A Claim to Life; The Real Cost of Denied Insurance Claims

Years ago when working as a nurse in an ICU, I was exposed to my first eating disorder patient. She was so malnourished and had thrown her electrolytes so off balance with restricting and purging, that she went into cardiac arrest. Ironically, she arrested while at church among a congregation of people who don't believe in medical intervention. After 2 minutes or so, her husband panicked and began CPR and asked someone to call 911. By the time she came to me, the CPR had saved her life but she had been without sufficient oxygen for long enough, that the patient will remain in a semi-vegetative state for the rest of her life.

I remember as a nurse on this case thinking how devastating this illness is and how each day of restriction or purging or bingeing is just like playing Russian roulette – where patients are so ill, that their behaviors could take their lives at any moment. I remember thinking that we, as nurses and doctors, knew how to stabilize them medically, but we knew very little about the psychological component that was so apparently needed to help them get well. I had no idea at that time that I would someday be working with this patient demographic as a nurse administrator.

Likewise, I had no idea at that time I would be spending day in and day out fighting with everything I have just to try to get them the treatment they need. Little did I know what a fight it would entail! And how would I know? In medicine, when a disease or illness begins claiming thousands of lives, millions of dollars are spent every year on education, research and prevention. Examples of this are seen with heart disease, cancer, strokes, and diabetes. As a nurse, I'm thrilled to know that we, as a society, recognize the need to intervene better and earlier in order to prevent deaths or other complications from those illnesses and to keep the costs associated with them down. Yet, approximately 11 million Americans suffer from an eating disorder. Anorexia has the highest mortality rate of any mental illness, and the death rate is 12x the expected of that for females ages 15 – 24. The suicide rate is 75x greater. Within 20 years from the time symptoms emerge, the death rate is as high as 20%. And yet, only 1 in 10 people with an eating disorder are able to get treatment. As a society, we embrace the need for intervention in order to reduce the incidence of diabetes. Yet we treat eating disorders like they are a dirty secret that we don't talk about, as though closing our eyes to the thousands of deaths that occur every year because of complications associated with them will somehow just magically disappear. But the deaths don't stop! Just ask the loved ones of Kari Lynn Devries and Nicole Lynn Boice - girls who died because they couldn't get authorization from their insurance companies to get the treatment they needed. Or you could ask Tracy Smith, Reanna Smith's mother, who was told by her insurance company in California that her daughter's eating disorder wasn't "life threatening" and denied care. Tracy took a new job in September of last year for the sole purpose of getting better insurance, but she had to wait until December. Unfortunately, Reanna died November 15th, just 2 short weeks before the new insurance would be in effect.

When we purchase a health insurance policy and pay our premiums, we anticipate that our insurance company will be there for us in times of need. That's why we get insurance in the first place. In fact, many Americans are being forced to pay higher and higher premiums while also being responsible for higher and higher deductibles, and yet, they do so because their expectation is that the cost will be worth it when something happens and medical costs are incurred. Imagine their shock when, after paying premiums for years to their insurer, the claims are denied for one reason or another. I hear their shock on the phone almost daily when I have to call and tell them that their insurance has denied the

level of care needed to help their loved one get well. The insurers deny, but they are not the ones who have to tell a parent that their sick child can no longer get the treatment needed to save her life. They are not the ones who have to attend the funerals of all the patients who die because needed treatment was denied due to lack of coverage.

And why should they? What is their incentive? Insurance companies know that many of their policies fall under the protection of the Employee Retirement Income Security Act (ERISA) – an act which was originally put into place to prevent employers from spending funds which were supposed to have been set aside for their employees pensions. However, as with most good things, there will be those who will abuse it for their gain. Because ERISA is a federal law, policies which fall under ERISA do not have to comply with state regulations and consumer protections. The law does not allow federal judges or juries to award punitive damages. Additionally, if the patient who was denied coverage dies, the insurer cannot be ordered to pay anything to the patient's survivors. Thus, the insurer is absolved of any responsibility to pay.

