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HEALTH INSURANCE

Vulnerable Payers Lose Billions to Fraud and Abuse

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VULNERABLE PAYERS LOSE BILLIONS TO FRAUD AND ABUSE

Weaknesses within the health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Profiteers are able to stay ahead of those who pay claims for several reasons. First, the various health insurers operate independently, and this necessarily limits their ability to collaborate on efforts to confront fraudulent providers. Second, there are growing financial ties between health care facilities and the practitioners who control referrals to those facilities. Third, the high cost associated with legal and administrative remedies can hamper insurers' efforts to pursue fraud and abuse. Finally, even when a fraudulent provider gets caught by one insurer--Medicare, for example--the provider can focus its billing scams on other insurers, such as Medicaid or the private insurers.

Instances of fraud and abuse can be found involving all segments of the health care industry in every geographic area of the country. Frequently cited fraudulent or abusive practices include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

One fraudulent scheme in California is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. The scheme centered around mobile labs that used telephone marketing to offer routine diagnostic tests. Frequently, the labs and the referring physicians used phony diagnoses in submitting the insurance claims and paid or received kickbacks for the referrals. So far, the owners have been prosecuted successfully, yet virtually no monies have been recovered. Also, at least six similar schemes are known to be operating in southern California.

Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. Specifically, encouraging insurers to share information and pool resources must be weighed against concerns over privacy and antitrust issues; greater regulation of physician ownership and investment, against the subsequent administrative burden and the restraints on competition; and increasing staff to investigate and pursue health care fraud, against other investigative priorities, such as savings and loan and drug trafficking cases.

Therefore, GAO is asking the Congress to consider establishing a national health care fraud commission as a way to unite the efforts of public and private payers and to build consensus among representatives of divergent viewpoints. Membership could include insurers and staff from investigative and prosecutorial agencies.

Mr. Chairman:

I am pleased to be here today to discuss how fraud and abuse besets both public and private health insurers. In response to your concern about the effects of fraud and abuse on rapidly rising health care costs, we have issued a report today entitled, "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse" (GAO/HRD-92-69). The report explores the nature of health insurance fraud and abuse, the problems detecting and pursuing it, and a possible approach to begin addressing these problems systematically.

The size of the health care sector and the sheer volume of money involved make it an attractive and relatively easy target for fraudulent and abusive providers. Though no one knows for sure, health industry officials estimate that fraud and abuse contribute to some 10 percent of U.S. health care's current $700-plus billion in costs. This diverts scarce resources and contributes unnecessarily to the health care cost spiral.

What we found is that weaknesses within the health insurance system allow unscrupulous health care providers--and these include suppliers of medical equipment and services as well as practitioners--to cheat health insurance companies and programs out of billions of dollars annually. The weaknesses are many and do not fall into mutually exclusive categories, but in general they include the following:

- numerous health insurers that operate independently and are therefore limited in their ability to collaborate on efforts to confront fraudulent providers,
- growing financial ties between health care facilities and the practitioners who control referrals to those facilities, and
- the high cost associated with prosecuting fraud or pursuing civil remedies.

Ultimately, even when a fraudulent provider gets caught by one insurer, the provider can focus its billing scams on other insurers.

Repairing the system's weaknesses presents a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials. That is, greater scrutiny of medical records, requiring more patient and physician information, and regulating ownership of medical facilities must not unduly impinge on rights to privacy, must not create burdensome paperwork, and must not unnecessarily constrain free enterprise. Therefore, we have asked the Congress to consider establishing a

national health care fraud commission: first, as a way to unite the efforts of public and private payers and second, as a way to build consensus among representatives of divergent viewpoints.

Before I discuss our findings in detail, I'd like to provide some background on health insurance fraud and abuse.

THE NATURE AND PREVALENCE OF FRAUD AND ABUSE

Fraud and abuse encompasses a wide range of improper billing practices that include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services. Both fraud and abuse result in unnecessary costs to the insurer, but fraud generally involves a willful act.

As a practical matter, whether and how a wrongful act is addressed can depend on the size of the financial loss incurred and the quality of the evidence establishing intent. For example, small claims are generally not pursued as fraud because of the cost involved in investigation and prosecution.

Health care fraud has expanded beyond single health care provider fraud to organized activity affecting health care programs in both the government and private insurance sectors. For example, one fraudulent scheme that has troubled public and private payers in California over the past decade is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. This telemarketing scheme centered around getting people with health insurance covering fee-for-service providers to go to mobile labs, called "rolling labs," that did noninvasive tests, such as heart and blood-pressure measurements. Frequently, the labs and the referring physicians used phony diagnoses in submitting the insurance claims.

