



Health Insurance Fraud: An Overview

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A Health System-Wide Problem

In 2007, the U.S. spent nearly \$2.3 trillion on health care and public and private insurers processed more than 4 billion health insurance claims.¹ The National Health Care Anti-Fraud Association (NHCAA) has estimated that, conservatively, 3% of all health care spending—or \$68 billion—is lost to health care fraud. Other estimates by government and law enforcement agencies place fraud-related losses as high as 10% of annual health care spending;² at this rate, the losses in 2007 alone –over \$220 billion – would have been enough to cover the uninsured.

What is absolutely clear from virtually every reliable source on the subject is that health care fraud is a systemic problem affecting public and private insurers alike, in the individual market, the employer-sponsored group market, and public programs. Because Medicare and Medicaid are government-sponsored and thus are required to report on fraud, the problem is perhaps better known, but combating fraud is a challenge that faces both public and private insurers. Indeed, one survey found that since 1995, 90% of all private insurers have launched anti-fraud campaigns.³

The failure to systematically and routinely measure the scope of fraud is characteristic of the insurance industry as a whole, and it is not limited to the United States.⁴ Numerous government agencies have reported that no segment of the health care delivery system is immune from fraud⁵

¹ National Health Care Anti-Fraud Association. *The Problem of Health Care Fraud*. Consumer Alert found at: http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centra&wpscode=TheProblemOfHC Fraud

² *Ibid.* See also Federal Bureau of Investigation, Financial Crimes Report to the Public, Fiscal Year 2007. Available at: http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm

³ Cohen EL, Cesta TG. Evolution of nursing case management in a changing health care system. In: Cohen EL, Cesta TG, eds. *Nursing case management: from essentials to advanced practice applications*. 4th ed. St. Louis, MO: Mosby, 2004:399.

⁴ Clarke, M., “The Control of Insurance Fraud: A Comparative View,” *The British Journal of Criminology*, 30(1)(Winter 1990): 2.

⁵ “Health Care Fraud, Hearing before the Senate Select Comm. On Aging.” 104th Cong., 1st sess. (March 21, 1995) (prepared statement of FBI Director Louis J. Freeh).

and that instance of fraud and abuse can be found involving all segments of the health care industry and in every geographical area of the country.⁶

Fraud is Not Improper Payment

Black's Law Dictionary defines fraud as "a knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment." Improper payments or overpayments may not involve fraud at all if a payment simply was made or claimed in error. The law equates fraud with an intent to conceal or deceive or acting in a manner that conveys a reckless disregard for the truth of one's claims.

In the context of health insurance, fraud may manifest itself as deception of a public or private health insurer into paying claims that are not owed, or a reckless disregard for the truthfulness of claims that are submitted. Insurers have also been found to have engaged in fraud against group sponsors and members, by conspiring to overcharge plan members in relation to the benefits that were promised. This type of fraud is essentially an intentional manipulation of the claims payment process for financial gain through bribes, kickbacks, and racketeering.

Fraud is distinct from improper payments under public programs, which can arise from simple errors in documentation, coding, reporting, verification, and other technical matters related to the administration of public programs. Improper payments are reported annually by federal agencies under the Improper Payment Improvement Act of 2002 (IPIA).⁷ In recent years, as agencies increasingly have implemented the law, the amount of reported improper payments has risen and efforts have been undertaken to correct the underlying program administration standards and procedures that give rise to improper payments.⁸

How Widespread is Health Insurance Fraud and What Forms Does it Take?

Examples of fraudulent activity consist of fraudulent billing, kickbacks, up-coding services, bundling, and ghost patients. Estimates are that 80% of healthcare fraud is committed by medical providers, 10 percent by consumers, and the balance by others, such as insurers themselves and their employees.⁹

Table 1 presents an illustrative overview of the types of fraudulent conduct that have been pursued in court or reported in the press in recent years. These examples have been drawn from a systematic search of reported actions using legal search engines, as well as a review of legal journal and news articles on health care fraud-related actions. The types of fraud recovery actions described in Table 1 might be pursued privately by health insurers as civil fraud cases, while state Attorneys General or the United States Department of Justice also have wide-ranging powers under state and federal law to pursue health care fraud under numerous legal theories.

