



# HCCA's 12<sup>TH</sup> ANNUAL COMPLIANCE INSTITUTE

APRIL 13–16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

## Health Care Insurance Fraud and The DRA

**Jack L. Price, CFE, ALHC**

**Senior Manager, Enterprise Investigative Services  
BlueCross BlueShield of Tennessee**



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- **The definition of fraud can be as simple as “a deception made for personal gain” to legal definitions that require an intent to deceive**
- **Fraud is a criminal act but can also be a tort on the civil side of the judicial system**
- **In our work at BCBST we use a working definition of fraud that states that fraud is “an intentional misrepresentation of a material fact for the purpose of obtaining a monetary benefit”**
- **Abuse is also an activity that impacts all consumers. Abuse can be intentional but the offense does not rise to the criminal standards**

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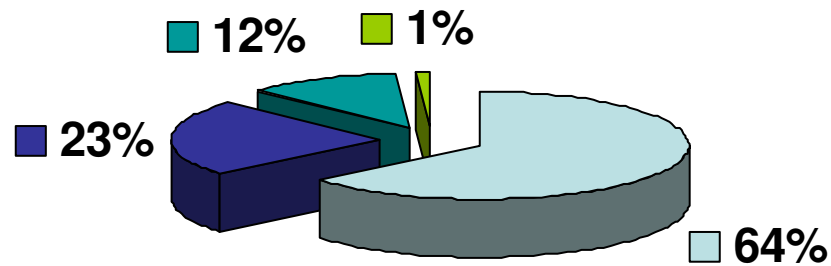
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- **It is estimated by various groups that fraud of all types costs the average American family in excess of \$5,000.00 a year in increased costs for goods and services due to fraud.**
- **It is estimated by various agencies and industry groups that health care fraud amounts to 1% - 10% of all health care expenditures.**

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**Total Fraud Costs = \$96.1 Billion**



- Health \$61.4 billion
- Property & Casualty \$22.4 billion
- Life \$11.8 billion
- Disability \$0.5 billion

Source: Gartner, 2006.

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- **It is estimated that during 2008, health care expenditures in the U.S. will be in excess of \$2 trillion dollars**
- **If the estimates of fraud are accurate, health care fraud will cost the U.S. between \$20 billion and \$200 billion dollars this year alone. Some experts believe these numbers are low and that the actual numbers are actually higher**

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- **The entire health care insurance model, like most all business transactions in the United States, is built upon the expectation of trust, honor and integrity between all the involved people and entities**
- **Due to the fact that health care insurance companies are expected, and even mandated by statute, to provide prompt payment to providers for services rendered, automated adjudication systems and processes have been created. These requirements are often windows of opportunity for individuals/entities to abuse or “game” the system**

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- **These windows of opportunity are utilized by a very small percentage of providers to obtain benefits to which they are not entitled**
- **This small percentage of providers is responsible for a very large financial impact on the entire system**
- **As a result, health care insurance companies have had to develop methods and processes to “trust but verify” the claim transactions while trying to minimize the impact on the honest providers and members**
- **At times, these processes and methods can slow the process and can sometimes cause friction between the involved parties**

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- **Some of the driving forces behind the increasing incidents of fraud are:**
  - 1. Money, money, money**
  - 2. Weakening social values regarding fraud**
  - 3. Weak criminal sentences resulting in reduced deterrence effect**
  - 4. Constantly evolving schemes to “enhance revenue”**
  - 5. Time required to investigate & prosecute fraud cases is most often measured in years**

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- **Side effects of health care fraud include:**
  - 1. Increased patient risk up to and including death**
  - 2. Higher premiums**
  - 3. Fraudulent diagnoses result in health histories that are inaccurate. This can lead to the inability of individuals to obtain life, health or disability insurance**
  - 4. Identity theft which also impacts the ability of victims to obtain jobs, insurance, etc.**

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- **Examples of common provider health care fraud acts are as follows:**
  - 1. Billing for services not rendered**
  - 2. Misrepresenting procedures that were actually performed but if submitted correctly would result in non-payment or lower payments**
  - 3. Submitting a false diagnosis code in order to bill for tests, surgeries, or other procedures that are not medically necessary, appropriate or reimbursable**

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- (Examples of common provider health care fraud acts continued:)
  4. Up coding
  5. Waiving patient co-pays and deductibles
  6. Unbundling
  7. Utilizing unlicensed individuals to provide services but billing under a licensed providers number as if the licensed provider performed the services

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- **Examples of patient fraud are as follows:**
  - 1.Loaning an insurance card to another person or using another persons card to receive benefits**
  - 2.Allowing a provider to conduct unnecessary services or tests and bill the insurance carrier in return for money or uncovered services**
  - 3.Forging or alteration of forms, receipts, claim forms or other documents in order to facilitate a payment that is not warranted.**

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- **How do we combat fraud?**
  - 1. Most insurance companies have Special Investigation Units that are stepping up their efforts to fight fraud. Most of these have “Fraud Hotlines” and email boxes for the public to report suspected fraud**
  - 2. Information sharing between the public and private sectors on individuals and organizations that are gaming the system**
  - 3. Insurance companies and governmental agencies are educating consumers**
  - 4. Insurance companies are training their employees to identify indicators of fraud**
  - 5. State and the federal government are passing more stringent laws with stiff sentences for fraudulent acts**

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- **How do we combat fraud? (continued)**
  - 6. Continue to leverage technology to facilitate discovery of the schemes hidden in the massive quantity of data involved with these cases**
  - 7. Continual education and training of SIU professionals to keep up to date on all new fraud schemes that are developed across the country**
  - 8. Participation in regional fraud working groups and task forces involving law enforcement agencies and other interested parties involved in the fight against fraud**

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- Case Examples

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