

Detecting Waste And Abuse In Health Care Spending

Law360, New York (August 03, 2011, 12:51 PM ET) -- By the end of this decade, health care spending will account for one-fifth of the United States' economy, according to an analysis released in July 2011 by actuaries for the Centers for Medicare and Medicaid Services.[1] Although most of the health care growth will come from Medicare and Medicaid, private payors will account for nearly a third of all health care spending, according to the actuaries. Since health care spending is projected to total \$4.6 trillion by 2020 (double what it is now), this means that \$1.4 trillion will come from private payors.

If these private payors do not act quickly, however, a staggering amount of that money may be squandered in spending that otherwise goes unnoticed. The Federal Bureau of Investigation estimates that three to 10 percent of health care spending — public and private — is spent on wasteful and abusive practices. By that measure, private payors will lose at least \$42 billion a year to waste and abuse — and possibly as much as \$140 billion, an amount matching the gross domestic product of New Zealand in 2010.

These wasteful practices include schemes such as double billing and overcharging for drugs and services, providing unnecessarily expensive care or prescriptions, incorrectly coding or documenting care or prescriptions, or even charging for health care never provided.

Rattled by the impact health care spending will have on their budgets, the federal government and many state governments have already implemented programs to crack down on waste and abuse. For example, in the Patient Protection and Affordable Care Act, Congress provided \$250 million a year to investigate claims of waste and abuse in publicly funded health care.

The legislation steps up penalties for those who submit false data in seeking payment from the government. The legislation also requires much more transparency in relationships, potentially exposing conflicts of ownership interests in laboratories, clinics and nursing homes. The legislation also requires pharmacy benefit managers to disclose more of their programs.

Likewise, state governments across the country are bulking up their enforcement staff to tackle health care waste. Even with the full police powers of the federal and state governments — and “deputized” whistleblowers acting as investigators under the False Claims Act — wasteful spending on health care is difficult to detect.

For private payors — the private insurance carriers, unions, managed health plans and self-funded plans that pay for patient care — uncovering and addressing waste can be even more elusive. Yet the freedom to contract affords a powerful incentive to address these issues, and private payors should maximize this leverage to combat these abusive practices.

The actuaries' analysis projects significant increases in demand for private payor coverage, particularly for prescription drugs and physician and clinical services. Prescriptions drugs will be used more as new drugs come online later in the decade and growth in generic drug usage levels off. Physician and clinical services will increase because those who gain coverage are likely to be younger and healthier. For this reason, prescription and physician will be used more than hospitals and more intensive services.

Most health care plans provide both a group health and prescription service. The contracts with the providers of these services should allow private payors access to the information on which the payment claims are based and allow for detailed reviews of all claims processed. payors' contracts should also require that the service provider certify that the service or prescription was provided in full accordance with state and federal law.

Even before these contracts are renegotiated, however, careful review of the paid claims and prescription data can expose wasteful practices. An analysis of the paid claims data can uncover double billing, false service or medically unnecessary procedures. Scrutiny of the pharmaceutical data can detect “shorting” drug fills, whether the cheapest form of a drug is being prescribed or whether rebates are being applied as contracted.

With health care costs projected to climb this decade, it is essential that private payors make the most of every dollar spent. Carefully drafted contracts written with an eye to protecting private payors — coupled with a close review of the claims data — can help combat wasteful and abusive practices and result in significant savings.

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[1] National Health Spending Projections Through 2020: Economic Recovery, Economic Recovery and Reform Drive Faster Growth, Sean P. Keehan, Andrea M. Sisko, Christopher Trffer, John A. Poisal, Gigi Cuckler, Andrew J. Madison, Joseph M. Lizonitz, Sheila D. Smith, Health Affairs (July 2011)(avail. at <http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full.html#sec-10>)

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