⁶ GAO. *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse 2* (1992).

⁷ P.L. 107-300 (107th Cong., 1st sess.)

⁸ GAO, *Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments* (GAO-09-628T) (April 22, 2009)

⁹ Coalition Against Insurance Fraud. *Go Figure: fraud data*. Available at: www.insurancefraud.org/stats.htm

These cases suggest that the most common type of fraud involves systematically overcharging insurers for the cost of items and services for which payment is specified either by contract or in law. Thus, for example, many pharmaceutical companies have been pursued by Medicaid programs for failing to adhere to federal prescription drug rebate requirements, with resulting major overcharges to state agencies. (Because the Centers for Medicare and Medicaid Services have not yet reported on cases of either improper payment or fraud under the Medicare Part D program,¹⁰ it is not possible to know the magnitude of such practices under Medicare). Similarly, hospitals have been charged with systematically upcoding Medicare claims to falsely elevate the cost of care.

Perhaps the most striking examples of fraud are those that involve the private health insurance industry itself. In these cases, the deception can involve either overstating the insurer's costs in paying claims, or systematically and deceptively under-valuing the amount owed by the insurer to a health care provider -- all with the intention of shifting increased responsibility for the cost of care to the plan member and group sponsor, in ways that violate the terms of the contract:

- In one recent New York case reported prominently in the press,¹¹ leading private insurers were found to have manipulated the prices they paid for physician services in order to systematically drive down the amount they owed for out-of-network physician care and thereby drive up members' financial exposure for the balance. This intentional manipulation of provider payments resulted in an estimated 10% to 28% increase in members' direct financial exposure for the cost of out-of-network care.
- A major hospital corporation-affiliated private insurer was found to have intentionally misrepresented in its bills to plan members the true price of its own hospitals' care, while secretly negotiating deep discounts with its hospitals. As a result, plan members were actually paying the majority of the hospital bills they incurred rather than the 20% copay they were promised.¹²

Vulnerable Populations Are the Most Likely Fraud Victims, Regardless of Whether the Fraud is Public or Private

Medicare and Medicaid may be susceptible to fraud in part because many investigative reports on victims of consumer swindles suggest that financial fraud is not uniformly distributed across all households; instead, it disproportionately targets the elderly, women, minorities, the less educated, and the poor.¹³ In other words, Medicare and Medicaid fraud may reflect the vulnerable nature of the populations that depend on the program rather than any failing on the part of either program. As a result, simply moving away from Medicare and Medicaid coverage and toward a system of private health insurance subsidies would in and of itself do nothing to curb fraud; it simply would privatize the victimizing of the poor and vulnerable.

¹⁰ GAO, Progress Made, supra note

¹¹ *The American Medical Association v. United Healthcare Corporation, et al.*, 2009 U.S. Dist. LEXIS 45610 (S.D.N.Y. May 7, 2009).

¹² *Humana Inc. v. Forsyth*, 525 U.S. 299 (1999); 119 S. Ct. 710; 142 L. Ed. 2d 753.

¹³ Lee, J., & Soberon-Ferrer, H. (1997). Consumer vulnerability to fraud: influencing factors. *Journal of Consumer Affairs*, 31(1), 70-89.

What Have Medicare and Medicaid Done to Combat Fraud?

Federal law contains extensive provisions to combat fraud in Medicare and Medicaid. Federal laws impose both civil and criminal liability for false claims, bribes and kickbacks, and racketeering. The Health Insurance Portability and Accountability Act of 1996¹⁴ created the Health Care Fraud and Abuse Control Program (under joint direction of Attorney General and Secretary of Dept. of Health and Human Services), a far-reaching program to combat fraud and abuse in health care, including both private and public health insurance plans. In FY 2007: the federal government won or negotiated approximately \$1.8 billion in judgments and settlements.¹⁵

Similarly, the Deficit Reduction Act of 2005¹⁶ contains provisions aimed at strengthening Medicaid anti-fraud protections. The provisions provide economic incentives to states that enact state false claims laws for use in Medicaid fraud suits, while requiring Medicaid providers to do more to combat fraud.

