IT'S TIME TO LEVEL THE PAYING FIELD

How to protect your group and members from the epidemic of medical overbilling

WellRithms™
LEVELING THE PAYING FIELD

info@wellrithms.com
wellrithms.com

3718 SW Condor Ave, Suite 100
Portland, OR 97239

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THERE ARE BILLIONS OF REASONS TO FIGHT HEALTHCARE OVERBILLING

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IMPOSSIBLE BILLINGS

A 47-year-old woman was diagnosed with cancer of her left breast. 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' bill edits and repricing.

Without WellRithms: ~~$99,380~~ → With WellRithms: $3,072

GUAGE ON GAUZE

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

An implant for the foot repair was billed at $3,645 despite there being no documentation it was used. The charges included $8,317 for an irrigation device that is never separately reimbursed. Perhaps most egregious was the facility charging $21,220 for ten boxes of gauze pads that cost $0.90 each. This charge appeared three times, 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.

Without WellRithms: ~~$761,464~~ → With WellRithms: $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.

Medical overbilling is estimated by the JAMA Network to have 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 contributing to skyrocketing health benefit costs.

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 202.[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]

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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

Individual provider greed, misaligned incentives, and health system abuses all contribute to the overcharges facing payers. Among costly practices are:

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.

Upcoding

Reporting a higher level of service than actually provided is commonplace.

Unbundling

This widespread practice of charging 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.

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.

01

KRAFT CHALLENGES AETNA

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

Kraft Heinz alleges 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.

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Purchasers Respond:Enough is Enough
Continued

02

UNIONS CHEATED

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]

03

INFLATED FEES

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]

THE BOTTOM LINE

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?

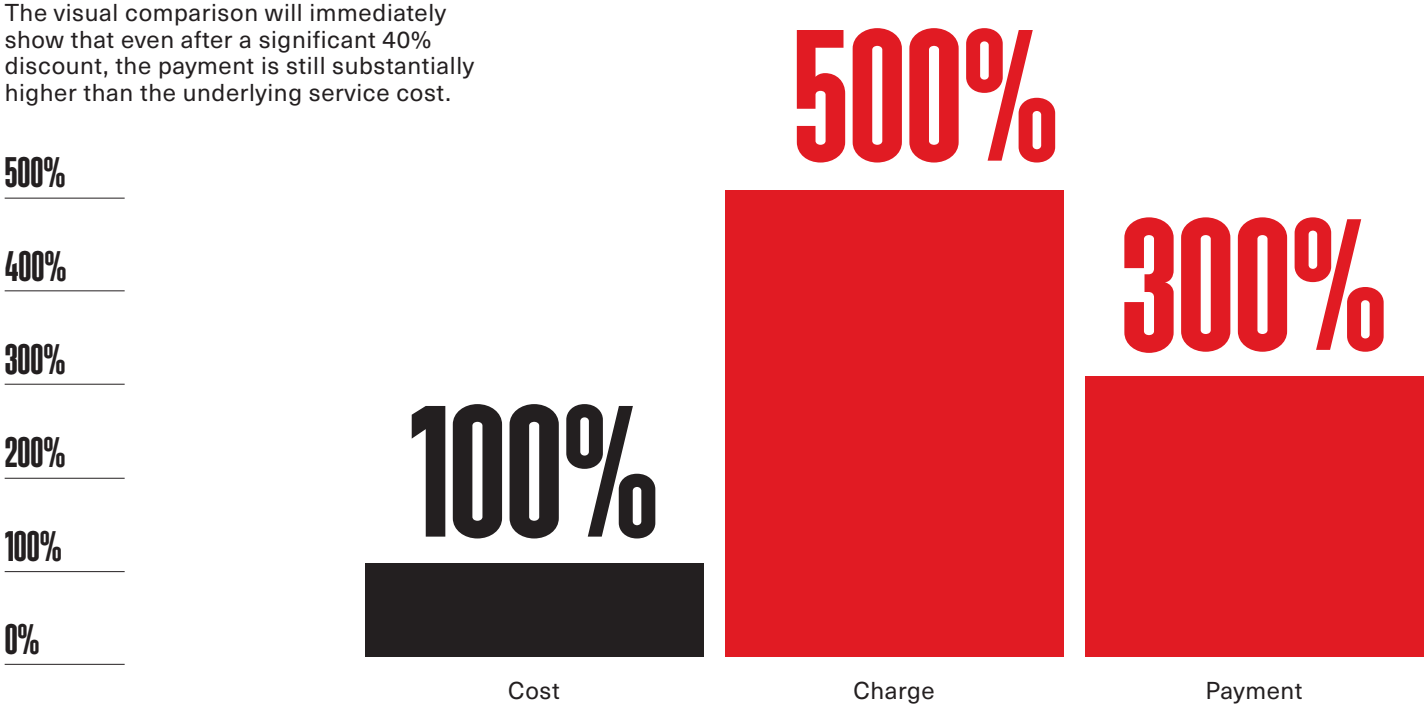
DEFENDING YOUR PLAN

Uncovering the Illustion of PPO Discounts

First, recognize that your networks' 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.

PPO DISCOUNTS ARE DECEPTIVE

The visual comparison will immediately show that even after a significant 40% discount, the payment is still substantially higher than the underlying service cost.



Defending Your Plan
Continued

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. So it defies logic to pay a hospital a flat multiple (e.g. 1.5 times) of Medicare's 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 price, so RBP is ineffective at understanding and repricing these.

THE INEFFICACY OF PROVIDER NEGOTIATIONS

Negotiating with providers is little more than a one-off, band-aid solution. It typically leaves purchasers paying more for care than they would pay using a fundamentally sound, cost-based approach. Plans rarely understand a provider's underlying costs because plans don't have that data. Providers know this, which gives them important leverage in a negotiated settlement. Negotiated settlements routinely result in overpayment. And providers leverage the patient against the plan by balance billing and collection threats.

THE BOTTOM LINE

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 largely 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, that mindset and toolset have emerged and have been recently proven in practice and in the courts.

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:

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

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

03 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.

04 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.

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

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

07 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.

LET'S LEVEL THE PAYING FIELD

CONCLUSION

Websites and brochures from the health industry's big players portray a blissful world with smiling families living life to the fullest. The reality facing those families and their group plans is far more grim.

Facing cancer, heart failure, surgeries, and countless other maladies, people need help when they are broken and most vulnerable, not a system laced with greed, dishonesty, and corruption that will break them financially. Health care payers do not need such a system either.

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.

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 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. We allow payers to transfer all legal and financial liability to us, 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.

Let's Level the Paying Field
Continued

PHYSICIAN OWNED

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