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The Need for Health Care Paid Claims and Pharmacy Benefit Audits: What You Don't Know May Hurt You

WILLIAM L. HURLOCK

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). Hailed as a monumental piece of legislation, the PPACA was the most sweeping overhaul of the nation's health care system in the history of the United States. As the initial euphoria subsides and we begin to digest the provisions of the PPACA, the key issues they are designed to address begin to take focus. One of the many notable provisions of this Act provides for a significant increase in funding to address waste, fraud, and abuse in the administration of the nation's health care programs.

WASTE, FRAUD, AND ABUSE IN HEALTH CARE

Indeed, all of the versions of the bills which recently emerged from the House and Senate contained an unprecedented array of aggressive tactics to fight waste, fraud, and abuse. Under the PPACA, Congress increased funding to combat these illicit and illegal practices by $250 million of the next five years. In addition, many existing statutes and regulations have been strengthened to confront the myriad of issues that impact overall quality of care and attribute to a direct and substantial increase in health care costs. For instance, the PPACA establishes new and stricter penalties for health care providers who submit false data on applications and penalties are increased for submission of false claims for payment or obstructing audit investigations related to Medicaid, Medicare, and the Children's Health Insurance Program (CHIP).

The most recent estimate from the Centers for Medicare and Medicaid Services (CMS) projects that the United States spends approximately $2.26 *trillion* a year on health care.[1] By the year 2016, CMS estimates that this figure will exceed $4.14 *trillion* per annum. This figure represents 19.6 percent of the total gross domestic product in this country.

Health care waste, fraud, and abuse account for a significant portion of this spending. The figures are appalling. The FBI estimates that these practices cost *both public and private health care programs* to be between three and 10 percent of all monies spent.[2] A simple exercise in arithmetic reveals that the cost of health care fraud is expected to rise from $67–$224 billion to $124–$414 billion *per year*.

The issue is not novel. Such abusive practices appear to be endemic to the health care field. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a national Health Care Fraud and Abuse Control Program (HCFAC) to address these serious issues. The HCFAC is administered by the United States Attorney General and the Department of Health and Human Services. In fiscal year 2009, the government recovered approximately $1.63 billion in judgments and settlements through this program.[3] Since inception of the HCFAC, approximately $15.6 billion has been returned to the Medicare Trust Fund.[4] The Congressional Budget Office estimates that approximately $1.75 is saved for every $1.00 invested to fight fraud.[5]

The terms waste, fraud, and abuse are often raised in the health care context. However, these terms are often not defined and many cannot agree as to their actual meaning. While not an exact science, these terms are best viewed on a compendium. These practices include, but are not limited to, charging for health care services or prescriptions that simply were not provided—to overcharging or double-billing for health care services or prescriptions—to rendering inappropriate or unnecessary care or medicines.

These practices detrimentally increase the costs associated with health care for every segment of the economy. Fraud increases the costs employers must pay to purchase coverage for their employees. This in turn increases the cost of conducting business—a cost which is eventually passed on to everyone. For the government sector, health care fraud increases taxes and places a greater burden on already precarious budgetary issues. The impact associated

with fraud is even more pronounced for individuals. Often, the costs associated with health care fraud can mean the difference of one's ability to afford coverage.

Combating Fraud, Waste, and Abuse

Most are in agreement that due to the extremely complex nature of our current health care system it is extremely difficult to detect and pursue claims of wrongdoing. The fee-for-service payment system and the extremely fragmented delivery of health care services make the system ripe for abuse. A lack of coordinated data between treatment and diagnosis also hinders detection. This phenomenon is further compounded by an acceptance and apathy towards health care fraud in general.

While it is difficult to detect and pursue claims of fraud, certain steps can be taken to discover and detect waste, fraud, and abuse. Every year, trade unions, private employers, managed care organizations, governmental entities, and insurance carriers spend *trillions* to administer their health care programs.

Most health care plans contain a group health and pharmaceutical component. Each program is equally important and each presents a potential avenue for waste, fraud, and abuse. A review of the paid claims data for these programs is an effective tool to help identify and combat waste, fraud, and abuse.

Quite simply, the group health component consists of all claims for medical services. The pharmacy benefit program is administered separately. Often, although not always, these programs are serviced by pharmacy benefit managers.

As stated above, systemic practices of waste, fraud, and abuse are not unique to government-funded health care programs, but also directly impact those plans in the private sector. Based on the aforementioned disturbing statistics, it is incumbent on plan administers to conduct an audit of their group health and pharmaceutical benefits programs.

Indeed, a simple review of the paid claims and pharmacy benefits data for these programs can result in significant savings. In so doing, it is important to identify a firm with expertise in these two different and highly specialized components of health care plans. Once these reviews have been performed it is important to identify the right entity with the expertise to adjudicate claims that arise as a result of the audit.

An analysis of the paid claims data of group health component can detect instances where a health care provider may have engaged in double billing—billing the plan twice for the same medical procedure. It could also uncover instances where a health care provider may have billed for services that were never rendered or were medically unnecessary. This is best detected by a reviewing and comparing the reported diagnosis to the reimbursed billable claim treatments.

On the pharmaceutical side, a review of the prescription spend can uncover instances where prescriptions may have been filled with invalid or incomplete physician prescriber information, often resulting in attendant abuses. These reviews can identify where a prescription plan administrator may have engaged in "shorting" (where prescriptions were not completely filled, but the plan was charged for a full prescription) and "switching" (where patients may be changed from a branded drug going off patent [a generic substitute] to a more expensive drug remaining on patent). Most importantly, they can determine whether the program is receiving the rebates it is entitled under the contracts.

Conclusion

The cost is too high. The aforementioned trends reveal a disturbing pattern. In this current economic climate plans are being forced to do much more with a lot less. It is important for plan administrators to act proactively. After all as the old saying goes: "A billion here and a billion there and pretty soon you are talking real money."

Notes

1. Federal Bureau of Investigation *Financial Crimes Report to the Public—Fiscal Year 2008* at p. 8. (Most recent version available as of this writing.)
2. *Id.*
3. The Department of Health and Human Services and the Department of Justice *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2009*, May 2010 at 1.
4. *Id.*
5. Congressional Budget Office *Budget Options, Vol. 1: Health Care*, December 2008 at p. 209.

William L. Hurlock is a partner in the firm of Seiger Gfeller Laurie LLP where he focuses on health care law. In addition, he serves as an adjunct professor at Seton Hall Law School where he teaches health care related courses. The author may be contacted at whurlock@sgllawgroup.com.