Finally, 2009 legislation amending the Civil False Claims Act (Fraud Enforcement and Recovery Act (FERA))¹⁷ expands scope of liability under False Claims Act and gives government enhanced investigative powers.

Table 2 shows the past decade of fraud recoveries. As the Table indicates, Medicaid recoveries have steadily increased as the laws have been toughened. As the impact of the 2006 reforms and greater public policy attention to fraud grows, these recovery figures can be expected to increase still further.

Conclusion

Fraud – whether committed by health care providers, plan members, or insurers themselves – is an unfortunate but real part of the health care landscape. As the national health reform legislation takes shape, keeping an attentive eye on anti-fraud provisions will be a critical element of reform. Since the victims of fraud are disproportionately likely to be lower income and vulnerable populations, the central issue will be not whether public programs serve as the basis of expanded insurance program but whether anti-fraud safeguards are a firm, fixed feature of final reform legislation. This means considering steps to strengthen the reach and scope of the HIPAA insurance fraud provisions of 1996, including strong protections related to marketing, enrollment, consumer protections, health care access, and claims payment into final legislation, requiring anti-fraud compliance procedures for all insurers participating in a reformed health care system, and sufficiently funding federal and state oversight agencies to assure that cases of fraud are quickly detected and addressed.

¹⁴ P.L. 104-191 (104th Cong., 2d Sess.)

¹⁵ Ibid.

¹⁶ P.L. 109-171 (109th Cong., 2d Sess.)

¹⁷ Senate Bill 386, 111th Congress (May 20, 2009).

Table 1. Health Care Fraud Across the Health Care Industry: Private Health Insurance, Medicare, and Medicaid

Private Health Insurance ■ Medicare ■ Medicaid ■

| ACCUSED COMPANY | INDUSTRY | TYPE OF FRAUD | RECOVERY |
|---|----------------------------------|---|------------------------------|
| UnitedHealth ¹ | Managed Care | Underpaid consumers (10%-28%) by manipulating database it used to pay customers for out-of-network services | \$350 million |
| McKesson ² | Pharmaceutical | Fraudulently inflated prices of approximately 450 drugs charged to insurers and consumers | \$350 million ³ |
| HealthNet ⁴ | Managed Care | ERISA and RICO violations by underpaying consumers in several states | \$215 million |
| Cleveland Clinic ⁵ | Integrated Health Care System | Medical identity theft; false claims | Unknown |
| Tenet ⁶ | Hospital | False claims, Kickbacks | \$900 million |
| TAP Pharmaceuticals ⁷ | Pharmaceutical | False claims, Conspiracy, kickbacks | \$ 559.5 million |
| St. Barnabas Hospitals ⁸ | Hospital | False claims | \$265 million |
| HCA ⁹ | Hospital | False claims, kickbacks | \$631 million |
| HealthSouth ¹⁰ | Rehabilitative Medicine Services | False claims | \$325 million |
| Ciena Healthcare Management, Inc. ¹¹ | Nursing Home | False claims from inadequate care in nutrition and hydration, the assessment and evaluation of needs, care planning and nursing interventions, medication management, fall prevention, and pressure ulcer care, including the prevention and treatment of wounds. | \$1.25 million ¹² |

¹ *American Medical Association v. United Healthcare Corp.*, 588 F.Supp.2d 432 (S.D.N.Y. 2008)

² *New England Carpenters Health Benefits Fund, et al. v. First DataBank, Inc. and McKesson Corp.*, 244 F.R.D. 79 (D. Mass. August 27, 2007)

³ This settlement is a preliminary court approved settlement entered on March 31, 2009 and the hearing on final approval is scheduled for July 23, 2009. Available at: <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aVpLVzpsq1NI>.

⁴ *Wachtel v. Health Net; McCoy v. Health Net; and Scharfman v. Health Net*, 239 F.R.D. 81 (D. N.J. December 6, 2006).

⁵ *Walecia Ronrad, A New Ailment: Medical ID Theft*, N.Y. Times, June 13, 2009.

⁶ *United States v. Tenet Healthcare Corp.*, C. A. No. 03-206 (C.D. Cal. Jan. 9, 2003).

⁷ *United States ex rel. Durand v. TAP Pharmaceuticals*, CA No. 00-12618-GAO (filed May 1996 in the E.D. Pa., later transferred to D. Mass, settled Sept. 28, 2001).

