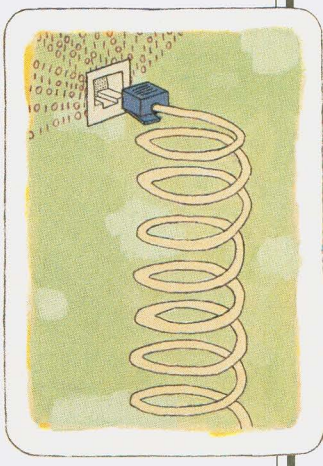
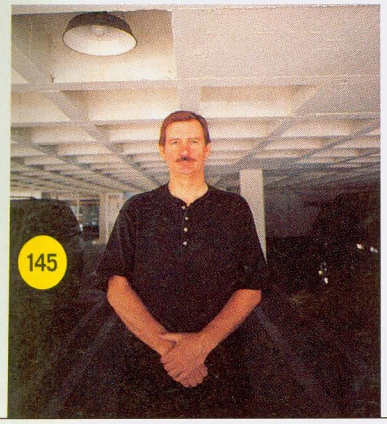
FEATURES

MID-YEAR INVESTMENT REPORT





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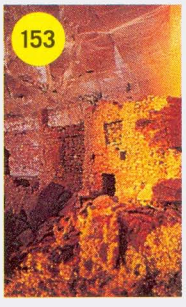


