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Protecting You and Your Company from Health Insurance Overbilling

Nicholas J. Zoogman
Joshua Gold

Your company's health insurance company may be guilty of overbilling. As a result, your company could be losing significant sums of money and may be exposed to liability. Estimates place the amount of certain health plan overcharges in the billions of dollars.

The potential for overbilling should be a major focus for all companies. Civil lawsuits, state and federal probes, and even criminal investigations have disclosed numerous instances in which companies and their employees have been victims of gross overbilling for health plan benefits and services by their managed care and health insurance companies.

Policyholders can take steps to minimize the potential impact of health insurance company billing practices which siphon money from the company's bottom line and expose them to potential Employee Retirement Income Security Act (ERISA) liability. By conducting spot audits and cross-checking health plan bills against those issued by the health care providers, for example, companies can increase the likelihood that their health plans are delivering the promised care *at the promised price*.

The Dominance and Ramifications of Managed Care

Managed care has rapidly come to predominate the health care industry. Unfortunately, the dramatic changes in health care have made it increasingly more difficult for consumers and buyers of managed care plans and services to understand all of the implications and dynamics involved with their purchase. Frequently, health plan provisions and terms are difficult to understand and may even contradict representations made in accompanying promotional materials and presentations.

Managed care and health insurance companies have been able to negotiate, if not compel, deep discounts for a variety of health procedures and treatments with health care providers (e.g., doctors, hospitals, clinics). This very ability to influence the prices of medical treatments creates the potential for overbilling. While there is nothing inherently wrong with a health insurance company negotiating for the lowest provider price, too often policyholders have not been the beneficiaries of these discounts nor have the discounted prices been adequately, if at all, disclosed.

Remaining Alert About Copay Billing

The health care billing abuses can be divided into two broad categories. The first involves copay or co-insurance obligations. Under many health insurance plans, the policyholder pays a portion of the medical care costs—an 80/20 percentage split is common, with the insurance company typically paying 80 percent and the policyholder paying the remaining 20 percent. For example, if the policyholder has a medical procedure which costs $1,000, then the policyholder's copayment obligation would be 20 percent of $1,000, or $200.

Suppose, however, that the policyholder has the same above procedure, but the insurance company previously negotiated a significant discount for the cost of that procedure with the health care provider. Instead of billing $1,000, the health care provider charges only $400 for the procedure. What can happen—and what has happened—is the health insurance company still bills the policyholder for the copayment obligation at the undis-

counted price of $1,000. That means that the policyholder is still paying $200—which also means that the policyholder is paying a whopping 50 percent copayment instead of the agreed upon 20 percent copayment.

Copay billing practices such as these may involve violations of: the terms of the health plan policy; state and sometimes federal laws; rules and regulations governing insurance and health care plans; and assurances made in health insurance company brochures and by health insurance company representatives.

As a result of these undisclosed billing practices, companies are placed in the difficult position of sifting through all of the managed care jargon, plan provisions and representations to determine whether health plan benefits are being delivered at the agreed upon prices. This, of course, is a critical task because many companies may be considered to be fiduciaries or co-fiduciaries under ERISA.

Because ERISA imposes certain duties upon plan administrators, company executives should monitor their health insurance plan's costs and ensure that they comport with the terms of the plan and any applicable state or federal regulations. Even if the company is not experiencing any direct out-of-pocket expenses by reason of copay billing, it still may have a fiduciary obligation to remedy any wrong affecting the employees' health plans.

Additionally, and in order to improve and maintain good relations with its employees, a company should remain vigilant in protecting its employees' interests. Ignoring abuses and overcharges affecting employees' health benefits sets the stage for unwelcome litigation. An employee-plan participant need not be financially devastated to make a case regarding copay overcharges. In fact, the copay controversy—implicating billions of dollars in overcharges—is believed to have been exposed by a man whose wife was overcharged less than $80 under their health plan.

Indeed, courts have recognized a company's potential stake in seeing that the health plan lives up to its promises and terms. In *McConocha v. Blue Cross Blue Shield of Ohio*, for instance, a federal court held—over the repeated objections of the health insurance company—that a company had standing to sue its health insurance company over copay overcharges. The court had ruled in a companion decision that the insurance company had breached its fiduciary duty by charging health plan participants (the employees of the company) inflated copayments and for failing to disclose that fact. The court ruled that by virtue of the company's potential ERISA liability in connection with the copay overcharges, the company had standing to sue the insurance company although it was not itself victimized by the overcharges.

An associated problem caused by copay overbilling has to do with health plan benefit limits. Naturally, maximum or lifetime benefits are reached more rapidly when inflated—instead of discounted—prices are used by the health insurance company to calculate an employee's lifetime benefits. This can, of course, prove disastrous for a plan beneficiary who, for no reason other than that the insurance company is using an inflated price to calculate benefits, must dip into savings for coverage that really should still be available.

Third Party Administrators and Self Insurance

The second area in which overbilling may adversely affect policyholders involves self insured health plans. Here, the company rather than the employees bears the economic brunt of overcharges. Often, companies which self insure for their health plans use health insurance or managed care companies to administer the health plan. These are usually referred to as third party administrators or "TPAs."

Unknown to many companies that use TPAs, however, is that the TPAs sometimes negotiate steep discounts with providers that are not passed along to the self insured company. Thus, the TPA not only pockets the fee it charges for administering the plan, but also the margin between the "list price" it charges the company for the health care procedure and the actual price it pays the provider (which, of course, is often drastically lower). Companies may also be charged excessive administration fees if the administration fee is calculated as a percentage of provider costs under the health plan.

The result is that the company is being overcharged—sometimes to the tune of millions of dollars. Companies thus need to audit their plans and see if their health insurance companies have been sharing provider discounts. Currently, the

United States Department of Labor (DOL) is auditing approximately 40 health plans nationwide in connection with overbilling. The DOL has already sued one health insurance company in Massachusetts, charging that it overbilled various policyholders by as much as $180 million.

Steps to Avoid Unpleasant Surprises

At least three clear objectives should be present for any company offering health plans to its employees. First, preservation of the company's assets should be emphasized—especially in the context of self insured companies utilizing TPAs. Second, employee interests should be protected by ensuring that they are not being overcharged for health-related services promised at specific rates. Third, in order to avoid potential ERISA liabilities, companies should be alert and proactive in monitoring delivery of health plan benefits.

Using an auditing company may be helpful in detecting any overcharges in connection with the company's health plan. Experience shows, however, some health insurance companies will be less than cooperative when a company seeks to initiate an audit of its health plan. As a result, some companies have had to resort to litigation in order to recoup overpayments made to their health insurance companies. ■

JOSHUA GOLD IS A SHAREHOLDER IN AKO'S NEW YORK OFFICE. JOSHUA CAN BE REACHED AT (212)278-1886 OR **jgold@andersonkill.com**