



Health Insurance Association of America

# HEALTH INSURERS' ANTI-FRAUD PROGRAMS

## RESEARCH FINDINGS 1999

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# HEALTH INSURERS' ANTI-FRAUD PROGRAMS

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RESEARCH FINDINGS  
1999

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# **HEALTH INSURERS' ANTI-FRAUD PROGRAMS**

**February 2000**

## **PREFACE**

The Health Insurance Association of America (HIAA) has conducted several surveys in the past to collect information on the development of insurers' anti-fraud programs and the effectiveness of these programs. This is the fourth report since the HIAA's initial one from 1989 activities which was the first to present quantifiable data on anti-fraud programs and their savings. Since that time HIAA has conducted similar surveys in 1993, 1996, and now in 1999. Trends over time have shown more companies becoming involved in, if not actually establishing, anti-fraud associations and programs. This increased involvement has resulted in a greater number of suspected fraud cases being investigated and substantial savings for companies and their policyholders.

HIAA conducted the current survey from March to June 1999, requesting data for 1996, 1997, and 1998. We asked each company if it had established any health care anti-fraud programs and/or any special investigative units and if it identified any suspected fraudulent health care claims. We also asked for the number of cases investigated, types of cases investigated, and estimated savings.

To expand the breadth of the survey, HIAA enlisted the assistance of the Blue Cross and Blue Shield Association and the National Health Care Anti-Fraud Association. Surveys were sent to the combined constituents of these organizations, totaling 207 questionnaires. Responses to the survey came from 58 companies/health plans, representing a response rate of 28 percent. These large, medium, and small respondents represent approximately 40 percent of the private insurance industry. However, since some companies either do not track all of the requested information, do not have data available, or have just recently implemented anti-fraud programs, the results that follow represent a conservative approximation of number and type of fraud cases and savings.

Not all companies could supply complete data. And, since more companies were able to provide data for the most recent time period, 1998, the savings and program information is taken from this year alone while the total number of suspected claims was measured over the period 1996 to 1998.

While HIAA has conducted similar surveys in the past, the number and composition of responding companies has changed. These differences may account for variations when comparing trends over time between the surveys, however, collectively HIAA's anti-fraud surveys demonstrate that, over time, more companies are establishing programs and are joining anti-fraud associations resulting in greater numbers of suspected fraud cases being investigated and in substantial savings for companies and their policyholders.

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## EXECUTIVE SUMMARY

Private insurers and health plans responsible for managing their clients and beneficiaries health care dollars continue to take an increasingly active role in detecting suspected cases of health care fraud. A substantial increase has been reported in the number of cases investigated by companies over the past few years with substantial savings as a result.

- Companies responding to the survey reported an average net savings per company of \$5.5 million during 1998. Combined total savings of all responding companies equaled \$232 million.
- The total number of suspected fraud cases investigated in 1998 was 42,371.
- The cost/savings benefit of companies' anti-fraud operations increased over 50 percent from 1995 to 1998. Companies' anti-fraud operations saved over \$11 dollars for every dollar spent in 1998 compared to \$7.50 in 1995
- In 1998, approximately 80 percent of all reported health care fraud cases were the result of provider actions, while 10 percent of fraud cases were the result of consumer actions. The remaining 10 percent fell into an other category.
- More than 9 out of 10 companies (95 percent) have implemented ant-fraud programs. Though the earliest year in which a company established a program was 1970, almost half of the companies (48 percent) started their programs within the past ten years.
- Almost all companies (96 percent) conduct anti-fraud training programs for their employees. Ninety-one percent conduct claims audits. Sharing investigative information with law enforcement agencies and formally referring cases to them is done by 91 percent and 95 percent, respectively. Sharing investigative information with other insurers is done by 87 percent of respondents.
- Fifty-six percent of respondents have established fraud hotlines, and 55 percent have conducted awareness programs for policyholders and/or the general public.
- Almost three-fourths (73 percent) of companies with anti-fraud programs receive a percentage of their claims electronically, ranging from 5 percent to 83 percent, with the median percentage received via electronic means at 39 percent.
- Three-quarters (75 percent) of responding companies use computer software to assist in detecting possible fraud, including in-house fraud detection screens in claims processing.

## INTRODUCTION

Health care fraud continues to be a serious and pervasive problem in our health care system, and continues to be frequently cited in the media as a major factor for the increased cost of health care in the United States with headlines such as “U.S. Cites Criminals’ Raids on Medicare and Medicaid.”<sup>1</sup> The aforementioned article describes how organized criminal groups now find it lucrative to form or corrupt medical entities for the purpose of bilking insurance programs.

Depending on the estimating organization, health care fraud ranges from 3 percent to 25 percent of all claim dollars paid. It was in a 1992 report to Congress that 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. Today, that 10 percent would approach \$100 billion. It is estimated that for the California’s Medi-Cal program alone, losses due to fraud may exceed \$1 billion.

While perpetrators of fraud continue to take more innovative approaches, health care payers have stepped up their efforts in tracking and identifying potential fraud before any payment is made. Additionally, many states and the federal government have enacted anti-fraud legislation. Since the enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996, the federal government and states have toughened laws against health care abuse and established fraud and abuse control programs. Federal agencies are required to join to form a national program to coordinate federal, state, and local law enforcement to combat all forms of public and private health care fraud. States also continue to pass legislation requiring insurers to establish special units to investigate suspicious claims or contract with an outside company for that service.

The importance of combating health care fraud and its spread must be kept visible to payers, legislators, and the public. To this end, the Health Insurance Association of America (HIAA), Blue Cross and Blue Shield Association (BCBSA), and the National Health Care Anti-Fraud Association (NHCAA) have combined their resources in conducting this most recent survey to heighten companies’ awareness of health care fraud and present information on anti-fraud programs

Recent reports on the results of government crackdowns on fraudulent activities lend support to the effectiveness of these programs through the monies that can be saved. Over the past several years, the Inspector General’s office of the Health and Human Services Department has collected millions of dollars in settlements and fines from organizations accused of engaging in fraudulent activities.

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<sup>1</sup> Robert Pear, New York Times, November 4, 1999.

