Battling sophisticated medical fraudsters

Can insurers tackle smart, tech-savvy criminal gangs who are increasingly involved in medical fraud? *Alex Wright* investigates

Medical claims fraud is on the rise across the board – driven by people becoming increasingly desperate due to the cost-of-living crisis, and unscrupulous medical providers taking advantage of opportunities to defraud their patients' insurers.

People appear to be more willing to enable fraud, too. In a study published in June, the Coalition Against Insurance Fraud reported that more than 20 per cent of Americans said they would help their medical provider fraudulently bill their insurer for treatment they had never received.

Allianz Partners USA has reported a seven per cent increase in fraud investigations, from more than 1,400 cases in 2021 to just above 1,500 in 2022. Of those from last year, 105 cases were denied for fraud, with 15 to 20 of those undergoing further investigation by a US State Department of Insurance. At the same time, the insurer has also experienced a steady rise in claims values.

But that is just the tip of the iceberg, with claims expected to rise as travel starts to return to levels seen before the pandemic. As the criminals realise that they can get away with it, they will continue to try their luck.

The bottom line is that fraudsters – particularly organised criminal gangs with resources and technology at their disposal – are becoming increasingly smarter and more sophisticated in their methods, with fraud being committed across multiple borders. This includes using different names for policies they claim on and filing many claims that are up to the acceptance limit, as well as lodging the same claim on policies with different insurers – all making it harder to detect, investigate and prove fraud.

"Fraudsters are becoming savvier," said Richard Cliffe, Fraud Manager at Collinson. "We've seen instances where they will take out policies in different names and use credit cards that are not genuine.

"Fraudsters do their homework on travel insurers and assistance providers and have a greater understanding of the front and back-end processes. Customers can notify insurers of a claim by telephone, email, online or by post. With online claims, fraudsters will learn what the acceptance limits are for a claim to be accepted. For tele-claims, fraudsters may do their homework by calling the claims team to assess what is acceptable and what is not."

Among the more prevalent types of fraud is medical tourism. This is where policyholders try to pass off scheduled routine medical services or cosmetic surgeries as emergency care required due to an accident that happened while they were travelling.

Medical provider fraud

It's not just the customers that are perpetrating the fraud. Medical providers and third-party billing agencies are getting in on the act too, upcoding their bills or charging for services that were never rendered in the first place.

"Overall, we have seen an increase in prices in recent years," said Christina Eure, Special Investigator and External Anti-Fraud Coordinator at Allianz Partners USA. "The significant inflation facing consumers gives providers air cover to increase prices and is also an incentive for claims fraud as soaring costs mean people are eager to receive money from any source."

AMREF Flying Doctors said that owners of small, privately run medical clinics or hospitals will sometimes collude with the patient to inflate a bill or invoice, with the promise of the doctor getting a cut when the claim is paid. Others prepare two bills, they said, with the patient paying a small amount but then presenting the inflated amount to their insurer.

Other sharp practices include dual pricing by medical providers, with one price for cash payers and locals and another for »

internationally insured patients, who can sometimes pay more than double for the same service. Then there are those who fabricate documents and lodge claims without involving a medical facility or who make up a fictitious medical provider, getting hospital or clinic staff to steal original letterheads to produce fake bills.

"In one case in the US last year, the medical facility that was put on the bill never even existed," said Matthew Smith, Executive Director of the Coalition Against Insurance Fraud. "Another increasingly prevalent area is upcoding, where the time for a procedure or treatment is unnecessarily increased and, with it, the fee charged too."

Dan Kaine, Senior Partner, Risk and Crisis Advisory at Inherent Risks, said that the majority of fraud and overbilling is being driven by certain assistance providers and some insurers who seem oblivious to it. Because of agreements with cost containment providers, medical facilities will therefore overbill patients, he said.

"Those providers have agreements with insurers that they charge 20 per cent of the amount they save them," said Kaine. "Therefore, agreements are made between hospitals and assistance providers that bills are inflated, sometimes by as much as 50 per cent.

"The assistance provider 'negotiates' this amount down by, let's say, 40 per cent (and takes 20 per cent of that as their fee), and the hospital still gets to bill 10 per cent over what the bill should have been. Hospitals keep doing this because their bills keep getting paid. Insurers, meanwhile, are oblivious."

