

HEALTH INSURERS' ANTI-FRAUD PROGRAMS

HEALTH INSURERS' ANTI-FRAUD PROGRAMS

**RESULTS OF A SURVEY
OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA**

Thomas D. Musco

Kathleen Fyffe

Shannon Pohlman

1997

CONTENTS

Preface

Executive Summary

Introduction

Findings

 Fraud Cases by Type of Fraud

 Provider Fraud

 Consumer Fraud

 Fraud Cases by Type of Perpetrator

 Case Referrals for Potential Prosecution/Penalties

 Savings from Anti-Fraud Activities

 Managed Care Anti-Fraud Activities

 Companies Internal Anti-Fraud Operations

 Activities of Companies' Anti-Fraud Programs

Conclusion

Footnotes

ILLUSTRATIONS

Tables

- Table 1.....
Number of New cases Investigated
- Table 2.....
Realized Savings from Anti-Fraud Programs

Figures

- Figure 1.....
Years Anti-Fraud Programs were Established
- Figure 2.....
Location of Anti-Fraud Activities
- Figure 3.....
Anti-Fraud Organizations in Which Companies Participate
- Figure 4.....
Number of Fraud Cases Investigated 1993-1995
- Figure 5.....
Suspected Fraud Cases by Type
- Figure 6.....
Provider Fraud Cases by Type 1995
- Figure 7.....
Consumer fraud Cases by Type 1995
- Figure 8.....
Fraud Cases Allocated by Type Of Perpetrator 1995
- Figure 9.....
Net Savings from Anti-Fraud Activities 1993-1995
- Figure 10.....
Average Dollars Saved per Dollar Spent
- Figure 11.....
Realized Savings from Anti-Fraud Programs 1995
- Figure 12.....
Activities Included in Anti-Fraud Programs
- Figure 13.....
Safeguards to Detect and Prevent EDI Fraud

PREFACE

The Health Insurance Association of America (HIAA) has conducted several surveys in the past to collect information on: 1) the extent to which insurers had developed anti-fraud programs and 2) their effectiveness. HIAA's report on 1989 activities was the first to document quantifiable data on anti-fraud programs and their savings. Since that time HIAA has conducted similar surveys in 1993 and again in 1996. 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 August to November 1996, requesting data for 1993, 1994, and 1995. The survey 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. The survey also asked for the number of cases investigated, types of cases investigated, and estimated savings for the past three years.

Responses to the survey came from 110 companies, 5 of which did not have suitable business to complete any of the survey. These responding companies represent large, medium, and small insurers. These companies represented approximately 15 to 20 percent of the insurance industry based on premium volume. 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. Since more companies were able to provide data for the most recent time period, the 1995 figures contain the most complete and accurate reflection of the industry.

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. Therefore, while it is believed that the trends within each survey are consistent, no comparisons have been made across the time spans of different surveys.

Thomas D. Musco and Kathleen Fyffe, staffers at HIAA, wish to thank Shannon Pohlman for her invaluable assistance in producing this report while an intern at HIAA.

EXECUTIVE SUMMARY

A combination of more companies taking an active role in detecting suspected fraud cases and an increasing amount of fraudulent activities are responsible for the dramatic results seen over the time period covered by the current HIAA survey. A substantial increase has been reported in the number of cases investigated by companies and the resultant savings from these investigations. The following points are major findings from the survey:

- Companies responding to the survey reported average net savings per company during 1995 of \$2.3 million. Combined total savings of all responding companies equaled \$260 million.
- The total number of suspected fraud cases investigated was 42,950 in 1995.
- The cost/savings benefit of companies' anti-fraud operations increased almost 75 percent from 1993 to 1995. Companies' anti-fraud operations saved over \$7.50 for every dollar spent in 1995 compared to \$4.30 in 1993.
- 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.
- Almost 9 out of 10 companies (87 percent) have implemented anti-fraud programs. Though the earliest year in which a company established a program was as long ago as 1970, over half of the companies (52 percent), started their program within the most recent 5 years from 1991 to 1996.
- Almost all companies (92 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 89 percent and 86 percent respectively. Sharing investigative information with other insurers is done by 76 percent of respondents.
- Forty-two percent of respondents have established fraud hotlines and 32 percent have conducted awareness programs for policyholders.
- Sixty-two percent of companies with anti-fraud programs receive a percentage of their claims electronically, ranging from 1 percent to 95 percent, with the median percentage received via electronic means at 32 percent.

- Almost three-quarters (73 percent) of responding companies use computer software to assist in detecting possible fraud, including in-house fraud detection screens in claims processing, contracting with claims clearinghouses or service bureaus, and contractual protections with providers or billing agents.

