Future Uncertain as Health Plan Settlements Expire

BY ALICIA AULT
Associate Editor, Practice Trends

LAS VEGAS — As more of the agreements signed by several large insurers to settle a class action suit alleging inappropriate billing practices expire, the possibility is increasing that the companies will return to the same behavior, especially given that many are being accused of violating the terms already, reported a compliance expert.

Several of the health plans have said they will continue to comply with the terms of their settlements once they expire, but "not all have said that," said Edward R. Gaines III, vice president and chief compliance officer for Healthcare Business Resources in Durham, N.C., who spoke at a meeting on reimbursement sponsored by the American College of Emergency Physicians.

Mr. Gaines said that noncompliance among all the plans that have settled has continued to be an issue, which is being dealt with in the courts and administratively. But, "the problem is, once the settlement agreement expires, I can't go back into federal court through an easy process to make my complaint heard," he said.

The settlements were struck in response to Multidistrict Litigation 1334, which was certified as a class action in U.S. District Court for the Southern District of Florida in 2002 and named Aetna Inc., Anthem Insurance Cos. Inc., Cigna, Coventry Health Care Inc., Health Net Inc., Humana Inc., PacifiCare Health Systems Inc., Prudential Insurance Co. of America, United Health Care, and WellPoint Health Networks Inc. as defendants. The suits alleged that the insurers violated the federal Racketeer Influenced and Corrupt Organizations Act by engaging in fraud and extortion in a common scheme to wrongfully deny payment to physicians.

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Several state and county medical societies filed the suits on behalf of virtually every physician in the nation—about 900,000 doctors. United Health Care and Coventry both were summarily released from the litigation. Their release has been upheld on appeal. Aetna and Cigna struck agreements that entailed an immediate payout in response to claims filed by physicians, some changes in billing behavior, and an agreement to provide prospective relief—$300 million from Aetna and $400 million from Cigna.

Cigna's 4-year agreement has now expired, and Aetna's 4-year agreement expired in June 2007; but Aetna's agreement was extended through June 2008 because of compliance disputes. After an investigation, the New Jersey insurance department fined Aetna $9.5 million in June 2007 for failing to properly pay for out-of-network providers. The insurer is paying nonparticipating physicians only 125% of Medicare rates and informing patients that they are not responsible for the difference.

ACEP, the North Carolina chapter of ACEP, Wake Emergency Physicians, and the North Carolina Medical Society subsequently followed up with a complaint to the North Carolina insurance department in November, said Mr. Gaines. The North Carolina group is challenging bundling of 12-lead ECGs into evaluation and management codes, and bundling of other procedures that use the CPT-25 modifier codes.

"If we don't get prompt action from Aetna, we're going back to court [to] ask for an extension of the settlement agreement term," he said.

The American Medical Association and Aetna recently announced that they are working together to resolve outstanding complaints.

Prudential's agreement expires in 2009, and agreements with three other insurers expire in 2010: HealthNet, Anthem/WellPoint, and Humana.

Agreements were reached with 90% of the nation's Blue Cross and Blue Shield plans and the Blue Cross and Blue Shield Association last April, but the final settlement date was being worked out at press time. The Blues plans agreed to similar terms as did the other payers, with one exception: Anthem/WellPoint and the Blues plans refused to accept assignment of benefits. In fact, the Blues plans were willing to walk away from the settlement if they did not win that concession, said Mr. Gaines.

The court gave preliminary approval last November to a settlement with the West Virginia–based Highmark/Mountain State Blue Cross Blue Shield. Claims could still be filed through February 2008.

Mr. Gaines urged physicians to hold the health plans that settled accountable to their agreements.

Information on settlement terms and how to dispute claims can be found at www.hmosettlements.com. ■

States Looking Inward, Striving for Transparency as Health Tabs Grow

BY ALICIA AULT
Associate Editor, Practice Trends

WASHINGTON — With health care expenses accounting for the single largest expense in their budget, states are increasingly looking for solutions from within, not from the federal government, according to an annual accounting of state legislative trends compiled by the Blue Cross and Blue Shield Association.

