

Did I Produce a Catastrophic Claim or Am I a Victim of Fraud?

By Michael L. Frank

It was a sunny day on December 11, 2015 when I woke up ready for a partial hip replacement. By the end of the day, I was a catastrophic claimant... or maybe a victim of fraud. You'll be the judge. The surgery lasted less than two hours and required a one night hospital stay. In summary, I was in the hospital for less than 24 hours after the surgery. The hospital bill came to about \$140,000.

The health insurance and reinsurance industries have seen a significant increase in catastrophic claims as well as overall health insurance costs. Is healthcare fraud a driver of this trend? Well, I believe fraud accounts for one-fourth to one-third of total costs. I challenge you to take the quiz below and come to your own conclusions. When you do, if your reaction is similar to mine—read on—I urge you to share your views with politicians and regulators, to encourage them to take meaningful action against healthcare fraud, which arguably is the main driver of high medical costs and insurance premiums in the United States.

Question #1: Are you surprised by this bill?

If you answered “yes,” then you might wonder, why was the bill so high? The answer is simple. I was charged for items not provided. The list is long but here are a few examples:

- J I received one implantable device manufactured by Smith & Nephew but the hospital billed me for eleven. The hospital confirmed that this was not a clerical error.
- J I was billed for multiple physical therapy visits, which were billed at excessive rates, but had none. Had my surgery not been delayed more than five hours due to an overcrowded emergency room (a common event in this hospital, I was told), then I would have had the first day's physical therapy post-surgery. The problem was that I did not get into my hospital room until very late in the evening, so the physical therapy did not take place the day of the surgery. It didn't take place the next day (Saturday) since the physical therapists were not on duty on the weekend.
- J I was charged for someone else's durable medical equipment. The patient was a woman. I guess the hospital violated the other patient's HIPAA (Health Insurance Portability and Accountability Act of 1996) rights but maybe that patient doesn't mind since someone else was asked to pay her bill.

If your answer is “no” then you have probably become jaded by the industry when you hear stories about hospitals and healthcare providers, including this one, and you believe that these are standard billing practices. The reader of this article will come to learn that a significant amount of fraud occurs with in-network providers and the insurance industry has lagged behind, and in some cases, been an enabler of these actions.

Question #2: How much does an implantable device cost?

The cost of the device to the hospital is approximately \$1,500. This estimate was validated by the manufacturer and the hospital. The hospital charged \$70,456.48 for it and stated that this is their standard billing practice. This

is 47 times the amount of the cost to the hospital, and this claim was paid as an in-network benefit. R&C must stand for either “Reasonable and Customary” or “Ridiculous and Criminal.” You decide.

Question #3: Why would the insurance company pay this claim?

My insurance policy, a small group, fully-insured product, contains a patient bill of rights that allows for two appeals. The insurance company states that the claim was valid, even though they later confirmed with me after I discovered the facts that it was fraudulent. A little puzzling, but not without its positive aspects since this decision increased my chances of getting into the Guinness Book of World Records as the man with “eleven” hips. I thought about applying for Guinness, but I figured that after reviewing the surgical report Guinness would find out I only had one hip surgery. Besides, common sense tells everybody that no one can have more than two hips.

I spoke to the insurance company after the second appeal and asked why they were willing to pay so much for an item that costs only \$1,500? The response was: “how do you know the costs?” I replied that the manufacturer disclosed the cost which I validated with the hospital. The insurance company, instead of thanking me for alerting it about an abuse and giving it a chance to investigate and reopen/correct the claim, wondered why I had called the manufacturer. My response was that I wanted to know the cost because \$70,000 seemed excessive. In turn, I posed the following questions to the customer service department:

-) Why didn’t the insurance company research the costs of the device and procedure? No response was given.
-) Why wouldn’t the insurance company go back to the hospital and demand a corrected bill? The response was that the hospital bill passed the insurance company appeal process, which was two levels of review.
-) Can I review the sections of the provider contract that are relevant to my claim, given the fact that there are errors and the Explanation of Benefits (EOB) does not provide details? The response was that nothing could be done other than contacting the local insurance department.

An important question I did not ask is why the insurance company’s claims adjudication system did not reject a claim with astronomical utilization?

After almost a year of back and forth, the insurance company acknowledged that it paid for “eleven” implantable devices instead of one. The hospital’s collection agent validated this finding as well as the hospital’s own staff. Despite my numerous requests, the insurance company still will not provide any supporting documentation on why these claims were deemed valid.

