# FRAUD, WASTE & ABUSE

## IN HEALTH CARE CLAIMS

SMARTLIGHT ANALYTICS

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# Health Care Fraud, Waste, and Abuse

## A Serious Problem That Needs Your Attention

As a self-funded employer, you play a vital role in protecting the integrity of your health care program. According to recent studies, the percentage of employees covered by self-funded private health plans is at an all-time high of 67%. Fraud, waste, and abuse (FWA) is a substantial problem for private payers. To combat FWA, health plan sponsors must be diligent about protecting their organization from abusive practices and policy violations that result in the wasteful spend of their employee health care dollars.

**The majority of workers in the US are covered by self-funded private plans.**

This document provides the following tools to help protect your health care program and your members from FWA:

- Education of fraud, waste, and abuse (FWA) as it relates to the health care claim payments
- Examples of health care FWA
- Overview of fraud and abuse laws

The vast majority of health care professionals work ethically to provide high-quality medical care and submit proper claims. Trust is not only core to the physician-patient relationship, but also to the claim payment process. However, a relatively small number of bad actors exploit health care payment programs, costing self-insured plans tens of billions of dollars every year. These providers are motivated by illegal personal, or corporate gain and create the need for strategies that combat fraud, waste, and abuse and ensure that appropriate quality medical care is received by plan members.

## Problem Description

Employers lose billions of dollars every year thanks to unchecked—and undetected—fraud, waste, and abuse in employer-funded health plans. In fact, according to the National Health Care Anti-Fraud Association (NHCAA), losses due to healthcare fraud can be up to $300B annually. Studies estimate that approximately 3-10 percent of any population's annual health expenditures are wasted on fraud, waste, or abuse. This means that for a health plan that covers 100,000 lives, annual losses due to FWA can add up to $50M annually.

***So why aren't all employers fighting against waste in their health care?***

Simply put, most employers are not fully aware of the depth of the issue in their own plans. The most common belief is that it is not happening to them. Additionally, many employers are not armed—in terms of time, staff, and expertise to identify overpaid claims. And quite frankly, they shouldn't be. Employers should be focused on producing and selling the best products and services their company creates, not tracking down and remediating improper claim payments. Assembling the expertise internally is not only cost-prohibitive but can also be inefficient.


**10%**

Approximately 10 percent of any population's annual health expenditures are wasted on health care fraud, waste, or abuse.

# Differentiating Between Fraud, Waste, and Abuse

As fiduciaries of your health care plan, you are the designated steward of your employee health plan. To understand the distinction between fraud, waste, and abuse, we provide some definitions and examples:

- **Fraud** is the intentional deception or misrepresentation to secure gain.
- **Waste** in health care claims refers to careless mismanagement.
- **Abuse** is associated with medically unnecessary services and charges.

## What is Health Care Fraud?

Fraud in health care claims is defined as outright illegal acts done intentionally to trick the system for monetary gain. Health care fraud typically includes one or more of the following:

- Knowingly submitting false claims with misrepresentations of fact to obtain a payment for which no entitlement exists.
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by health care programs.
- Knowingly making misrepresentations of fact to obtain payment for a higher reimbursement than is otherwise entitled.
- Knowingly misrepresenting the services provided to receive payment for a non-covered service.

Anyone with a financial motive can commit health care fraud. Fraud schemes range from solo ventures to widespread activities by an institution, hospital, or group. Schemes range from surgeons violating anti-kickback statutes to laboratories billing for tests not performed. As fiduciaries of your health care plan, you must be rigorous in protecting your plan.


# Examples of Health Care Fraud

Billing for an implantable device during a surgical session when it was not provided. This is an example of knowingly billing for supplies not provided or documented.

Billing for a two-hour physical therapy visit when only a 15-minute massage was performed. This is an example of knowingly making misrepresentations of fact to obtain payment for a higher reimbursement than is otherwise entitled.

Ordering daily drug screenings for a patient when a daily drug test is not needed. This is an example of knowingly ordering medically unnecessary services for patients.

Billing for daily chiropractic services even when the patient cancels the appointment. This is an example of billing for a service that is not provided.