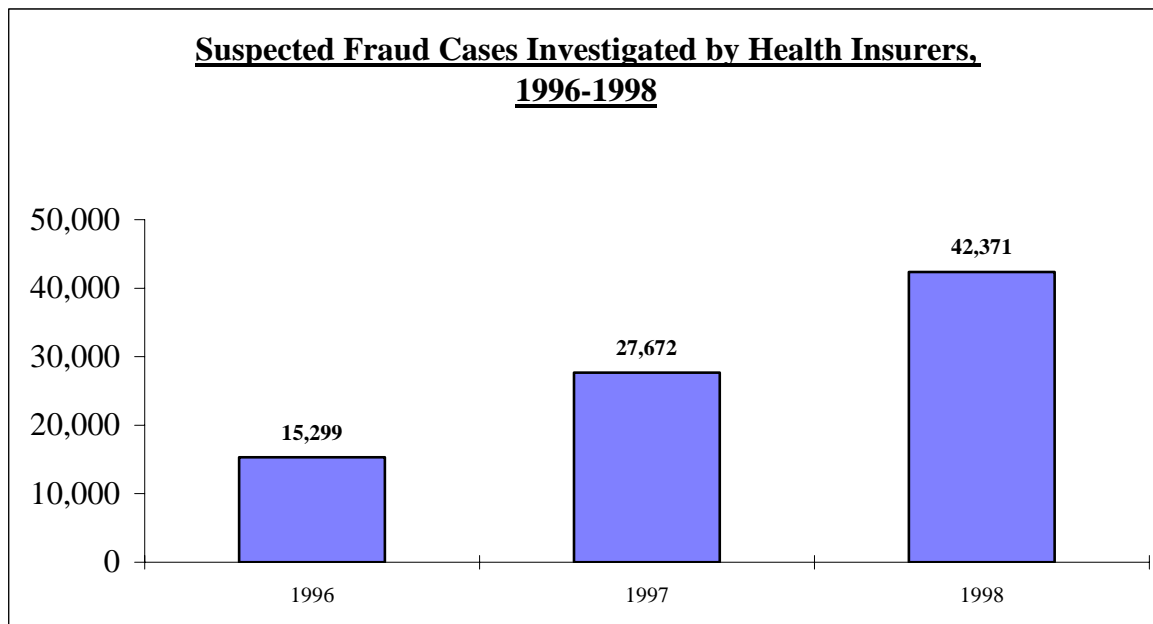
## FINDINGS

As new and expanding fraud schemes are employed to drain dollars from the health care system, payers must be ever vigilant in combating these activities. Placing increased emphasis on these efforts are, however, justified. In the year 1998, companies responding to the survey reported an average net savings per company of over \$5.5 million, up almost 240 percent from 1995. These amounts already take into account the expenses incurred by companies in conducting their anti-fraud activities. Total savings of all responding companies amounted to \$230 million. Since not all companies could respond, this amount may represent only a small portion of the estimated potential savings that might have been reported.

Fraud can occur throughout the lines of business in which companies are involved. Most companies responding to this survey are involved in lines of business other than strict medical expense. Half or more of the respondents are also providing dental benefit programs, Medicare supplement policies, hospital indemnity and long-term care products.

The average number of suspected fraud cases investigated per company actually increased between 1996 and 1998, from an average of 478 to 942. This does not necessarily mean that fraudulent activities are on the rise. This increase may be due in part to the heightened awareness of fraudulent activities occurring in the health care industry. With a greater number of companies instituting anti-fraud programs in more recent years, the total number of suspected fraud cases investigated increased by over 175 percent, from 15,299 in 1996 to 42,371 in 1998 (Figure 1).

Figure 1

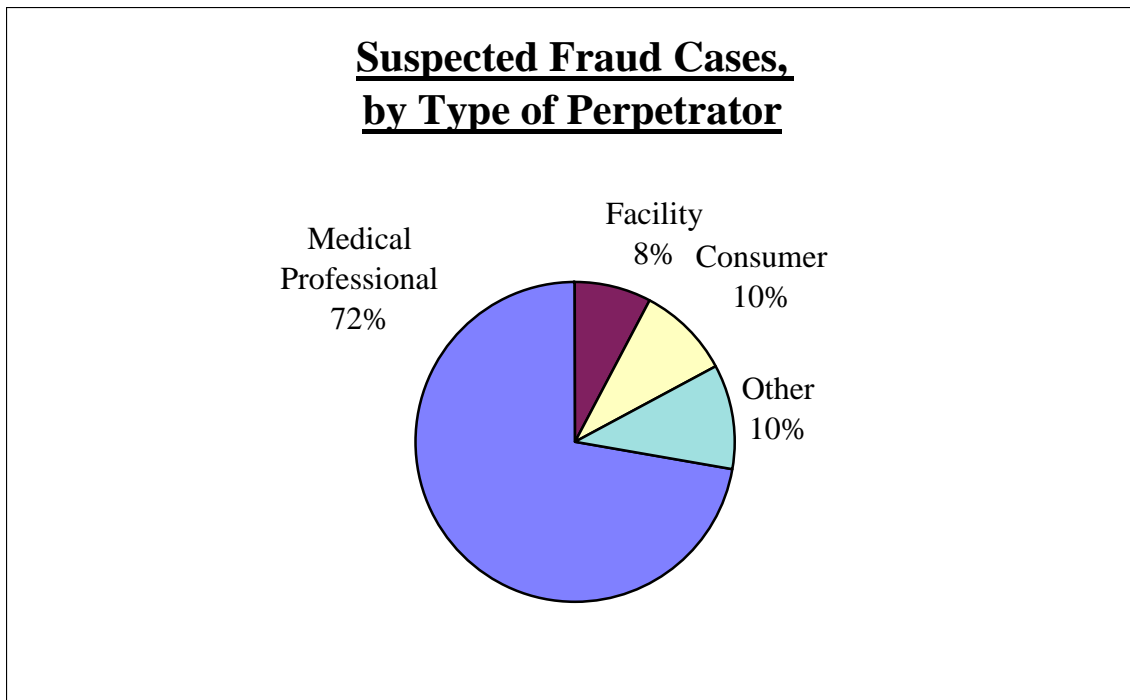


The cost/savings benefit of companies' anti-fraud programs increased over 50 percent to over \$11 for every dollar spent in 1998, compared to \$7.50 in 1995.

### **Fraud Cases by Type of Perpetrator**

In recent years, the percentage of fraud attributed to providers has remained relatively constant, while the percentage of suspected consumer fraud cases has declined, being replaced by other categories of perpetrators. In 1995, approximately 78 percent of all reported health care fraud cases were the result of provider actions, while 20 percent of fraud cases were the result of consumer actions. As of 1998, provider fraud accounted for approximately 80 percent while consumer fraud made up approximately 10 percent (Figure 2). The remaining 10 percent were related to laboratories, pharmacies, billing agencies, medical suppliers, and agents. Within the area of provider fraud, of the 80 percent of suspected cases herein 72 percent was for professionals with 8 percent for facilities.

