STAYING AHEAD OF THE PACK: EMERGING TRENDS & ISSUES
HEALTH CARE REFORM—A POTENTIAL PLAYGROUND FOR FRAUD

With the upcoming Health Care Reform Act, health care fraudsters will be using new tactics to defraud the system. In this session, we will discuss an overview of the Health Care Reform Act and some noted changes that will have the most significant impact. You will also learn the timeline of these expected changes to prepare you and your company.

TAMARA TURNER, CFE, PMP
President
Norfolk, Virginia

Tamara Turner, President of T.R. Turner & Associates, Inc., holds an MBA from Old Dominion University, and has acquired the certifications of PMP (Project Management Professional), Six Sigma, and CFE (Certified Fraud Examiner). She has over 15+ years of professional experience in the areas of information technology, fraud, training, and health care. Ms. Turner has held numerous leadership positions, in which she has received many Host Leadership Awards, served on a variety of fraud task force and compliance committees, and has managed several audit departments.

T.R. Turner and Associates, Inc. also provides customized training for law enforcement, enterprise-wide organizations, and small businesses.

The staff at T.R. Turner & Associates, Inc. uses insight and creativity to enhance their customers’ experience. Staff members are available to fully serve those companies that wish to improve their processes and develop leaders within their organization in the hope that they will fully realize that what truly defines the foundation of a business is its complete environment.

“Decisions made today are the building blocks for tomorrow.”

“Association of Certified Fraud Examiners,” “Certified Fraud Examiner,” “CFE,” “ACFE,” and the ACFE Logo are trademarks owned by the Association of Certified Fraud Examiners, Inc.

©2011
HEALTH CARE REFORM—A POTENTIAL PLAYGROUND FOR FRAUD

Overview
On March 23, 2010, President Obama signed into law the Patient Protection Affordable Care Act (PPACA). This law was intended to create a comprehensive health care program that would lower health care costs, place more accountability on insurance companies, guarantee choice, and ensure quality health care for all.

Some of the changes that were implemented in 2010 as groups renewed after September 23, 2010, are as follows:

Insurance Reforms

- The elimination of pre-existing conditions for dependents under 19. This prevents insurance companies from refusing coverage to those with pre-existing conditions.
- Rescission of policies except when determined to be fraudulent or an intentional misrepresentation.
- The elimination of dollar lifetime limits on essential benefits.
  - Ambulatory patient services
  - Emergency services (Same cost sharing in and out of network)
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorders
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Restricted annual dollar limits for essential benefits.
- Grandfathered plans—Group plans that were already in existence before Health Care Reform.
These groups will have to maintain the same plan and benefits to maintain their status. Some of the exceptions are as follows:
- Authorization requirement for Emergency Room visits
- Cost sharing for preventive care
- Emergency services for non-grandfathered plans do not require pre-auth; however, they may be subject to medical necessity review by the insurer.
- Zero cost sharing for patients for preventive care services.
- Relief for Medicare patients hitting the prescription drug donut hole.
- Increased efforts around fraud, waste, and abuse for Medicare and Medicaid.

**Expanding Access to Health Care**
- Extending coverage of dependents to age 26 under their parent’s policy. (Unless they have a health care sponsored insurance benefit plan at their place of employment—Grandfathered plans only).
- Extending the “poverty limit” thresholds to cover more individuals under the Medicaid umbrella.

**Future Changes**
In addition to the following recently implemented changes in 2010, there will be several changes under Health Care Reform that will be forthcoming in the next few years. The changes will truly have an impact on the health care industry.

**2011**
- MLR (Medical Loss Ratio) Health insurance plans must ensure that 80–85 percent of the premium dollars are used for medical care instead of administrative costs and must be prepared to
HEALTH CARE REFORM—A POTENTIAL PLAYGROUND FOR FRAUD

provide rebates to consumers if they spend less than the required amount.

- HHS (Health and Human Services) will mandate policies and procedures to justify significant increases to premiums from insurers. The federal government will force insurers to obtain approvals for rates if they fall outside of the guidelines established by HHS. It will also require insurers to post rate increase justifications online through the exchange process to ensure consumers have all of the necessary information when comparing prices for health care selection.

- Payment reduction in Medicare reimbursements

2012

- Implementation of ACO models (Accountable Care Organizations) to encourage physician collaboration to establish integrated payment bundles that will gain economies of scale and quality improvement.

- Tracking of hospital readmission rates by CMS for certain high-utilization or high-cost conditions to improve the quality and care for Medicare recipients and place better controls on unnecessary spending.

- Restructure the member correspondence document (explanation of benefits) to provide consumers with more information regarding services they have received. This is in collaboration with the new internal appeals process.

2013

- Administrative simplification will focus on streamlining and adopting a more uniformed process for eligibility, claim status, and electronic funds transfers. There are a few significant changes already in motion, such as the ANSI 5010 version
HEALTH CARE REFORM—A POTENTIAL PLAYGROUND FOR FRAUD

change, which has a compliant date of January 1, 2012, and the ICD10 changes, which have a compliant date of October 1, 2013.

