Research Brief: Insurers' Efforts to Prevent Health Care Fraud

January 2011

The issue of fraud prevention has emerged with a new sense of urgency among administrators of public health insurance programs. In January 2010, the Department of Health and Human Services and Department of Justice launched a series of Regional Health Care Fraud Prevention Summits aimed at increasing awareness for health care fraud. In September 2010, a significant anti-fraud provision was signed into law by President Obama as a part of the Small Business Lending Act. This anti-fraud provision requires Medicare's traditional fee-for-service program to flag potentially fraudulent claims prior to payment. This new provision challenges Medicare to use predictive modeling techniques, such as those used by private insurers, to proactively identify health care fraud.[1]

Over the past 25 years, America's health insurers have taken an active and aggressive role in combating fraud. A 2000 report based on a national survey of health insurers identified the main types of health care fraud reported by health insurance plans and described the anti-fraud programs plans had in place from 1996-1998.[2]

This report presents updated information based on AHIP's 2010 study of fraud and abuse claims, detection strategies, and reported savings attributable to anti-fraud efforts from 2006 to 2008. The study included both quantitative data collection and open-ended questions that allowed anti-fraud professionals to describe their views and challenges.

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[1] A series of publications by the HHS Office of Inspector General (OIG) describes existing anti-fraud efforts in federal programs, including Medicare and Medicaid. In fiscal year 2010, the Health Care Fraud and Abuse Control Program reported that "the Federal government won or negotiated approximately $2.5 billion in health care fraud judgments and settlements…" The federal anti-fraud program was funded by $577 million in federal mandatory and discretionary allocations in 2010. http://oig.hhs.gov/publications/hcfac.asp

[2] Thomas D. Musco and Kathleen Fyffe, Health Insurance Association of America (HIAA), "Health Insurer's Anti-Fraud Programs" (February 2000). http://www.ahipresearch.org/PDFs/22_FRAUDREPORT.pdf

Summary Table. Estimated Cost Savings Resulting from Anti-Fraud Programs, 2008

Company Size	Combined Enrollment	Plans' Estimated Net Savings per Enrollee	Cost per Enrollee	Savings per Enrollee
Large Plans (more than 5 million enrollees)	84,086,643	$3.45	$0.25	$3.70
Medium Plans (1 million to 5 million enrollees)	9,143,786	$1.05	$0.65	$1.70
Small Plans (fewer than 1 million enrollees)	1,949,182	$2.70	$1.30	$4.00

Source: America's Health Insurance Plans.

Survey respondents included a cross-section of health plans ranging from small, regional companies to large, multi-state commercial carriers. In total, responding companies had 95 million enrollees. However, individual health plans' measures of the costs of anti-fraud efforts and the resulting savings were defined in a variety of ways. Likewise, some questions were applicable to the anti-fraud operations of some plans, but not to others. Thus, the overall results are best interpreted as indicative of several health plans' anti-fraud experiences and not necessarily representative of all anti-fraud efforts in the industry.

Among the large companies in the survey, estimated net savings from anti-fraud operations (savings less costs) were over $3 per enrollee, resulting in an estimated total net savings of nearly $300 million in 2008 (see Summary Table). For the medium-sized companies reporting, estimated net savings were about $1 per enrollee and 2008 total net savings were about $10 million. For smaller companies, estimated net savings were about $2.70 per enrollee, and total net savings reported were approximately $5 million in 2008.

Companies were asked to estimate only costs and savings directly attributable to their anti-fraud efforts. This would include costs of special programs or employees dedicated to fraud prevention or detection, as well as savings from improper payments recouped or prevented. However, the estimates do not include the impact of deterrence, which is likely the largest associated savings from insurers' anti-fraud programs. The knowledge that health plans have robust anti-fraud measures and controls likely prevents inappropriate billings or claims in the first place.
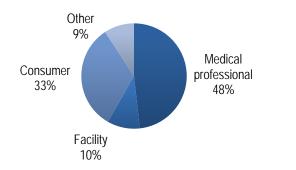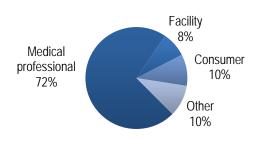
Figure 1-A. Suspected Fraud Cases, by Type, 2006-2008

Figure 1-B. Suspected Fraud Cases, by Type, 1996-1998

Source: America's Health Insurance Plans.
Notes: Figure 1-A. Percentages derived from responses from responding
companies with 57,704,076 covered lives. Figure 1-B taken from the
February 2000 HIAA anti-fraud report.

Consumer fraud represents an increasing share of suspected fraud cases. In this survey, responding companies with over 57 million covered lives reported data detailing health care fraud by type and by category of medical professional. In the time period 2006-2008, cases involving medical professionals represented 48 percent of fraud investigations, while 33 percent of suspected fraud cases involved consumers. By comparison, in the time period 1996-1998, medical professionals accounted for 72 percent of cases and consumer fraud was suspected only 10 percent of the time (see Figures 1-A and 1-B).