Figure 2

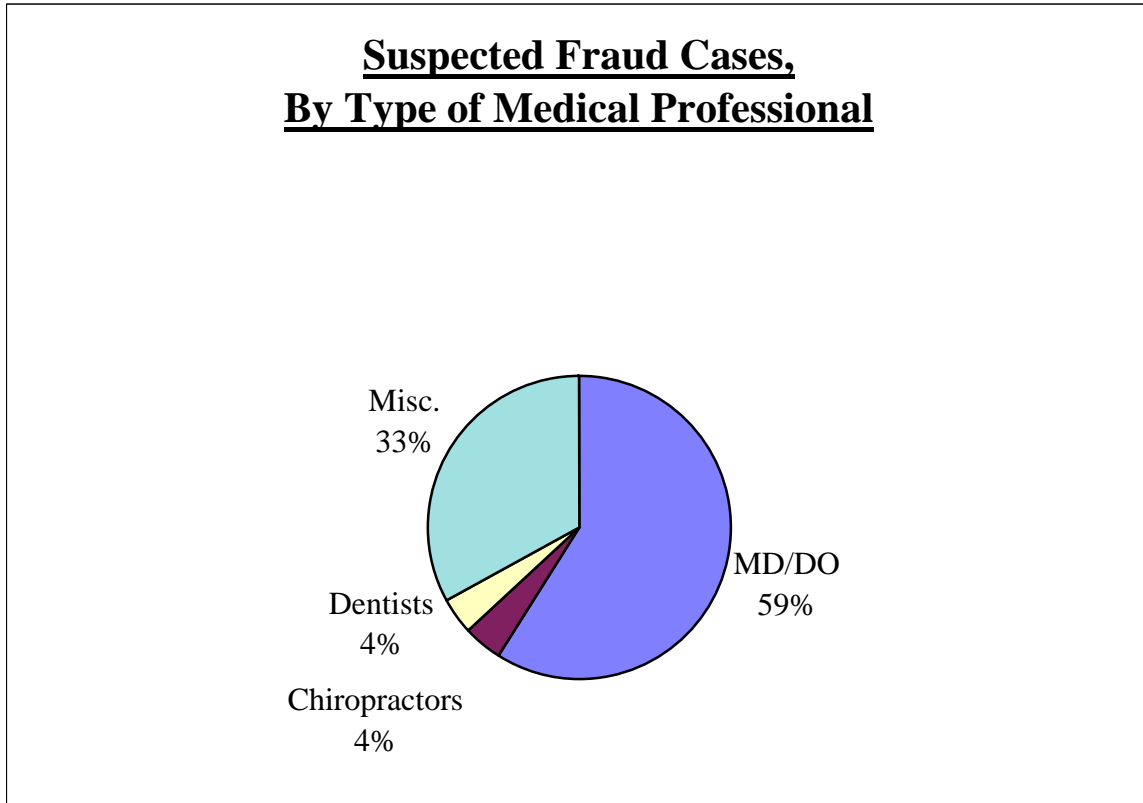


#### Provider fraud

In surveying companies, this year's survey asked for instances of suspected fraud by type of provider and type of fraudulent activity. Within the medical professional area, physicians constituted the largest percentage of suspected fraud cases with 59 percent of the total (Figure 3). All other categories of health professionals constituted much lower

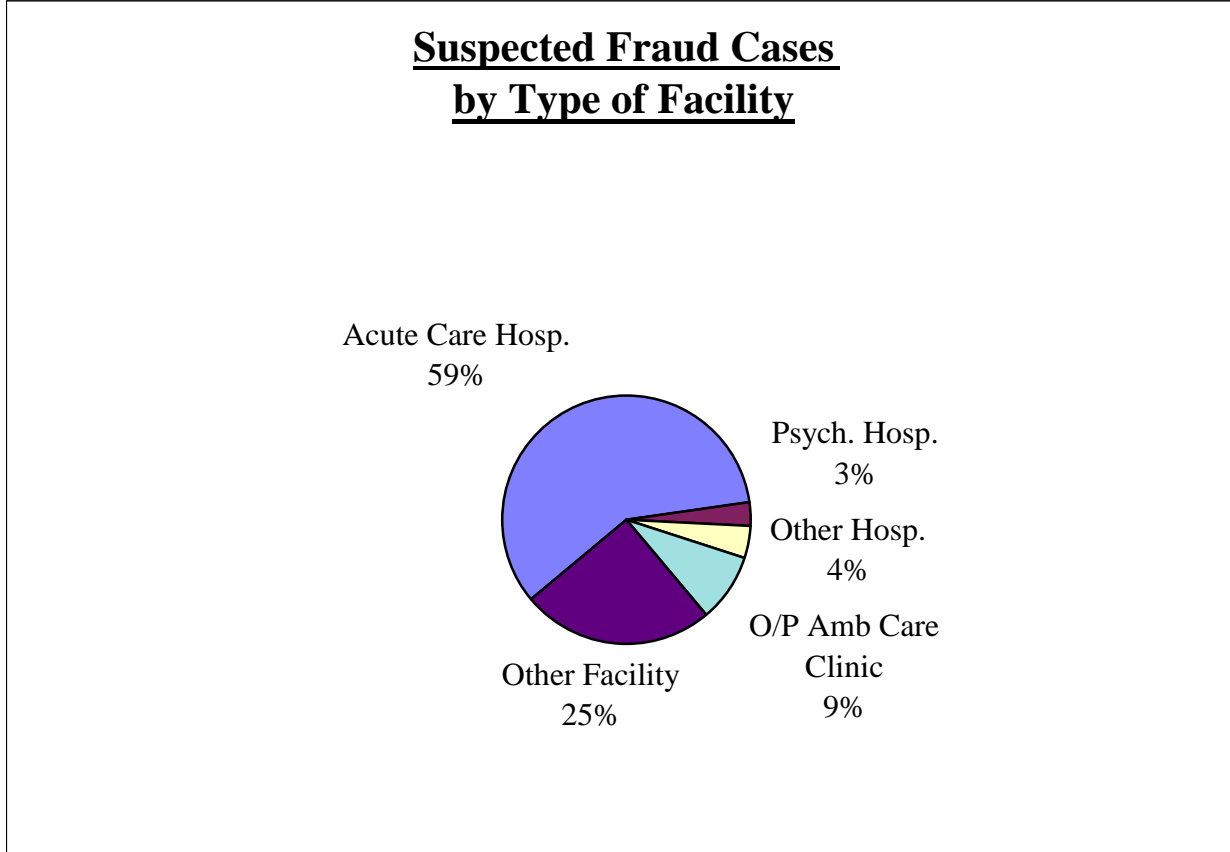
percentages of suspected fraud cases. Cases of suspected fraud from dentists constituted 4 percent of the total, chiropractors another 4 percent with all other medical professionals making up 33 percent.

Figure 3



For cases of suspected fraud by health facilities, acute care hospitals constituted 59 percent of the total cases reported (Figure 4). Outpatient or ambulatory care clinics made up 9 percent of the total. Psychiatric hospitals made up only 3 percent of the suspected cases reported.

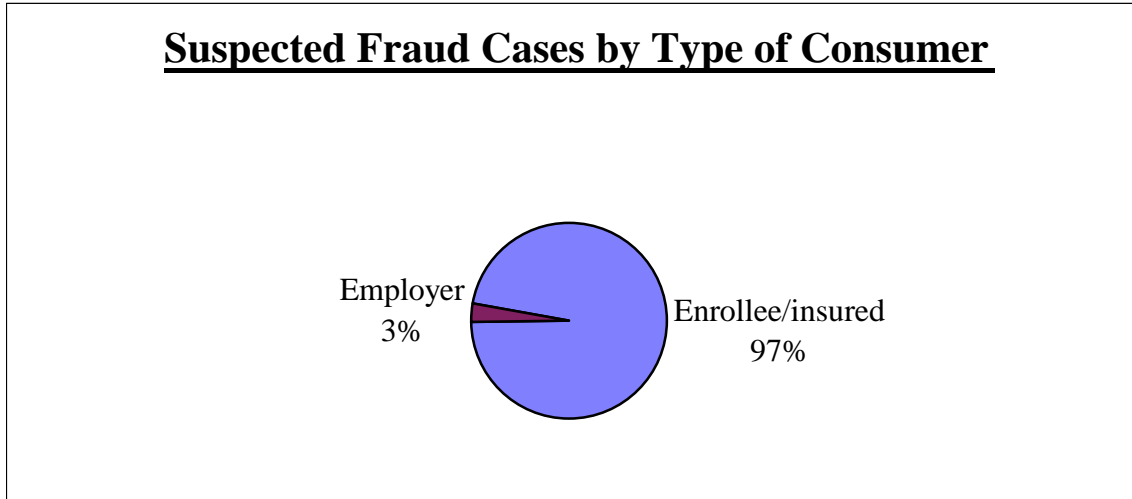
Figure 4



#### Consumer fraud

Cases of suspected fraud by consumers made up about 10 percent of all cases. By far, with 97 percent of the cases reported, beneficiaries or claimants were most identified as the perpetrator (Figure 5). Other unspecified fraud constituted 3 percent of all consumer cases.

