

# Forbes

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## Slicko

**Michael Moore's got it wrong. The problem with health insurers isn't that they reject too many claims but that they pay too many | By Neil Weinberg**

**I**N HIS SENSATIONALIST DOCUMENTARY *Sicko*, Michael Moore slams health insurers for being too chintzy in paying claims. Not yet available for viewers: a feature film exposing the insurers for being too generous. But that is, in fact, a big problem for corporations that cover their employees' health costs, albeit not a problem that tugs at the heartstrings.

When, you ask, would an insurer ever be liberal in its payments? Answer: when it's paying with someone else's money. Many corporations self-insure for medical coverage, using the insurance company only to process the bills.

Look at a suit filed by AutoNation against UnitedHealthcare in a Florida federal court last August. The nation's top car retailer charged UHC with paying for services not covered, failing to collect copayments, miscalculating benefits and paying claims for thousands of ineligible people. All told, AutoNation claims the overpayments cost it in excess of \$10 million over 18 months. UHC settled the suit late last year for undisclosed terms. Both firms declined to elaborate.

"The types of errors in this lawsuit are exactly what we find all the time," says Matthew Dubnansky, an accountant and partner with Baltimore, Md. health care auditor TMDG LLC.

UHC says its claims-payment accuracy exceeds 99%. But Jeffrey Barber, a medical claims auditor with Accu-Rate in El Paso,

Tex. (which gets paid for finding overcharges), argues that excessive and unjustified costs consume as much as 20% of health care spending. Over the past seven years he has dug through hundreds of corporate and municipal plans and says on balance they're a little better than Medicare Part A, in which an audit shows overcharges for hospitalizations billed on a pay-per-service basis gobbled up 16.4% of spending, or \$13.6 billion, in fiscal 2004.

Among the excessive and bogus bills Accu-Rate has uncovered: an \$89,000 night in a hospital for a patient who wasn't even admitted; a hip replacement expensed to the wrong person; and bills for workers in Iowa charged to a firm whose employees are all in New England. When Accu-Rate audited the plan of Springfield, Mass., it found the city severely lacking in spending controls and paying bills for 250 ineligible people. (Springfield's personnel director did not respond to requests for comment.)

Companies employing more than half of private-sector workers, as well as many states and cities, self-insure. That means the employers and their workers kick in the cash used to pay claims. If costs go up, they're the ones on the hook to pay more. Typically, employers hire a UHC, Blue Cross Blue Shield affiliate or someone else to handle the paperwork.

The problem of overcharging such plans is costing publicly listed companies so dearly that Barber says it's given birth to

a new hedge fund strategy (none of whose practitioners want to be identified): buy into firms with poor medical cost controls and boost their earnings—and share prices—simply by cutting the waste. "A lot of employers have absolutely no controls over health care spending or any idea whether the claims they're paying are for their own employees," Barber says.

Complexity accounts for part of the problem. Billing specialist CorVel, for example, counts 9 million rules governing workers' compensation claims. Such rules cover everything from dialysis reimbursement rates to copays for office visits, and little mistakes add up. One administrator failed to levy a \$15 copay fee on 50,000 appointments, costing the plan an extra \$750,000, auditor TMDG found. "Administrators won't tell clients, but when we push them they'll admit some plans are unadministrable," says TMDG's Dubnansky.

Even employers who try to keep tabs on costs face daunting challenges. The typical explanation of benefits may tell a patient he is receiving a 50% break on lab tests. The information might make its recipient feel good, but it is useless in deciphering whether the charges are appropriate or how much the administrator actually paid the provider. Often the employers sponsoring such plans fare little better in uncovering what those charges really bought. One bare-bones hospital bill FORBES reviewed listed items such as "Med-Sur Supplies: \$28,265.92."

And if employers want to audit bills, their hands are often tied. A Blue Cross & Blue Shield of Massachusetts contract restricts audits to 150 claims and states that any troubling trends discovered cannot be used “to calculate the financial impact of errors in a population of claim payments”—meaning, don’t even think about extrapolating the cost. The carrier says that it pays over 99% of claims accurately, that its audit sample size is big enough to produce statistically significant conclusions and that if it is in error it makes health plans whole.

When auditors asked UHC to disclose how much Cranston, R.I. was paying for the services the city was underwriting, a company official e-mailed back that “the hospital contracts we have negotiated are proprietary—no fee information will be provided,” according to an e-mail supplied by Barber. UHC says it provides hospital fee information during audits it supervises in its own offices.

Administrators who discover overpayments often fail to pursue refunds for self-

#### COMMON ERRORS THAT DRIVE UP COSTS FOR SELF-INSURED PLANS

- Paying for ineligible patients
- Paying for services not covered by plan
- Duplicate payments for service
- Failure to obtain preauthorizations
- Failure to conduct medical necessity reviews
- Failure to charge copayments

insured plans. Dubnansky recalls a case in which an employee ran up a \$95,000 hospital bill after he left his company. The employer informed the insurance company, but the latter still made no effort to recoup the money. Dubnansky says it’s not in its interest to do so. Some service agreements are cost-plus arrangements, so the higher the bills the higher the fees. Forcing providers to pay back plans also angers doctors and hospitals, which then get stuck

playing debt collector. Some Blue Cross Blue Shield contracts state that they will not pursue “retro-termination” payments, or those made in error to cover patients who’d become ineligible, Dubnansky says.

Hospitals are accessories to overcharges, too. When they are double-paid by two plans, each thinking it is the primary carrier, for example, they often keep the cash unless someone demands it back.

The game gets more sinister still. In a criminal probe that could have national implications, Barber says the FBI has interviewed him about a midwestern hospital that tripled its “usual, customary and routine” prices so it could claim to be granting big discounts—and still gouge self-insured plans. UHC and Anthem Blue Cross & Blue Shield paid \$125,000 and \$25,000, respectively, last year to settle charges by the Ohio Department of Insurance that they paid consultants inappropriate compensation to win business. It’s hard to imagine a health insurer that gets a contract through possible fraud would be especially diligent in tracking claims. **F**

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