

Fraud and Abuse in Managed Care

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The concept of Fraud

Fraud and abuse in managed care is an extremely important problem world over and it requires much attention. Nowadays, from day to day, criminals invent new methods of fraud in this area. The basic principle of fraud is introducing the victim to misleading settings, building a trust relationship with him/her, and taking advantages of that trust. The fraudster induces the victim under one or another pretext voluntarily to hand over money, property, or rights to the fraudster. This “voluntariness” makes fraud a special phenomenon among the number of other acquisitive crimes. First, even realizing that he/she has been deceived the victim often does not go to the police being ashamed of the gullibility or being sure that the police will not be able to do anything. Secondly, to prove the components of crime can be also difficult, as it requires objective confirmation of the deception. Fraud is built on the deep knowledge of psychology and human behavior patterns. The strategies and tactics of fraud are usually well thought out. They are aimed at achieving the objectives with minimal risk for the fraudster. There are different ways of fraud. Sometimes, there are quite simple and primitive methods; however, in some cases, the scammers implement a complex plan and work in the group. There are different forms of fraud. Fraud in managed care occupies an important place. Fraud in managed care is the intentional deception or misrepresentation implemented by a person knowing that the deception could lead to some unauthorized benefits for him/her or another person/company. It includes any act that constitutes fraud in accordance with the applicable federal or state law. Fraud in managed care exists in many options - from individual facts of theft of medical equipment to the actions of the entire criminal organizations involved in kidnapping of the patient information and creation of existing only on paper companies to bill insurance companies for the provision of fictitious services to patients (Bucy, 1996).

The Report of the World Health Organization

According to the World Health Organization, the annual cost on health care in the world reached 5.7 trillion dollars. However, 7.295 % of the amount (415 billion dollars) is lost because of fraud and medical errors. This problem is extremely widespread in the world. According to the National Health Care AntiFraud Association of the USA- NHCAA, every year 750 billion dollars are spent on the pharmaceutical market. 10-25 % of spending on public procurement including procurement on pharmaceutical means is lost because of corruption. According to Lou Saccoccio, the executive director of NHCAA, in 2011, the U.S. received damages in the amount of 75 billion dollars because of fraud in managed care. The imposition of strict sentence to criminals did not reduce a number of cases of fraud in managed care (Busch, 2012). Recently, however, private insurance companies and government programs start to pay more attention to the prevention of such cases. The forgery of doctor's signatures on the prescription or theft of medical equipment may seem insignificant on the scale of a single medical facility. Nevertheless, if to sum them up, the annual loss is evaluated by billions of dollars that could be used for patient care. According to experts, fraud and abuse in managed care cost the individual governments of developed countries from 12 to 23 billion dollars per year. In developing countries, there is the leakage of purchased medicines and operating costs up to 89%. Fraud is the last large group of health expenditure, which has not been minimized yet. For example, in China, some families use the insurance card of a family member with the best terms and conditions of insurance services. In South Africa, people demand the monetary compensation for the medical services that they did not receive in reality. However, in such countries as the U.S., where providers present a bill directly to insurance companies, health care fraud can take the form of overstating the cost of medical services. In other words, codes of services with higher value are specified. According to a study of the University of Portsmouth, in 2008-2009, about 3% of the funds

allocated to the National Health Service of the United Kingdom was lost because of fraud. 10 years ago, the comparable figure was over 5% bigger. The United States made some progress in providing anti-fraud campaign. The federal agency “Centers for Medicare and Medicaid Services” was created. It is responsible for the health insurance program for the elderly people. There is also the public health program for low-income countries. To identify patterns of fraud in health care, technologies of predictive modeling are used. Such systems study application for reimbursement of the insurance claim as they arrive and determine the scale of the risk (Busch, 2012).