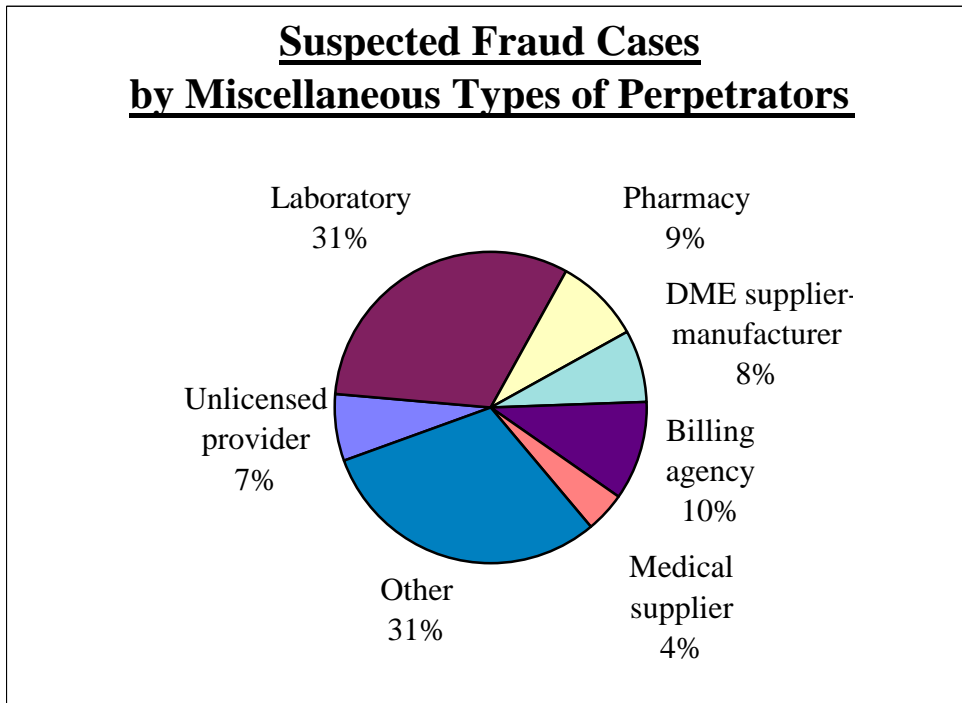
Figure 5



Fraud by others

Grouped under suspected fraud by “others” were categories such as laboratories, pharmacies, DME supplier, billing agency, home health agency, and unlicensed providers (Figure 6). The major perpetrators in this area of suspected fraud were laboratories (31 percent), DME/medical suppliers (8 percent), billing agencies (10 percent), and pharmacies (9 percent).

Figure 6



## **Fraud Cases by Type of Fraud**

For their anti-fraud programs, companies were asked to categorize newly investigated cases of suspected fraud and by type of perpetrator. Respondents were first asked to identify the amount of suspected fraud committed by consumers, providers, agents, and employees. Respondents were then asked to identify specific categories of perpetrators, such as physicians, dentists, or hospitals, et al. Respondents were asked to provide the above data for the year 1998. In terms of overall cases of suspected fraud, companies were asked to identify these for the period 1996 to 1998. There was a substantial increase in this number from 15,299 in 1996 to 42,371 in 1998, almost a three-fold increase.

Within each area of suspected fraud – provider, consumer, and other – companies were asked to identify the particular type of fraud perpetrated. Where more than one type of fraud was detected in specific cases, companies could indicate cases for more than one category of fraud. Therefore, the sum of the percentages for each category could total more than 100 percent.

### **Provider Fraud**

Fully one-third (34 percent) of all provider fraud was comprised of billings for services not rendered (Table 1). This was the most prevalent type of identified provider fraud reported by responding companies. Other relatively common types of suspected fraud involved service upcoding (22 percent), fraudulent diagnoses or dates of service (18 percent), and suspected fraud having to do with pharmacy claims (10 percent). Unlike past surveys, this year's results did not show a relatively high occurrence of waivers of copays and deductibles, with these suspected activities at only 8 percent. In the past, companies had indicated that this type of activity accompanied almost all other types of fraud.

Table 1

#### **Suspected Provider Fraud by Type**

Upcoding	22%
Billing for services not rendered	34%
Fraudulent diagnoses or dates	18%
Fee splitting	4%
Waiving copays and deductibles	8%
Pharmacy provider fraud	10%
Other	35%

### **Consumer Fraud**

Consumer fraud falls into several categories, but the most prevalent type suspected by insurers was falsifying of claims (Table 2). This type constituted over one-third (36

percent) of the claims flagged by insurers for review. Other common types of fraud perpetrated by consumers were misrepresenting information on applications for insurance (14 percent), false records of employment to qualify for benefits (13 percent), and fraudulent activities related to pharmacy benefits (12 percent), such as forged or altered prescriptions, or selling prescriptions.

Most companies responding to the survey did indicate some incidence of other miscellaneous fraud, but could not specifically identify the type.

Table 2

**Suspected Consumer Fraud by Type**

False records of employment/eligibility	13.2%
Falsifying claims	36.2%
Misrepresentation on applications	13.9%
Sale of health insurance coverage information	2.5%
Consumer fraud related to pharmacy	12.0%
Other	25.9%

**Case Referrals For Potential Prosecution/Penalties**

As part of their anti-fraud programs, companies are increasingly passing information along to state and other agencies for follow up and potential prosecution of suspected fraud cases. For responding companies the number of cases referred to other organizations or agencies numbered at least 1,200, but could be as many as 2,500 in 1998, because suspected fraud cases could be referred to more than one organization.

Over 1,200 cases were referred to state insurance fraud bureaus for further investigation. Almost 1,100 cases (possible including many of those also referred to fraud bureaus) were referred to law enforcement agencies for criminal investigation or prosecution. Much smaller numbers of cases were referred to federal or state regulatory agencies (196), state licensure boards (66), or pursued for civil action (55).

A substantial number of cases have resulted in criminal convictions, civil judgments, administrative sanctions, and/or judgments resulting in restitution or monetary awards.

Much of the referral activity has been spurred by state mandates requiring companies to establish special investigative units to investigate suspected fraud. Moreover, these mandates have heightened companies' awareness of potential fraud activities with referrals to outside agencies becoming part of their routine practice.

## Savings From Anti-Fraud Programs

As important as deterring fraud through detection and prosecution, is the savings that can be achieved from anti-fraud activities. The dollar benefit of these programs far outweighs their costs. They also indicate to policyholders and consumers the efforts of insurers to protect the health care dollars entrusted to them for the payment of medically necessary services.