INCONSPICUOUS CONSUMER

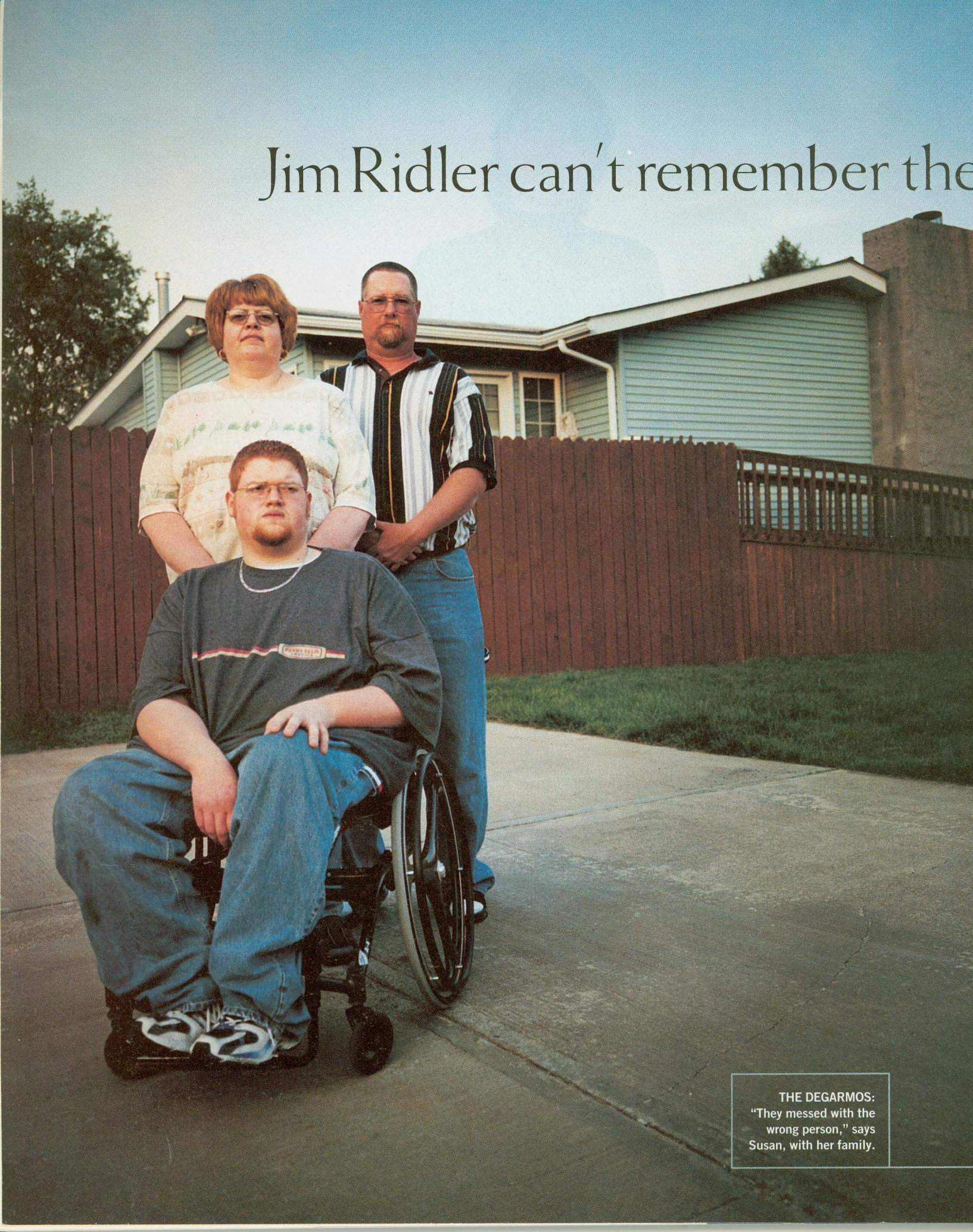
Adding Insult to Injury

IT'S BAD ENOUGH BEING HURT IN AN ACCIDENT. BUT THESE DAYS, HEALTH PLANS AND HOSPITALS ARE COMPOUNDING THE PAIN—BY CLAIMING BIG PARTS OF VICTIMS' SETTLEMENTS.

BY MICHELLE ANDREWS PHOTOGRAPHS BY PABLO AGUILAR

LIEN ON ME: "They had no humanity," Pam Henline says of her hospital.

Jim Ridler can't remember the



THE DEGARMOS: "They messed with the wrong person," says Susan, with her family.

accident that left his body shattered,

only the moments that led up to it. It was shortly after noon that Friday in August 1995, and Ridler, then 35, had been out running errands. Headed back to his home outside Franklin, a small town in southern Minnesota, he was zipping down two-lane Highway 19 on his motorcycle, just half a mile from the turnoff to his house. Suddenly, a minivan coming the opposite way swerved into his path. It hit him head-on, sending him sprawling more than 200 feet into a ditch. His injuries were so severe—he broke his neck, collarbone, hip, several ribs and all of the bones in both legs, and ripped the triceps in his right arm clean through—that he had to be airlifted to a hospital near Minneapolis for treatment.

Over the next four months, he was moved from hospital to hospital as doctors tried to piece him back together. After a dozen surgeries, they still couldn't say for sure whether he'd ever walk again. But at least by then he had gotten settled in at a hospital closer to his home, so his family could visit him every day. In the meantime, he had his lawyer start legal proceedings against the driver of the minivan.

Ridler's nightmare, though, wasn't over. While still in the hospital recuperating, he got a phone call that really shook him. It was from his lawyer, Jim Lord.

"I'm afraid I've got some bad news for you," Lord started out. Even if Ridler won the suit, Lord explained, he might not be able to collect all the money. Seems his health plan wanted a big chunk of the cash to cover what it had spent on his care. "You're joking, right?" Ridler asked.

Nope, Lord assured him. He explained that Ridler's health plan had a clause in its contract that allowed it to stake such a claim, a right known in insurance circles as subrogation.

"So I pay the premium, and then when something happens that I need the insurance for, they want their money back?" Ridler asked incredulously. "The way I figure it, my health insurance is just a loan."

Ridler eventually settled the suit for $450,000. He felt he had more coming to him, but that was all the liability insurance available. Nonetheless, the health plan got its share: a whopping $406,000. As for Ridler, after paying his attorney fees, he was left with a grand total of $29,000. "I feel like I was raped by the system," he says.

As astonishing as Ridler's case is, it's by no means unique. Buried in the contracts of many health plans is dull, boilerplate-sounding language that allows the plan to get reimbursed for its costs if members collect on personal-injury suits. Most people aren't even aware that these subrogation clauses exist until they've been in an accident and try to recover money. Then they become *very* aware. "Health plans are getting more aggressive about going after these dollars," says Roger Baron, a law professor at the University of South Dakota who has studied subrogation. "It's the biggest underrated issue there is."

Health plans defend themselves this way: They contend that by covering an accident victim's medical costs up front—rather than making the victim wait for a resolution on who is liable—they are doing that person a favor. They point out that in a personal-injury suit, the victim seeks compensation for health care costs, not just for pain and suffering and lost income. Why, then, shouldn't that money go to the health plan?

Fair point, in theory. But the reality is, plaintiffs don't always get fully compensated. A defendant's liability insurance often dictates the maximum settlement in these cases. Once the health plan takes its cut, there may be little left for the injured person to rebuild a life with.