Consumers should wonder whether the insurance company paid the claim (clearly, they cut a check to the provider for payment) or consumers did? Arguably, consumers paid it since they are held responsible for care not provided, and any resulting premium rate increases because of excessively paid bills. Unfortunately, my claim is one of many, which means that consumers across the country subsidize fraud through unnecessarily higher premium rates.

Should the insurance company, once it is aware of fraud, do the following:

-) Require the healthcare provider to correct its bill?

- J Offset payments to the healthcare provider against these fraudulent dollars amounts?
- J Cancel the providers contract for fraud so that it is no longer an in-network provider, so that future members of the insurance company are less likely to go to this provider?
- J Have better checks and balances in its claims system to edit and pend future claims for fraud?

Understandably, hospitals and insurance plans partner with the intention of offering a competitive product. But fraud should not be allowed to be part of the arrangement. Some regulators have shared with me that some hospital executives and some insurance company executives have hidden compensation arrangements such as kick-backs based on volume, which may be a reason why insurance companies are taking a “blind eye” or “deaf ear” to consumer complaints of fraud. Unfortunately, with healthcare fraud, consumers are the ultimate losers. Maybe the insurance company prefers to leave “sleeping dogs lying” than contesting the claim.

At the time of this writing, the questions I asked have not been answered satisfactorily or at all by the hospital that committed fraud against me, or the insurance company that helped enable it. I hope the insurance department’s fraud unit and the state attorney general will have better luck in getting answers than I did.

Question #4: Did you get an estimate of the cost for your surgery?

Prior to the surgery, I approached the insurance company for an estimate of the cost of the procedure; the insurance rep told me to ask the question to the provider but the provider referred me back to the insurance company. This reminds me of the Abbott and Costello skit “Who’s on First?” Transparency and accountability is clearly a serious problem in the insurance industry. The irony is that this is an in-network claim so transparency should be greater rather than non-existent.

Question #5: Which of the following practices do you think constitute fraud?

Hint: You may think, as many do, that billing for services not rendered is easy to detect and combat. If so, think again because the situation is more complex.

- a. Upcoding Office Visits – When is the last time you went to a doctor’s office and got a bill for a visit with a 99212 CPT code? A CPT (Current Procedural Terminology) code is a 5-digit code that explains your medical services by healthcare providers. The 99212 code is a common code for a regular office visit. However, many providers, especially in-network providers, choose to bill at more expensive codes since they expect the insurance company to pay most of the cost. Since I have a high deductible plan and out-of-network costs for office visits are less expensive with certain providers, I often choose to go out-of-network. However, shouldn’t in-network services be more affordable? Well, in a perfect world fee schedules would be compared like apples-to-apples. However, if your in-network healthcare provider upcodes procedures to higher CPT codes (e.g., CPT code 99214 or greater), then you are better off going out-of-network, since these higher codes result in higher fees to the doctors. In my case, the out-of-network provider bills for a lower severity procedure code (e.g., CPT code 99212) which, after the dust is settled, is less expensive. If you have time, I recommend you review your medical bills to see whether the CPT codes have changed over time. The healthcare provider’s coding practices certainly have. And this trend has been amplified by billing companies hired by providers to maximize income through upcoding. The doctor’s office (and the billing company) tell me that this is the standard practice. The

billing company as part of their standard practice can tell you the dollar thresholds that each individual insurance company uses for reviewing claims so they know the required level to stay below to stay under the “radar scope.” Do you believe this constitutes fraud?