The 1998 survey results indicate a level of total savings similar to that of the survey conducted for 1995. Total 1998 savings were over \$232 million. Companies that reported both their total savings and their anti-fraud budgets showed gross savings of \$223 million compared to total budgets of \$20 million. Thus, in aggregate their net savings were \$203 million (Table 3). Net savings from anti-fraud programs have been increasing over the time span that HIAA has conducted these surveys. Part of this increase is due to the increase in awareness and program establishment and thus the number of companies able to report such savings.

In 1998, responding companies saved \$11.41 for every dollar spent on anti-fraud programs. This is a substantial increase in a continued upward trend in savings. In 1995, companies reported savings of \$7.59 for every dollar spent on anti-fraud programs, with survey results of \$6.05 saved in 1994 and \$4.34 saved in 1993.

As companies expand their anti-fraud programs, providers and consumers who commit fraud are more likely to be caught and convicted -- actions that will also serve as a deterrent to others who might be tempted to engage in fraudulent activities.

Table 3

### Savings Realized from Anti-Fraud Programs

Passive savings (no monies paid)	\$	64,086,542
Monetary recovery/restitution (active savings)		34,126,328
Saving identified, but not yet recovered		116,614,282
Allocated savings		214,827,153
Unallocated savings		17,374,023
Overall total savings		232,201,176
Budget for anti-fraud programs	\$	19,564,906
Companies who provided both savings and budget figures:		
Savings		223,319,127
Budget		19,564,906
Net Savings	\$	203,754,221
Saving per dollar expenditure		\$11.41

## **Managed Care Anti-Fraud Activities**

The health care industry continues its evolution in developing new or modified benefit plan design, with managed care programs now constituting the vast majority of plans through which people obtain their health care coverage. This shift to managed care has brought some advantages in combating health care fraud, however, because managed care arrangements retain certain features of the fee-for-service payment system the number of cases may be fewer and the types of fraud uncovered different, but fraud continues to be a problem.

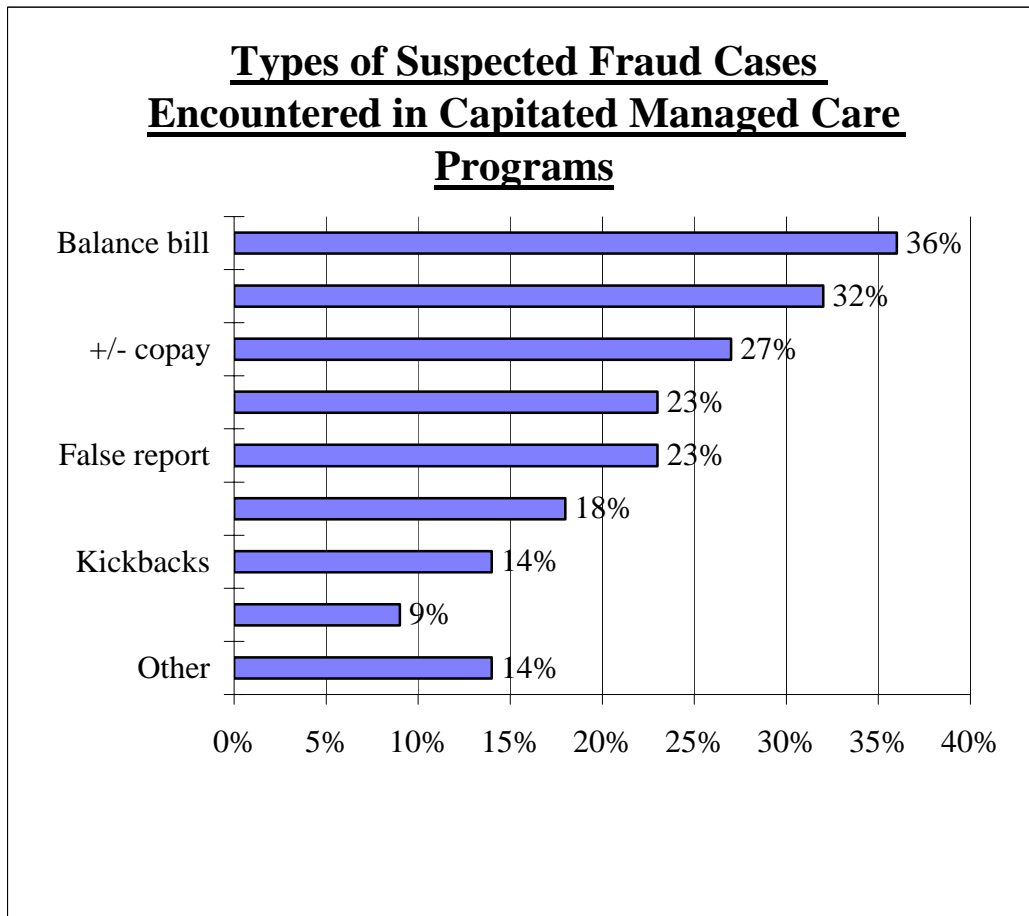
While not specific as to the amount of fraud that is perpetrated through managed care plans, HIAA's previous survey on anti-fraud activities has reported various activities of suspected fraud already documented under managed care arrangements, such as embezzlement of capitation funds, fraudulent subcontracts, and falsification of new enrollee registrations.

Results for the current survey indicate that 60 percent of the respondents conduct some of their health coverage business through managed care arrangements. Forty percent of respondents have some of their health plan enrollments through capitated managed care programs. Capitated programs represent almost 12 percent of these companies' total health care expenditures. Companies indicated having processed over 3.6 million patient encounters for capitated enrollees.

With a significant percentage of the respondents involved in managed care programs, responses to questions of suspected fraud should be indicative of the experience of a large portion of the industry. HIAA asked if incidents of suspected fraud were detected and of what type. Though the number of cases of suspected fraud in capitated programs reported by responding companies was relatively small, less than 1 percent compared to the number of patient encounters, over half of the respondents (55 percent) had detected some cases.

A substantial percentage of respondents with capitated managed care programs reported detecting fraud in a number of categories (Figure 7). The most often cited type of fraud in capitated programs was balance-billing patients whose plans prohibited such billing, reported by 36 percent of respondents. Other common types indicated were submitting claims for non-providers, but charging the provider rate (32 percent), undercharging or overcharging copayment amounts (27 percent), falsifying reports (23 percent), and falsifying treatment costs (23 percent).