The outcome of this scheme so far is that the owners have been both sued and prosecuted successfully, yet virtually no monies have been recovered. Also, at least six similar schemes are known to be operating in southern California. In fact, one of our Los Angeles office evaluators was solicited by phone last year for over $700 worth of tests. During the phone interview, however, the caller withdrew the offer when our evaluator explained she was covered under an HMO-type plan rather than a fee-for-service arrangement.

Schemes of this nature highlight several serious problems facing public and private payers. First, large financial losses to the health care system can occur as a result of even a single scheme. Second, fraudulent providers can bill insurers with relative ease. Third, efforts to prosecute and recover losses from those involved in the schemes are costly. Finally, schemes can be quickly replicated throughout the health care system.

HEALTH INSURANCE SYSTEM HIGHLY VULNERABLE TO FRAUD AND ABUSE

Now I would like to explore a few characteristics of the environment in which the California billion-dollar scheme can flourish. This entails reviewing the problems involved in detecting fraudulent billings, developing cases for prosecution, and recovering fraudulent payments.

First, I will discuss what is involved in detecting providers with fraudulent billing patterns.

- Over a thousand payers process 4 billion claims a year to pay hundreds of thousands of providers using different payment methods and billing regulations. In November 1991 a Forum on Administrative Costs headed by the Secretary of Health and Human Services and composed primarily of private insurers set forth goals to streamline the paperwork involved in health insurance administration.

- Providers' claims are paid by many insurers, making billing patterns hard to identify. Thus, a provider who bills for more than 24 hours of visits on a single day might not be discovered when claims are split among many insurers.

- Sharing data among autonomous insurers for the purpose of detecting aberrant billing patterns is largely not feasible for two reasons. First, laws protect the privacy of patients' medical records. And second, the data collected on insurance claims are quantitatively and qualitatively different for each insurer.

Now I will discuss the environment from the standpoint of developing a case against a provider suspected of health care fraud.

- There has been a rapid expansion of freestanding, ambulatory care facilities, many of which are not licensed and are therefore more difficult to monitor.

- Insurers are limited in their ability to trace and hold accountable the source of fraudulent billings in unlicensed medical facilities.

- Physicians frequently invest in medical facilities but are not always required to disclose their investment in facilities to which they refer patients. Insurers, moreover, have no systematic way of monitoring referral patterns.

Finally, I will discuss what is involved in prosecuting health insurance fraud.

- Successful prosecutions may take years, involve an investment of considerable staff time and financial resources, and may not result in insurers recovering their money.

- The nature of certain laws can impede private insurers' efforts to pursue fraud. For example, some states lack anti-kickback statutes that prohibit physicians from profiting from referrals. Furthermore, the language of anti-kickback statutes is so broadly written that in states with these laws there is much debate surrounding their use and therefore a reluctance to impose them.

- In some jurisdictions, federal prosecutors may not accept criminal health care cases involving less than $100,000 because of limited resources.

The ultimate condition undermining the effective pursuit of fraudulent providers is that one insurer's efforts can result in scams being shifted to other insurers. For example, in the rolling-labs scheme, when Medicare excluded the lab owners who were cheating the program, the owners concentrated their billing activities on private insurers.

CONCLUSION AND MATTER FOR CONGRESSIONAL CONSIDERATION

In conclusion, we believe that both public health insurance programs and private health insurers are vulnerable to fraud and abuse but separately appear unable to combat it successfully. Despite the commonality of fraud and abuse problems, diverse and autonomous insurers have few means of collaborating systematically to solve them. In our view, if the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies were more coordinated, the attack on health care fraud and abuse would be more fruitful.

Therefore, we are asking the Congress to consider establishing a national health insurance fraud commission that would be composed of a balanced and diverse membership. In particular, the membership could include the diverse private payers and their public payer counterparts, state regulators, and law enforcement officials. Such a commission could be responsible for analyzing trade-offs and developing recommendations to the Congress. Key issues would likely include (1) how insurers can standardize claims information and billing rules, (2) how insurers can coordinate case development and prosecution efforts, (3) whether and how to regulate currently unlicensed medical facilities, and (4) what rules should govern physicians' referrals to medical facilities in which the physicians have a financial interest.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions.