

# California and National News

## **Aetna Lawsuit Points to Surgery Center Out-of-Network Gaming and Kickbacks**

An ambulatory surgery center management company, Bay Area Surgical Management, LLC (BASM), has been sued by Aetna Life Insurance Company for what Aetna alleges is a fraudulent scheme. BASM supposedly attracts referrals by offering illegal kickbacks to its surgeon-owners. BASM recruits **owner-surgeons who are “in-network”** for insurance plans (such as Aetna) to “self-refer” their insured patients to have surgery performed at one of **BASM’s “out-of-network” surgery centers**. BASM sets its own surgery center facility fees and bills Aetna (and other insurance companies with generous out-of-network benefits) exceedingly high sums. While patients normally would be deterred from undergoing surgery at a BASM center because their co-pay would be extraordinarily high, BASM allegedly has taken patients’ reactions to having to pay that exceptionally large co-pay out of the equation. How? Aetna alleges BASM’s patients are assured that they do not have to ante up what would be those (huge) co-payments or deductibles related to the inflated billings. BASM’s routine waiver of patient co-payments allegedly is concealed from the insurance carriers. These unfettered billings yield meteorically high profits, of which BASM supposedly keeps 25 percent and distributes the remainder to the surgeon-owners of the surgery center. The self-referring physicians’ return on their apparent well-below-market investment dwarfs the most lucrative arm’s-length return from otherwise seemingly legitimately operated ambulatory surgery centers. In fact, the return from the center that induces the patient referral is typically higher than the separately paid professional fees (which the surgeons collect as well). Aetna posits that the physicians’ annual return on capital, supposedly typically 200 to 1,200 percent, constitutes **kickbacks (unlawful self-referral for apparent excessive compensation)**. Safeguarding patients from kickback-motivated self-referrals prevents the harmful consequences of medical/surgical decisions that primarily are motivated by the financial interests of physicians and other entities. The Medical Board of California and other interested state (and even federal) parties may well decide to investigate such schemes that appear to constitute fraudulent and unethical behavior. Moreover, with the egregious billings, ultimately the affordability of health care is being jeopardized and the ethical principle of social/distributive justice is being violated. What is clear is that the scheme outlined above is a strong inducement to ethical corruption of a community of physicians. On the other hand, the business practices of health insurance carriers, in particular the excessive profits that they extract from health insurance premiums, divert money from the care of patients to the pockets of executives and shareholders, and thus similarly pervert justice.

*Adapted from [http://www.sccaseinfo.org/pa6.ask?full\\_case\\_number=1-12-CV-217943&crumbs=civil](http://www.sccaseinfo.org/pa6.ask?full_case_number=1-12-CV-217943&crumbs=civil). (Feb. 2, 2012)*

**Marketing Back Surgery and Its Profits** Tri-City Regional Medical Center, a nonprofit hospital in Hawaiian Gardens, Calif., has become a center for back surgery performed on workers' compensation patients. The center's spinal fusion business has jumped from \$3 million to \$65 million in one year. Much of this economic benefit accrued from the hire of a richly rewarded (\$3.2 million over three years) non-physician marketer/consultant to recruit surgeons to operate in the hospital. That individual also supplied spinal implants through distributorships he owned, inflating the costs of the spinal hardware two- to 10-fold. He may have used some of these profits for what is alleged by some to constitute kickback monies to referring chiropractors and surgeons who brought their workers' comp back surgeries to Tri-City.

Across the nation, there has been a remarkable upward trend in the total amount of money spent for back surgery. California employers paid \$7 billion in insurance premiums for workers' comp in 2010, and spinal fusion surgery accounted for 40 percent of inpatient hospital charges. In addition to a previous racketeering conviction for which the marketer had spent 21 months in jail, he also established a business association with another entrepreneur (who, likewise, benefitted through a similar process of hardware distributorships and surgeon/patient recruitment) at Pacific Hospital in Long Beach. In fact, in the first decade of this century there were over 5,000 of these procedures performed at Pacific, the total billings exceeding by threefold those of any other hospital in California! Our state's Workers' Compensation Division permits hospitals to bill separately for spinal implants—that is, not including the cost of such in the overall surgery charges, the rule for Medicare and Medicaid. That separate billing policy elicited an additional cost of \$55 million in 2008! Incredibly, the division doesn't limit the amount of markup for distributors, although it does restrict a hospital's markup.

*Adapted from an article in The Wall Street Journal by John Carreyrou, Tom McGinty and Joel Millman, Feb. 9, 2012.*

**Medicare Scam Tops All Records** Federal agents arrested a Dallas-area physician—with the able assistance of his office manager and Texas home health care agencies—for the largest ever scheme of a single physician in conspiring to defraud Medicare/Medicaid (\$375 million). Dr. Jacques Roy and others allegedly billed “asleep-at-the-wheel” Medicare for services that were unnecessary or not even provided! All busy Dr. Roy did was approve 500 times as many patients (5,000 vs. 100) as the average physician for home health care services. This nimble physician, himself, certified more Medicare patients than any other medical U.S. practice!

*Jeffrey Young, Huffington Post, April 4, 2012.*

### **Spine Surgeons Take Double Cut by Implanting Their Own Devices**

A growing number of spine surgeons now use hardware from medical device companies they own rather than implants from third-party manufacturers. This conflict of interest can constitute an incentive to operate more frequently and even unnecessarily. In 2008, spinal fusions became the 16th most common inpatient operation in the U.S., jumping up from 37th in 1998, and now account for an over \$10 billion industry. A federal anti-kickback law prohibits hardware producers from paying surgeons to use their products, but those companies have skirted this by entering into partnerships with the spine surgeons, paying them consulting fees and royalties for help in designing the devices. In some cases, those surgeons would use the company's device exclusively and then author favorable research. But now there is an avalanche of surgeons establishing their own companies and making and using their own hardware. The FDA has a less stringent approval process for medical devices that approximate those already approved. Surgeons simply have to submit mechanical testing data attesting to their hardware as being "substantially equivalent" to existing devices, and FDA approval usually is obtained within 90 days. But spine surgeons don't hold a monopoly on this conflict of interest: orthopedic surgeons have their hip and knee replacement hardware, and cardiologists and cardiac surgeons their devices.