Figure 7

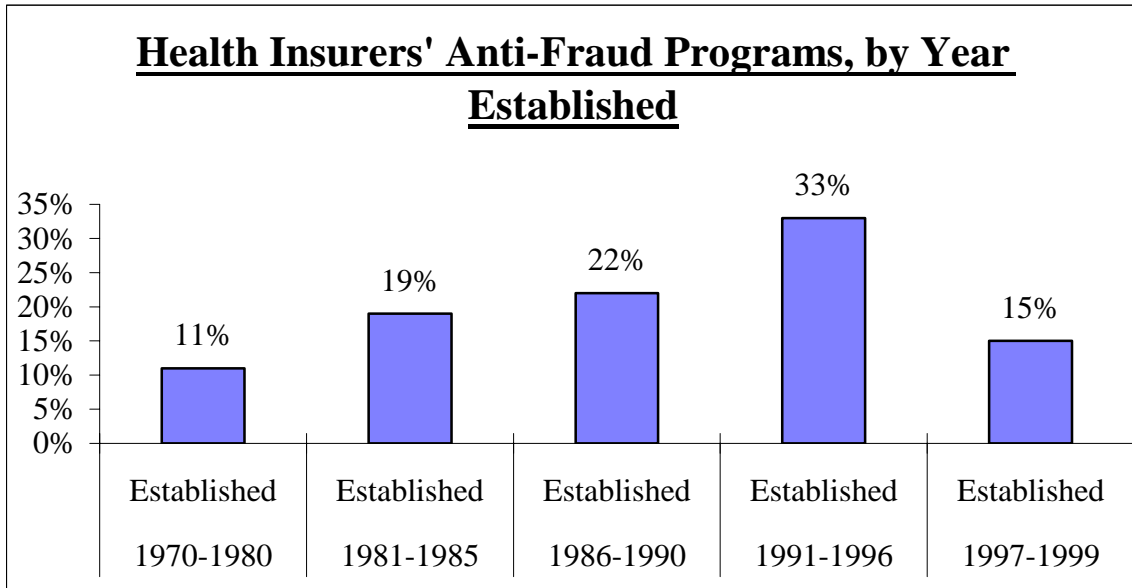


### **Companies' Internal Anti-Fraud Operations**

Of the 58 responding companies, 55, or 95 percent, have implemented anti-fraud programs. Though some programs may have been established as long ago as 1970, almost half (48 percent) have been created within the last ten years between 1991 and 1999 (Figure 8). Eleven percent were established between 1970 and 1980 and 41 percent between 1981 and 1990.

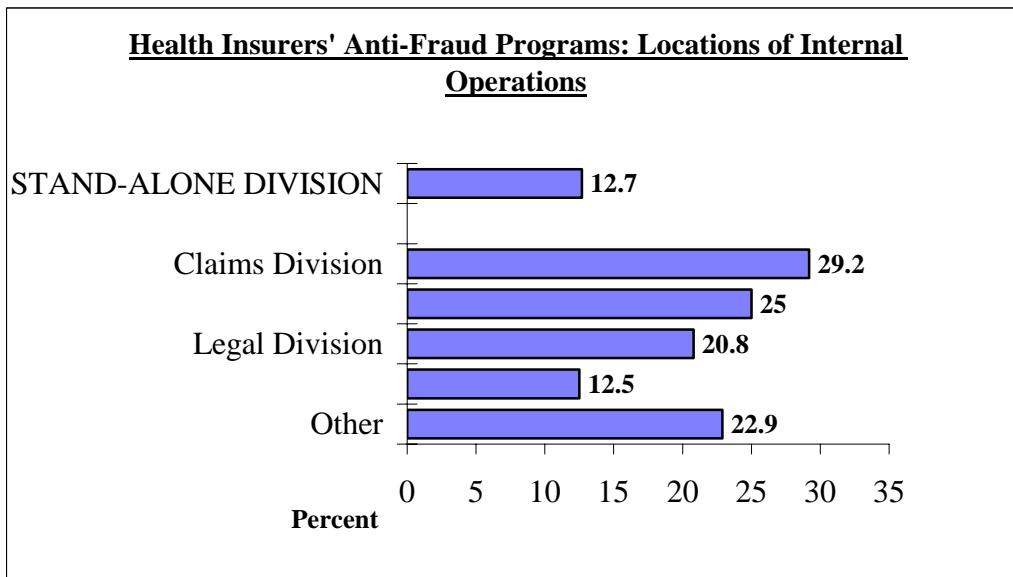
Much of the recent activity by companies in establishing anti-fraud programs has been spurred by legislative actions. With many jurisdictions proposing or having enacted some anti-fraud legislation, 15 percent of the survey's respondents indicated that their program was developed as a direct result of state mandates. Eighty-five percent of companies with an anti-fraud program have established a specialized investigative unit (SIU).

Figure 8



Similar to HIAA’s survey results for 1995, most companies in 1998 had established their anti-fraud activities within some other division of their organization (Figure 9). Only 13 percent (compared to 15 percent in 1995) had set up a stand-alone unit apart from other business operations. For the other 87 percent of companies, the most common area to house a unit devoted to anti-fraud efforts was the claims division (29 percent). Internal audit and legal divisions were the next most frequently cited areas with 21 percent and 13 percent respectively.

Figure 9



Most anti-fraud units handle suspected claims from several company areas or product lines. However, perhaps because of increasing focus on medical fraud, a larger percentage of respondents now have their anti-fraud units handle medical claims only. Compared to 1995 when only 27 percent of the fraud units handled only medical claims, now fully 40 percent of these units handle only these claims.

In establishing and maintaining their anti-fraud programs, health insurers generally determine the number of personnel required for these units based on a combination of the workload or case volume that needs attention and the budget or funding level set aside for the program. These factors (case load and budget) were the primary determinants for 62 percent and 66 percent, respectively, of responding companies. State mandates were a factor for 16 percent of respondents.

The average number of full time equivalent employees assigned to health care anti-fraud activities has remained unchanged from the 1995 survey conducted by HIAA. Companies now have an average of 7.2 FTEs assigned to these activities compared to 7.3 in 1995.

In addition to the number of personnel required to handle the claims referred to anti-fraud units, almost all companies look for certain qualifications in their personnel. A background in health and/or claims is cited most frequently as a requirement, with 57 percent and 52 percent respectively, by responding companies. Other frequently sought background experience is computer/systems and law enforcement (38 percent and 36 percent respectively). The designation of Certified Fraud Examiner is specifically required by almost half (45 percent) of respondents. Other designations frequently sought are those of a Certified Insurance Fraud Investigator (21 percent) and Certified Internal Auditor (12 percent).