INTRODUCTION

Health care fraud continues to be a serious and pervasive problem in our health care system, frequently cited in the media as a major factor for the high cost of health care in the United States with headlines such as “Health insurers see rise in scams; fraud costing \$100 billion a year” (Footnote 1).

Depending on the estimating organization, health care fraud is estimated to range 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, the figure mentioned in the cited headline.

Activity has been increasing on both the payer and perpetrator sides over control of the health care dollar. 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, payers have had added to their arsenal the support of state and federal governments which have passed legislation taking more direct aim at fraudulent activities.

The recently enacted health insurance reform legislation known as the Kassebaum-Kennedy Act (PL 104-191) toughens laws against health care abuse and establishes a fraud and abuse control program. 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. To this end, the act appropriates almost \$1.7 billion over the next seven years. States are also on the move with legislation requiring insurers to establish special units to investigate suspicious claims or contract with an outside company for that service.

Recently, health care fraud is also mentioned as evolving into more than a traditional white collar crime activity, with reports over the past few years of organized crime activities in the health care industry.

The Federal Bureau of Investigation notes that organized crime has penetrated many sectors of the health care industry. (Footnote 2.) The FBI has seen illegal drug distributors switch from drug dealing to health care fraud schemes, apparently because there is less of a risk of being caught and imprisoned. Further, the FBI reports that throughout the United States, organized crime organizations have involved physicians and attorneys. For example, these organizations have set up storefront medical clinics, diagnostic testing companies and bogus law offices. In south Florida, health care fraud has become increasingly violent as evidenced by cases of kidnappings and homicides. (Footnote 3.)

The importance of combating health care fraud and its spread must be kept visible to payers, legislators, and the public. To this end, several organizations have gotten even more aggressive in taking action to heighten companies' awareness of health care fraud, present information on anti-fraud programs, and suggest action to combat this growing problem. The Health Insurance Association of America (HIAA) and the National Health Care Anti-Fraud Association (NHCAA) are two such organizations. HIAA has conducted several surveys in the past to collect data on the extent to which insurance companies have instituted activities to combat fraud. One such survey was conducted in 1989, providing data on the distribution of fraudulent claims by type of perpetrator. That same survey provided the first data-supported indication of the potential savings that could result from private organizations anti-fraud programs. HIAA conducted follow-up surveys in 1993 and again in 1996. The results of this most recent survey are reported here.

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 over \$1.1 billion in settlements and fines from health care organizations accused of engaging in fraudulent activities.

Findings

A combination of more companies taking an active role in detecting suspected fraud cases and an increasing amount of fraudulent activities are responsible for the dramatic results seen over the time period covered by the current HIAA survey. A substantial increase has been reported in the number of cases investigated by companies and the resultant savings from these investigations.

From 1993 to 1995, companies responding to the survey reported an increase in average net savings per company of almost 250%, from \$935,000 to \$2.3 million (see methodology for discussion of company responses over this time period). 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 \$260 million. Since not all companies could respond, this amount may represent only a small portion of the estimated potential savings that might have been possible if all companies had responded. If other companies in the health care industry achieved results proportionate to those of the average responding company, total industry savings conceivably could be well over \$1 billion, all other factors being equal.

The average number of suspected fraud cases investigated per company actually declined between 1993 and 1995 from an average of 875 to 660. This result may be due to data having been reported from larger, established anti-fraud units in the earlier years, with more data from newer, perhaps smaller units for the more recent time period, and does not indicate any negative impact of anti-fraud programs. For several companies with large anti-fraud programs, the average number of cases per company was 1,050, while the median was about 140. With a greater number of companies instituting anti-fraud

programs in more recent years, the total number of suspected fraud cases investigated increased by a third from 32,440 in 1993 to 42,950 in 1995.

The cost/savings benefit of companies' anti-fraud programs increased almost 75 percent from 1993 to 1995. Companies' anti-fraud programs saved over \$7.50 for every dollar spent in 1995 compared to \$4.30 in 1993.

Fraud Cases by Type of Fraud

For their anti-fraud programs, companies were asked to categorize newly investigated cases of suspected health care fraud by type of fraud and by type of perpetrator. By type, 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, hospitals, etc. Respondents were asked to provide the above data of the years 1993, 1994, and 1995.

A substantial increase has been seen in the number of suspected fraud cases investigated over the time period in the current survey (see methodology). The number of suspected fraud cases investigated by responding companies increased over 32 percent in two years from 32,442 in 1993 to 42,951 in 1995. (See Figure 4 and Table 1.)