- b. Specialty Visit – Upcoding is more prevalent with specialists. My ENT (Ears, Nose, and Throat) provider is a good example. At an ENT office, a certain diagnostic procedure is completed in about one minute and requires no anesthesia or cutting. This procedure involves putting a rubber hose in your nose and it has a camera at the end of it. It used to be billed as one diagnostic procedure but now it is billed as two more expensive surgical procedures (i.e., throat and sinus surgery). The cost can be as high as \$1,000, four to seven times what it used to be. Should this routine one-minute procedure cost close to this much? You might need a tissue after the diagnostic procedure since it might make your eyes tear. If the procedure does not, then the medical bill will. Do you believe upcoding is fraud?
- c. Excessive Billing for Lab – Most Americans have had some level of blood work in their lives and experienced receiving a bill from a third-party laboratory for blood work with billed charges of more than \$1,000 (I have experienced over \$2,000) and the lab receives a payment of less than \$50, and deems that payment acceptable. Is \$2,000 a reasonable charge when the insurance company’s payment of \$50 (or less) is more than acceptable to the laboratory or healthcare provider?
- d. Changing Billing Practices to Add More Procedure Codes to a Bill – An individual goes for a routine stress test (e.g., diagnostic heart procedure), and the bill now shows an additional office visit on the itemized bill on top of the stress test. This has been a common practice with billing companies and physician practice management companies for all types of specialties. In some cases, the physician is not even present (not even in the building). In other cases, a physician assistant is now being billed as the physician. Similarly, my ENT example of two questionably surgical procedures above included an extra office visit from the physician on top of the two surgical procedures plus an additional procedure for looking into my ear with a light, which was billed as a third procedure. From start to finish of seeing the doctor, the costs are well in excess of \$1,000, or more than \$250 per minute for a four-minute office visit. Is this fraud?
- e. Billing Out of Multiple Locations – Often insurers or any business outsource the administrative and billing functions to firms that are domiciled in low cost areas. But in the healthcare industry, many billing companies are in high-cost cities, which is odd especially when care is delivered in the suburbs or rural areas. Since many providers are paid based on a Medicare RBRVS (Resource-Based Relative Value Scale) fee schedule, or a percentage of it, it follows that bills generated in high cost areas are correspondingly expensive. (RBRVS is a common fee schedule used in the Medicare, Medicaid and Commercial HMO markets for reimbursing physicians.) To maximize revenue, healthcare providers will bill in high cost locations, not where the service was rendered, to receive a higher fee schedule under RBRVS (they are paid on a higher cost regional rate than the location where the service was physically provided). Can there be any other reason to explain why the major healthcare providers perform their administrative and billing functions out of New York City and Boston instead of low cost areas? Do you consider this fraud?
- f. Implantable Devices – Anyone with an implant (e.g., hip replacement, knee replacement, shoulder replacement, pace maker implant, etc.) should consider looking at his/her bill to see if you can figure out

what was paid. Since EOBs seldom disclose the number of devices (or units) implanted, how can we know how much the hospital billed per device, how much the insurance company paid per device, and how many implants were performed? The collection agency shared a report from the insurance company showing the number of units on it, which was how I determined that I was billed for eleven implantable devices. If the insurance company can give this level of reporting to healthcare providers and its billing companies, then it should similarly do the same thing for its covered members. Insurance companies and regulators can easily audit billed charges with this level of transparency, and when they do so common sense should prevail. One would think that my case constitutes a simple audit, or does it?

If you are a consultant or work for an insurance company, you learn a lot by auditing paid hospital claims for implantable devices. I suspect that you would find that the billing practices of certain providers are systematically fraudulent. The hospital that over-charged me clearly admitted this.

If you have been using the same physician for years and learned that your doctor joined a larger physician practice, such as an independent practice association (IPA), or an accountable care organization (ACO), then it would be interesting for you to review the bills before and after. You will probably see a variety of changes, such as outlined above.

Unfortunately, this defenseless crime does not stop when you die, since your estate may receive bills, including false ones, once you pass away. I personally experienced this with a parent, aunt, grandparent, etc. Unfortunately, excessive, and fraudulent bills upon an individual's death is commonplace.

Question #6: Can providers and the companies that providers hire to handle their billing be prosecuted under the Racketeer Influenced and Corrupt Organizations (RICO) Act if fraud is involved? Is there interest in information from "whistle blowers" or is the preference to turn a blind eye or deaf ear to certain situations?

We traditionally think of RICO as applicable to organized crime and the mafia, but fraudulent billing on a large scale may qualify as RICO. For practical purposes, the decision is up to regulators and legislators. At the time of this writing, both are reviewing my case.

Similarly, one wonders whether there is a place for "whistle blowing" in situations like this—the disclosure by a person, usually an employee in a government agency or private enterprise, to the public or to those in authority, of mismanagement, corruption, illegality, or some other wrongdoing.