### **Activities Of Companies' Anti-Fraud Programs**

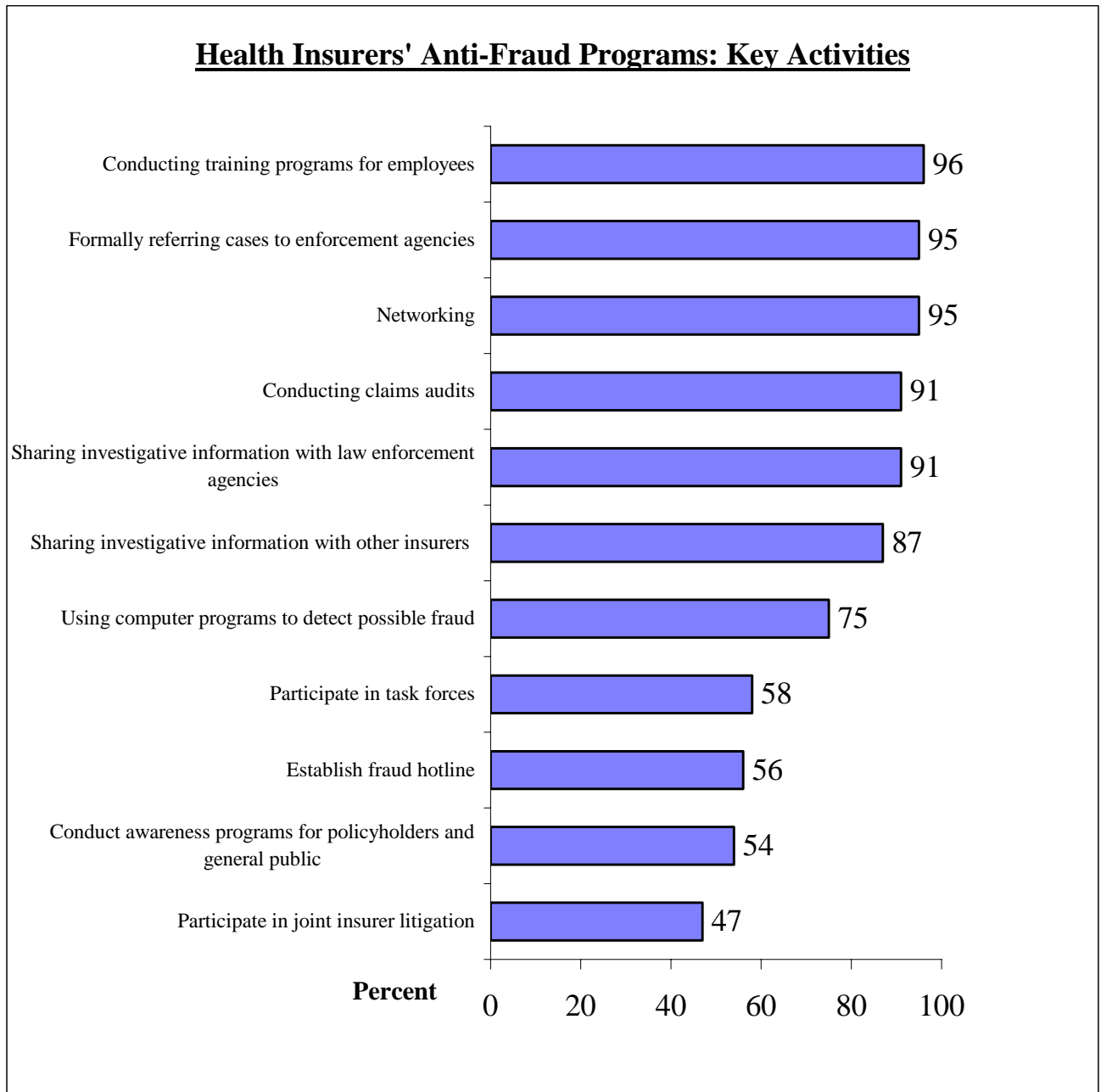
Staying one step ahead of fraud perpetrators requires ongoing reinforcement of, and support for, anti-fraud programs. In doing so, companies use a variety of techniques to maintain awareness and detect and report suspected fraudulent claims. Almost all areas of activities asked of in the current HIAA survey demonstrated increased company participation compared to these same activities in the 1995 survey.

Almost all respondents (96 percent) conduct training programs for their employees. This is an essential part, along with conducting claims audits (91 percent of companies) in the detection of suspected fraudulent claims.

Insurers individually may detect relatively small amounts of suspected fraudulent activities. However, if the same entity is perpetrating fraud on numerous providers and/or payers, networking with other organizations allows for possible comparison and accumulation of data into a larger case attractive to prosecutors. Networking with other entities and sharing information is an increasingly common activity among health care payers with 95 percent now engaged (Figure 10). Formally referring cases to

enforcement agencies is done by 95 percent of respondents, up from 86 percent in 1995. Sharing investigative information with law enforcement agencies is done by 91 percent compared to 89 percent in 1995. And sharing investigative information with other insurers has increased from 76 percent of respondents to 87 percent in 1998.

Figure 10



Organizations devoted to anti-fraud efforts facilitate the sharing of information and the dissemination of information on legislative developments and data issues. Of companies with anti-fraud programs, 93 percent belonged to one or more anti-fraud organizations.

Eighty-three percent of respondents belonged to the National Health Care Anti-Fraud Association (Table 4). Forty-five percent belonged to the Association of Certified Fraud Examiners and 34 percent belonged to International Association of Special Investigative Units. Other organizations that many respondents belong to include the Institute of Internal Auditors (IIA) and the National Insurance Claim Bureau (NICB).

Table 4

Anti-Fraud Organizations to Which Health Insurers Belong

<u>Percent of Companies that Participate in any Anti-Fraud Organizations</u>	<u>93</u>
National Health Care Anti-Fraud Organizations (NHCAA)	83
National Insurance Crime Bureau (NICB)	15
Coalition Against Insurance Fraud (CAIF)	8
Association of Certified Fraud Examiners (ACFE)	45
International Association of Special Investigation Units (IASIU)	34
Health Insurance Association of America (HIAA)	72
American Society for Industrial Security (ASIS)	15
American Institute of Certified Public Accountants (AICPA)	17
Institute of Internal Auditors (IIA)	28
Other	28

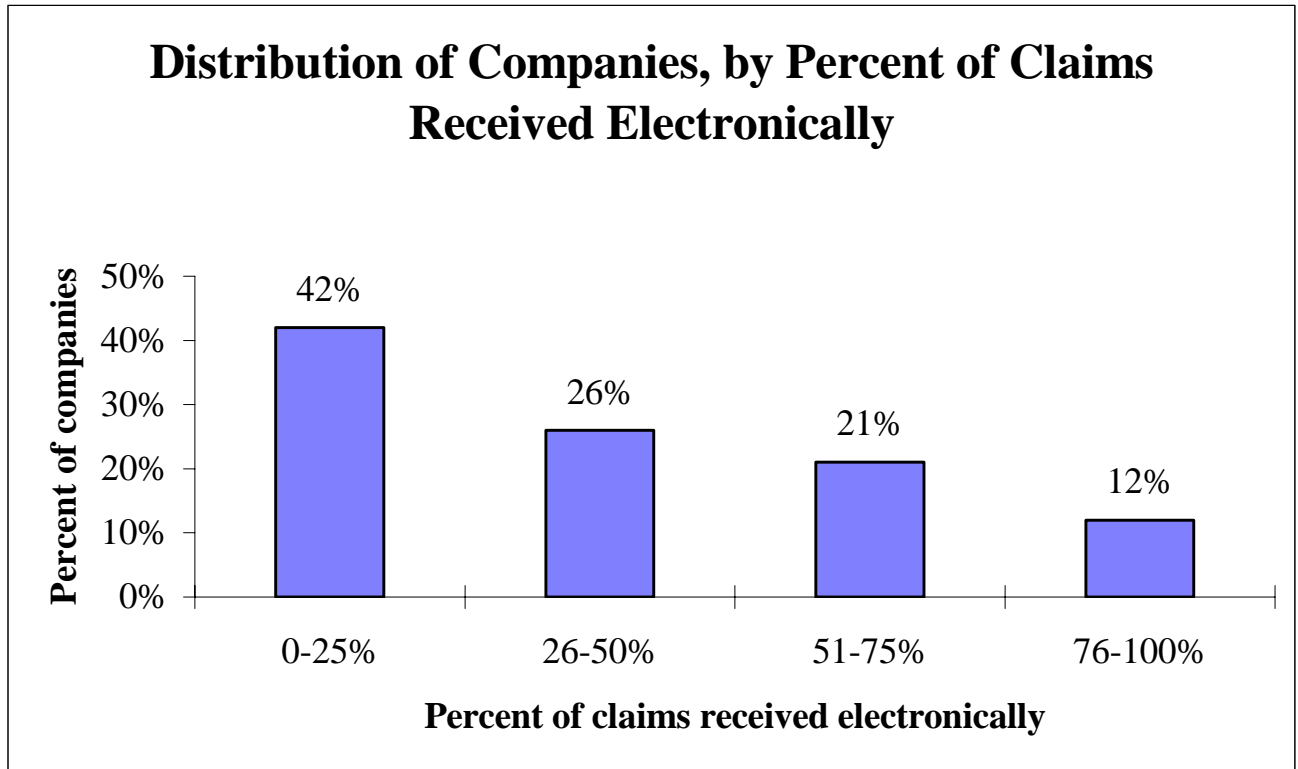
The first line of, and in many instances the best, defense against fraudulent claims are conscientious consumers that review their bills against the services they've received. Consumers can request copies of their bills and audit them for accuracy. They can compare charges to services that were actually received, or review the charges for what may seem to be overpriced services. Many health care plans recognizing this role have adopted anti-fraud programs that encourage consumer participation. Fifty-six percent of respondents to the survey have set up fraud hotlines to take consumer calls and 55 percent have set up fraud awareness programs for policyholders or enrollees or the public in general.

