



Testimony of the
National Health Care Anti-Fraud Association
to the House Insurance Committee
House of Representatives, Commonwealth of Pennsylvania
January 28, 2010

Chairman DeLuca, and the members of the Pennsylvania House Insurance Committee, thank you for providing the opportunity to submit testimony and share our views on the important issue of identifying and preventing health care fraud and specifically the critical role that information sharing plays in health care fraud investigations.

The National Health Care Anti-Fraud Association (NHCAA) was formed in 1985 by private health insurers together with government agencies responsible for the investigation of health care fraud. As a private-public partnership against health care fraud, one of NHCAA's primary purposes is to serve as a forum and catalyst for the sharing of information about health care fraud investigations and emerging health care fraud schemes. Our members comprise the nation's most prominent private health insurers as well as those Federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

NHCAA's Mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud.



NHCAA pursues that Mission by:

- Maintaining a strong private/public partnership in combating health care fraud;
- Providing unparalleled learning opportunities through The NHCAA Institute for Health Care Fraud Prevention;
- Providing opportunities for private- and public-sector information sharing on health care fraud investigations and issues;
- Serving as a national resource for health care anti-fraud information and professional assistance to government, industry and the media; and
- Recognizing and advancing professional specialization in the detection, and investigation and/or prosecution of health care fraud through accreditation of health care anti-fraud professionals.

Our Members include 84 private-sector insurance members representing 200+ corporate entities, 77 public-sector members representing Federal, state and local government departments and agencies, and 500+ individual members who are typically health care fraud investigative personnel.

NHCAA represents those professionals who serve as the first line of defense against health care fraud, which we estimate conservatively accounts for 3 percent of our nation's annual health care spending—or \$69 billion. Other estimates by government and law enforcement agencies such as the FBI place the loss due to health care fraud as high as 10 percent of our annual health care expenditure—or an astounding \$230 billion.

The Challenge of Health Care Fraud

Health care fraud is a pervasive and costly drain on the United States health care system. In 2008 (the most recent year for which full statistics are available), Americans spent \$2.3 trillion dollars on health care.¹ Of those trillions of dollars, the Federal Bureau of Investigation (FBI)

¹ See Department of Health & Human Services, Centers for Medicare & Medicaid Services, National Health Expenditures: <http://www.cms.hhs.gov/NationalHealthExpendData>



estimates that between 3 percent and 10 percent was lost to health care fraud. In other words, between \$69 billion and \$230 billion was stolen from the American public through health care fraud *in a single year*.² To put the size of the problem into perspective, \$230 billion is approximately the Gross Domestic Product ("GDP") of Portugal and is higher than the GDP of 138 countries, including Denmark, Ireland and New Zealand.³

The costs of health care fraud are borne by all Americans. Whether an employer-sponsored health insurance, an individual insurance policy, or taxes to fund government health care programs, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits or coverage. For employers, health care fraud increases the cost of purchasing health care for their employees, which in turn drives up the cost of doing business. For individuals the effects are more immediate and more devastating: the increased cost of health insurance due to health care fraud can mean the difference between being able to afford health insurance or not. For state and federal public health care programs, health care fraud means higher taxes, fewer benefits and increased budgetary challenges.

Moreover, it is clear that many of the same individuals and entities that perpetrate fraud against government health care programs also perpetrate these frauds against the private sector. Accordingly, any effective steps in the fight against health care fraud must address and incorporate both the public and private sectors.

Health Care Fraud's Human Face

In addition to being a financial problem, health care fraud has a human face. The victims of health care fraud include unsuspecting patients who are subjected to unnecessary or dangerous medical procedures, whose medical records are falsified or whose personal and insurance information is used to submit fraudulent claims. According to the FBI:

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

³ See World Bank, Domestic Product 2007, PPP at: <http://siteresources.worldbank.org/DATASTATISTICS>.



One of the most significant trends observed in recent health care fraud cases includes the willingness of medical professionals to risk patient harm in their schemes. FBI investigations in several offices are focusing on subjects who conduct unnecessary surgeries, prescribe dangerous drugs without medical necessity, and engage in abusive or sub-standard care practices.