## What is Health Care Abuse?

Abuse describes practices that may directly or indirectly result in unnecessary costs to the health care plan. Abuse also includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care. The difference between “fraud” and “abuse” depends on specific facts, circumstances, intent, and knowledge. Abuse does not require proof of intent. Examples of abuse include:

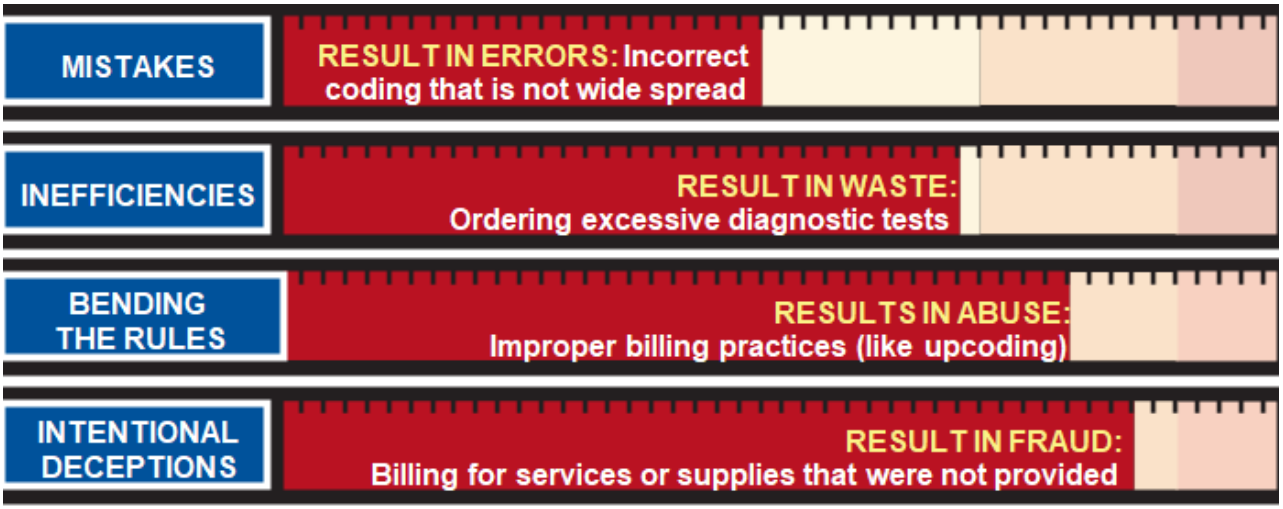
- Billing for unnecessary medical services.
- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes.

## What is Health Care Waste?

Waste in health care is any activity that doesn’t add value to patient care. Medical billing and coding errors are unfortunately common. Examples of wasteful spend include:

- Billing specialist enters a diagnosis code that doesn't accurately reflect the service provided.
- The same test, procedure, or product is charged twice.
- A typo in the number of units being charged to be more than what was actually received.

**Examples along the range of possible types of improper payments.**



# Federal Laws Governing Health Care Regulations

## ERISA

The Employee Retirement Income Security Act (ERISA) is a federal law from 1974 that governs how self-funded employers provide benefits plans to employees. ERISA ensures minimum standards are set for employer-sponsored private health plans.

## Plan Sponsors Rights Under ERISA

ERISA requires that plans be allowed access to claims data to fulfill the required monitoring functions.

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of group health plan participants and their beneficiaries. These responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them.
- Carrying out their duties prudently.
- Following the plan documents.
- Holding plan assets in trust.
- Paying only reasonable plan expenses.

## Plan Sponsors Obligations Under ERISA

ERISA requires that health plans monitor the performance of the service providers hired to assist with administering the plan. The duty to act prudently is one of a fiduciary's central responsibilities under ERISA. It requires expertise in a variety of areas. A fiduciary who lacks that expertise will want to hire someone with the professional knowledge to carry out those functions.

# LEGISLATION

## Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) prohibits plans from entering into agreements with service providers that restrict the plan from obtaining electronic access to claim and encounter data for all plan participants.

## Hospital Price Transparency and Disclosure Act of 2018

This rule requires health systems to publicly post the costs of their items and services online. The prices must include standard charges for all items and services for all payers and health plans and a standard charges list or a price estimator tool for the 300 most common services.

The policy aims to help consumers compare hospital prices and better estimate their cost of care before a hospital visit. Plan sponsors can also benefit from this law by verifying that the plan is not being charged more than the published rates.