For now, the legality of subrogation is based on a patchwork of federal and state statutes and case law that varies wildly. The issue is still being hammered out in courts throughout the country, and one of the fundamental questions being raised is this: If you have to pay back your health plan for its costs, what exactly are you getting for your premiums? "The problem with subrogation is that it turns the promise of insurance coverage into an illusion," Baron says.

Until the 1960s, subrogation, though common in property insurance, wasn't even permitted in personal-injury cases. Under pressure from auto insurers, which were looking to protect the medical-payment portion of their policies, many states began to allow it. Today only a handful—among them, Pennsylvania, Virginia, Arizona, Missouri and Georgia—prohibit it.

Health plans are not the only ones going after personal-injury money. Squeezed by ever-tightening margins, hospitals, too, are scrambling to bring in extra bucks, and accident settlements make a tempting target. Hospitals have their own collection tool: state statutes that allow them to place liens on an injured person's recoveries.

Originally, these laws were intended for cases in which the hospital provided free treatment to patients who had no health insurance. Now hospitals are applying the statutes to managed-care patients, placing liens for the difference between what the health plan paid and what the hospital says was its true cost. Never mind that the hospital had a contract to treat these patients at a *discount.*

Tenet Healthcare, which operates 112 hospitals nationwide, has stopped issuing liens until several lawsuits on the matter are resolved. Still, the hospital defends the practice. "Managed care is designed to cover regularly scheduled care, not emergency and traumatic care," says spokesman Harry Anderson. "We believe we should be able to recoup the full cost of services in those cases."

Pam Henline has a much different perspective. In 1996, she was driving on the freeway near her San Diego home when a tow truck drifted into her lane. She slammed on the brakes, losing control of her car and smashing into a concrete construction bar-

rier. The crash partially severed her spine, leaving her with very limited use of her arms and legs. She sued the tow-truck driver and won $8 million, a judgment still under appeal. She also got about $2.5 million in various settlements related to the accident.

When she received the first lien notice from Scripps Memorial Hospital in La Jolla, Calif., she was still a patient there. Even after her health plan paid the hospital what it owed, Scripps wanted an additional $16,000. Outraged, Henline refused to pay. The hospital continued to send her notices, at one point, she says, even threatening to ruin her credit rating. Still, Henline wouldn't budge. "I said to myself, 'We are not going to give in on this.'" She sued to have the lien lifted, and last year a state judge sided with her, saying that the hospital's contract with the health plan precluded such liens. Now Henline, 55, is pursuing another aspect of her suit against Scripps—her claim that its hardball tactics caused her emotional distress. A lawyer for Scripps denies that the hospital threatened Henline's credit rating but declined to comment further.

"I was really badly injured," Henline says. "They had no humanity, no regard for me as a person. I was just money to them." Adds her lawyer, LaMar Brown of the San Diego firm McClellan & Brown, "It's as if a paramedic saved your life but then stole your wallet."

It's one thing for a health plan or hospital to get reimbursed for its costs. It's quite another for it to seek money it never paid out. Yet that's what some managed-care companies are doing with subrogation.

Susan DeGarmo found out 10 years ago when her HMO asked for reimbursement on her son's medical bills. In 1990, Stephen DeGarmo, then 10, had been hit by a pickup while riding his bike to football practice near the DeGarmos' Mozart, W.Va., home—a terrible accident that left him paralyzed from the waist down. The DeGarmos sued the driver and collected a $750,000 settlement, plus $200,000 from their underinsured-motorist policy.

Since she worked in the business office of a doctors' practice, Susan DeGarmo was familiar with subrogation. Still, the $128,000 that the HMO, the Health Plan of the Upper Ohio Valley, was demanding seemed high to her. So she did some research. She called the hospital in Columbus, Ohio, where Stephen had been treated, and got an itemized list of charges. What she discovered infuriated her. The HMO had paid much less than the $128,000 it now was seeking.

Susan had stumbled across what her attorney calls "the dirty little secret of managed care": Health plans often use subrogation to go after a hospital's billed charges—the fee for full-paying patients—even though the health plans get a *discount*. According to the DeGarmos' lawyer, the Health Plan of the Upper Ohio Valley actually paid only $70,000 to treat Stephen. (The HMO disputes that estimate as too low.) "My sense is that this is extremely widespread," says the DeGarmos' lawyer, Don Kresen of Gold, Khourey & Turak in Moundsville, W.Va. How can health plans justify it? In the DeGarmos' case, the HMO pointed to language in its contract that let it collect "prevailing rates."