In recent years, the percentage of suspected provider fraud appears to have decreased while the percentage of suspected consumer fraud has increased substantially. In 1993, approximately 92 percent of reported health care fraud resulted from provider actions, and only 7 percent from consumer actions. 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. (See Figure 5.)

Provider Fraud

In 1995, of specifically identified cases of suspected provider fraud, the type most frequently reported was billing for services not rendered, which accounted for 59 percent (See Figure 6). Providers may bill under false procedure codes to raise the level of payment, or fraudulent billings may come from two or more providers for the same service to the same patient on the same day.

Next in order of frequency was fraudulent diagnoses or dates of service, which accounted for 15 percent of the provider cases. Providers may alter the diagnosis to accommodate coverage provisions of insurance programs or change dates of service to fall within coverage requirements.

Providers routinely waiving co-payments and deductibles accounted for 5 percent of fraudulent activities. However, some health insurers believe this practice is much more widespread and may accompany most other types of health care fraud. In such cases, the cost to the patient may be zero, but the charge to the insurer may be inflated to cover the provider's costs.

The remaining 20 percent consisted of other types of provider fraud.

Consumer Fraud

In 1995, of the suspected consumer fraud cases categorized by type of fraud, the most frequently reported type was falsifying claims. This accounted for 69 percent of the cases. (See figure 7.) Misrepresentation on applications accounted for 16 percent, false records of employment/eligibility accounted for 9 percent, and the remaining 6 percent consisted of various other types of consumer fraud.

Other perpetrators (agents, employees, etc.) of suspected fraud constituted about 2.5 percent of the identified suspected fraud cases investigated for 1995.

Fraud Cases by Type of Perpetrator

Companies were asked to identify the cases of suspected fraud they investigated by specific type of perpetrator. These categories consisted of professionals, facilities, consumers, and others. A substantial number of companies were able to provide a categorization of the cases they investigated, producing new data on the distribution of suspected fraud cases.

Of the suspected fraud cases investigated in 1995, the most frequently reported category of perpetrator was professionals with 76 percent of all the allocated cases by type. Some specific types of professional cases mentioned, not in any order indicative of frequency, were chiropractors, dentists, physical therapists, and physicians. Next in frequency were facilities, accounting for 12 percent, with acute care hospitals, outpatient or ambulatory care centers, and psychiatric hospitals receiving specific mentions. Cases of suspected consumer fraud constitute 5 percent of reported cases, with both beneficiaries and employers having been part of suspected fraud investigations. The remaining 7 percent were other types of suspected perpetrators, including laboratories, medical suppliers, and pharmacies. (See Figure 8.)

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 (which increased in number by 75% since 1993) the number of cases referred to state insurance and fraud bureaus increased by over 200 percent from 470 in 1993 to 1,537 in 1995. Again, much of this increase may be caused by more and better reporting of companies in recent years.

Much of this increase has been spurred by state mandates requiring companies to refer potential fraud cases. Moreover, these mandates have heightened companies' awareness of potential fraud activities with referrals to outside agencies becoming part of their routine practice. In 1993, 84 percent of cases were referred by state mandate and 16 percent were referred voluntarily, compared to 69 percent and 31 percent respectively in 1995.

The number of cases referred for criminal investigation or prosecution increased by over 100 percent from 260 in 1993 to 566 in 1995. And the number of criminal convictions obtained increased 150 percent from 47 to 115. The number of criminal convictions, however, cannot be directly correlated to the number of cases referred for prosecution in their respective years. Current convictions may be the result of cases investigated and referred from previous years. With increased communications and sharing of information, the success rate in convictions should continue to increase. Some companies have had additional success with civil actions against suspected fraud perpetrators. The number of cases pursued via civil action showed similar increases from 1993 to 1995.

Savings From Anti-Fraud Activities

Perhaps as important as deterring fraud through detection and prosecution, if not more so, is the savings that can be achieved from anti-fraud activities. In previous surveys of the HIAA, it has been shown that the dollar benefit of these programs far outweighs the costs of their implementation. They further indicate to policyholders and consumers the efforts taken by companies to protect the health care dollar entrusted to them for benefit payments toward medically necessary services.

In 1995, companies reported total savings of \$262 million, a 180 percent increase from total savings of \$94 million in 1993 (see methodology). Companies that reported both their total savings and their anti-fraud budgets showed gross savings of \$134 million compared to total budgets of \$18 million. Thus, in aggregate their net savings were \$117 million. (See Table 2.)

