The

CRISIS OF MEDICAL OVERBILLING

How to Protect Your Group and Members

WellRithms™ | Fall 2023

Hidden Medical Billing Abuses

A 47-year-old woman was diagnosed with unilateral breast cancer. She underwent surgery to remove both breasts and lymph nodes in her left armpit to lower the risk of recurrence. The surgeon billed for three mastectomies and charged $99,380. He ultimately accepted $3,072 after WellRithms' clinical review with bill review and repricing.

Overbilling Exposed

Cancer Surgery

Surgeon Billed Charges	$99,380
Accepted Fair Rate	$3,072
Amount Overbilled	**$96,308**

Officer Hospital Bill

Hospital Billed Charges	$761,464
Accepted Fair Rate	$187,782
Amount Overbilled	**$573,682**

A police officer, injured in the line of duty, sustained a severe open fracture of his heel bone. Care of his injury required multiple surgeries and skin grafts to reconstruct his foot, and he was hospitalized for 20 days.

The hospital charges included $3,645 for an implant used to reconstruct his foot despite there being no documentation to substantiate its use. Additional charges included $8,317 for an irrigation device that is never separately reimbursed by insurance, and $21,220 for ten boxes of gauze pads that cost $0.90 each. This charge appeared three times on the bill, totaling more than $63,000 for $9 worth of supplies.

The final hospital bill came to $761,464. After WellRithms' review and repricing, the hospital accepted payment of $187,782.

The Growing Cost Burden

Neither case was an anomaly. The business of medicine is replete with systemic billing errors, abuses, and fraud. Unfortunately, most companies, unions, and other plan sponsors don't see the silent siphoning of their benefits funds.

JAMA Network Open estimates that medical overbilling cost between $289 billion and $324 billion in 2019,[i] or roughly $1,000 for every person in the U.S.[ii] Consider that number in light of your plan's members and dependents. Under the JAMA cost estimate, a group with 10,000 members and dependents could conceivably be paying $10 million in overbilled charges.

Meanwhile, overbilling continues to skyrocket and inflate health benefit costs at an unsustainable rate.

High Dollar Claims On the Rise

Million-dollar-plus claims per million covered employees rose 45% from 2019 to 2022.[iii]

A Common Problem

20% of self-insured employers had at least one member with over $1 million in claims from 2018 through 2021.[iv]

Catastrophic Claims

A 2019 survey of employer health plans reports that 64% of respondents experienced a claim above $500,000, and 31% of participants reported a claim exceeding $1,000,000.[v]

Threat to Healthcare

Nearly 8 in 10 employers consider high-cost claims a significant threat to employer-sponsored healthcare, with an increasing number of companies facing claims in excess of $2 million.[vi]

If the projected 7% health premium increases for 2024[vii] continues year-over-year for a decade, health benefit costs will double. This overhead cost puts U.S. employers at a competitive disadvantage globally.

The Root Causes of Overbilling

It's difficult to pinpoint a single root cause for why medical overbilling exists to the degree that it does. Misaligned incentives, systemic financial irresponsibility, mismatched technology across the country, differing political agendas, and the corporate restructuring and consolidation of healthcare providers with private equity all contribute to the overcharges facing payers. No matter the cause, the costly practices include:

- Upcoding. This is a commonplace practice of reporting a higher level of service.
- Unbundling. Under this practice providers charge for separate parts of a procedure that are included in the primary procedure, such as billing separately for the closure after surgery, as if it were independent of the surgery. Unbundling is analogous to an auto shop charging for an oil change and billing additionally to lift and close the car's hood.
- Gaming stop-loss outliers for workers' compensation claims. Within most states, workers' compensation claims are paid according to predetermined fee schedules. If billed charges exceed a specified threshold, fee schedules are replaced by a percentage of charges for the entire bill. So providers are financially motivated to inflate charges by unbundling services, upcoding, and charging for services / materials / medication not provided.
- Exclusion lists, or "skip lists." These are secretly negotiated contracts between hospital systems and third-party administrators (TPAs). The hospital systems offer what they claim to be their lowest rate for agreements from the TPAs that charges will not be rigorously reviewed.
- Egregious physician overbilling. We often see surgical and other bills exceeding justifiable charges by a factor of ten or more. For example, a spine surgeon, coded as a co-surgeon, recently charged $445,000 for a two-level fusion and decompression.

One could assume that their group's plan administrator is working hard to stop provider overbilling. However, plan administrators lack the incentive to challenge providers when the dollars at stake are not their own but rather belong to the self-funded plan.

Purchasers Respond: Enough is Enough

Several recent lawsuits have charged that major insurers are going beyond simple neglect of their self-funded clients' interests and have secretly overcharged plans.