To complicate matters further, it is important to understand some key points related to insurance as a business. Insurers are comprised partly of share holders who meet regularly to look at the company's financial reports. One of the things they look at is the value of the company's stock shares. There are numerous things which impact the value of the stock. One of those things is how many shares have been sold. Another one is the company's profits. Wendell Potter, a former top executive with Cigna healthcare, wrote in his book, *Deadly Spin*, about how such tools are manipulated by insurers to serve the share holders.

By jacking up premiums and shifting more cost to their policyholders through high deductibles, insurers are able to manipulate an obscure ratio especially important to their shareholders called the medical-loss ratio (MLR) – or the percentage of health insurance premiums collected that are then used to pay for medical claims. Of note, the medical-loss ratio has dropped from 95% in 1993 to a mere 80%. It most probably would have gone even lower had the federal government not intervened and require that insurers maintain a medical-loss ratio of at least 80%, meaning that at least 80% of the premiums they collect must be spent on medical costs with the remainder being spent on overhead. The more premiums the insurer can collect and the less they can pay out on medical costs, the greater their profits are, thereby driving up stock prices. Canceling individual policies when the individual gets sick, getting rid of small-business customers who file more claims than expected, denying claims, increasing rates so high that customers don't or can't renew their policies, and shifting costs to the consumers are the ways insurance companies cut their medical expenses and keep their medical-loss ratio down. Ironically, it's known in the industry as "purging."

When comparing the medical-loss ratios and consolidated profits in the second quarter of 2009 to the same quarter in 2010, the majority of major for-profit insurers in this country reduced the amount they paid out on medical claims while at the same time increasing their profit by several million dollars.

Another key method used by insurers to achieve excessive profits and CEO pay is to use their capital to repurchase company stock on the open market. This drives up share prices and increases the value of personal holdings acquired through stock options granted by the companies. According to the U.S. Securities and Exchange Commission filings, from 2003 to 2009, the seven largest for-profit health insurers spent an incredible $57.6 billion of their capital to buy back their own stock and propel share prices upward. As if this practice isn't disturbing enough, the physicians and medical directors for

insurance companies who call the shots on whether or not to pay for expensive treatments, often receive stock options as part of their compensation package. Thus, they benefit personally from denying claims, thereby increasing profits while lowering the medical-loss ratio, and in turn, increasing the value of their stock shares.

Rather than reducing premiums or improving benefits to consumers with the profits, insurers decide that it is more important to enrich already wealthy CEO's and top investors. Such evidence can be seen in additional reports from the U.S. Securities and Exchange filings. In 2009, the Cigna CEO, Edward Hanway, not only made a salary of $18 million, but then also gave himself a $110.9 million retirement package. CEO Stephen Hemsley of United Health Group banked $107.5 million in 2009, including $98.6 million from stock options.

After acknowledging in a 2008 conference call with financial analysts that her company had spent more on medical care during the previous three months than the analysts had expected, the CEO of WellPoint (the parent company for Anthem Blue Cross), Angela Braly, promised that in the future, "we will not sacrifice profitability for membership." True to her word, in 2009, Angela Braly got a 51% raise to $13.1 million at the same time that Anthem attempted to increase 2010 premiums to consumers by as much as 39%. Anthem, assuming that most Americans were ignorant enough not to catch on, blamed the rate hike on the weak economy and the soaring cost of medical care.

I recognize that insurers in this country are large in number and that the money they acquire from consumers enables them to have a loud voice. But then I can't help but think of the thousands of people who die every year because these same insurers denied them coverage for necessary treatment. Who will be their voice? How many people did Cigna or United have to deny in order to pay those exorbitant salaries to their CEO's? How many lives did it cost? If even one of those deaths had been your loved one, you would agree that even one life is too high a price to pay simply to appease the greed of others. I join my voice with everyone else here today on behalf of those who have died because they were denied treatment. We will be their voice and we will continue fighting against that which is wrong! We ask that you give them the voice they deserved by supporting the FREED act – which requires insurance companies to pay for necessary and life-saving treatment.