Countries that made significant strides in the fight against fraud have effective systems of financial and management reporting, underpinned by robust forms of audit. According to Grayson Clarke, an expert on the management of project funds cooperation between the EU and China in the field of the social reform, the government of China tested a variety of measures to combat fraud in the health sector, one of which is to provide the centralized supply of hospital drugs. This allows elimination the receiving of bribes for doctor’s recommendations of certain drugs and the sale of pharmaceutical products. In China in 2011, a law on social insurance came into effect, which would contribute to a significant reduction of the fraud incidents. This law identifies numerous types of health insurance as well as measures to combat fraud. As in other countries, in China there is little evidence of fraud in health care. However, fraud in the area of health insurance is extremely widespread. The recently adopted administrative and legal measures should reduce the extent of the problem.

It is necessary that each country makes a comparison of the cost of the same treatment procedure or drug in different regions and clear explanations of the causes of these differences. When creating an appropriate financial reporting system, modern information technologies have reliable significance. For example, a computer program used by health care

providers in Norway helps prevent fraudulent payments before they leave the system (Busch, 2012).

Some of the professionals working in the health sector for a number of reasons deny the problem of fraud. They do not want to admit large-scale financial losses. However, the anti-fraud experts say that as long as the scale of the problem is not recognized, it is impossible to take concrete steps to address it. Nowadays, many countries recognize the existence of the problem. Evidence of this was the holding of the first global summit on the prevention of fraud in managed care. Representatives from different countries including Canada, New Zealand, South Africa and some countries from the European Union took part in the event, held on November 15, 2011 in Atlanta, USA. Experts in this field agree that cheaters in healthcare share common motives - the desire to get the financial arguments and are confident of their impunity in the system. To minimize the number of the fraud incidents, professional ethics of health workers should be at a high level. The idea itself is great; however, in real life, it is hardly feasible (Busch, 2012).

Counterfeit Drugs

An extremely important issue in the managed care is the counterfeit drugs. It should be recognized that counterfeit (fake) drugs exist all over the world. They can be a mixture of harmful or even toxic substances that do not have therapeutic properties or contain an insufficient amount of active ingredients. The use of these drugs can lead to ineffectiveness of treatment and even cause death. The fight against their appearance on the pharmaceutical market is a significant global health problem. To determine the extent of the problem in one country and the whole world in general is difficult for a number of reasons. The information about counterfeit drugs enters central structures from a great number of sources. These are reports of the national regulatory authorities in the turnover of pharmaceutical products, law enforcement agencies, pharmaceutical companies, and non-governmental organizations, as

well as directed researches of used pharmaceutical products in specific territorial areas or therapeutic groups. Because of the multiplicity of sources of information on the availability of counterfeit medicines, the collection of statistical data is a difficult task (Navarro, 2007).

Official investigations of the turnover of counterfeit medicines can only give an idea of the situation at a certain point without dynamic performance. Manufacturers of counterfeit drugs are extremely flexible in the methods used to simulate medical products and prevent their detection. There is a possibility to change their nomenclature so that by the time of publication of the results of the study these data may already be outdated. As a result, information can often only be available after the completion of the official investigation. The commodity chain of medicines consists of links needed for creation, control, management, and consumption of pharmaceutical preparations. The corruption in the pharmaceutical industry is present in all parts of the chain - from research and development to distribution and sales promotion.

In most developed countries with effective legal and regulatory systems and market control, counterfeit medicines are detected rarely. According to experts, they account for less than 1% of the market value. However, in many countries in Africa, some parts of Asia and Latin America, as well as countries with economies in transition, the proportion of sold counterfeit medicines is extremely significant. The prevalence of counterfeit drugs can vary widely not only between geographical regions but also within the countries: for example, between urban and rural areas and different cities (Baumann, 2007).

It is possible to forge any kind of medication. The largest number of reports of counterfeit medicines considers antibiotics, antiprotozoal drugs, and steroid hormones. Obviously, expensive drugs and maximized profits are the main purposes of manufacturers. Unlike substandard drugs, the appearance of which is associated with the presence of concrete problems in the manufacturing process of the well-known manufacturer, counterfeit

drugs are made with the intention to mislead consumers. It is a fact of fraud. As the channels of production and distribution of counterfeit drugs is extremely difficult to track, their turnover is difficult to stop. However, even the appearance of isolated cases of counterfeit drugs demonstrates the vulnerability of the system of the quality control. Several other factors complicate the problem. The production of such drugs does not require large capital investments. As a rule, they are made in small, adapted rooms and basements. In the production process of counterfeit drugs, cheap raw materials and equipment are used. In this case, the buyer has no way to determine the quality of purchased goods (Navarro, 2007).