Many companies have supplemented their claims processing and fraud detection operations with computer software to detect potential fraud. This aspect of detection will become increasingly important as the savings potential continues to rise and incoming claims switch more to an electronic, rather than paper, base. Not only will there be less direct human intervention in processing claims, there will be less documentation, initially, upon which to verify correct diagnoses and procedure coding.

Three-fourths (75 percent) of responding companies with anti-fraud programs use computer software to assist in detecting possible fraud.

Almost three-fourths (73 percent) of companies with anti-fraud programs receive a percentage of their claims electronically. The percentage range of claims received in this manner is from 5 percent to 83 percent, with the median percentage received via electronic means at 39 percent. This compared to a median of 32 percent in 1995. In 1998, one third of the respondents received at least half of their claims electronically (Figure 11).

Figure 11

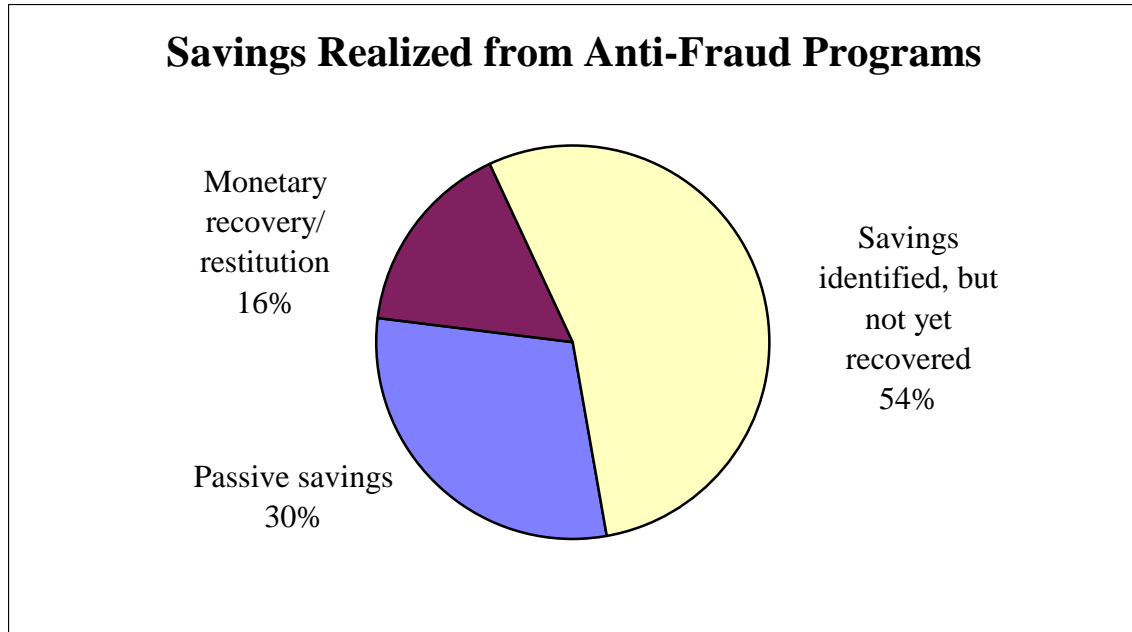


As the tide of claims moves to electronic media, companies can use several safeguards to protect against potential fraud. The majority of responding companies that receive electronic claims use in-house fraud detection screens in claims processing systems to detect and prevent fraud (64 percent). Other methods used by respondents include contractual protections with providers or billing agents (31 percent), and contractual protections with claims clearinghouses or service bureaus (26 percent).

The most effective way to save money is to prevent fraud from occurring. Further, detecting fraud before payment on a claim is made stems the flow of funds to these activities. In 1998, almost 30 percent of the allocated savings occurred where no monies were paid (Figure 12). The remaining savings were gained from overpayments recovered (16 percent). The largest segment of potential savings is from losses identified, but not yet recovered (54 percent). However, since these monies are not yet realized, the actual amount of savings is difficult to predict. The figures used for actual savings are conservative. In some cases it is difficult to quantify how much was saved because

potential fraud was deterred or prevented before it could spread. Thus, actual savings are probably more substantial than reported savings.

Figure 12



Though the data presented in this and past surveys of HIAA demonstrates the cost savings potential of establishing anti-fraud programs, insurers and health plans need to decide on how best to implement these programs. Companies may consider tracking suspected fraud cases by dollar volume and case volume as well as perpetrator type and type of fraud. Thus, they could determine areas where the most fraud and potential savings occur and could then focus their anti-fraud efforts in those areas.

Even in the absence of more sophisticated programs, there are measures that plans can implement that are low cost and would prove to be effective as both a tool to combat fraud and promote increased consumer involvement. These include networking with other organizations and establishing fraud hotlines and awareness programs for policyholders and the general public. Publicizing to employees, patients, and providers that an insurance company has an anti-fraud program, including a hotline, will help facilitate the development of an effective program.

In instituting anti-fraud programs, savings obviously need to exceed the budget to be cost effective. Insurance companies should recognize that they may initially incur substantial start-up costs. However, the longer a program has been in place and active, the more efficient it will become at decreasing fraud and increasing savings

## **CONCLUSION**

Health care fraud continues today, as it did since the HIAA's last report, to be a pervasive problem. It increases the nation's spending for health services and siphons off health care dollars that should be used for legitimate purposes within the health care system or for other outside needs. As managed care programs now constitute the vast majority of health plans and alleviate the need for surveillance of some past fraud types, insurers need to be vigilant for the new fraud schemes these plans bring. In addition to audits and reviews of individual claims, fraud detection must include evaluations of patterns of care to continue to be effective in solving this problem.

This report illustrates the savings that can be achieved from anti-fraud programs. As managed care has achieved broad market share, it approaches limits in its ability to inhibit increases in health care expenditures through the provision of cost effective, necessary, and appropriate medical services. Therefore, fraud detection and prevention will remain increasingly important in the effort to keep health care expenditures within reasonable limits.