⁸ *United States ex rel. Monahan v. St. Barnabas Health Care System, Inc.*, C.A. No. 02-5702 (D.N.J. June 15, 2006).

⁹ *United States, ex. rel. Alderson, v. Columbia/HCA Corporation*, Case No. 99-3290 (RCL), part of Case No. 01-MS-50 (RCL) (D. D.C. 2003).

¹⁰ *United States ex rel. James Devage v. HealthSouth Corporation, et al.*, Civ. Action No. SA-98-CA-0372FB (W.D. Tex.); *United States ex rel. Manning v. HealthSouth Corporation*, (W.D. Tex.); and *United States ex rel. Brupbacher & Associates and Michael C. Freeman v. National Institutional Pharmacy Services, Inc.* (D. N. Mex.) (cases settled Dec. 30 2004).

¹¹ *U.S. ex rel. Denise Hubbard v. Ciena Healthcare Management, et al.*, CV-03-60175 (E.D. Mich.).

¹² This case involves fraud against both the Medicare and Medicaid programs.

| ACCUSED COMPANY | INDUSTRY | TYPE OF FRAUD | RECOVERY |
|--|------------------------|---|--|
| United Health Group and other insurers ¹³ | Insurance | Fraud, misrepresentation, deception through use of company-owned Ingenix system to systematically undervalue its payment obligations for physician services in order to shift the cost of out-of-network coverage from the insurer to members and plan sponsors | Approximately \$100 million |
| Humana | Insurance | Fraud, deception involving concealment of the actual cost of hospital services from plan members | |
| Amerigroup ¹⁴ | Insurance/Managed Care | False claims involving the treatment of pregnant women and other patients | \$225 million |
| Merck ¹⁵ | Pharmaceutical | False claims, Kickbacks | \$650 million |
| Serono Group ¹⁶ AstraZenica Pharmaceuticals ¹⁷ Wyeth ¹⁸ | Pharmaceutical | False claims, Kickbacks | \$567 million \$160 million Qui tam action pending |
| Bristol-Meyers Squibb ¹⁹ , KV Pharmaceuticals, Roxane Laboratories, Abbott Laboratories, Aventis Pharmaceutical, Teva Pharmaceuticals, Schering Plow/Warrick, Forest Laboratories, Baxter International, Dey Pharmaceuticals, Bayer Pharmaceuticals | Pharmaceutical | False Claims | \$123.75 million |
| Omnicare, Inc. ²⁰ | Pharmaceutical | False claims by replacing brand-name with generic drugs or switching dosage strengths | \$49.5 million |

¹³ *The American Medical Association v. United Healthcare Corporation, et al.*, 2009 U.S. Dist. LEXIS 45610 (S.D.N.Y. May 7, 2009).

¹⁴ *United States, ex rel. Tyson, et al. v. Amerigroup Illinois, Inc., et al.*, 2007 WL 781729 (N.D.Ill. March 13, 2007).

¹⁵ *State of Nevada ex rel. Steinke v. Merck & Company, Inc.*, 2006 WL 1506901(D. Nev. May 31, 2006).

¹⁶ *United States ex rel. Driscoll v. Serono Laboratories, Inc.*, C.A. No. 00-11680 (D. Mass. August 17, 2000).