When the DeGarmos refused to pay, the health plan sued them. The family then countersued, alleging fraud and demanding punitive damages. Their suit became one of four class actions Kresen brought against the Health Plan of the Upper Ohio Valley. In 1998 the HMO settled the suits for a total of $9 million, spread among roughly 3,000 plaintiffs. "They picked the wrong person to mess with," says Susan, still outraged. "They were trying to steal money from my son. He needs that money to take care of himself for the rest of his life."

The Health Plan of the Upper Ohio Valley, which no longer goes after billed charges, says it was punished for doing nothing more than what personal-injury plaintiffs do. "If a plan member sues, he goes after the hospital's *billed* charges," says Dave Mathieu, vice president of marketing. He also points out that by collecting the higher amounts, the HMO could keep its premiums lower than it would otherwise.

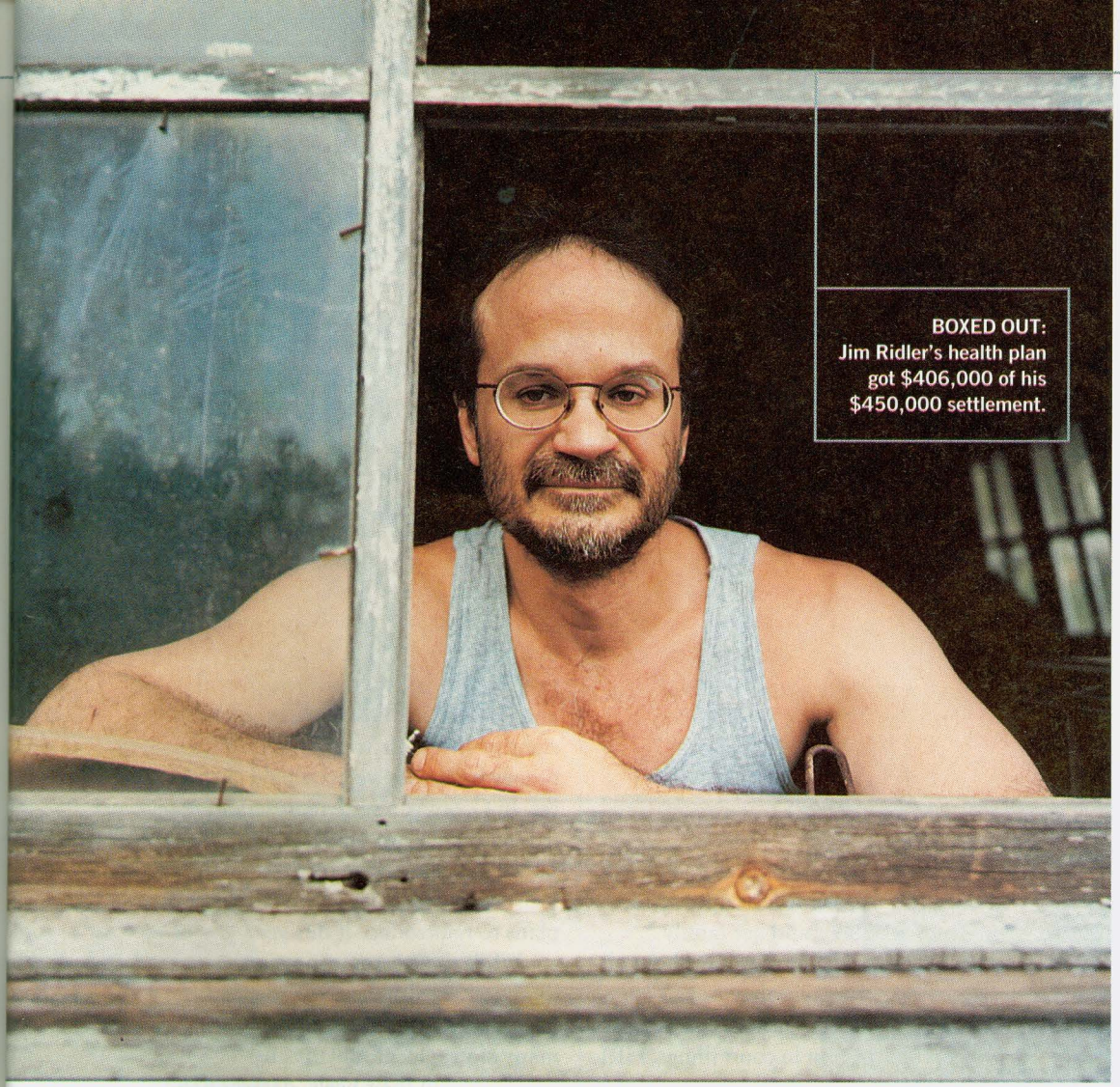
California state senator Adam Schiff finds the whole thing appalling. "It's an illustration of HMOs overreaching," says the Democrat. "When they go after compensation in excess of their costs, they're depriving victims of revenues that may be very necessary to help them recover." As chairman of the state's Senate Judiciary Committee, he proposed a bill this year that would prohibit managed-care companies in California from collecting more than they spend on members' care.

