MANAGED CARE REINSURANCE

ING AMERICAS

ING Re

Published by ING Re

HEALTHCARE Management Forum

Reinsurance Solutions

IN THIS ISSUE:

VOLUME 6 • NUMBER 1
FIRST QUARTER 2004

1
Mitigating Losses from Health Care Fraud and Abuse
By David Cammack

5
What Does the New Medicare Drug Benefit Mean for You?

Mitigating Losses from Health Care Fraud and Abuse

By David Cammack

"One hundred fifty billion dollars" is a staggering figure. Combine it with the phrase "in losses," and the number becomes a nightmare. That nightmare – $150 billion in losses – is one estimate of the cost of health insurance fraud in America. According to new figures from the Centers for Medicare and Medicaid Services, U.S. health care spending reached nearly $1.7 trillion[1] in 2003. Some quick algebra shows health insurance fraud wastes nearly a tenth[2] of America's health care resources.

Fraud, by definition, is not self-revealing. You can only count what you detect. Losses from fraud or abusive billing practices are impossible to measure; they can only be estimated. The latest estimates from U.S. Department of Health and Human Services (HHS), the National Health Care Anti-Fraud Association[3], the National Insurance Crime Bureau, the Coalition Against Insurance Fraud[4] and the Centers for Medicare and Medicaid Services vary widely. But whatever the estimate, the figures are monumental – ranging from $45 billion to $150 billion lost each year. ▸

(Continued from page 1)

Some patients have become "paper pawns" through fabricated histories that threaten their future insurability and employability.

Everyone is a victim. The immediate targets of fraudulent billing practices are private health payers and government funded health plans. But payers, employers and patients pay the price in higher premiums, lower benefits, higher taxes and higher co-payments. Survey reports from Mercer Human Resource Consulting found the average employee in 2003 costs U.S. employers $6,215 in annual health benefits, up 10 percent from $5,646 in 2002[5].

Between 1998 and 2003, the cost of health benefits rose by an astonishing 48 percent[6]. A 1999 Health Insurance Association of America (HIAA) report, "Health Insurers' Anti-Fraud Programs,"[7] cited fraud as a contributing factor to that meteoric rise.

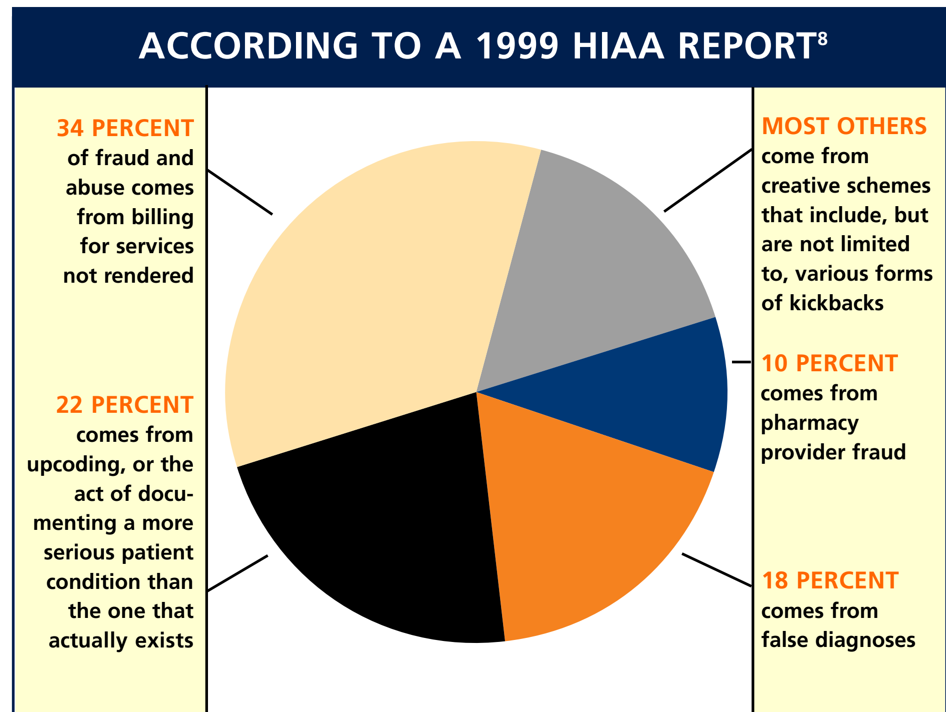
The impact goes beyond cost; quality of care can also be compromised with false or inflated claims. The health and well-being of patients can be jeopardized when they are exposed to unnecessary and dangerous tests and procedures. Some patients have become "paper pawns" through fabricated histories that threaten their future insurability and employability.