Four responding companies provided examples of the medical claims per potential fraud case associated with medical professionals. In these four health plans, the average claims cost exposure per investigated fraud case was between $7,000 and $21,000 in 2008. Based on data from five responding companies, the average cost per case associated with potential consumer fraud was around $2,500 in 2008.

Fraud referred to law enforcement or regulatory officials. Several of the larger responding companies reported data concerning their referrals of potential fraud cases to law enforcement authorities. For example, three insurers, covering a combined total of over 35 million enrollees reported referring 13 percent of potential fraud cases to either law enforcement agencies or federal and state regulatory agencies.   Two insurers, covering a combined total of over 36 million enrollees, noted that 21 percent of potential fraud cases reported to law enforcement agencies resulted in criminal convictions.

Open-ended questions looking into the changing dynamics of health care fraud. Survey respondents commented on a range of potentially fraudulent activities including:

- Performing medically unnecessary services or procedures for the sole purpose of producing more insurance payments;
- Misrepresenting non-covered treatments as medically necessary covered treatments for the purpose of obtaining higher insurance payments;
- Falsifying patient's diagnosis to justify tests, surgeries, or other procedures;
- Billing patients for services already paid for; accepting kickbacks for patient referrals;
- Sales of durable medical equipment that is not needed or unnecessary; and
- Committing mail or wire fraud.

Responding companies reported that the use of technology in electronic billing and funds transfer in the past decade has created new opportunities for fraud and they have modified their anti-fraud programs accordingly. Health plans are using technology to expand their capabilities for detecting fraud, such as through the implementation of electronic "smart flags" that quickly identify suspected cases of fraud. Companies are hiring and training personnel to become more knowledgeable about health care fraud and prevention. Companies also reported that their auditors are working across multiple disciplines with clinical and pharmacy personnel and law enforcement officials to expand their fraud detection and enforcement capabilities.

The following five open-ended questions generated perspectives on the changing dynamics of health care fraud and detection:

What do you foresee that could be done with anti-fraud programs over the next 5 years?

- "Modeling with analytics to identify aberrant claims earlier…eliminate pay and chase scenarios."
- "Development of cost effective and efficient pre-payment fraud detection programs/initiatives."
- "Give more real-time information to providers [concerning] their activities, billing practices and coding issues."
- "More sophisticated system edits…this is not the time to cut back on Special Investigations Units (SIUs) and anti-fraud activities."
- "Stronger policy language, improved technology, agent training, increased support from insurance departments."
- "Two-way communication between the government agencies and the commercial SIUs."

What do you foresee that could be done outside the insurance industry over the next 5 years to reduce fraud?

- "Fraud awareness education to members, providers…educating members to question their treatment recommendations."
- "Educating consumers of the high costs associated with health care fraud."
- "Health care reform legislation could require greater effort and emphasis be placed on rooting out fraud."
- "National publication of disciplinary action taken against providers."

Why has the prevalence of health care fraud increased in the past 10 years?

- "Sophisticated schemes and poor economy."
- "Punishment for insurance fraud remains relatively minor."
- "Increase in electronic billing and electronic funds transfer."
- "Sophisticated technology has contributed to the rise in identity theft."
- "Perception that fraud will not be detected or punished."
- "Lack of enforcement on a federal level relative to payment of restitution."
- "Use of claims bundling software by providers."

How have your company's anti-fraud programs changed in the last 10 years?

- "Introduction of 'smart flags' to effectively monitor specific fraudulent activity…Additional staff were assigned to pre-pay monitor and review claims from flagged providers."
- "Expanded use of data mining to proactively detect fraud and abuse."

- "Training claims personnel to identify potential fraudulent or abusive claims."
- "More focused on pre-payment investigations."
- "Stronger working relationships across multiple disciplines."
- "Enhanced staff level contracting with a vendor for predictive modeling analytics for all states."
- "Usage of automation, data-mining and other proactive techniques."
- "Analytical review of historical and current data."
- "Better staffed in quantity and experience, adding clinical, pharmacy, and law enforcement training staff to existing claims auditors."

What do you foresee as the biggest challenges with health care fraud over the next 5 years?

- "Informal caregivers…"
- "Developing systems that can identify fraud proactively."
- "Identity theft, insurance fraud is looked at as a victimless crime."

- "Onslaught of up-coding, over-utilization, phantom billing and anything else to augment the revenue streams of those providers."
- "Less interest and focus on fraud from the government than on the commercial side of the business."
- "Finding better and faster techniques for prevention and early detection of fraud."
- "Electronic claims submission and the increasing emphasis on timely processing of claims required by various state mandates."
- "Ability of insurers and the claims systems to quickly react to fraud in a pre-payment environment."
- "Moving from primarily retrospective to primarily prospective."
- "Cooperation between the public and private sectors…better oversight and additional funding will be required."

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