Tami Rockholt, owner of Rockholt & Associates, said: "All of a sudden a minor accident can end up in hundreds and thousands of dollars' worth of medical bills. Sometimes the patient is part of the fraud, but other times they are just a naive pawn in it all."

Reluctance to act

The problem is that many times insurers are reluctant to take fraud cases to the relevant authorities. That's because the cost of investigating and prosecuting the offender is often greater than paying the claim, particularly for travel insurance, where the premiums and margins are low.

"The process of investigating a case can be long and protracted, especially when the insurer does not have a reliable partner to do the groundwork on its behalf," said the spokesperson for AMREF Flying Doctors. "In some instances, the insurer may not want to be involved in a public spectacle involving a fight with the client.

"For the majority, declining to pay a fraudulent claim is adequate. Pursuing legal action in a foreign country is cumbersome and costly. The insurer would most likely have to engage legal expertise or support locally.

"The medical fraud attempts we see are not exorbitant, making the fraud less suspicious in the first place. So, finding an amicable solution with the claimant or even settling the case in the knowledge that it is fraudulent may be the simplest and cheapest solution for the insurance company.

"Pursuing it legally may become more expensive than paying the fraudulent bill, with the added risk that the fraud cannot be sufficiently proven in court."

Then there is the issue of trying to pursue fraud that occurred in a different jurisdiction. That just adds to the complexity and resources needed and time taken to properly investigate and resolve the matter.

"There are many barriers in travel cases that make these cases particularly complex to prosecute," said Eure. "For example, where did the fraud occur? Did the fraud occur in the place where the insured lives or in a foreign country during their travel?

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"Local authorities and Departments of Insurance in the US don't have jurisdiction over international fraud. Even if, for example, all travel takes place in the US, it probably crosses multiple jurisdictions, or even multiple states."

Another issue is that even if the insurer takes the case to the relevant authority, often they themselves are too under-resourced or busy to properly investigate and prosecute it.

Collinson has checks in place to monitor for duplicate claims for the same incident. Where fraud is proven, it will write to the claimant to let them know the claim has been declined and their policy has been voided, and that it may inform the police or relevant authority about it. And if the crime meets the Insurance Fraud Enforcement Department's (IFED) criteria, it will refer it.

Collinson works with the City of London Police's IFED to investigate suspicious claims from UK residents. Each referral to IFED is assessed against a scoring matrix, which provides an overall score to determine if it is accepted or not.

For perpetrators living outside the UK, Collinson liaises with that country's law enforcement agency to determine if a criminal prosecution can be pursued. In such cases, it has to understand and adapt to how that particular authority works.

Raising awareness and training

But prevention is often better than the cure. By raising greater awareness, insurers can stop fraud happening in the first place, which requires upfront investment in detection tools and personnel.

Internally, Collinson makes sure that its claims team has the tools needed to detect and report suspected fraudulent claims. That includes fraud awareness training and knowledge of the technology it has in place.

"Tackling fraud is extremely difficult, let alone investigating evidence, so it's fair to say that it's also about awareness and disruption rather than prosecutions alone," said Cliffe. "Insurers need to invest in experienced counter-fraud experts as well as develop and invest in fraud detection tools, therefore striking a balance between human and artificial intelligence skills.

