Fraud, waste and abuse - why healthcare is so expensive

Some of the most significant contributors to soaring healthcare costs are fraud, waste and abuse. These are difficult to detect, monitor and prevent because the perpetrators are at every level of the delivery chain from healthcare providers at the top to policy holders at the bottom with many abusive acts playing out under the radar, for months, even years.

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“It is estimated that healthcare fraud costs the sector between 5% and 15% of total pay-outs,” says Lynette Swanepoel, healthcare and insurance forensic specialist at the SA Fraud Prevention Services (SAFPS).

“Fraud is definitely a serious element, but on top of that the healthcare industry also has to contend with waste and abuse of benefits,” she says. One example of healthcare fraud is collusion between the policy holders and healthcare service providers such as doctors and pharmacists, where some doctors or pharmacists will supply non-covered items such as toiletries and baby products, falsely claiming these as medicine from the healthcare insurers.

ATM scams

“Then there’s what we call ATM scams.” A patient will approach a healthcare service provider with a sad story to extract cash based on sympathy. The provider will claim this as services rendered. “What worsens this scenario is that the monetary value is usually escalated,” she adds. The healthcare service provider, for example, may dole out R500 and then claim for services valued at R1,500.”

In addition, once a healthcare provider has a patient’s medical aid number they could continue to submit fictitious claims on an ongoing basis, sometimes without the knowledge of the policy holder.

Hospital cash plans

Swanepoel says many incidents of abuse of hospital cash plan products have been detected and investigated in recent years. Policy holders who perpetrate such abuse would typically coerce a healthcare service provider to admit them to hospital with a fictitious ailment so that the policy holder may benefit from the cash plan pay-out. The healthcare service provider would also benefit from such unethical behaviour.

The fundamental problem with this is that not only is the insurer of the cash plan losing funds, but the medical schemes are

losing far more when claims for such events are settled.

Dental fraud

Another example of fraudulent practice is when dental practitioners provide policy holders with gold inlays, for which the medical schemes do not provide benefits. To cover the cost of these inlays, the services are claimed under the guise of multiple fillings.

“Fortunately, most healthcare insurers have very good managed care systems in place to prevent and detect such practices.”

The same names pop up all the time

“Fraud, waste and abuse is opportunistic behaviour. Many ‘fraudsters’ know the rules, and they know where they are able to take chances. Then it’s greed that perpetuates the behaviour. There are many repeat offenders and those who have worked in healthcare forensics for a long time, will see the same names showing up for scrutiny.

“For many of the perpetrators, remaining undetected or being dealt with too leniently, the misappropriated wealth has become a lifestyle which they need to maintain. It is therefore often obvious that one cannot rehabilitate such individuals.”

“It is important to note that when it comes to fraud, waste and abuse, the perpetrators in the medical fraternity are in the minority. The majority of healthcare service providers are reputable and would also like to see such unethical behaviour dealt with,” Swanepoel says.

Although some of the major insurers and administrators are now utilising sophisticated tools which can perform upfront scoring of claims, many still pay claims at face value. However, if a healthcare insurer receives a tip off it can and will institute a retrospective analysis of claims, where unusual patterns and anomalies are easily detected.

Penalties and sanctions

Swanepoel says penalties and sanctions should take the form of a multi-pronged approach. The Health Professions Council of South Africa sometimes imposes fines on reported healthcare professionals and others are permitted to pay admission of guilt fines.

“The problem with this system is that healthcare insurers still do not recoup their losses and for this reason may opt to employ the services of the criminal justice system and the asset forfeiture unit, which is a costly process.”

She believes that regulatory bodies could act more vigorously regarding fraud, waste and abuse, which causes healthcare insurers to be reluctant to report the incidents to these bodies. In South Africa we are bound by Section 34 [1] [b] of the Prevention and Combating of Corrupt Activities Act, 2004 and are obliged to report cases of fraud in excess of R100,000 to

the authorities.

Collaboration

One such crucial measure would be collaboration across all silos and boundaries in healthcare. “The healthcare industry should finally stand united in the fight against fraud, waste and abuse.”

The SAFPS is encouraging all the role players to come aboard its new initiative, which comprises a listings database where details of reported and investigated cases can be captured to enable all members of the initiative to mitigate their risk with the sharing of information on irregular activities.

Another important aspect of this initiative is the coordination of collaboration among healthcare insurers, where knowledge, skills, operating structures and many other important aspects can be shared.

“We are urging all our healthcare colleagues to send out the right message to the perpetrators, that we are just as smart and adaptable to ever changing circumstances and environments to combat fraud, waste and abuse effectively and that we will stand united as an industry, she says.