medical groups not owned by UnitedHealth using the Medicare agency's Medicare Data on Provider Practice and Specialty database.

The Journal attributed Medicare patients to each medical group based on the office and annual wellness visits listed in the data each year.

Graphics in this article are based on the Journal's analysis unless otherwise noted