There is a prime example of the consequences of such fraud in the WHO Bulletin. 57-year-old Steven Schneider (a doctor) and his 52-year-old wife Linda (a nurse), who illegally distributed prescription drugs in Heysvill, Kansas, in 2010, were sentenced to 30 and 33 years in prison respectively for fraud and other offense. Working in a private clinic, a married couple prescribed patients opioid analgesics without proper indications and controlling the process of taking the drugs. Their illegal activities led to more than 100 cases of overdose of drugs that required emergency medical care, as well as 68 cases of death due to the overdose. In 2010, an investigation of the case, which had lasted for four years, was attended by a number of U.S. law enforcement and health care organizations. It was named “the investigation of the year” by the National Health Care Anti-Fraud Association. According to the investigation, the material losses of the actions of spouses incurred by 93 insurance companies and more than 500 patients exceed 20 million dollars (Busch, 2012).

In developing countries, people spend great sums of money on medicines. Some people are looking for cheaper medicines and often find them in deregulated markets, where the probability of counterfeit drugs is very high. Counterfeit drugs bring huge profits. As many countries still have not enacted legislation toughening liability, the manufacturers of counterfeit medicines often do not fear prosecution. The growth of pharmaceutical

ingredients and drugs in international trade exacerbates this problem. For example, in recent years, in the context of the proliferation of counterfeit drugs, the value of trade through the brokers and free trade zone with weak or no regulation increases. To combat the appearance of counterfeit drugs on the pharmaceutical market, WHO recommends a range of responses. The strict legal and regulatory control of the turnover of pharmaceutical products by national regulatory authorities can greatly help in preventing the appearance of counterfeit medicines. WHO provided direct support to countries in strengthening the regulation of pharmaceutical products in the national markets. Governments of countries with developing economies should improve legislation in the sphere of production, export, import, storage, distribution, supply, and sale of pharmaceutical products. This will increase the guarantee of its safety, efficacy, and quality. The establishment of effective regulatory and supervisory structures in the area of the drugs turnover is extremely important for developing countries. WHO recommends the governments of these countries to provide such structures with all kinds of political support, provide adequate financial resources and powers for monitoring the quality of pharmaceutical preparations (Navarro, 2007).

Prescription and non-prescription drugs in the United States under federal law must meet the standards of the USP (United States Pharmacopeia). By the way, USP is a non-governmental and non-profit organization staffed by volunteers in accordance with the rules to prevent conflicts of interest. Non-compliance standards of quality, purity or potency identified during testing prescribed by the USP are considered fraud if these differences are not clearly demarcated in the instructions for medical use. If the medicine is not described in an official compendium, it is considered falsified in the case of non-quality standards specified in the instructions, specifications of the manufacturer, or application for marketing authorization. The main reasons for the withdrawal of drugs from the pharmaceutical market are as follows: inconsistency of packaging requirements, violation of temperature storage

conditions, reduction of quality of the active substance, chemical contamination, the excess of the permissible level of impurities/degradation products (Navarro, 2007).

Medical Insurance

One more widespread type of fraud is fraud in medical insurance. From year to year, billions of claims of health insurance are worked up by health professionals and individuals to meet medical expenses. Still, in different cases, criminals attempt to mislead the insurance companies for financial gain. The act of a deliberate attempt to falsify or deceive the requirements of health insurance in an attempt to get more money from the health insurance company is considered fraud with health insurance. With health care costs reaching great levels all over the world, legal people who commit fraud of health insurance are a considerable part of the problem. When a medical professional or insurance company must spend more time sorting out the possibility of fraud, the costs of staffing and management increase and medical cost increases, as a result. Two most common forms of fraud with the health insurance are a false registration of requirements and false claims of bodily injury.

