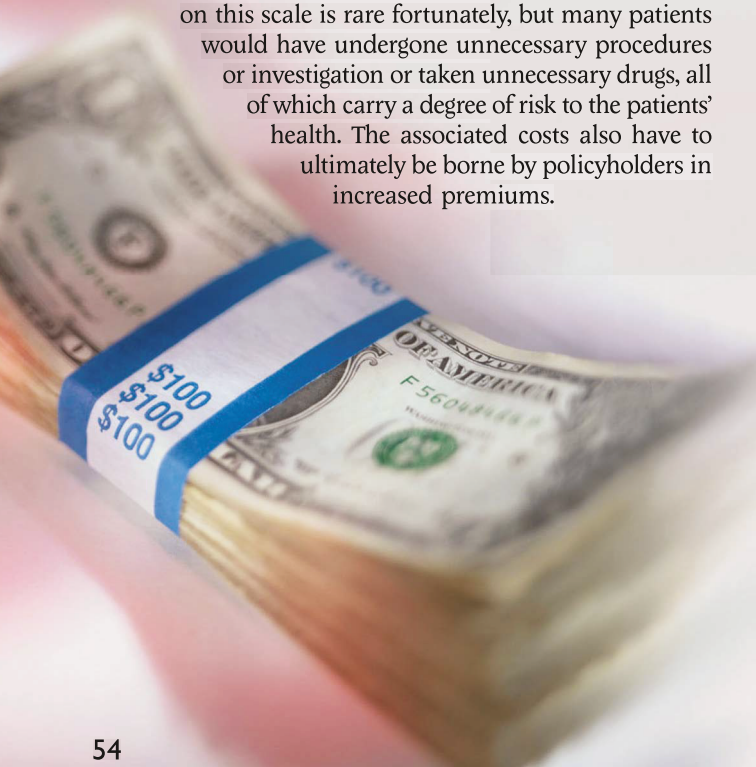
Tackling health insurance fraud

Mr Colin Weston of **RGA** looks at what is being done to combat the growing phenomenon of health insurance fraud, and whether more actions are needed.

It is impossible to accurately quantify the cost of health insurance fraud but, with real and sustained growth both of premiums and number of lives covered, the problem is set to escalate. In the US, which spends more on health than any other country in the world (16.2% of GDP in 2009, according to the World Health Organization), it is estimated that between US$68 billion and $175 billion is lost annually to health fraud.

The problem may not be on the same scale in the MENA region, but there is already evidence that it is a real concern. In January 2010, the Health Authority of Abu Dhabi (HAAD) took 39 patients, doctors and insurers to court for a variety of offences, including charging for medical services that had not been provided, making fraudulent claims and using fake insurance cards. In 2009, Daman reported that it had recovered $1.6 million in fraudulent claims from clinics and the Saudi Arabian newspaper Al-Hayat reported that Saudi health insurers were losing $320 million annually to fraudulent activity.

It is sometimes said that insurance fraud is a victimless crime, a view that the readers will wholeheartedly reject, but with health insurance there can be a far more human face. In October 2010, eight doctors working at the Santa Rita Clinic in Milan, Italy were jailed for performing a total of 83 unnecessary operations on unsuspecting patients in order to claim reimbursement. The surgeries included an unnecessary mastectomy on an 18-year-old girl and three lung operations on an 88-year-old woman. Abuse on this scale is rare fortunately, but many patients would have undergone unnecessary procedures or investigation or taken unnecessary drugs, all of which carry a degree of risk to the patients' health. The associated costs also have to ultimately be borne by policyholders in increased premiums.



Perpetrators and types of fraud

It is known that professional criminals have targeted health insurers, in some cases setting up complex frauds. These include fraudsters in the UK who, having previously gained access to patients' insurance details by collaborating with motorcycle couriers used to transport specimens and accounting information, continued to bill unsuspecting insurers for a number of years after the closure of a pathology laboratory. In India, fraudsters targeted a government-run scheme for those living below the poverty line by colluding with such residents in the state of Kanpur to submit claims for fictitious treatment.

However, the majority of fraud involves real patients who are often unsuspecting bystanders, unaware that anything is wrong, while the providers of medical care milk the system using well-known techniques including:

- **Up-coding**: Charging for a more complex treatment than actually performed – for example, charging for a therapeutic procedure when only a diagnostic procedure was performed;
- **Unbundling**: Charging for the constituent parts of a procedure – for example, charging for the harvesting of a vein to be used in a coronary artery bypass;
- **Duplicate billing**: Charging twice for the same service – for example, charging for the interpretation of x-rays or scans where the interpretation has already been charged by the radiologist;
- **Over-utilisation**: The provision of unnecessary investigations of treatment – for example, from keeping a patient too long in hospital, requesting unnecessary or extended investigations to over-prescription of drugs.
- **Phantom billing**: Charging for treatment, tests of drugs that were never provided – for example, charging for a bottle of pills when only one was used.

Fraud detection

Methods of claims submission are constantly evolving, with the majority of insurers requiring that all planned admissions to hospital, along with some outpatient treatments, be pre-authorised. Some insurers accept electronic submission of claims with HAAD, leading where other regulators are likely to follow, mandating that most providers submit and all insurers accept claims in this way.

The changing face of claims submission and processing calls for different methods of adjudication and assessment. Electronic submission should remove the necessity for insurers and Third Party Administrators (TPAs) to employ armies of administrative staff to capture information already captured by the providers in the form of their invoices. Systems should be able to automatically allocate

billed expenses against insured benefits and calculate the amount to be paid. These reductions in administrative burden should allow the insurer more time and resources to detect and combat fraud.

Identifying fraud often involves detecting deviations from normal behaviour, including:

- A condition that arose suddenly;
- The request for extra test, treatment or drugs;
- A treatment that could be provided as an out- or day-patient is provided as an inpatient;
- A patient staying in hospital for longer than necessary;
- The performance of a more complex procedure;
- Higher costs than normal; and
- Providing treatment which does not relate to the condition claimed.

Currently, insurers and TPAs generally rely on the experience of claims assessors and the knowledge of medical staff to judge whether treatment is medically necessary and the costs reasonable and customary. However, the length of stay for the same treatment may vary by patient depending on age, sex and co-morbidities, meaning that the requested treatment or period of hospitalisation looks about right. With the advent of greater automation, the statistical norms for all of the above can be accurately calculated. For example, for a male aged 52 requiring a quadruple coronary artery bypass, the average length of stay will be X days and the average cost will be XX. Deviations from these calculated norms can be automatically identified and referred for investigation by physical staff who, freed from the drudgery of data transfer, can concentrate on investigating and confirming the medical requirement for and cost of treatment and visiting providers to audit the billed costs against actual treatment records.

Predictive or analytic models used in some systems take this further by identifying the unusual care and billing patterns of previously-identified fraudulent activities in current claims. The size of data needed for these advanced systems to work effectively excludes them from use in all but the largest insurers or TPAs who administer business on behalf of a number of insurers. However, players who rely heavily on health business should be exploring and implementing the latest technologies.

Employing efficient administrative systems should speed the assessment and settlement process for the majority of eligible claims with only random sampling and regular audits required, thereby identifying those cases that have a higher likelihood of being fraudulent for proper investigation.

Insurers and TPAs must not shy away from questioning doctors. If they are asking to admit a patient for a procedure that could be performed as an out- or day-patient, the treating doctor should be asked to medically justify the admission. The medical team at the insurer or TPA should be aware of latest best practice and treatment protocols and should challenge doctors who are not performing to these standards – but they must be armed with proven and reputable data.

Action needed

Having identified fraudulent activity, the insurer must decide what to do. If it is an individual policyholder attempting the fraud, the action is often clear and decisive, with the claim rejected and cover rescinded. Nevertheless, insurers seem reluctant to take punitive action, such as removing a provider from their network, concerned that acting alone they may end up with a more-restrictive provider network than their competitors.

In the UK, the Health Insurance Counter Fraud Group has engendered a collaborative approach with all the UK's health insurers working together to identify and tackle fraud. A common fraud detection system available to all member companies allows sharing of information on a real-time basis. Once identified, insurers reclaim substantial sums from providers, share evidence with the police, report wrong-doers to the General Medical Council and publicise cases in the press.

Both medical and insurance regulators need to be aware of the problem and work with insurers to identify and eliminate fraud. Insurance regulators can act as central driving forces and even go as far as HAAD to employ investigative staff. Medical regulators should take notice of cases bought to their attention and act against providers when inappropriate treatment or billing practices are proven.

Tackling insurance fraud has been described as attempting to squash a partially inflated balloon – as soon as you squash one part, it pops out elsewhere. But all the parties involved in the chain – the insured population, the insurers and the providers – are reliant upon each other, and there should be a process where the insured receives the treatment he or she requires, the provider generates a reasonable profit and the insurer covers the cost of that treatment. Medical insurance is set to continue to grow and with it the opportunities for fraudulent activity. All the parties involved must work together in tackling this scourge.

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