Net savings from anti-fraud programs have been increasing over the 1993 to 1995 time span of this current survey. Compared to the \$27 million in 1993, the net savings of \$55 million in 1994 and \$117 million in 1995 demonstrate increases in savings of over 100 percent each year (see Figure 9). Part of this dramatic increase is due to a increase in the number of reporting companies from 1993 to 1995 able to report such savings.

In 1995, responding companies saved \$7.59 for every dollar spent on anti-fraud programs. This is an increase from \$6.05 saved per dollar spent in 1994 and \$4.34 saved per dollar spent in 1993. (See Figure 10.)

These trends result from more companies and increased initiating of anti-fraud programs and efforts from companies with established anti-fraud programs. Only one quarter of respondents to the current survey reported on savings for 1993 versus almost one half for 1995. As companies expand their anti-fraud programs, providers and consumers who commit fraud are more likely to be caught and convicted. These actions will also serve as a deterrent to others who might be tempted to engage in fraudulent activities.

Managed Care Anti-Fraud Activities

The health care industry has been changing over the past 10 to 15 years. What was an industry of companies providing health insurance policies to pay claims has shifted to one of health care service provision and resource management with emphasis shifted from claim services to health care management. Today over 75 percent of all persons with private health care coverage have such through some managed care arrangement. With this change has also come different types of fraudulent activities. In testimony presented by HIAA before congressional committees and in recent publications, it has been mentioned that companies need to maintain vigilance in their anti-fraud programs. The movement to managed care will continue certain features of the fee-for-service system of payment because not all arrangements rely completely on pre-paid financing (Footnote 4.) But, many believe managed care should reduce the potential for fraudulent acts since there are fewer consumer claim filings in such systems. Still, various activities of suspected fraud have already been uncovered under managed care arrangements, such as embezzlement of capitation funds, fraudulent subcontracts, and falsification of new enrollee registrations (Footnote 5.)

For the current survey, companies were asked to indicate the extent to which they conduct health care business on a managed care basis and what types of suspected fraudulent cases they have uncovered. Of the responding companies with anti-fraud programs, 69 percent (63 companies) conduct business through managed care arrangements. Reported total enrollment in managed care plans from 44 companies that could provide data exceeded 30 million enrollees with a company median of over 300,000. For plans that could provide both enrollment and claim volumes, the average number of claims processed per enrollee was 2.9.

Few respondents could provide actual figures for the number of suspected fraudulent claims they identified through their managed care programs. However, slightly more than one quarter (26 percent) of the respondents with an anti-fraud program indicated that they had some managed care business on a capitated basis and identified by type the suspected fraudulent claims they had uncovered. In these capitated programs some companies uncovered suspected fraudulent claims for submitting higher than actual encounter rates, submitting claims for services by non-providers, and undercharging or overcharging co-payment amounts. Balance-billing patients whose plans prohibit such billing was also suspected. Other types of suspected fraud were falsifying

reports/credentials in order to be admitted into a network and paying/accepting kickbacks for patient referrals.

Companies Internal Anti-Fraud Operations

Of the 105 responding companies, almost 9 out of 10 (87 percent) have implemented anti-fraud programs. Though the earliest year in which a company established a program was as long ago as 1970, only 7 percent created programs before 1980. Twenty percent of responding companies began their program between 1981 and 1985, with 21 percent beginning programs between 1986 and 1990. Over half of the companies (52 percent), started their program within the most recent 5 years from 1991 to 1996 (See Figure 1).

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, 25 percent of the survey's respondents indicated that their development of special investigative units (SIU) or fraud detection programs were the direct result of state mandates.

In establishing a unit or division to handle anti-fraud efforts, only 15 percent of responding companies set up a stand-alone unit apart from other business operations. For the other 85 percent of companies, the most common area to house a unit devoted to anti-fraud efforts was their claims division (35 percent). Internal audit and legal divisions were the next most frequently cited areas with 21 percent and 12 percent respectively (See Figure 2). Most anti-fraud units handle suspected claims from several company areas or product lines. Of companies that gave a response to this question, 27 percent of the fraud units handle medical claims only and 73 percent handle claims from multiple product lines, depending on the products offered.

In establishing and maintaining their anti-fraud programs, health insurers generally determine the number of personnel required for these units based on the workload or case volume that needs attention. This is the primary determinant for 58 percent of responding companies. The company's budget or funding level was cited as a determinant of personnel needs by 5 percent of responding companies, with a balance between budget and workload indicated by 4 percent. The average number of full time equivalent employees increased 20 percent from 6.1 in 1993 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 claims is the most frequently cited experience sought in their staff, required by 77 percent of the responding companies. Other frequently sought qualifications are for personnel with some medical or law enforcement background, required by 32 percent and 29 percent of companies respectively. The designation of "Certified Fraud Examiner" is specifically required by 21 percent of respondents. Eighteen percent require other unspecified qualifications and approximately 7 percent have no specific qualifications.