FBI Financial Crimes Report to the Public, Fiscal year 2007

http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health

For example, in January 2009, Robert Ignasiak, a family physician in a small community in northwestern Florida was sentenced to 24 years in prison for a myriad of health care fraud counts, including unlawfully dispensing drugs resulting in the death of patients. The two and a half year investigation uncovered that Ignasiak, a licensed physician who owned and operated Freeport Medical Clinic, prescribed controlled substances to patients without determining a sufficient medical necessity for the prescription of these substances and in quantities and dosages that would cause patients to abuse and misuse the substances.

Ignasiak prescribed controlled substances to patients knowing the patients were addicted to the substances, misusing the substances, or were "doctor shopping" and were requesting additional quantities of controlled substances for their drug habits. The federal government successfully demonstrated that the use of controlled substances dispensed by Ignasiak resulted in the death of two patients. Ignasiak issued prescriptions that were false and fraudulent because they were not based upon medical necessity and were issued outside the usual course of professional practice, and because Ignasiak lacked documentation in patient files justifying the prescriptions. Ignasiak caused pharmacies to file claims with Florida Medicaid, Medicare, TRICARE and other health care benefit programs for filling the false and fraudulent prescriptions he issued.

The Importance of Information Sharing

Staying one step ahead of those who are intent on committing health care fraud requires continual information sharing and collaboration among the various law enforcement and prosecutorial agencies, regulatory agencies and private health insurers.



NHCAA's 84 corporate members (representing more than 200 health plans) and 77 Federal, state and local law enforcement and regulatory agencies routinely and voluntarily share information through NHCAA's Special Investigation Resource and Intelligence System (SIRIS) database, in-person information sharing meetings, electronic fraud alerts, and various work groups focusing on major health care anti-fraud initiatives. This information sharing is critical to the success of national health care anti-fraud efforts. Those perpetrating fraud against the health care system do so indiscriminately across the range of government health care programs and private health plans. Without effective information sharing, broad schemes targeting multiple payors of health care become nearly impossible to detect.

An excellent example of effective information sharing are meetings NHCAA held recently in Florida which brought together representatives of private insurers, the FBI, the Centers for Medicare and Medicaid Services (CMS), HHS-OIG, the Justice Department, the Miami U.S. Attorney's Office, representatives from the Medicaid Fraud Control Units and state and local law enforcement to address health care fraud schemes which have emerged in South Florida and are beginning to spread to other areas of the country. The details of the emerging schemes, investigatory tactics, and the results of recent prosecutions were discussed with the dual goals of preventing additional losses in South Florida and preventing the schemes from spreading and taking hold in other parts of the country.

Another compelling example, and one closer to home, is the recent conviction of Lancaster pediatrician Saroj Parida of submitting fraudulent claims for infant sleep apnea monitoring of over \$7,000,000 to at least twenty one private insurance companies, over \$600,000 to Medicaid, and \$200,000 to U.S. Dept of Defense TRICARE program. The health insurance companies paid Dr. Parida \$3,000,000 for services not provided before the scheme was uncovered. Capital Blue Cross investigator Kate Amato, acting on a beneficiary's complaint made to their member services hotline, uncovered the basic scheme, and then shared the information concerning the scheme with federal and state law enforcement and other insurers at an NHCAA information sharing meeting. Other insurers opened independent investigations, as did Medicaid and TRICARE, and uncovered the lucrative and far-reaching fraud. Dr. Parida has been sentenced



this month to 8 years in prison and ordered to pay \$7.1 million in full restitution.

Too often, however, information sharing in health care fraud cases is a one way street with the private sector regularly sharing vital information with the public sector—either voluntarily or through mandate—without reciprocal information sharing to bolster the fraud fighting efforts of the private sector. This inequity works counter to a coordinated fraud fighting effort because the private sector—whether in commercial products or in government-sponsored programs such as Medicare Part D or Medicaid —plays an important role in safeguarding our nation's citizens against health care fraud.

In many circumstances, the government representatives believe that they do not have the authority to share information about fraud investigations with private insurers. However, guidelines developed by the Department of Justice and the Department of Health and Human Services for the operation of the Coordinated Health Care Fraud Program established by HIPAA provide a strong basis for information sharing. "The Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans" (<http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm>) recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud. We believe that these Principles also should be emphasized or incorporated in any new state legislation to ensure that the goal of an effective and coordinated health care fraud program can be developed.