"Health care spending represented nearly one-third of total state expenditures last fiscal year," said Susan Laudicina, BCBSA director for state research and policy at a briefing for reporters. And, she noted, as the economy weakens, health care costs will continue to rise, while tax revenues will fall. That will add to the pressure to find creative solutions, she said.

"The challenge for state lawmakers is how to avoid cutting existing programs like Medicaid and the State Children's Health Insurance Program while also finding new ways to cover the uninsured and contain costs," said Ms. Laudicina.

The most significant trend observed in the states: an attempt to expand coverage. About half of the state legislatures debated universal coverage or expansion programs for children in fiscal 2007. State mandates requiring individuals to buy insurance were introduced in 12 states. All failed, largely because they are controversial, Ms. Laudicina said.

Connecticut and New York expanded eligibility for SCHIP to 400% of the federal poverty level and seven other states raised eligibility to 300%, but those efforts are threatened by a rule change issued by the Department of Health and Human Services last August that ostensibly caps eligibility at 250% of the federal poverty level. Eight states have sued to challenge that ruling.

Eight states—Connecticut, Indiana, Kansas, Louisiana, Maryland, New York, Texas and Washington—created programs in which public funds are used to subsidize the cost of private employer-sponsored health insurance to Medicaid-eligible workers. Oklahoma expanded its subsidy program, making more people eligible.

So-called "transparency" initiatives are gaining ground, also. These are proposals that require hospitals—and in some cases, physicians—to publicly share information on infections and other adverse events, and also other quality data and pricing. Twenty-one states debated proposals that would require transparency on some level. Transparency bills were enacted in 10 states: Arkansas, Delaware, Georgia, Indiana, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington.

In Texas, for instance, the state is now requiring hospitals and physicians to provide patients with estimates of charges if requested. Hospitals also will be required to tell patients if there is the possibility that an out-of-network provider will be working in an in-network facility, and to inform them there may be costs to the patient as a result.

The Texas law reflects a growing concern that patients aren't aware that they may be balance-billed, Ms. Laudicina said. Eleven states will take up transparency measures in 2008.

The annual State Legislative Health Care and Insurance Issues report compiles information from the BCBSA's survey of 39 independent Blue Cross and Blue Shield plans. ■

Health Care Spending Projected To Reach $4.3 Trillion by 2017

BY MARY ELLEN SCHNEIDER
New York Bureau

Health care spending in the United States is projected to consume nearly 20% of the gross domestic product by 2017, according to estimates from economists at the Centers for Medicare and Medicaid Services.

Health care spending growth is expected to remain steady at about 6.7% a year through 2017, with spending estimated to nearly double to $4.3 trillion by 2017, the CMS analysts said in a report published online in the journal Health Affairs.

The 10-year projections come from the National Health Statistics Group, part of the CMS Office of the Actuary, and are based on historical trends, projected economic conditions, and provisions of current law.

The analysts project that spending for private sector health care will slow toward the end of the projection period, while spending in the public sector, including Medicare and Medicaid, will increase. Much of the increase will be fueled by the first wave of baby boomers entering Medicare in 2011. The increase in the number of Medicare enrollees is projected to add 2.9% to growth in Medicare spending by 2017, according to the report.

The CMS economists projected that growth in spending on physician services would average about 5.9% per year through 2017, compared with 6.6% from 1995 to 2006. These projections are based on current law, which calls for steep cuts to physician payments under Medicare over the next several years. If Congress were to provide a 0% update over the next decade, the average annual growth from 2007 to 2017 would rise to 6.2%, according to the report.

On the hospital side, growth in spending is projected to accelerate at the beginning of the projection period because of higher Medicaid payments but to slow toward the end as a result of projected lower growth in income. Home health care will likely be one of the fastest growing sectors in health care from 2007 through 2017, with an average annual spending growth rate of 7.7%, according to the report.

Growth in prescription drug spending is expected to accelerate overall through 2017, because of increased utilization, new drugs entering the market, and a leveling off of the growth in generics. The analysts reported that Medicare Part D would have "little impact on overall health spending growth" through 2017. ■