*John Carreyrou and Tom McGinty, The Wall Street Journal, Oct. 8, 2011.*

### **Aetna Takes It "in the Ear"—and Doesn't Like It**

In another insurance scam, two Houston physicians self-referred their in-network (participating physician) insured patients to their own out-of-network (non-participating facility) Humble Surgical Hospital in order to charge what might be considered to be *humbling* fees, including a bill for almost \$100,000 for the removal of ear wax! The patients allegedly were comforted by being informed that they would not suffer from the huge co-pays or deductibles that would result from the vastly inflated out-of-network facility fees. It appears that California and Texas are vying to be top-ranked in medical insurance scams.

*Courthouse News, Dec. 12, 2001.*

### **Health Insurance Costs Escalate, Wages Unchanged**

From 2003 to 2010, the average cost of health coverage for California families and their employers increased 52 percent, to \$13,819 annually. During that period, family income rose only 4 percent. Employers wrestle with this burden and continue to pay the major part of those costs, but more frequently they are making employees contribute a larger share in the form of new co-payments, higher deductibles, and cutbacks in health care benefits. In negotiations, unions have tended to forgo wage raises in favor of lowering employees' share of cost for health coverage. However, the cost to the average working family for its

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portion of health premiums increased 68 percent, from \$2,282 to \$3,845, over those seven years. The public experiences premium increases, but justification is largely not provided, and regulators need more power to restrict rate hikes. This is particularly critical in light of the federal PPACA requirement of proof of health insurance by 2014. The insurers claim that higher premiums reflect higher costs of medical care incurred by new technology, higher drug costs, an enlarging aged population with chronic illnesses, unfettered end-of-life costs, and an unbridled utilization of available services.

*Commonwealthfund.com (Nov. 21, 2011) and Sandy Kleffman, San Jose Mercury News.*

**California Middle Class Declines as Gap Between Poor and Rich Enlarges** Less than half of California's families can be classified as middle class (income \$44,000 to \$155,000). Thirty years ago over 60 percent of families qualified for the middle income bracket. Until 2006, there actually was a net economic improvement, the number of families moving into the upper class outnumbering those that fell into the lower class. However, while the hard-hit economy reduced the economic standing of most families, the lower classes were most adversely affected: their income decreased by 21 percent while the upper class dropped by only 5 percent. For decades, the nation has witnessed the widening income gap, but California's income divide continues to surpass that of most other states. Education, rather than race or income, was the largest determinant in how people have been able to cope with the economic downturn.

*Matt O'Brien, San Jose Mercury News, Dec. 8, 2011.*

**California Continues to Lack Control Over Insurance Industry Rate Hikes** Although on Jan. 1, 2011, California regulators at the Department of Managed Health Care (DMHC) were given expanded authority to scrutinize health insurance rate hikes and to require documentation justifying these raises, they continue to be void of any enforcement powers. The new law (SB 1163) permitted state regulators to determine that a rate hike was excessive, but persuasion, cajoling or public shaming were the only armamentarium available to counter such hikes—and they have proven largely ineffective. The Department of Insurance has been somewhat effective in blunting rate hikes in 17 percent of 300 cases it reviewed in 2011. The DMHC was successful in negotiating several reductions with Health Net and Kaiser, but Anthem Blue Cross flatly refused to budge with its huge premium increases. Further legislative efforts, such as AB 52 (Feuer), have run into stiff lobbying opposition.

*Adapted from article by Sandy Kleffman, San Jose Mercury News, Jan. 15, 2012.*

### **CMA Requests Amendments to Medical Liability Reform**

The CMA has sent a letter to the U.S. House of Representatives leadership that *opposes* H.R. 5. This bill does support aspects of medical liability reform, and in addition, it also favors repeal of the Independent Payment Advisory Board (IPAB), which CMA strongly *favors*. This apparent confusion regarding the CMA's stance is explained by the fact that the CMA has "serious concerns with two additional medical liability provisions in H.R. 5 that will expose California physicians to even greater liability despite the bill's stated legislative intent to reduce health care costs and [medical malpractice] insurance premiums." The two provisions of major concern include 1) the fair share rule; and 2) no punitive damages for medical products and devices that comply with FDA standards. The fair share rule would preempt California's joint and several liability law and would "dramatically increase the potential for physicians to face enforcement proceedings against their personal assets." The law would make it necessary for physicians to purchase "increased medical professional liability insurance coverage," and would increase physician liability premiums in California. The CMA requested two amendments to the law that would recognize state laws already in place, including "any state law that governs the allocation or recovery of damages among tort feasons." In the second instance, the letter also expressed concerns with granting complete immunity from punitive damages to medical product and device manufacturers, distributors, and suppliers, but *not* physicians. CMA is seeking to fix the distressing provisions so that it can support the other favorable parts of the bill.

CMA Alert, *March 19, 2012.*

### **CSA Needs Your Home Address and Your Zip+4!**

*If you have not given us your home address, please update your information online at [www.csahq.org](http://www.csahq.org) under Membership/Member Profile Update, or call the CSA office at 650-345-3020. The CSA database offers the CSA the ability to give members contact information for their legislators. Since legislative districts are determined by home address, your zip+4 is essential to provide you with this information.*