The Importance of Pre-payment Review

Many of the problems with health care fraud arise from a key fact about the health care system that holds true for both public and private programs: payment to providers is essentially built on the honor system, and various laws require both public programs and private health insurers to pay claims quickly or face penalties. This "honor system" derives from the combination of state-law based "prompt pay" requirements and the enormous volume of health care claims. While data analysis systems are improving (and may be improved even more as additional health care



information moves into electronic data), most claims are not reviewed until after they are paid, if at all. Therefore, a key means of improving the fight against fraud is to both enhance the current efforts to share information – so that information about fraudulent providers can be distributed more efficiently – and to provide additional payment leeway to private and public programs in resolving suspected fraudulent claims. While hundreds of millions of dollars have been recovered in health care fraud enforcement efforts, this “pay and chase” mentality – where claims are paid and subsequent investigations are conducted – will never sufficiently address fraudulent providers, particularly the kind of “phantom providers” who simply can take their fraudulent financial windfall and disappear.

Dedicated Resources

The recent fraud-fighting successes in Florida demonstrate the importance of dedicating specific resources to the problem of health care fraud. On the whole, the Department of Justice reports that since the inception of the Health Care Fraud and Abuse Control Program in 1997, the government’s health care fraud enforcement efforts “returned nearly \$4.50 for every dollar spent on health care fraud enforcement.” The focused South Florida effort demonstrates how creative, efficient operations, relying on investigators and prosecutors with specific health care experience specifically dedicated to the operation, can make a significant difference in the fight against health care fraud.

Anti-fraud resources yield significant results on the private side as well. Through its biennial *Anti-Fraud Management Survey* over the last several years, NHCAA has been able to demonstrate that the anti-fraud investigative units operating within our member companies consistently use the financial resources dedicated to their departments to yield impressive returns for their organizations. The *NHCAA Anti-Fraud Management Survey for Calendar Year 2007* shows an average return on investment of 7.6 to 1. So for every dollar entrusted to a private insurer’s investigative unit, \$7.60 is returned to the company through recoveries, savings and prevented losses.



Lack of Effective Controls for Entry and Re-entry into the System

The health care system is also subject to access by unscrupulous providers, sometimes with little or no scrutiny. Providers can easily enter the system and begin submitting claims so long as they have what appear to be a valid license and a tax ID number. For example, in South Florida, front companies were being created to enter the system and submit claims, only to move on and go through the process all over again to re-enter the system under a new name and tax ID number. In fact, CMS took the significant step of decertifying all of the DME providers in the area and requiring them to seek re-entry into the Medicare system. It has also had to take similar action for home health care providers for the same reasons.

In addition to these initial licensing issues, state medical boards are inconsistent in their license suspension and revocation actions arising from fraudulent activities on the part of the providers they are responsible for licensing. These state boards – intended to be a frontline in the protection of health care consumers – often do not act effectively when confronted with health care fraud by licensed health care professionals. For example, in 1998 the Coalition Against Insurance Fraud published a report³ that examined the disciplinary actions of state medical boards against providers convicted of insurance fraud. The study examined records of medical providers convicted of felony charges related to insurance fraud in 12 states and compared those individuals with adverse licensing actions taken by state medical boards. The report found that “licensing boards often fail to take any actions against those licensees who commit felony offenses related to insurance fraud.” This lack of action, particularly when patient harm is a possible concern, is perplexing, particularly when state medical boards have several remedies at their disposal short of revocation of a medical license: reprimand, probation, suspension, sanctions, etc.



IMPROVING THE FIGHT AGAINST HEALTH CARE FRAUD

While it may be nearly impossible to completely eradicate health care fraud, some changes can be made to enhance antifraud efforts and make them more effective in controlling costs and protecting patients.

- Improved controls in public and private health care programs, particularly when attempting to identify fraud prior to the payment of a fraudulent claim.
- Improved control over provider entry and re-entry into the health care system.
- Increased resources on a state and federal level to efficiently prosecute fraudulent providers and remove them from the health care system.
- Improved two way flow of information between the private sector and the public sector.
- Improved information sharing and cooperation between public law enforcement agencies.

The National Health Care Anti-Fraud Association is committed to working with the Commonwealth of Pennsylvania to address health care fraud. We hope that this subcommittee will consider us resources and partners in this fight.

4 Coalition Against Insurance Fraud , Licensed to Steal: Action and Inaction by State Medical Boards, available at http://www.insurancefraud.org/med_providers_report.htm#summary