Some regulators would hold the insurance company responsible (why did it pay a fraudulent claim and why did it not act to correct the "error?"); others would focus on the providers (why did they bill for services that even they acknowledge were not delivered?). Personally, I believe that regulators should focus on the latter, i.e., the healthcare provider, since they are the source of the problem. In an ironic twist, the hospital that admitted to fraudulently billing me, sued me for refusing to pay my insurance policy's out-of-pocket costs towards the imaginary implantable devices and services not rendered. How many consumers lost their retirement savings or gone bankrupt due to excessive and fraudulent billing?

Is this a situation that should be addressed by the states or the federal government? The answer is not as straightforward as it might seem at first sight. Unfortunately, those committing fraud are one step ahead of those preventing fraud. However, fraud is a crime and should be punished as a crime. Could we learn something from the movie "The Firm," where the criminals were arrested by the feds for committing mail fraud? Maybe, since in

my case the fraudulent bills crossed state lines—the hospital’s billing office is one state, and I live in another state. The federal government regulates mail while the states regulate insurance.

As I write I am trying to be as clear as possible despite the complexities of the healthcare industry and related regulations. I must confess that despite my 30 years of actuarial experience, it took me more than a year to connect the dots. But once connected I could not help but wonder whether we will see more healthcare providers and executives going to prison for acting fraudulently.

Question #7: Why does the hospital need two collection agencies in my case?

This is a question that only the hospital can answer but I presume that the following reasons may apply:

- J The first collection agency shared with me a report that shows the number of units billed. I hadn’t seen it and neither had the surgeon. Both of us examined it line by line. The document provided clear evidence of fraud—the hospital billed for an implantable device eleven times. The surgeon and I also identified other fraudulent items by reviewing this specific report. Could it be that the collection agent was terminated for sharing this document with me?
- J Could the collection agency have determined that the bill was incorrect and, on moral grounds, resigned? The second collection agency received the same document but did not hesitate to try to collect the payment using unethical means, some of which are described further in this article.
- J Maybe the first collection agent determined that the invoice would not be paid if the dispute went to court.
- J Maybe the hospital runs its collections department like a baseball pitching staff, with one collection agency doing the warm up and the other finishing off the individual (defenseless consumer) in the court systems. A strategy to wear down a defenseless appointment through use of multiple collection agencies and deception. In my case, the first collection agent was not concerned with the legitimacy of the claim but instead with whether I was interested in applying for charitable care. Is it possible that once the hospital found out I had decided not to pass the debt to a charitable pool, it brought in the second agency to litigate and apply for “default judgement”?

An unfortunate lesson in this process is that healthcare providers hire collection agencies and attorneys to harass you to the point where you are too tired to fight and just give up.

Question #8: Why are healthcare costs so high?

There are many reasons. One is that the effects of medical inflation, which is always greater than the consumer price index, have compounded over time to alarming levels. Another is utilization increases, but here we must wonder how much is truly utilization and how much is the result of fraud due to overbilling, upcoding, code creep, etc.

Please note that it is not my objective to throw the healthcare provider community “under the bus” since there are many honest providers. However, there are more than just a few bad apples, so much so that when I relate my experience to others I frequently find out that my case is far from unique. Fraud will become more prevalent to the consumers as more consumers are migrating into high deductible plans. With high deductible plans, the

consumer pays the first level of health claims so will be more immediately subjected to fraud. However, the lack of transparency in the healthcare and insurance industry, will make fraud less detectible to the average consumer. They will believe they are grossly over-billed, but won't be able to detect why.

Health insurance reform should introduce more checks and balances to combat fraud, a criminal offense. Billing practices should be scrutinized. Consumers bear some responsibility because they seldom review the explanation of benefits (EOB) form. The EOBs need to be reformed as well since the utilization (frequency) data is excluded for many critical areas. Why can a healthcare provider, billing company and collection agency have access to more detailed and more transparent reporting than the consumer?

Insurance companies and claims administrators are more focused on Electronic Data Interchange (EDI) and what percentage of claims are paid without any human intervention as well as the speed by which a claim is paid. The higher these percentages results in less claims physically reviewed by trained claims personnel. The claims department used to be the checks and balances of the healthcare provider billing. Is it possible that insurance companies are cutting too much in administrative expenses around claims management (employee headcounts) to stay within target loss ratios and administrative budgets for regulatory and bottom-line purposes, and the resulting outcome is that fewer individuals are reviewing and appropriately adjudicating (processing) health insurance claims? Prior healthcare reform focused on cutting administrative costs of insurance companies and the result was the cutting of staff responsible for checks and balances of provider billing. New reform needs to target provider billing and healthcare fraud, while bringing back more checks and balances to the claims process.