Health care facilities earn on false appeals for payments in health insurance. As a result of fraudulent activity, swindlers get about 20-25% of insurance payments in the voluntary health insurance. Fraudulent actions of physicians and hospitals, diagnostic centers, and clinics can appear in billing for procedures that were not actually carried out, write-off drugs, and preparation of documents for a patient to visit the clinic. Insured people are prescribed the most expensive treatment, unnecessary medical preparations, and expensive inspections. There are many cases where false diagnoses are diagnosed to healthy people, and the non-existent tumors are cut out. In many fraud schemes, according to experts, doctors themselves without any objective reasons increase accounts for screening and treatment. In turn, the abuse of the insured in health insurance is most commonly associated with a simulation of diseases, treatment of individuals, who are not insured under the contract and

receipt of services, which are not covered with this policy. In recent years, according to experts, the number of fraudulent activities in health insurance has extremely increased.

In the USA, money lost in insurance fraud account for billions of dollars annually. Fraud with health insurance can be averted by careful and accurate assessment, billing and recording of treatment by health professionals. It is up to health professionals, insurance companies, and consumers whether to work together to prevent this costly and damaging form of fraud or not (Beik, 2012).

Methods for Dealing with Fraud

The organization or its employees may have licenses, certificates, diplomas issued by organizations with big names but just sell papers for money having nothing to do with medicine. Clinics and centers of this kind often have a website on the Internet where nowhere confirmed diplomas, licenses, orders, and medals of doctors are posted with numerous positive feedbacks. Customers are attracted by the ability to have a consultation of a highly qualified professional. However, in reality, the “consultants” may be even without medical training. The patient can be “unofficially” offered services that are not included in the list approved by a license for medical activities for the organization offering to pay them extra without registration. The patient will not be able to prove service if it entails damage (McElroy & Martin, 1998).

In 2009, the U.S. Department of Justice, together with the Ministry of Health and Social Services joined forces to investigate fraud associated with the government program of medical service Medicare - health insurance of elderly and disabled people. In a few years, the total damage from fraud exceeded 4 billion dollars. 1330 people participated in 2.600 cases of uncovered fraud in Medicare. FBI estimates annual losses from fraudulent actions in the system of state insurance of elderly people and people with low income in the amount from 70 to 234 billion dollars. In 2005, the European network of anti-corruption and fraud in

health care was created. It included ten countries including Britain, France, and Germany. According to the organization, 5.6% of the budget allocated for medicine is stolen. As the total expenditure on health by 27 EU countries is around 1 trillion euros, the amount of loss including bribes makes 150 million euros a day (Busch, 2012).

Prices for managed care are constantly rising, and with them medical fraud is also growing all the time. The victims of such scams are severely ill people, who are ready to accept any help. A lot of people with severe forms of cancer and other difficult curable and incurable diseases are snookered. The general scheme of fraud in medicine is the same as in many other areas: to force the client to believe the fraudster and wheedle money from him/her in exchange for the ineffectiveness of the goods or services with an artificially inflated price (Baumann, 2007).

Nowadays, fraud and abuse in managed care reached unprecedented heights. According to the World Health Organization, today the annual cost of health care in the world amounts to 5.7 trillion dollars. Each year, more than 7%, or about 415 billion dollars are lost due to fraud and abuse in managed care. WHO experts urge countries to recognize the scale of the problem and take serious measures to solve it. The organization's experts point out that fraud in health care has different forms ranging from theft of the wheelchair to racketeering of criminal organizations involved in the kidnapping of patient information and creation of companies that exist only on paper and only for billing to insurance companies for fictitious services rendered to patients.

Managed care as a sector in reality is not different from any other sector. The main forms of human behavior remain the same. Successful reduction of the costs of fraud requires not just a reaction to its individual cases. The work to eliminate systematic weaknesses, opportunities for fraud and enhance general knowledge in the field of anti-fraud in order to withhold individuals from committing fraud is required. To reduce fraud to a minimum,

professional ethics of health sector workers should be at a high level. It is of fundamental importance. Studies conducted in recent years show that it is impossible to eliminate dishonest minority completely. However, the development of the strong culture, which does not accept fraud, and strong pressure from the side of colleagues can maximize the number of the honest majority (Baumann, 2007).

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