The Medical Loss Ratio & Fraud Prevention

EXECUTIVE SUMMARY

Studies show medical identity fraud is increasing due to a number of converging factors such as 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.

Studies also show this type of identity fraud is unique from traditional financial-related identity theft. Medical identity fraud has the potential to affect health outcomes for victims. This is because 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. Because of this unique twist, prevention and reduction of medical identity fraud is directly related to positive health outcomes.

Health insurance plans in the U.S. are limited in their fraud prevention efforts due to the Medical Loss Ratio (MLR). The ratio limits "administrative" spending to 15 or 20 percent of premium monies collected from plan members, with 80 to 85 percent of funds spent on quality healthcare. This is to ensure that the majority of healthcare premiums are spent on improving and maintaining quality healthcare and administrative spending is kept within certain limits.

Included within administrative expenditures are expenses related to "fraud reduction programs." By hampering health plans' full ability to deploy robust fraud reduction programs, particularly related to identity fraud, the healthcare industry is vulnerable to negative health outcomes as medical identity theft and fraud continues to grow. 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.

The Medical Identity Fraud Alliance (MIFA) and its members believe the current MLR formula puts individuals at risk and should be amended so detection and prevention of medical identity fraud are considered part of providing health quality improvements.

BACKGROUND

Medical loss ratio (MLR) is an insurance term used to describe the percent of premium an insurer spends on claims and expenses that improve healthcare quality. Congress requires insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement versus administrative expenses. This is the "ratio." 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. The formula is as follows:

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

ISSUE

The stated goals of the provision, which MIFA fully supports, were to improve transparency and accountability and enable health insurance customers to get more from their premium dollars on medical care rather than administrative fees. **However, the law and associated regulations are a significant hindrance to fraud and abuse efforts. Health plans should be incentivized rather than penalized for protecting health care information.** Currently, fraud reduction programs are classified as an administrative expense and is not included as a quality improvement cost.

UNINTENDED CONSEQUENCES

The Health and Human Services Final Fraud Rules allows insurers to **recover** funds, but does not allow **prevention** or fraud fighting expenditures to count in the Quality Improvement Expenditure that is deducted from the total of medical claims. This typically means fraudulent claims are paid and then the insurer must recover the funds in order to have those anti-fraud efforts not count against their administrative costs.

In practical healthcare, fraud prevention is closely aligned with quality healthcare. A common healthcare fraud is medical identity fraud. When medical identity fraud is perpetrated, the victim's health information becomes corrupted, or comingled, with that of the identity thief. This includes critical information such as allergies, diseases, blood type and other medical information that is necessary to provide quality healthcare.

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.

Contrary to the spirit of the law, the MLR:

1. Encourages a "pay and chase" model of fighting fraud and abuse, where fraudulent claims are paid and then chased for recovery.
2. Gives Health insurance companies a disincentive to prevent fraud, despite having developed and demonstrated tactics and policies that work.
3. Penalizes insurers for efforts that improve quality healthcare and services and keeping costs down.

MIFA conducted an informal survey of health plans in order to see how MLR is affecting fraud reduction activities. About one-third or respondents indicated their organization experienced unintended consequences as a result of MLR. Most notable is two-thirds of those who

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

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.

Some specific statistics that stood out included 1) on average, health plans are spending a total of 52 cents per year, per member to fight fraud, 2) the special investigation units within the Plans have an average of one fraud investigator for every 192,000 Plan members and 3) over the past two years, on average, fraud fighting expenses have decreased by 10% while actual fraud instances has soared.

Further, 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

Medical identity fraud prevention programs should be considered an allowable cost rather than a purely administrative expense. While anti-fraud programs may be considered normal business expenditures in ordinary business circumstances, in the case of medical identity fraud, these programs are tied to the health and well-being of consumers. Congress and/or regulatory agencies should remove any impediments to stopping fraudulent claims to protect patients not only from others using their information to receive care or to scheme the government, but to also protect consumers from negative health outcomes due to corruption of their medical records from medical identity fraud. Additionally, insurers should be encouraged to provide fraud protection to prevent patients from having medical care or services not provided to them appear on their medical records.

CONTACT

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