- EMR (Electronic Medical Records). This will allow physicians quicker access to the patient’s entire medical record to increase quality and efficiency around patient care.

2014

- Pre-existing conditions for age 19 and older will be removed as a barrier for gaining affordable health insurance coverage. Insurance companies will no longer be able to exclude coverage for treatment of individuals with pre-existing conditions. This will also limit the carrier from charging higher rates based on health status, gender, or other factors. Rate structure can vary based on age, geography, size of the family, and tobacco use.

- Establishing the health insurance exchanges for the small group and individual product markets will give consumers more ability to shop for the plan that fits their needs so that any income level can be better positioned to afford insurance coverage.

- Limiting the deductible and MOOP (max out of pocket) for health plans for small group employers.

- Limiting waiting periods for coverage to 90 days.

Fraud Risk

There will be the potential for an increase in fraudulent behavior as the Health Care Reform changes are implemented. Some of the changes that might be more prevalent to fraud are as follows:

- The elimination of lifetime limits on essential benefits.

- This is an opportunity for fraud under the consumer and the provider. Prescription benefits are considered an essential benefit, and with the
removal of dollar limits, the potential selling of medications might be a consequence of this change.  
- Rehabilitative services could be a potential gold mine for providers, as the new ruling could encourage physicians to prolong care or up-code their billing to increase the consumer’s recovery time. There also could be additional billing of supplies that were not used or were not medically necessary.  
- In many cases, there will not be any additional costs to members for using out-of-network providers, nor will there be the need for an authorization for emergency services. Since the member cost sharing might not be affected, members might use more out-of-network providers under their plan. Several benefit plan structures will be forced to pay the provider the requested charges for services rendered. Plans that do not retro-review these services might pay for services that have not been rendered or were not medically necessary.  
- Providers will potentially have a reduction in cash flow due to the zero cost sharing that will not be applicable from consumers for certain preventive care, such as:  
  - Annual gynecological exams  
  - Colonoscopy  
  - Mammograms  
  - Well child visits  
  - Routine annual immunizations  
- This could encourage providers to bill for services that were not truly rendered or engage patients in discussions that could allow them to bill for services that still incur cost sharing.  
- There is a heightened awareness around Medicare and Medicaid Fraud as regulatory information is released and implemented. Some of the new initiatives that are being directed to combat fraud are:
HEALTH CARE REFORM—A POTENTIAL PLAYGROUND FOR FRAUD

• Increased federal sentencing guidelines for health care fraud offenses for crimes that exceed $1,000,000.

• Enhanced provider/supplier oversight for enrollment into Medicare, Medicaid, and CHIP programs. Depending upon the level of fraud risk, a provider could be subjected to fingerprinting, site visits, and criminal background checks before it may be allowed to bill for services under Medicaid, Medicare, or CHIP. This law will also allow the withholding of payment during the investigation time frame to any Medicare or Medicaid provider if there is a credible fraud allegation. This law can also prevent new providers from joining when necessary to support the fight against fraud.

• High-risk fraud providers will be required to serve at least 40 percent of non-Medicare beneficiaries to better manage those agencies that cater to Medicare only.

• Data sharing will allow various agencies the opportunity to access CMS claims and payment systems to allow for additional monitoring of fraud.

• Investment into human capital through increased dollars under the affordable care act will provide an additional $350 million dollars over the next ten years to assist with the fight against fraud through the (HCFAC) Health Care and Fraud and Abuse Control Account.

Regulations have not been finalized in all cases.

☐ Consumer fraud might become more prevalent around the cancelation of polices due to fraud. Insurers will have to be more robust in their identification of fraud, as well as prove deliberate intent. In the past, it appeared to be a “gray area” on the intentional misrepresentation of fraud. Insurers might become
more reserved in rescinding policies due to the potential backlash and publicity that they might experience.

- The dependent age of 26 has already been questionable as a risk for consumer fraud. Typically, if the dependent on the application has the same last name as the policy holder, additional verification is not required. Some insurers did not require additional verification for those dependents that were enrolled on or after September 23, 2010.

- Medical Loss Ratio percentages will be a difficult process to manage. It will require massive oversight to manage the responsibility of the insurer. However, fraud behavior might be able to develop during the early stages of MLR. It will be very easy for insurers to allocate dollars to medical care when in actuality some of the time should be counted as administrative. For example, an insurance plan assigns a nurse to manage a diabetes case management program full-time. However, she only spends 20 hours a week on the program and the remaining time is spent on paperwork.

- The changes to the EOB (explanation of benefits) will assist consumers in better understanding the care and type of services they have received from their provider. It will provide an audit of services so that the consumer can determine if all services indicated were rendered.

In closing, we find that the Health Care Reform is intended to allow all Americans the opportunity to have quality health insurance at an affordable price. The voluminous numbers of individuals that are not covered today, but will be eligible for coverage in the near future, will open doors to not only fraud, but waste and abuse as well. The changes are so significant to our current health care industry that we are sure to create several fraudulent opportunities. Some of them we can prepare for, and some of them we will find out too late and pay the piper at that time.