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THE POWER TO PROSPER

Health Reform Looks to Eliminate Medical Fraud

By: Barbara Mannino

Health reform has ramped up anti-fraud efforts, but the almost $70 billion price tag that is paid out to fraudsters each year demonstrates that health fraud is still an enormous problem.

The National Healthcare Anti-Fraud Association estimates that approximately 3% of the $2.5 trillion in annual health-care spending is lost to. According to Lou Saccoccio, NHCAA executive director, the government reports an even larger figure: 10% of total health-care expenditures or $225 billion, which includes not only intentional fraud, but the grayer area of mistake-driven waste and abuse.

The financial ramifications are staggering, and the trickle-down effect hurts subscribers—both individual and corporate--who are forced to pay higher premiums and more money out-of-pocket.

As providers necessarily cut back to save dollars, subscribers receive reduced benefits and coverage. In some cases, premium spikes may make-or-break a person's ability to buy insurance.

Experts say that in some respects, the new health reform has made the public more vulnerable to falling victim to medical scams. Crooks prey on the confusion that comes from change and peddle fake medical plans door-to-door and discount medical cards disguised as insurance. Deadly Medical Consequences

When thieves steal your identification and make false claims against your policy, hospitals or other providers are on the hook for the cost of service and you are left with a diminished credit rating and "a bill for an amputation that never occurred," says James Quiggle, director of communications for the **Coalition Against Insurance Fraud**. Identity theft can have potential deadly ramifications: Your blood type may be recorded incorrectly, or a drug to which you are allergic goes unnoted or your health record shows usage due to a bogus claim.

Fraud also brings medical consequences, including unnecessary surgeries or procedures, over-prescribing or illegal prescribing of pain killers and other controlled substances.

The faces behind the fraud vary from savvy business people, members of organized crime and a small minority of dishonest physicians. And their bag of trucks include scams like upcoding, in which a provider bills for more time and service than actually provided, overbilling, creating phantom lab medical equipment companies and false home-health services and clinics.

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Coalition Against Insurance Fraud

In 2005, the authorities and a group of Blue Cross Blue Shield companies successfully investigated and prosecuted a "Rent a Patient" scheme: workers at outpatient clinics recruited patients to undergo unnecessary procedures in exchange for cash or free or discounted cosmetic surgery.

More recently, 20 people in South Florida were indicted in a con involving approximately $200 million in Medicare billing for alleged mental health services to Alzheimer's and dementia patients who were not eligible for and would not benefit from purported partial hospitalization programs.