Meanwhile, Don Kresen, the DeGarmos' lawyer, plans to file several more cases in coming months against HMOs that he says collected inflated charges. "Managed care took its eye off the ball, lost its moral compass and forgot the people it was supposed to take care of," he says. "This is just one more manifestation of that."

'It's as if a paramedic saved your life but then stole your wallet,' one attorney says of hospitals placing liens on patients' claims.

For a long time, even after it became legal in many states, health plans and hospitals didn't much bother to go after personal-injury money. "It was a cumbersome, manual process that took a lot of time," says Bill Howard, a principal with benefits consultant William M. Mercer. But now sophisticated data-identification and tracking software makes the process much more automated. Subrogation has even spawned a cottage industry of companies that handle collections for a fee—generally a quarter to a third of what they recover.

These benefits-recovery firms—they don't like being called collection agencies—have the process down to a science. It starts with identifying possible personal-injury cases. Clients send them magnetic tapes, disks or e-mails with information on pa-



BOXED OUT: Jim Ridler's health plan got $406,000 of his $450,000 settlement.

tients' diagnoses and treatments. The recovery companies then search for any of the few dozen codes they've identified as likely to be accident-related—anything from bruises to broken bones to sprains. Once they've generated a list of potential victims who have medical bills above a certain amount, claims examiners typically write to them, asking whether their injuries were caused by an accident. If the answer is yes, the company then begins to keep tabs on them to see if they make a personal-injury claim. If they do, the company steps in to pursue some of the cash.

The biggest of these recovery companies is Louisville, Ky.–based Healthcare Recoveries Inc. As of the end of March, the 750-employee company was working $1.2 billion of potential claims. Last year HRI, whose biggest customer is United HealthCare, recovered $226 million for its clients, up from $178 million the prior year. HRI's cut: 27 percent. But according to one former claims examiner, the company is so intent on maximizing its collections that it often crosses the line into questionable practices.

When he went to work in HRI's Pittsburgh office in 1995, Steve Pope, then 35, was still looking for his niche. He had dropped out of college after three and a half years, then spent two years auditing law-school classes. He bounced from job to job, sometimes at plaintiffs' law firms. He joined HRI after seeing a help-wanted ad that promised extensive training.

As a claims examiner, Pope handled roughly 400 cases at any given time. His job: to stay on top of them to make sure HRI collected whatever it could. Gradually, over the three years he worked there, Pope became disillusioned with the company. He felt its collection practices were sleazy, and that the constant pressure to bring in money often overrode ethics.

One case in particular rankled him. It involved a 16-year-old girl named Courtney Ashmore who had been riding a four-wheeler on a country road near her home in Tupelo, Miss. The owner of the bordering land had strung a cable across the road, and Ashmore ran right into it, nearly decapitating herself. Her family collected $100,000 from the property owner.

Their health plan, which had paid $26,000 for Ashmore's care, was an HRI client. The case was assigned to Pope, and following standard procedure, he contacted the family's attorney, Roy Parker Jr., to follow up. Parker insisted on seeing a copy of the health-plan contract that showed the subrogation clause. But after searching the file cabinets in the office, Pope couldn't find a contract for the Tennessee Valley Regional Housing Authority, the employer whose health plan was involved.

According to testimony he gave in a suit that Ashmore's family later filed against HRI, Pope informed his supervisor of this and was told to send a page from a generic contract—one that included a subrogation clause. Later, Pope found out that the Tennessee Valley plan did not, in fact, mention subrogation. Still, he testified, he was told to continue to pursue the money anyway.