Kraft Heinz Company Employee Administration Board, et al. v. Aetna Life Insurance Company

The plaintiff argues that Aetna paid millions of dollars in provider claims that never should have been paid and wrongfully retained millions of dollars in undisclosed fees.[viii]

Kraft Heinz alleges that Aetna failed to give the company its own medical claims data, paid duplicate claims, failed to properly collect overpayments, and reprocessed claims for a lower amount while failing to refund or credit Kraft Heinz. The suit asserts that Aetna subsequently negotiated lower payments to out-of-network providers while keeping the difference, and then comingled plan assets with its own account.[ix]

Kraft Heinz also alleges Aetna applied less rigorous claims adjudication standards to self-funded plan claims than it applied when adjudicating claims for its fully funded plans. Furthermore, the suit alleges that Aetna induced providers to join Aetna's network by agreeing to place providers on exclusion lists that commit Aetna to providing limited or no scrutiny of provider claims.

Trustees of International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund et al. v. Elevance, Inc., et al.

Plaintiffs allege that Elevance (formerly Anthem) repriced claims for reduced payments, charged the union the higher price, then kept the savings due back to the plan.[x]

The appeal in Massachusetts Laborers' Health and Welfare Fund, et al. v. Blue Cross Blue Shield of Massachusetts

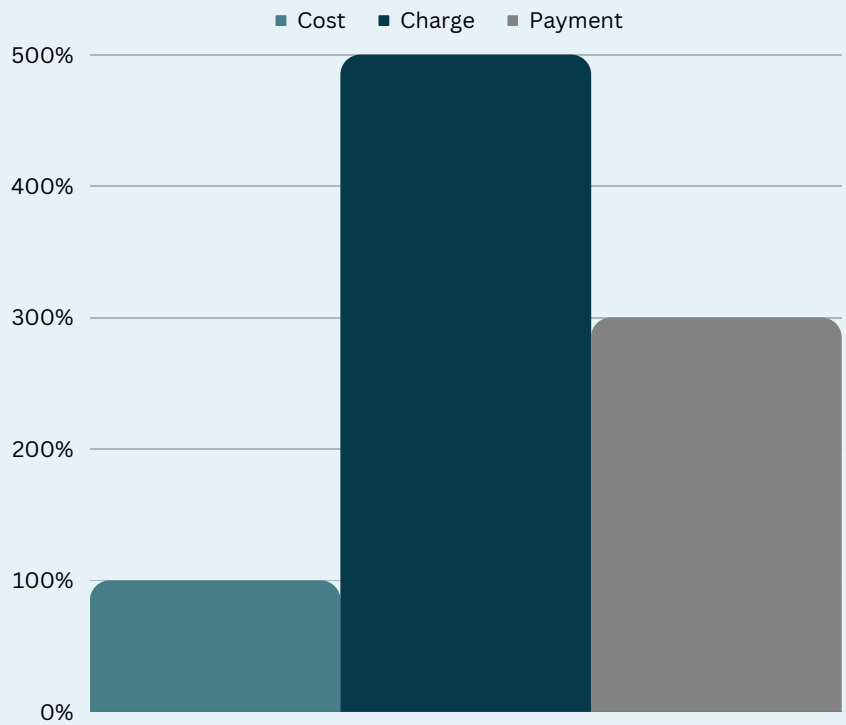
The health and welfare fund alleges that Blue Cross failed to accurately price claims, which caused millions of dollars in plan overpayments. The fund alleges Blue Cross calculated some claim payments exceeding what providers billed, processed erroneous pricing for hospital stays and procedures, and retained recovery fees where overpayments stemmed from its own errors. The appeal also alleges that Blue Cross retained inflated recovery fees by applying the recovery percentage to the higher original claim amounts instead of the lower recovered amount.[xi]

When your organization is fighting for talent, fighting economic headwinds, and fighting global competition, it shouldn't have to fight its health care partners over the integrity of their business practices. Yet if a plan administrator does not advocate on the plan's behalf, what can your organization do to protect itself?

Defending Your Plan

The Illusion of PPO Discounts

·Recognize that PPO discounts are not the solution. PPO discount percentages have been in place for decades, yet overbilling has worsened. PPO discounts that are a percentage of billed charges are phantom savings, as charges are inflated to egregious levels. If a hospital charges five times its underlying service cost, a 40% PPO discount still results in payment that is three times the service cost.



Hospital Markup and PPO Discounts

PPO DISCOUNTS

After a typical discount of 40%, a payment is still three times the underlying service cost of a hospital with a charge-to-cost ratio of 5:1.

The Pitfalls of Reference-Based Pricing

If PPO discounts are not the solution, neither is reference-based claims repricing, i.e. a multiple of Medicare reimbursement methodology. Reference-based pricing (RBP) is arbitrary and therefore not legally defensible. Medicare underpays hospitals for some services and overpays for others. It defies logic to pay a hospital a flat multiple (e.g. 1.5 times) of Medicare reimbursement. RBP is a blunt instrument that can result in a hospital being paid less than its costs or paid a greater-than-reasonable margin. Moreover, complex, high dollar claims frequently do not have a Medicare reimbursement allowance, so RBP is an ineffective method to reprice these claims.