My experiences with fraud has made me re-think some common issues of our current health insurance economy. As an example:

- J When we are concerned about access to healthcare for the uninsured, is it truly access to care, or protection from excessive healthcare billing and fraud. Arguably having insurance coverage creates a certain level of insulation against fraud, so how exposed are these uninsured individuals against excessive billing on even routine claims if no insurance is in place?
- J When hospitals and physicians submit claims to the bad debt pool for uncollected healthcare fees and are only receiving roughly 10% of their outstanding balances. At first blush, this seems unfair to the healthcare providers, at least the ones that are not committing fraud. However, should the bad debt pool pay for the eleven implantable devices, services not provided (e.g., the rehabilitation never received), the \$2,000 lab bills that healthcare providers accept \$50 as paid in full by insurance companies, code creep, upcoding, etc.?
- J Common sense suggests that going to an in-network provider should be more cost effective than going out of network. In my personal experience, it has been more cost effective to go out-of-network rather than larger in-network healthcare providers such as IPAs or an ACO, since out-of-network providers tend to bill at a lower intensity rate and usually only bill for services provided. You also get an out-of-network bill at the door when you leave so any surprised billings can be immediately handled. The larger in-network providers say that they will bill your insurance company, and then you get surprised with a confusing and potentially excessive bill.

Unfortunately, fraud is always one step ahead of fraud prevention, but there are some immediate things that can be done to mitigate some of the fraud.

- J Most states have little regulation around healthcare billing fraud or excessive bills. Any regulations in place today are more for out-of-network providers and balance billing or “shock billing.” Most healthcare claims and healthcare fraud occurs with in-network providers, and the rules to protect the consumer, and ability to act against fraud are limited. I know that I was “shocked” to see what the hospital, which was in-network, billed me. Healthcare fraud is a crime so prosecute it as such, and this should include a focus on in-network providers as well as out-of-network providers. Regulators historically have left the challenges of fraud for in-network providers to the insurance companies, but unfortunately this is not working. If you are a victim of a crime, then you should know who to contact and there should be few obstacles to doing so (today there are many obstacles, which are outlined in this article).
- J If an insurance company wants to be passive about fraud, or in my case, be an enabler of it, then should the insurance regulators permit the insurance company to file for premium rate increases that include fraudulent claims in it? Better yet, should audits be done to investigate fraud and if found, then require the insurance companies to act or be forced to remediate (forced premium rate reductions)? It would force the insurance company to act against the healthcare provider for an obvious fraud, either reversing the bill, and even better yet, removing the provider from its network. Removing the provider from the insurance company’s network might reduce the number of times that provider commits fraud to the insurance company’s members. Imagine having a narrow network of providers that do not commit fraud, and the impact on healthcare spending.
- J More reform is needed around transparency so that we know before a medical procedure, especially those procedures that are scheduled in advance, that appropriate estimates are provided. It will mitigate some of the fraud, since an estimate showing eleven implantable devices will stand out. A \$1,500 ENT visit for 4 minutes will stand out. A \$2,000 lab will stand out. Reform is not perfect, since we have significant requirements around privacy of information (e.g., HIPAA), but if your HIPAA rights were violated like mine were, then who do you contact? The insurance company will send you to the insurance department, who will send you to the state attorney general, who in turn sends you to the federal government. If we contemplate laws around fraud and transparency, then let’s make the venue to report it transparent, and easy to report to the proper authorities.
- J The health insurance industry has been using debit card technology for more than twenty years. When you go to the doctor’s office, you can use the debit card for logging when an office visit starts and when it ends. This way, the right duration and CPT code is used. It will capture the appropriate location of the care and who provided it (e.g., physician vs. physician assistant vs. technician). The consumer will not be billed for time in a waiting room. Consumers need to have “skin” in the game as well so there should be penalties for not complying at the consumer level
- J Common sense reviews are needed.
- o Again, how does eleven implantable devices get paid? Should a human being review the claim before it gets paid?
 - o How about a short questionnaire being sent to a patient that asks them questions around whether certain services (e.g., rehabilitation, other services) were performed as billed? Confirmation questions should be asked about the dates of procedures including discharge dates, as well as the location of procedures. Did you see a doctor or a physician assistant? Were you given a cost estimate and what was it (not just the \$20 copay but the full cost to all parties)?

