



May 14, 2010

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From: Louis Saccoccio
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Re: PPACA Medical Loss Ratio Provisions

As the only national organization focused exclusively on the fight against health care fraud, the National Health Care Anti-Fraud Association (NHCAA) respectfully submits the following comments for consideration as the NAIC develops medical loss ratio (MLR) definitions and standards under the Patient Protection and Affordable Care Act (PPACA). Specifically, NHCAA offers its insight on the nature of health care fraud in today's health care system.

Protecting the public from health care fraud has been NHCAA's sole focus since its inception in 1985. This year marks twenty-five years of the private-public partnership that is the foundation of NHCAA. Our members comprise the fraud investigation units of private health insurers and those public-sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. A list of our members is attached.

The importance and necessity of combating fraud in the health care system was a frequently heralded theme throughout the health care reform debate over the past year. Our experience has taught us that while fighting fraud is most often described in economic terms, the most significant impact is felt in human terms. Health care fraud often causes patient harm, sometimes with devastating results. Undoubtedly, efforts to eradicate this insidious problem do have a direct correlation to health care quality and the quality of life of all Americans.

The following are several examples that illustrate how health care fraud fighting efforts impact health care quality:

- **Anti-fraud efforts identify and prevent unnecessary and potentially harmful medical care and procedures.**
 - Shockingly, the perpetrators of some types of health care fraud schemes deliberately and callously place trusting patients at significant risk of injury or even death. While distressing to imagine, there are cases where patients have been subjected to unnecessary or dangerous medical procedures simply because of greed. Patients may also unknowingly receive unapproved or experimental procedures or devices.

- **Anti-fraud efforts protect, maintain and ensure the accuracy of patient medical records.**
 - Perpetrators of fraud exploit patients by entering into their medical records false diagnoses (medical conditions they do not have), or of more severe conditions than they actually do have. Unless and until this discovery is made (often when circumstances are particularly challenging for a patient), these phony or inflated diagnoses become part of the patient's documented medical history. With the advent of electronic medical records, ensuring accuracy has become even more important and challenging.

- **Anti-fraud efforts identify systemic patterns where necessary care is billed, but not received by the patient.**
 - This fraud scheme can happen in any situation but it is particularly prevalent among our nation's vulnerable, senior population. The withholding of medically necessary care can lead not only to patient harm, but death. NHCAA is familiar with a case where a chain of nursing homes withheld basic quality of care items from patients while billing Medicaid for items and services never provided.

- **Anti-fraud efforts identify dangerous prescription drug abuse by patients and overprescribing by some physicians.**
 - Prescription drug abuse is a growing problem. Addicts will go "doctor shopping" in order to get multiple prescriptions from several physicians and will then fill them at different pharmacies. Often, it's the insurer that is best able to connect the dots and identify potentially fatal overprescribing by physicians and the resulting prescription drug abuse by patients.

- **Anti-fraud efforts identify pharmacy fraud.**
 - When a patient fills a needed prescription but receives a drug that is diluted, a lesser amount than prescribed, or altogether false it can most certainly affect the health of the patient. NHCAA is familiar with a tragic case where a pharmacy diluted chemotherapy drugs destined for very ill cancer patients.

- **Anti-fraud efforts identify and prevent medical identity theft.**
 - Using a person's name or other identifying information without that person's knowledge or consent to obtain medical services, or to submit false insurance claims for payment, constitutes medical identity theft. It can result in erroneous information being added to a person's medical record or the creation of a fictitious medical record in the victim's name. Victims of medical identity theft may receive the wrong (and potentially harmful) medical treatment, find that their health insurance benefits have been exhausted, and could become uninsurable for life insurance coverage and impact their ability to obtain employment. Untangling the web of deceit spun by perpetrators of medical identity theft can be a grueling and stressful endeavor and the effects of this crime can plague a victim's medical and financial status for years to come.

- **Anti-fraud efforts identify unqualified or unlicensed providers of medical care.**
 - Being treated by a provider who is unqualified or unlicensed is a dangerous proposition with potentially serious results.

While health care fraud is a complex issue that can manifest in myriad ways, the examples above demonstrate how anti-fraud activities improve and ensure health care quality.

Preserving patient safety is at the core of what NHCAA members do and our members invest heavily in the resources necessary to wage an effective battle against health care fraud. Human capital in the form of fraud

investigators, analysts, medical advisors and other anti-fraud professionals is essential, of course. In addition, advances in technology over the last several decades have revolutionized the way we fight health care fraud and NHCAA members have been quick to embrace these innovations.

Unfortunately, criminals have a habit of being innovative too, inventing new methods or perfecting old ones to advance their own nefarious dealings with increasing regularity. The determination of fraudsters to perpetrate their crimes coupled with an utter disregard for patient safety demands that serious investments in anti-fraud efforts continue.

Health care consumers expect insurers, and the regulatory agencies that oversee them, to enlist the best tools available to fight health care fraud to protect not only their premium dollars, but also their well-being. Simply put, an investment in fighting health care fraud is an investment in patient safety, and hence an investment in quality.

Beneficiaries in state and federal programs also benefit from the investments private insurers make in anti-fraud efforts. Often insurers identify fraudulent schemes that threaten their private subscribers and report these schemes to law enforcement where it is discovered that beneficiaries in public programs also have been similarly victimized. As a facilitator of information sharing between the private and public sectors, NHCAA has seen this situation play out countless times.

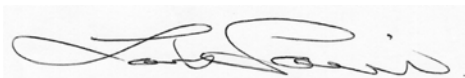
While the NAIC considers what constitutes “activities that improve health care quality,” we encourage you to review a 2004 report authored by the U.S. Department of Health and Human Services, Office of Inspector General titled “Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors” (available at <http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf>).

Section IV, beginning on page 7, third column, examines health care fraud from a quality perspective. The report identifies “[t]he predominant criminal and civil fraud theories” as “medically unnecessary services and “failure of care,”” and explains that, “When medically unnecessary services are provided, the patient is unnecessarily exposed to risks of a medical procedure[.]” The report goes on to provide examples of criminal and civil court cases involving providers that failed to properly investigate medically unnecessary procedures.

Regarding the second fraud theory, “failure of care,” the report again provides examples, including one where a rehabilitation center “entered into a \$1.9 million civil False Claims Act settlement to resolve allegations that it provided worthless services to patients, resulting from systemic understaffing at the facility, where deficient services and abuse caused six patient deaths.” Stories of how health care fraud have resulted in patient harm are not only sobering but sadly easy to find. Clearly health care fraud does have an adverse impact on patient safety and health care quality.

Thank you for allowing NHCAA the opportunity to comment on the development of definitions for medical loss ratio under the Patient Protection and Affordable Care Act (PPACA). If we can be of additional assistance, please let us know.

Sincerely,



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