Payments Uncertain as Insurers’ 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 at an emergency medicine meeting.

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 Southern California College of Emergency Physicians.

Mr. Gaines said noncompliance among all the plans that have settled has continued to grow, and “the problem 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.

Mr. Gaines said that the most significant settlement is a 2004 agreement with Aetna and Cigna in which the companies will pay $400 million plus interest—$100 million from Aetna and $300 million from Cigna.

The suit is pending in the U.S. District Court for the Southern District of Florida and alleges that the companies are underpaying professionals for services rendered to Medicare beneficiaries.

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States Looking Inward as Health Tabs Grow and Tax Revenues Fall

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 state fiscal spending in 2005, up from nearly 29% in 2000,” 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 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,” Ms. Laudicina said.

The most significant trend observed in the states is 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 of those failed, largely because they are controversial, she 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 200% of the federal poverty level. Eight states have used to challenge that ruling.

Eight states—Connecticut, Indiana, Kansas, Louisiana, Maryland, New York, Texas, and Washington—created programs in which public funds subsidize the cost of private employer-sponsored health insurance to Medicaid eligible workers.

Florida expanded its existing subsidy program, making more people eligible.

So-called health “fair trade” 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. Transparencies bills were enacted in 10 states: Arkansas, Delaware, Georgia, Indiana, Minnesota, New Jersey, Oregon, Pennsylvania, Texas, and Washington.

In Texas, for instance, the state now requires hospitals and physicians to provide patients with estimates of charges if requested. Hospitals will also be required to tell patients if there is a 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 are not aware that they may be balance billed, Ms. Laudicina said.

Eleven states will take up transparency measures in 2008, she said.

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—Medicare and Medicaid—will increase. Much of the increase will be fueled by the first wave of baby boomers entering Medicare in 2017.

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 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 payments.

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 at over 10% through 2017, because of increased utilization, new drugs entering the market, and a leveling off of the growth in generics. The analysts estimate that Medicare Part D would have “little impact on overall health spending growth” through 2017.

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