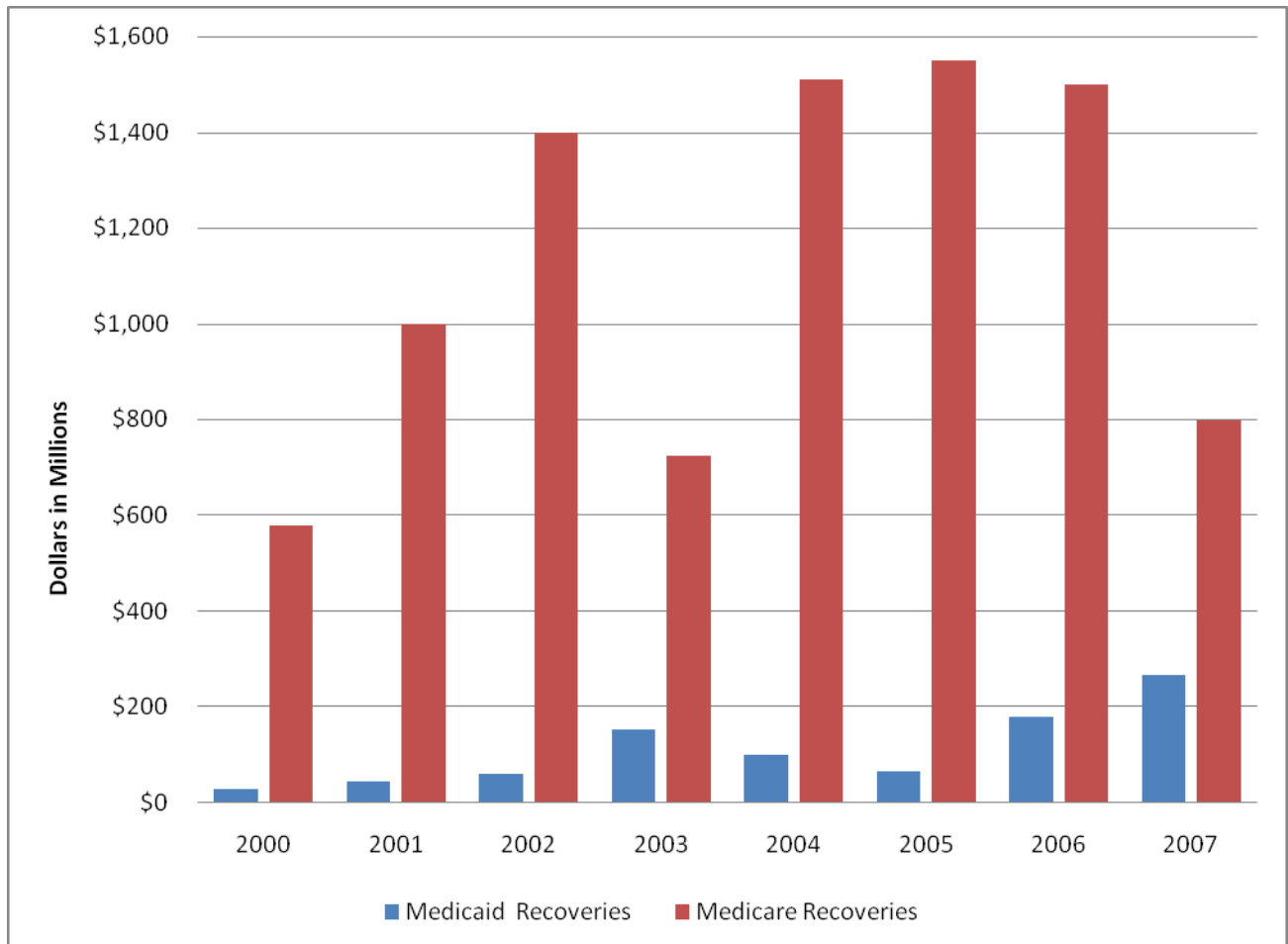
¹⁷ *Alabama v AstraZenica*, [reported in] BNA, 18 Health Law Reporter (June 3, 2009).

¹⁸ *United States. ex. Rel. Kieff v Wyeth*, C.A. No. 03-12366DPW (D. Mass); USDOJ intervention May 18, 2009, [reported in] BNA Health Law Reporter 18:687 (June 3, 2009).

¹⁹ *Alabama v Abbott Laboratories*, No. CV-05-219 (Ala. Cir., Ct. May 22, 2009), [reported in] BNA Health Law Reporter 18: 685 BNA) (June 3, 2009).

²⁰ *United States et al., ex rel. Bernard Lisitza v. Omnicare, Inc.*, 01 C 7433, and *United States et al., ex rel. David Kammerer v. Omnicare, Inc.*, 04 C 2074 (N.D. Ill.).

Table 2. Federal Health Care Fraud and Abuse Program Recoveries by Fiscal Year¹



¹ Chart made with data published in the Health Care Fraud and Abuse Control Program Reports from fiscal year 2000-07 available at <http://www.oig.hhs.gov/publications/hcfac.asp>.