Activities of Companies' Anti-Fraud Programs

Staying one step ahead of fraud perpetrators requires ongoing reinforcement of, and support for, anti-fraud programs. Companies use a variety of techniques to maintain awareness and detect and report suspected fraudulent claims. Almost all companies (92 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. (Figure 12)

Insurers may individually experience 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 a common activity among health care payers. Sharing investigative information with law enforcement agencies and formally referring cases to them is done by 89 percent and 86 percent respectively, of respondents. Sharing investigative information with other insurers is done by 76 percent of respondents.

Organizations devoted to anti-fraud efforts have developed to facilitate this sharing of information as well as dissemination of information on legislative developments and data issues. Of companies with anti-fraud programs, 92 percent belonged to one or more anti-fraud organizations. Eighty-six percent of respondents belonged to the National Health Care Anti-Fraud Association. Nineteen percent belonged to the Association of Certified Fraud Examiners and 15 percent belonged to International Association of Special Investigative Units. Other organizations that many respondents belonged to included National Insurance Claim Bureau (NICB), and other various regional organizations. (See Figure 3).

Consumers also play an important role in uncovering suspected fraud. In many instances the consumer is the first and perhaps best defense against fraudulent claims. A patient can request a copy and audit his or her bill against services that were actually received, or review the charges for what may seem to be overpriced services. Many health care plans, recognizing the consumers role, have adopted anti-fraud programs that encourage consumer participation. Forty-two percent of respondents have established fraud hotlines and 32 percent have conducted awareness programs for policyholders.

Fraud has become a large problem in terms of the amount of health care dollars going to perpetrators. With a corresponding potential for large savings, 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 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.

Almost three-quarters (73 percent) of responding companies with anti-fraud programs use computer software to assist in detecting possible fraud.

Already, approximately 62 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 1 percent to 95 percent, with the median percentage received via electronic means at 32 percent. Here, 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 electronic fraud (71 percent). Other methods used by respondents include contractual protections with claims clearinghouses or service bureaus (39 percent), and contractual protections with providers or billing agents (36 percent) (See Figure 13).

The most effective way to save money is to prevent fraud from occurring. Further, detecting fraud before payment on a claim is made also stems the flow of funds to these activities. In 1995, about 70 percent of the allocated savings occurred where no monies were paid (See Table 2 and Figure 11). The remaining savings were gained from overpayments recovered (20 percent) and payments identified, but not yet recovered (10 percent). 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.

Insurance 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.

To decide upon anti-fraud measures, health insurance companies may consider those listed above, especially networking with other organizations, using computer software to detect potential fraud cases, and promoting consumer and employee awareness of potential fraud. Since fraud cases are often difficult for insurance companies to detect, but the savings can be very high, insurance companies may also consider offering incentives for consumers to assist in detecting suspected fraud cases. Publicizing to employees, patients, and providers that an insurance company has an anti-fraud program, including a hot-line, will help to facilitate the development of an effective program.

In instituting anti-fraud programs, savings obviously need to exceed the budget in order to be cost effective. Insurance companies should recognize that they may initially incur substantial start-up costs. However, the longer a program has been active in place, the more efficient it will become at decreasing fraud and increasing savings. The significant savings achieved through their programs will help to contain health care costs for the public and premiums for policyholders.

CONCLUSIONS

Health care fraud continues to be a pervasive problem that 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. The switch from traditional fee-for-service benefit plans to managed care programs offers some relief from certain types of fraud seen in the past, but brings its own unique fraud schemes. 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 continuing/ongoing savings that can be achieved from implementation of effective anti-fraud programs. As managed care achieves broader market share and 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 become increasingly important in the effort to keep health care expenditures within reasonable limits.

FOOTNOTES

1. “Health Insurers See Rise in Scams; Fraud Costing \$100B A Year” The Bergen Record, June 2, 1996.
2. Louis J. Freeh, Director, Federal Bureau of Investigation, Statement before the Senate Special Committee on Aging, March 21, 1995.
3. “Medical Fraud Growing Increasing Violent, Organized,” The Miami Herald, September 26, 1996.
4. Bill Gradison, President, Health Insurance Association of America, HIAA’s Views Of Health Care Fraud, statement before the Senate Special Committee On Aging, March 21, 1995.
5. Health Care Fraud Control, The State of the Art, Malcolm K. Sparrow, John F. Kennedy School of Government, Harvard University, Cambridge, 1995, 128.

j:\doc\membphes\fraudtmc.doc