

## Scenario #7 – Joyce Holmes, insurance claims department manager

Joyce has been working for a large for-profit insurance company for twenty-five years. She is 52 years old, divorced, and in good health. She has, however, sought relief from the stress of her job and is seeing a mental health counselor. With her son out of the house, this is the first time that she has been able to travel some and finally buy her dream house.

She began as a file clerk and over the years was promoted, most recently, to be the Manager of the claims department of more than fifty employees. She has taken industry courses in claims management, but has no professional medical training. The CEO of her company was fired by the board of directors and given a \$1.2 million severance plus lifetime health benefits last year.

Joyce's best friend is the secretary to the Chief Financial Officer and says that the company is joining several other large insurance companies to lobby against health care reform. They will be running ads in prime time and have doubled the number of lobbyists in Washington.

Joyce went with some people from work to see the movie *Sicko!* and was shocked to hear her colleagues call Michael Moore a liar. She has had to work with procedures developed by the finance department that set up many barriers and cumbersome appeals for the last ten years. She has been increasingly unhappy at work, feels like she is on the wrong side of what is right, but doesn't know what else she could do for work that would pay her the kind of money she makes. She found well over 1 million "hits" on Google when she searched with the words: "claims health insurance issues."

A 2006 survey based on data from nearly 25 million claims, processed by a total of 26 large and small health plans in the United States.

From Center for Policy and Research, America's Health Insurance Plans

- The percentage of claims received electronically was 75 percent in 2006, up from 44 percent in 2002.
- There is often a significant time lag before health insurance plans receive claims from health care providers. In 2006, 29 percent of claims were received from health care providers more than 30 days after the date of patient service, and 15 percent of claims were received from providers more than 60 days after the service was provided.
- Health insurance plans processed 98 percent of "clean" claims within 30 days, up from 94 percent in 2002. Processing time is the number of days from when a claim is received until the claim is paid, denied, or "pending" for further information. ("Clean" claims are those for which no additional information is needed.) Fourteen percent of claims in the survey were "pending" or delayed, usually because of incomplete or incorrect information.
- Approximately two-thirds (68 percent) of all claims are now adjudicated automatically; that is, processed without manual intervention. Among electronic claims, 71 percent were adjudicated automatically in 2006, up from 49 percent in 2002. Forty-four percent of paper claims were adjudicated automatically in 2006, up from 27 percent in 2002

- Electronic claims are less costly to process than paper claims. The average cost of processing a clean electronic claim was 85 cents, nearly half the \$1.58 cost of processing a clean paper claim. Pended claims requiring manual or other review cost \$2.05 on average per claim to process.

Some of the facts stated in Sicko that bothered Joyce the most:

- "A study by Citizen Action, a consumer group, reports that doctors, hospitals, insurance companies and other providers of medical services made campaign contributions of \$ 79 million during the 1993-1994 election cycle. The insurance industry passed out \$16 million. The American Medical Association, which objects to cost-control measures, contributed \$ 3 million." From Harrop, "The big lie about health reform," *Rocky Mountain News*, August 20, 1995.
- Aetna: "Aetna Inc. ... settled with the plaintiffs, which include the medical associations of California and Texas. Aetna agreed to pay the plaintiffs \$120 million." Milt Freudenheim, "Class-Action Status Is Upheld for Doctors Suing Insurers," *New York Times*, September 2, 2004. See also, Susan Beck, "HMO Postmortem," *American Lawyer*, October 10, 2003. Settlement Agreement.
- Blue Cross/Blue Shield: "Sixty-seven Blue Cross/Blue Shield companies across the nation have paid the United States a total of \$117 million to settle government claims that Medicare made primary payments for health care services that should have been paid by the Blue Cross/Blue Shield private insurance companies, the Department of Justice announced today." "Blue Cross/Blue Shield Companies Settle Medicare Claims, Pay United States \$117 Million, Agree To Share Information," Department of Justice News Release, October 25, 1995.
- Michael B McAllister earned \$3.33 million in compensation as CEO of Humana. "Forbes 2006 Executive Pay list," April 20, 2006.
- John W Rowe earned \$22.2 million in compensation as CEO of Aetna. Rowe has since left Aetna. "Forbes 2004 Executive Pay list," April 21, 2005.
- Bill McGuire has stock options worth \$1.6 billion at the end of 2005, as CEO of UnitedHealth Group. Robert Simison, "SEC Investigates UnitedHealth Over Stock-Options Practices," *Bloomberg News*, December 27, 2006; Michael Regan, "Business 2006: Who Won, Who Lost," *Associated Press*, December 26, 2006.
- There are four times as many health care lobbyists as there are members of Congress. According to the Center for Responsive Politics, in 2005 there were 2,084 health care lobbyists registered with the federal government. With 535 members of Congress, that's 3.895 lobbyists per member.