Historically, our government has given grants to healthcare providers to become ACOs and has helped finance large healthcare providers in their acquisitions of healthcare providers. This gets financed by the consumer through higher taxes as well as higher insurance premium rates, since those larger providers now bill at higher bill rates (e.g., higher percentage of a fee schedule) and more intensive bill rates. Some of those providers have committed fraud. Since we need more checks and balances on provider billing fraud, then maybe creating healthcare grants to aggressively go after billing fraud and creating better transparency would be an interesting start. The industry has significant technology in place to mitigate fraud, which would be a great start even if you can't eliminate it. The industry needs to spend more on checks and balances, and government grants should be focused in that area, if the government wants to spend additional costs on healthcare.

Although this article illustrates some extreme examples, many other examples are every day procedures. This year, for example, a member of my family had a routine colonoscopy. A few years ago, this cost was under \$1,000 (combined insurance company and member cost), and now it is significantly above \$2,000 and approaching \$3,000. The actual bill received this month for a routine procedure was \$5,218 (billed charges) and after insurance company discounts was \$2,630. The cost went up close to 300% in three years, and in this case, bills came from four different providers (and counting). Further, both procedures were 100% the member's cost, i.e., my family's cost, due to the member having a high deductible, so these costs are all "apples-to-apples." The insurance company discount was 49.6% (almost 50%), which on the surface sounds great, but clearly discount rates have become less meaningful since the billed charges don't appear to have a rational basis to them. In just a few years, the cost increases for routine colonoscopies have gone up significantly (2.5 times). A 50% discount on costs that increased more than 2.5 times over three years has little meaning or value to the member. Unfortunately, industry experts now believe that reported discounts off bill charges (or percentage savings) is a meaningless statistic. My example above highlights this.

By the way, the cost estimate provided by the provider for this procedure was less than \$900, and yet the provider (or in this case a series of providers) billed for \$2,630. Is this the true cost of the service or just a situation whereby a provider assumes the member has insurance and someone else is paying the full tab for services. In my case, 100% of this cost is mine, but in other cases, 100% of the cost might be a combination of the member and the insurer. If the insurer pays, then the collective pool of members pays the next year through higher premiums.

The industry currently has few checks and balances so there is nothing to stop excessive billing and inflation of bills.

Question #9: What can the consumer do if he/she receives an erroneous or fraudulent bill?

Here are some general ideas and strategies to consider:

- J Confirm that the charges were adjudicated by the insurance company and examine the EOB before paying. If you overpay, you may end up not recovering what is not your responsibility. The insurance company's review is not going to catch all billing issues (e.g., this article), but it will catch some. If the consumer overpays a healthcare provider, the likelihood of getting a refund is minimal. How many people do you know got a refund check from a healthcare provider due to an overpayment?
- J If you receive a questionable bill, call the provider for an explanation instead of the billing company. The provider may not be aware of how the billing company processes claims and in some cases such practices

may surprise your healthcare provider. It is very common for billing companies to change the codes (e.g., upcode) that your physician has put in the system to a more expensive billing code to maximize payments from the insurance companies and the consumer.