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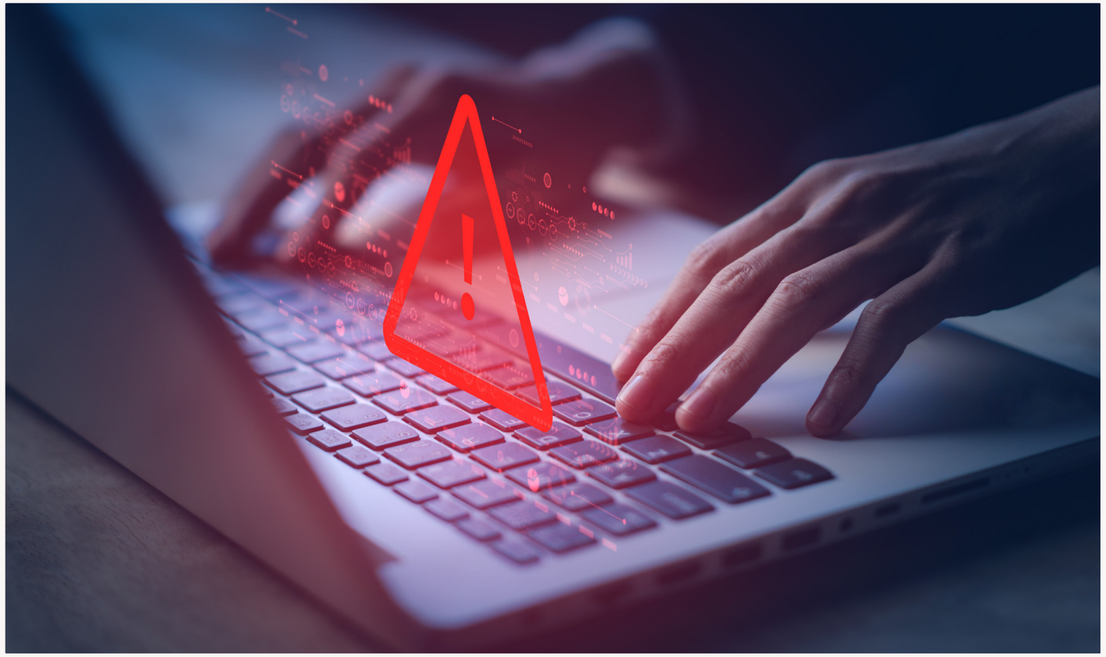
Allianz Partners USA uses a fraud prevention training programme to enable its employees to identify red flags and indicators of fraud to look out for. It is also being assisted by technology in this respect.

Eure said: "Our focus is on protecting our policyholders, investing fraud cases thoroughly and referring the fraud we find to the appropriate authorities to pursue prosecution. When we deny fraudulent claims or investigate and negotiate inflated bills, we are protecting our policyholders from higher premiums.

"Investigating thoroughly means that we can pass on good referrals for cases to the appropriate authorities and assist better in their prosecutions." »



AXA Health also invests in and uses systems-driven data detection and analysis throughout the claims process to identify suspicious billing and enable it to make recoveries. But the company's biggest focus is on working with the relevant authorities to tackle the problem.

"AXA Health does refer to the relevant authorities and takes appropriate and proportionate action, particularly when there is concern about patient safety," said Pallavi Bradshaw, Deputy Chief Medical Officer at AXA Health. "We also take appropriate legal action where this is warranted.

"In addition, we have fostered greater links with IFED and the General Medical Council to better understand our business activity and audit and investigation approaches.

"Alongside this, we have focused in recent years on improving our relationships with governance teams at hospitals and clinics, as well as professional bodies and medical regulators, to foster a more open means for information-sharing with a particular focus on patient safety, in order to improve joint learnings. AXA Health launched a patient safety forum, which encourages cross-industry learning from clinical incidents, with senior health leaders committing to fostering open safety cultures to reduce avoidable patient harm."

Chris Carnicelli, CEO of Generali Global Assistance, said: "When it comes to fraudulent claims, it's in our interest to be in communication with our competitors. Working with other travel insurers helps us identify repeat offenders and patterns of behaviour.

"Internally, our staff participate in annual fraud training programmes, so we can learn from past instances and know what to look for in order to best prevent and reduce fraud moving forward."

AMREF asks the medical facility concerned to provide verifiable medical reports, price lists and invoices. In Kenya, it will send one of its staff or a private investigator to the hospital to look into the case, while outside of the country it uses investigators, who will then draft a report with their findings, which is shared with the respective assistance partner.

For its part, IFED has been increasing its engagement with insurers through webinars and newsletters. The Travel Insurance Claims Committee and the Insurance Fraud Investigators Group also enable information and intelligence to be readily shared to combat the problem.

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The Association of British Insurers has also been proactive in fighting fraud, running a 'Sun, Sea & Scam' campaign before the summer of 2022, recommending that travellers check that their travel insurance meets their requirements before leaving, including the clauses relating to fraud. Within this, it provided examples of fraudulent travel claims, such as a person claiming they were sick after eating in a hotel's restaurant.

There are steps that insurers can take to expedite the investigation process too. These include being more organised and thorough in filing and storing their claim documentation before presenting it to the relevant authority, to ensure that they have a cast-iron case.

As an industry, there also needs to be better data sharing among insurers and the relevant authorities. Additionally, greater cooperation is required between different jurisdictions when a fraud is perpetrated in a different place from where the claimant lives. ■