The Inefficacy of Provider Negotiations

Negotiated settlements are little more than a one-off, band-aid solution. These negotiations typically leave purchasers paying more for care than they would pay using a fundamentally sound, cost-based approach. Hospital charges have no relationship to the cost of care and cost data is not readily available to payers. Providers know this, which gives them important leverage over the payer when negotiating. Negotiated settlements routinely result in overpayment, and providers leverage the patient against the plan by balance billing and threatening collections.

In short, plan administrators lack the incentive to dig deep for plan savings for fear of alienating hospital networks that offer fierce resistance. As a result, the current system is structurally broken, leaving groups and members fending for themselves.

An entirely new paradigm of medical billing and reimbursement is essential to breaking the escalating cycle of overbilling that continues to choke payers. A new mindset and toolset are needed to protect groups and members. Fortunately, such a mindset and toolset have both emerged and are proving to be successful.

The Medical Billing Transformation Paradigm

The elements of a transformed medical billing and payment integrity model are clear. Such a system is built upon the following principles and practices:

Bills are reviewed prior to payment, not after the fact.

The obsolete model of reference-based pricing is replaced with actual provider cost data as the basis for repricing.

Proven data analytics and algorithms are harnessed to evaluate provider bills line-by-line. These are based on hospital Medicare cost reports, as well as cost-to-charge ratios, by cost centers and revenue codes.

Advanced rules look for coding compliance with the National Correct Coding Initiative, medically unlikely edits, bill type classification, outpatient code edits, and duplicate checking. Billing anomalies and abuses are flagged and then reviewed by expert physicians.

Multiple validation points are used to confirm repricing is consistent with geographic differences, other payer sources, regional market indicators, and usual provider reimbursement.

Reimbursements follow defensible bill review and repricing that will stand up in court.

Companies providing repricing services will accept legal and financial responsibility for the proposed reimbursement, to protect plans and members from balance billing and other risks.

Conclusion

Websites and brochures from the health industry's big players portray a blissful world with smiling families living life to the fullest. The harsh reality facing the average heath care consumer is far more grim.

When cancer, heart failure, traumatic injuries, and other maladies strike, people are broken and most vulnerable. They need help and care from a system they can trust, not a system laced with greed, dishonesty, and corruption that will break them financially.

The business of medical billing and reimbursement requires a complete overhaul. It will not be transformed by the entrenched beneficiaries of its dysfunctions. Fortunately, that transformation is now in its early stages on the frontier of principled medical payment. Payers deserve a level paying field.

About WellRithms

WellRithms protects the financial wellness of purchasers using proven algorithms of data science. The company is recognized nationally for the highest standards of payment integrity, built upon extensive data and AI, and powered by unparalleled technical, medical, and legal expertise. Unlike other medical bill review and repricing analytics companies, WellRithms brings expertise to both group health and workers' compensation markets.

No other payment integrity company provides our savings guarantee. When necessary, WellRithms will assume all legal and financial liability for problem claims, thereby guaranteeing the recommended payment amount. Shield Indemnification™ protects the plan and member from provider balance billing and collection threats and helps protect workers' compensation payers through faster bill closure, reduced litigation time, and predictable expenses.

A physician-owned and operated company, WellRithms has more than 25 years of experience defending fair reimbursement in courts throughout the country and setting case law. The courts continue to rule that our reimbursement methodology is fair and reasonable. WellRithms is fiercely committed to working in the best interest of any plan fiduciary.

---

i JAMA Network, "Waste in the US Health Care System Estimated Costs and Potential for Savings." 2019.

ii US Census Bureau latest population estimate of 334,233,854 on Jan. 1, 2023.

iii Annual High-Cost Claims and Injectable Drug Trends Analysis Report, Sun Life. May, 2023.

iv Annual High-Cost Claims and Injectable Drug Trends Analysis Report, Sun Life. May, 2023.

v Aegis Risk Medical Stop Loss Premium Survey. 2019.

vi National Alliance of Healthcare Purchaser Coalitions, “High-Cost Claims Fastest Driver of Healthcare Expense for Employers.” June 2, 2023.

vii Health Care Costs Pulse Survey: 2024 Cost Trend, International Federation of Employee Benefit Plans

viii United States District Court for the Eastern District of Texas, filed June 30, 2023

ix See Excessive Fee Litigation Spreads to Health Plans, Davis Wright Tremaine LLP, August 9, 2023.

x See Excessive Fee Litigation Spreads to Health Plans, Davis Wright Tremaine LLP, August 9, 2023.

xi See Excessive Fee Litigation Spreads to Health Plans, Davis Wright Tremaine LLP, August 9, 2023.

WellRithms™