The Medical Loss Ratio: Fraud Prevention and Patient Protection

MEDICAL IDENTITY FRAUD ON THE RISE/HEALTH CARE AT RISK

Studies show medical identity fraud is increasing due to a number of converging factors such as the high black market value of protected health information (PHI) and the recent, dramatic increase in electronic PHI and electronic health records (EHR), making cybercrime lucrative. It does not appear that medical identity fraud will subside in the near future.

- An increasing number of medical records are being corrupted with erroneous medical information, putting the victims of this type of identity fraud at a serious health risk.
- When medical identity fraud is perpetrated, the victim's health information becomes corrupted, or comingled, with that of the identity thief's health information.
- Unlike financial identity theft, medical identify theft has the potential to negatively impact health outcomes for its victims.
- When an individual's medical record is corrupted with information from an identity thief, the victim may suffer misdiagnosis, mistreatment or experience a delay in receiving the proper healthcare due to confusion about the individual's actual health status. Information such as allergies, blood type and diseases may be incorrect in a health record.
- Studies show that over 20% of medical identity fraud victims have experienced misdiagnosis, mistreatment or a delay in receiving care due to misinformation or confusion about their true health status or health history.[1]
- Improved fraud reduction programs can reduce these negative health outcomes, increasing quality improvement.

MLR OVERVIEW

Medical loss ratio (MLR) is an insurance term used to describe the percent of premium an insurer spends on claims and expenses that improve health care quality. Congress requires insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement versus administrative expenses. Insurers must issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurers to spend at least 80% (private insurers) or 85% (Medicare) of premium dollars on medical care. Fraud reduction programs are classified as an administrative expense and are not included as a quality improvement cost. The formula is as follows:

$$\frac{\text{Medical Claims + Quality Improvement Expenditure}}{\text{Earned Premiums - Taxes, Licensing and Regulatory Fees}}$$

ISSUE: MLR SEVERELY INHIBITS FRAUD PREVENTION EFFORTS

MLR was created to improve transparency and accountability and enable customers to get more from their premium dollars on medical care rather than administrative fees. However, **MLR is having a pervasive effect on medical identity fraud prevention, putting individuals at risk of medical identity theft.**

[1] *Fifth Annual Study on Medical Identity Theft*, February 2015, http://medidfraud.org/2014-fifth-annual-study-on-medical-identity-theft/.

By hampering health plans' full ability to deploy robust fraud reduction programs, particularly related to identity fraud, the healthcare industry and the patients they serve are vulnerable to negative health outcomes as medical identity theft and fraud continues to grow. Health plans should be incentivized rather than penalized for protecting health care information. The current MLR formula and should be amended so detection and prevention of medical identity fraud are considered part of providing health quality improvements. Contrary to the spirit of the law, the MLR:

1. Encourages a "pay and chase" model of fighting fraud and abuse.
2. Gives health insurance companies a disincentive to prevent fraud, despite having developed and demonstrated tactics and policies that work.
3. Penalizes insurers for quality healthcare improvement efforts and keeping costs down.

RESEARCH/KEY STATISTICS

The Medical Identity Fraud Alliance (MIFA) conducted an informal survey of health plans in order to see how MLR is affecting fraud reduction activities.

- About one-third indicated their organization experienced unintended consequences as a result of MLR.
- Two-thirds of those who experienced unintended consequences had budget cuts in, or elimination of, "administrative" or "innovation" investments to detect, prevent and/or mitigate medical identity theft and fraud, such as payments systems that help reduce fraud.
- One-third of those with negative consequences indicated a reduction of personnel to fight medical identity fraud.
- On average, health plans are spending a total of 52 cents per year, per member to fight fraud,
- The special investigation units within the Plans have an average of one fraud investigator for every 192,000 Plan members.
- Over the past two years, on average, fraud fighting expenses have decreased by 10% while actual fraud instances have soared.
- One hundred percent of respondents indicated they believe reducing identity fraud can contribute to quality healthcare.
- Respondents agreed that when medical records become corrupted with incorrect information from an identity thief, there is potential for a bad health outcome if a person is given an incorrect diagnosis or mistreated based on the information from the identity thief.

SOLUTION

Prevention and reduction of medical identity fraud is directly tied to the health and well-being of consumers. Congress and/or regulatory agencies should remove barriers to the fight against fraudulent claims in order to protect patients. These fraud prevention programs should be considered an allowable cost rather than a purely administrative cost under the MLR.

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