In his testimony, Pope recalled another time he closed a file because he found out that the case took place in Virginia, where health care subrogation is not allowed. But when the attorney for the injured person contacted HRI to ask about the claim's status, Pope said he was "ordered" by the company to reopen the case. HRI eventually collected about $8,000 that it "is absolutely not entitled to," he testified. In an interview later, he adds that his supervisor told him: "If the attorney is stupid enough that he doesn't know that, we'll take the money."

For Pope, the Virginia case was the last straw. In August 1998 he gave notice that he was leaving. "These practices were so widespread, and I just got tired of being told to cheat and steal from people," he says. As a parting shot, Pope couldn't resist engag-

THE INSIDER: "I just got tired of being told to steal," says ex-claims examiner Steve Pope.

ing in a little sabotage. He put notes in his files saying certain cases were months away from settlement, even though it was imminent. He knew that once a plaintiff had the check in hand, it was much harder for HRI to collect. Pope even called one family to assure them that, contrary to what the claims examiner was threatening, HRI probably would not sue them because their claim was too small.

A few months after leaving HRI, Pope was sitting at his dinner table one night, just thinking about the company and what it was doing. Impulsively, he picked up the phone and called Roy Parker Jr., Ashmore's attorney. He left a message saying he had some important information that Parker might find interesting. The phone rang back almost immediately. It was Parker's father, who was also working on the case.

"What can we do for you, Mr. Pope?" he asked. By this time, the Parkers had gotten a copy of the health plan on their own and knew that it did not include subrogation. They were in the midst of suing HRI in a Mississippi state court.

"I wanted to tell them they were on the right track going after the company, that they [HRI] knew they had no subro language," recalls Pope, who now sells sewing machines at a Sears store in Pittsburgh. "And I wanted to apologize to Courtney Ashmore and her family."

What does HRI have to say about all this? "It is company policy not to comment on ongoing litigation," says CFO Douglas Sharps. But in court filings, HRI denied the family's claims that it falsely asserted subrogation.

Some critics of health care

subrogation and liens see signs that, ever so slowly, the tide is turning against these practices. Roger Baron, the law professor, says the notion that subrogation should be prohibited or at least restricted "seems to be gaining ground" in courts and legislative houses. He points out that a number of states—25 at last count—have adopted doctrine, through either statutes or case law, requiring that injured people get fully compensated before health plans can collect any share of personal-injury money.

In March, a Maryland appeals court went even further. It ruled that the state's HMO Act prohibited managed-care companies from pursuing subrogation at all. "An HMO, by its definitions, provides health care services on a prepaid basis," the court said. "A subscriber has no further obligation . . . beyond his or her fee."

Though the ruling's impact is limited to Maryland, lawyers who are challenging subrogation hail it as a landmark. "The Maryland case is very significant because it says that HMOs are prepaid plans, that they shouldn't be able to collect twice," says Don Kresen. "That's the argument I've been making for six years. Finally, a court says it's right." The issue will get sorted out more in coming months, as at least a dozen class actions challenging various aspects of subrogation are pending in at least nine states, including Florida, Texas and Illinois.

Courts are also chipping away at hospital lien practices. Recent higher-court rulings in Arizona, New Mexico, Texas and Wisconsin have struck down the right of hospitals to recover additional money once they've been paid by insurers. In Georgia, a state representative introduced a bill last year to eliminate hospital liens altogether in that state. The legislation didn't go anywhere, but she plans to reintroduce it this year.

While there is some movement in this direction, health care subrogation and liens still remain back-burner issues in many states. Health plans and hospitals are digging in their heels, determined to continue these practices. "Unless there's an aggressive arm of consumerism, the industry basically just gets what it wants," Baron says.

That means, for the foreseeable future, there may be a lot more people like Jim Ridler. It's been five years since his motorcycle accident, but his legs still bear the heavy scars. Though he has recovered enough that he can walk, Ridler, now 39, has metal rods in his thighs, and some days he's in a lot of pain. His brush with subrogation left him so wary of insurers that he no longer carries health coverage.

Eventually, Ridler did receive some additional compensation for the accident—a $228,000 settlement from the owner of a fertilizer spreader that had stopped beside the highway, causing the minivan driver to swerve. Still, he says bitterly, "the money I got didn't even come close to making up for all the pain and suffering I went through." SM