Health or private medical insurance is in many markets one of the fastest growing lines of business, however unfortunately health as an insurance sector is often beset by fraudulent activity.

**Definition of Fraud**

There are activities that would meet a legal definition of fraud and many other activities, sometimes referred to as 'soft fraud', that whilst not meeting the high legal definition nonetheless are a significant cost to the industry and need to be identified and tackled.

Each jurisdiction will have their own legal definition, however the United Kingdom's Fraud Act of 2006 clearly defines fraud in three categories:

- Fraud by false representation
- Fraud by failure to disclose information
- Fraud by abuse of position

In each case to prove fraud it is necessary for an accuser to be able to prove both that the perpetrator had knowledge that their act would be considered dishonest and that there was intent to either make a gain for themselves or others or cause the other party to make a loss or risk of a loss.

Within the field of life insurance fraud is normally committed by the insured and is often premeditated. It is usually in the categories of non-disclosure or misrepresentation.

However in health insurance fraud is often perpetrated by the providers of care and is often opportunistic in nature. Hospitals, doctors and other medical practitioners are placed in a position of trust by the patient and have the opportunity to abuse that position for their own gain. Some estimates have put the amount of fraud committed by providers as more than 80% of the total fraud committed under health insurance policies.

In the first years of a policy an insurer may be able to contest a claim even if they cannot prove knowledge and/or intent. However many health insurance policies include a non-contestability period after which time the insurer would need to meet the legal definition of fraud in order to deny a claim.

**Fraudulent Practices**

**Over Utilisation** describes the over provision of medical services. Examples include:

- ordering an extra blood test
- performing an MRI scan when an x-ray would provide the same diagnostic information
- performing unnecessary surgery.

Policies are designed and priced to cover treatment that is medically necessary and the difficulty for the insurer is arguing that a service was not medically necessary when this has been prescribed by the treating doctor. Individual cases may be hard to argue and insurers will need to rely on best practice treatment protocols developed by the doctor’s peers.

**Unbundling** is where the doctor bills the insurer for the component parts of a procedure that should be considered an integral part of a single procedure.

An example of this would be a surgeon billing for the harvesting of a vein from a patient on whom they are performing a coronary artery bypass grafting. A bypass cannot be done without first harvesting the vein and the code setters will have taken into consideration all the component elements when setting the amount to be reimbursed in respect of that procedure.

**Up-coding** is where the provider describes and bills for a service greater than the one actually performed. By listing and billing for a more complex or higher level of service the practitioner can increase the amount charged. Examples include:

- billing for a therapeutic laparoscopy when the procedure was diagnostic only
- billing for a quadruple heart bypass when only a double had been performed.

Both unbundling and up-coding are difficult to identify because the services rendered will normally relate directly to the medical condition for which the insured person is claiming. Individual cases may be put down to miscoding or administrative error, the bills corrected and the claim paid. However insurers should be looking for and investigating repeated instances by the same provider.

**Duplicate Billing** is where the same service is billed to two separate payers. An obvious example would be an insured person submitting claims to more than one insurer for the same medical expense. Health policies are indemnity contracts and as such the insured person is only entitled to recover the cost of treatment once, even if the insured has more than one policy. Insurers need to ask about duplicate insurance and have systems and processes in place to identify dual cover and apportion expense according to each insurer’s liability.
A recent example of a more complex fraud involved a laboratory who had agreed an all-inclusive fee with a hospital. This fee included the processing and interpretation of the results. However in addition to being paid by the hospital (who passed these costs on to the insurer) the laboratory was also billing the patient or insurer directly for test interpretation.

**Phantom Billing** is billing for services or consumables that were never performed or provided. In a hospital setting there is a long supply chain between a doctor ordering a drug or service, that drug or service being provided to the patient, and the accounts department producing an itemised account of every drug or service consumed. It is not uncommon to see drugs and services on a patient’s bill that were either never ordered, or were ordered but never received.

This type of activity may be identified by asking the patient to sign each invoice to verify that they have received all the services billed. However it is becoming more common that insurers perform hospital audits comparing the patient’s physical medical records against the bill. If a drug or service was not ordered by a doctor and was not signed as having been administered the service is not considered as having been provided and the fee not paid.

**Collusion** is where the insured and the doctor collude to ensure that the patient’s claim is paid by an insurer even when the treatment is not strictly covered. This may involve:

- Failing to provide a full medical history where a pre-existing condition is known to be excluded
- Describing treatment or conditions in such a way that the true nature of the condition or treatment seems to relate to a covered condition.

For example, cosmetic surgery is normally excluded but signs and symptoms can be described in such a way that they justify the procedures performed as curative rather than cosmetic. Examples include:

- Back pain to justify a breast reduction
- Morbid obesity to justify bariatric surgery
- Obstructed airway or deviated nasal septum to justify rhinoplasty. In fact deception in relation to this procedure has become so prevalent in some markets that insurers specifically exclude it for whatever cause.

### Identifying and Acting on Fraud

Individual cases of these types of activity, which often trigger the monitoring and full investigation of a provider, maybe identified by good quality Claims Assessor with the right training paying close attention to the bills for services provided and having access to detailed and accurate medical information.

To identify and act on more wholesale abuse health insurers must accurately record and investigate the full spectrum of information in respect of the patient including:

- The condition(s) being treated
- A detailed description of treatment actually received
- The cost of each individual service.

By continuously monitoring length of stay and costs by condition and procedure - detailed to age, sex and co-morbidities - the insurer will be able to identify, for further investigation, providers whose treatment or billing practises appear to be different to their peers.

Some insurers are successfully employing specialist investigators and setting up investigation teams who are dedicated to identifying and tackling provider fraud.

In some countries insurers are working together and with other professional agencies and organisations. For example, in the UK all health insurers are members of the Health Insurance Counter Fraud Group and routinely share information about suspected fraudulent activity across a common IT platform. The group has reported doctors to the General Medical Council (who license doctors to practice), has actively engaged with the City of London Police Insurance Fraud Enforcement Department, and has exposed fraud in the national press.

Prevention is better than cure and partnering with providers can be effective method of prevention. Agreeing costs in advance – be it on a fee for service, procedure package or diagnostic rating group basis - limits the opportunity for some of the activities described. If that is not achievable, making sure that the providers know that you are monitoring them closely and making them justify their accounts is an important first step.