# What Fraud, Waste, & Abuse Costs Your Health Plan

## The Prevalence of FWA within Employee Health Care Claims

Intentional fraud and wasteful spend due to errors are ubiquitous in US health care claim payments. NHCAA estimates that 3-10% of your plan dollars are going towards FWA. The key to protecting your plan is to be committed to learning about the problem and proactive in identifying and removing it from your plan.

Employers can find it difficult, if not impossible, to find suspect billing by reviewing employee health care claims. Not only does the complex medical coding system make health care claims indecipherable to most outside of the medical billing community, but these abuses can also be extremely hard to identify when fraudulent providers are constantly finding new ways to beat the system. Artificial intelligence (AI), machine learning, and other analytic methods are the key to finding the hidden fraudulent or wasteful spend in employers' health care claims data.

## The Employer's Responsibility

Knowing exactly where health care dollars are spent is not just a budget management or cost-saving practice for businesses any more. As plan sponsors are reminded often, it is also a fiduciary responsibility under ERISA. Employers are accountable for spending employee health care contributions as well as the employer's contributions with the care, skill, and diligence of a prudent person.* C-level and board members can bear personal liability for organizational violations of ERISA. ERISA guidelines for prudent oversight of a health plan can be vague but have recently been strengthened with legislation (CAA 2021). There are best practices that not only limit fiduciary liability but also significantly reduce the unnecessary spend of plan assets.

*U.S. Department of Labor. Understanding Your Fiduciary Responsibilities Under a Group Health Plan. September 2015. https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan.pdf

## Increased Fraud from COVID-19 Pandemic in Medical Claims

Existing areas of vulnerability in our health care system could be ripe for additional fraud in a time when everyone in the health care system is in crisis mode, including the insurance carriers dealing with a massive influx in claims due to COVID-19.

With reduced restrictions on accessibility to treatment during the pandemic, the ability to conceal fraud is greater. Bad actors – those already intentionally committing fraud within the system – see every tragedy as an opportunity. Such players existed long before the pandemic. The pandemic has resulted in multiple new fraud schemes that are likely impacting your plan today.

## The Role of a Claims Administrator

Most self-funded employers rely on a standard carrier-approved audit to verify that payments on behalf of their plan are made accurately. Typical payment accuracy guarantees go as high as 98-99%. This guarantee is measured based on a random sample of 150-400 claims per year. The typical error rate uncovered during these audits is far below 1%.

However, these limited random samples cannot identify fraudulent or abusive billing resulting from systematic errors or intentional deception. Since, each randomly selected claim is manually reviewed in isolation, without context, claims intended to deceive the program are unlikely to be identified. Any findings from random sample audits are not extrapolated to other claims, resulting in low value to the plan.

With advancements in AI and inferential analytic methods and software, the entire population of even the largest employer's claims can be analyzed in minutes. These methods allow for the detection of anomalies in the specific population of claims and are proven to identify 10-100Xs more payment errors than traditional audits.

Health care carriers and TPAs have hundreds of clients that they service – and while they may have implemented measures to detect and correct the FWA found in the data, they typically do not have the bandwidth to provide focused attention to each individual employer. Additionally, there could be a conflict of interest consideration when your payment error detection team is the same team approving the claims itself and also the ones creating broad provider networks for competitive advantage. Partnering with a company that is completely independent of the administrator provides deeper value and commitment to finding and resolving FWA.

# Protect Your Dollars

The first step toward understanding your unique health care data is seeking analysis of your spend from an impartial entity that can provide insights into your employees' health care utilization patterns. An in-depth AI-focused analysis of your claim payments can highlight areas of concern and inform you on the best steps forward.

Recent legal changes and increased employer engagement has produced a loud and clear call for greater transparency in health care. Employers need access to their own claims data in order to exercise their fiduciary responsibilities. More than ever, employers are seeking access to their claim payment data in order to begin the process of lowering health care costs for the plan and its members.

**Educate yourself, exercise your fiduciary responsibility & protect your dollars!**

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*A Private Public Partnership Against Health Care Fraud - The challenge of health care fraud*. Published by NHCAA (National Health Care Anti-Fraud Association). 2021.

*Outreach and Education - Medicare Learning Network Booklet on Fraud & Abuse.* Published by CMS (Centers for Medicare & Medicaid Services), January 2021.

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