The U.S. health care system has inherent vulnerabilities that tempt and attract individuals or groups who may want to abuse the system. Our historical assumption of trust in our health care providers and their honesty leaves us exposed to their ethical choices. Another vulnerability is the sheer volume of payers and health care providers as well as the volume and diversity of claims that were not a consideration in years past. Electronic data exchange and other technological advances can present another kind of exposure for payers and patients to creative new schemes to defraud the system.

Perpetrators see health care fraud and abuse as a low-risk crime. The insurance industry offers an abundance of easy targets. Claims operations are geared toward processing massive amounts of claims efficiently and rapidly – with a focus on coding, not fraud. But health insurers have a powerful role to play. By establishing an aggressive, end-to-end fraud and abuse program, health plans can potentially save millions while continually providing accessible, affordable, high-quality care to their members.

What is Fraud and Abuse?

Fraud in the health insurance industry is intentional deception and misrepresentation resulting in the payment of unauthorized benefits or in the assumption of an inaccurate underwriting liability. Abuse in the industry is the practice of directly or indirectly causing financial loss to payers of benefits. According to a 1999 HIAA report[8], 34 percent of fraud and abuse comes from billing for services not rendered; 22 percent comes from upcoding, or the act of documenting a more serious patient condition than the one that actually exists; 18 percent comes from false diagnoses; 10 percent comes from pharmacy provider fraud, and most others come from creative schemes that include, but are not limited to, various forms of kickbacks. ▸



(Continued from page 2)

Who Commits Fraud and Abuse?

Organized crime rings. Many criminals are migrating from drug trafficking into the safer and more lucrative trade of health care fraud. These rings are based anywhere from Central America to Russia, and they are assaulting the U.S. health care system. A typical method used by these groups is fabricating claims from non-existent clinics using purchased or stolen patient information.

Brokers and insurance agents. Phantom employer groups, premium skimming, misrepresenting an employees health status or adding non-eligible members to employer groups are some of the favored practices of fraudulent brokers and agents.

Health plan employees. Some perpetrators of fraud are health plan employees who set up invalid health care provider records and divert payments to themselves or someone else. Other health plan employees have been caught selling ID numbers, processing false "pay to subscriber" claims or skimming premiums.

Plan members. Fraudulent practices among plan members include sharing or selling ID cards, submitting false claims or adding ineligible dependents.

Health care providers. Whereas most health care providers are honorable, some have admitted they feel "justified" in extracting payments that are not warranted. In a study published in 2000 by the Journal of the American Medical Association, "Fidelity and Deceit at the Bedside,"[9] 54 percent of physicians reported "using deception of third-party payers to obtain needed benefits." Thirty-nine percent reported exaggeration of a patient's condition, changing a diagnosis or reporting signs or symptoms that did not exist.

Physicians and other health care providers can commit fraud by performing excessive and unnecessary diagnostic services or "diagnosing" non-existent chronic conditions to hook patients into long-term services. They may also abuse the health care reimbursement system by inflating charges, upcoding, unbundling (billing separately for a group of related services in order to obtain higher reimbursement) and underutilizing resources in capitated arrangements.

Ignoring fraud creates risk, allows the problem to grow unchecked and increases avoidable payouts. On the other hand, a comprehensive program allows health insurers opportunities to prevent and recapture loss.

Ignoring fraud creates risk, allows the problem to grow unchecked and increases avoidable payouts. On the other hand, a comprehensive program allows health insurers opportunities to prevent and recapture loss.

Key Components of a Comprehensive Fraud and Abuse Program

The most effective anti-fraud and abuse programs are end-to-end and aggressive, and include elements of process assessment, detection technology, education, prospective investigations, recovery investigations and resolutions.

Process Assessment. Process assessment includes reviewing a health plan's operational areas with a focus on fraud and abuse vulnerabilities. An effective assessment should ask, "How strong are the plan's provider database, claims operations, contracting and medical management?" A completed assessment will identify mechanisms such as internal policies and procedures that could help prevent future inappropriate payments.

Detection Technology. A process assessment will likely find holes in an insurer's fraud detection capabilities, holes that are best managed with technology. An insurer may suspect abusive providers, but since fraud schemes are commonly statistical in nature, they are not generally revealed through single transactions. Effective detection technology will optimize identification of potentially fraudulent situations. Detection technology can deliver examples of behavior and allow insurers to document abusive patterns; it can retrospectively identify questionable providers from claims data; and it can analyze data to identify patterns of suspicious activity, targeting specific geographic areas and provider groups. Such technology will uncover irregular claims and treatment practices, as well as deliver advanced visualization, objective scoring and flexible reporting.

Anti-Fraud Education. Each year, various laws and regulations are passed requiring general fraud and abuse awareness education and specialized training for underwriters, ▸

(Continued from page 3)

claims examiners, investigators and other pertinent personnel. A successful anti-fraud program has, at its core, employees who are well informed and on the lookout for potential company exposures to fraud and abuse.

Prospective Investigations. Effective detection technology can facilitate prospective investigations, or investigations which uncover fraud and abuse before a claim is paid. Prospective investigations can realize significant savings. Recovering benefits already paid is much more difficult and much less profitable than preventing inappropriate payouts in the first place.

Recovery Investigations. If an investigation finds that a claim is inappropriately paid due to fraud or abuse, a comprehensive anti-fraud and abuse program will also have the capability to recover those funds. A straightforward approach to achieving recoveries includes identification of potential cases, investigation of the provider and applying the most effective resolution strategy.

Resolution. Resolution includes mitigation through prospective and recovery investigations, as well as long-term strategies that may include civil litigation, criminal prosecution, license revocation and sanction. Resolution strategies should result in timely, cost-effective resolution of payments.

The Critical Question

Health insurance executives who endeavor to implement a comprehensive anti-fraud and recovery program are faced with a critical question: Should we build the program in-house or should we outsource? To answer this question, they need to determine if they can find and keep the right people, if they have all the tools they need for prevention and recovery, if they can continually train their investigators and if they have the resources to keep up with a problem that will become increasingly sophisticated and widespread.

Conclusion

Any amount of money lost due to fraud is money wasted on the criminal or unscrupulous, money that could have been used to keep premium rates in check or to improve patient care. As health plans aim for increased success and profitability, a full-scale anti-fraud and abuse program can be as successful a profit-building strategy as raising premiums or adding new members. With health care costs rising at staggering rates, health insurers cannot afford to allow fraud to drain up to 10 percent of their resources. ■

David Cammack *has extensive experience in anti-fraud program design and development. He currently directs the Ingenix Advisory and Online Services Departments, responsible for aligning Ingenix anti-fraud resources and expertise with each client's unique needs. For more information, call (800) 765-6709 or write to inform@ingenix.com.*

REFERENCES

1. Heffler, Steven, et al. 2004. "Health Spending Projections through 2013." Journal of Health Affairs (11 February 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.79v1.pdf): W79-W93.
2. _____. 1999. Health Insurers' Anti-Fraud Programs. Washington, D.C.: Health Insurance Association of America. The first reference we can find that estimates up to 10 percent of the nation's health care spending is used to pay for fraud is mentioned in this report: "In a 1992 report to Congress, the General Accounting Office used an estimate of 10 percent or $70 billion of the nation's health care spending in 1991, a figure often used since then to represent the extent of fraud and abuse activities." Other sources include the FBI's Health Care Fraud Unit, whose website (http://www.fbi.gov/hq/cid/fc/hcf/about/hcf_about.htm) states: "Losses attributable to fraud and abuse have been estimated, by some, to be as much as ten percent of the nation's total annual health care expenditure," and the U.S. Department of Justice, which states in a publication titled "Cost of Crime and Victimization": "The U.S. General Accounting Office reports that health care fraud totals 10 percent of total healthcare expenditures each year, which puts annual heath care fraud losses at $100 billion."
3. _____. 2002. Health Care Fraud: A Serious and Costly Reality for All Americans. Washington, D.C.: National Health Care Anti-Fraud Association. Report cites NHCAA estimate that estimating that at least 3 percent of the national health care outlay is lost to outright fraud (does not include reimbursement abuse). Cites other sources stating that the loss could be as high as 10 percent.
4. "Insurance Fraud Rises to $85.3 Billion," in listing of news releases on Coalition Against Insurance Fraud website [cited 18 July 1997]; Washington, D.C. Available at http://www.insurancefraud.org/releases_1997.htm#071897. News release cites health insurance claims fraud as the major contributing factor in the 6.8 percent rise in the estimate of the cost of insurance fraud. From 1994 to 1995, "false health insurance claims alone rose 10.3 percent, from $53.6 billion… to $59.1 billion."
5. "US national survey of employer-sponsored health plans: Surprise slow-down in health benefit costs," in report summary on the Mercer Human Resources Consulting website [cited 8 December 2003]. Available at http://www.mercerhr.com/knowledgecenter/reportsummary.jhtml?idContent=1051300.
6. ibid., and Blaine Bos. 2001. 15th Annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans. Mercer Human Resources Consulting. Percentage cited was derived from finding the difference between average 1998 costs ($3817) and average 2003 ($5646) costs and dividing it by 1998 costs.
7. See reference 2.
8. ibid.
9. Bloche, M. Gregg. 2000. "Fidelity and Deceit at the Bedside." Journal of the American Medical Association 283 (April): 1881-84.

What Does the New Medicare Drug Benefit Mean for You?

Interim discount card

From spring 2004 through 2005, beneficiaries can buy a card (for about $30) estimated to shave 10 to 15 percent off drug prices at the pharmacy.

Interim low-income help

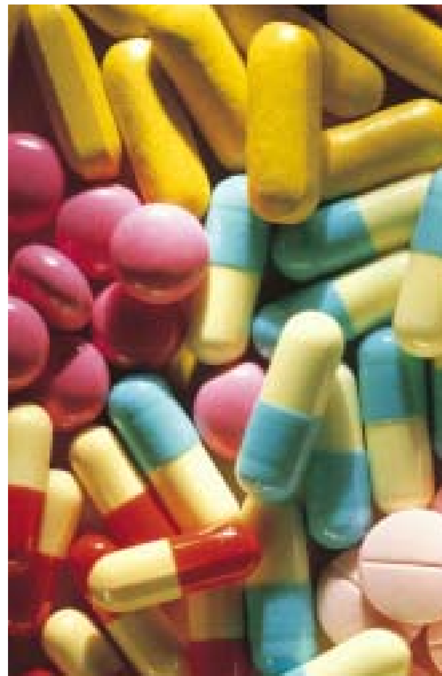
People with incomes below $12,390 ($16,720 for couples) in 2004 will each get $600 a year on the card.

Coverage choice

From January 2006 beneficiaries can choose to (a) stay in traditional Medicare, a current Medicare HMO or a retiree plan without signing up for the drug benefit; (b) stay in traditional Medicare and enroll in a stand-alone drug plan; (c) enroll in a private health plan that offers drug coverage and Medicare health services.

Drug benefit

Enrollees will have an annual deductible of $250, an estimated premium of $35 a month (may vary in private plans) and a 25 percent copayment of drug costs up to $2,250 in a year. After that, enrollees pay all drug costs until they have spent $3,600 out of pocket (equal to $5,100 in annual costs for those with no other drug insurance). At that point catastrophic



coverage kicks in, and enrollees pay five percent of prescriptions or copays of $2 for generics and $5 for brand names (whichever is greater).

'Dual eligible' subsidies

People eligible for Medicaid and Medicare will pay no premium or deductible and have no gap in coverage. They will pay $1 per prescription for generics and $3 for brand names. Copays are waived for those in nursing homes.

Other low-income subsidies

People with incomes below about $13,000 ($17,600 for couples) in 2006 and assets of under $6,000 ($9,000 for couples) will pay no premium or deductible and have no gap in coverage. They will pay $2 for generics, $5 for brand names and nothing above the catastrophic limit.

People with incomes between $13,000 and $14,400 ($17,600 and $19,500 for couples) in 2006 and assets under $10,000 ($20,000 for couples) will pay premiums on a sliding scale, a $50 deductible and 15 percent of drug costs with no gap in coverage. After spending $3,600 out of pocket in a year, copays will be $2 for generics, $5 for brand names.

Medicare Part B changes

The annual deductible for Part B (for outpatient care) will increase from $100 to $110 in 2005, then rise annually. The Part B premium will be linked to income for the first time, starting in 2007. People with incomes over $80,000 ($160,000 for couples) will pay more on a sliding scale.

http://www.aarp.org/bulletin/prescription/Articles/a2003-11-26-foryou.html

HEALTHCARE MANAGEMENT FORUM

Healthcare Management Forum is published by the Medical and Managed Care Reinsurance Team of ING Re. This publication's mission is to provide news and information to healthcare insurance professionals and thereby advance knowledge regarding healthcare insurance. The information contained in the articles represents the opinion of the authors and does not necessarily imply or represent the position of the editors or ING Re. Articles are not intended to provide legal, consulting or any other form of advice. Any legal or other questions you have regarding your business should be referred to your attorney or other appropriate advisor.

Copyright © 2004 ING North America Insurance Corporation. All rights reserved. ING Re includes the reinsurance business of ReliaStar Life Insurance Company, Minneapolis, and Security Life of Denver Insurance Company. No portion of this publication may be reproduced without permission from the publisher. For more information about articles, contact Kathy Petron, Newsletter Editor, ING Re, PO Box 20, Minneapolis, MN 55440-0020; telephone (800) 378-6965 or via email at kathy.petron@ing-re.com.

If you would like more information or copies of *Healthcare Management Forum*, or wish to submit an article or comment, please call us at the number above or write us at the address above.

EDITORIAL BOARD

Michelle Fallahi
Jane Johnson
Kathy Petron