- J Ask the provider for claim details such as average cost and number of units billed. The latter is a frequent source of fraud, often concealed with the lack of detail in EOBs. Even if your insurance company will not give this to you (mine didn't), the healthcare provider will get this report from the insurance company. This highlights a strong need for new regulations around transparency and disclosure, in clear language, of the number of units billed, so that the consumer is more on the same playing field as the providers, or at least has a remote chance to defend himself or herself.
- J If you intend to contest a bill, do so in writing and save a copy of the documentation. Be aware that the provider will immediately have the collection agencies deal with you. The agency will call you at all hours, especially weekends and holidays, and employ unethical means to force you to pay, such as taking legal action against you without notifying you about it. In my case, I am being sued by a hospital but never was properly served a summons. I found out about the actions initiated by the collection agency when a law firm contacted me to ask whether I was interested in legal representation. Upon contacting www.NYCourts.gov for advice, its knowledgeable staff advised me to report the collection agency to the New York Attorney General for unethical practices. Some examples of unethical practices include not being properly served or not being served at all, misrepresenting material information in the hope of obtaining a default judgement, improper reporting of the case number, and violating standard rules of the court system.
- J If you are dealing with a network of providers, request a copy of the contract under which the bill was adjudicated. The contract is a three-party agreement that involves the provider, the insurer and you. You have the right to request it although your request will most likely be denied by the hospital and insurance company. However, you should request. In my case, the hospital billed me at more than 4600% above their cost for an implantable device. As a consumer, you have the right to know how your claim was paid and asking for reasonable documentation so that a layperson can determine the cost. This is acceptable in other industries, so why not healthcare.
- J If you participate in an employer-sponsored health plan, contact the benefits manager in the human resources department. The benefits manager will have access to the insurance company's account manager and can become an advocate for you. As an individual, it is hard to get face-to-face time with the insurance company and the customer service department can avoid resolving the issue. The benefits manager has a little more leverage since they can call the sales person and account manager, requiring proper review and resolution. Larger employers will have service guarantees and could terminate insurance company contracts based on these types of actions. A benefits manager, chief financial officer or president of an employer would not be happy to hear that material claims are being paid by its insurance company, or third party administrator (if self-funded), for claims like the ones highlighted in this article.
- J Your insurance policy has a patient bill of rights that describes the appeals process. If you suspect your bill is incorrect, ask for clarification. Be aware that the patient bill of rights and the description of the appeals process are usually at the end of the policy, and they may list a third-party advocacy group if you are not satisfied with the response. Healthcare providers will provide you a contact for a third party as

well, although those third parties are very questionable organizations in some cases, and not in the best interest of the consumer in many cases. You can contact those individuals, but if you think you are a victim of fraud, then you might want to pursue other avenues. Healthcare providers like the hospital that I am dealing with may not wait for your appeals process to be completed, and may be taking other actions (e.g., legal action) against you, so be prepared. If a healthcare provider is willing to commit consistent fraud against its patients, then how far will they go to enforce or cover up the fraud.

- J If you are not satisfied with the response given to you, you may want to contact the insurance department. You must organize your documentation and forward it to the insurance department in your state. If you feel that you are a victim of fraud, then make your complaint to the attention of the “fraud unit” of the insurance department. Unfortunately, filing a complaint is a long and cumbersome process in any state. Regulators need to streamline it. It is important to know that insurance departments release reports about the number of consumer complaints received and resolved, so some organizations will take these open complaints seriously. Regularly follow up with the regulators if you file a complaint so that you know that it does not get lost on a pile of other papers.
- J Contact your state attorney general. The insurance department deals with insurance companies while the attorney general deals with other parties including healthcare providers. Submit your files to both organizations. They must be well organized, easy to understand, include copies of the medical bills in question, EOBs, and any other relevant documents.

You will need to contact more than one regulator and consumer advocacy group because each of them deals with a specific area (insurance companies, providers, etc.) and operates with limited resources. Your goal is to find a champion for your cause. If you believe that fraud is a crime, then is it unreasonable to file a police report in your local community?

- J Engage a private attorney to deal with civil matters, which may lie outside the scope of the jurisdiction (authority) of insurance departments and your state attorney general. The private attorney can also determine whether there is a court case against you, which to my surprise there was.
- J Write to your congressman, insurance department and legislator. We need laws to increase transparency and to protect us from fraudulent billing, especially as more individuals are forced into high deductible plans. The number of victims of unscrupulous healthcare providers and billing companies is staggering and it includes uninsured individuals who, when they have no choice but to access the healthcare system, find themselves alone fighting a system designed to favor providers and insurers.
- J If you are a victim of a crime (healthcare fraud is a crime), then tell others about your experience. This could include friends and family, as well as reporting to advocacy groups and online websites. For example, visit a website such as www.Healthgrades.com and provide feedback on your experience with that healthcare provider. Sometimes the healthcare provider does not even know that this fraud is occurring (they are not always seeing the bills from the billing companies), so letting your healthcare provider and others know is the only way to get resolution.
- J Last, but not least, consider changing providers and tell them why. Consider notifying your insurance company that you are changing providers since you believe that you are a victim of fraudulent billing.

One individual complaint may not make a difference, but multiple complaints from multiple consumers may not go unnoticed.

Question #10: In regard to my hospital bill, what is next?

I recently learned from a soliciting attorney that the hospital is suing me for not paying a portion of the claims even though most of the bill is for services not rendered. I'll have to defend myself in court and as such have retained outside counsel to assist me in this matter. The healthcare system is extremely complicated and the legal system is equally complicated to me. The healthcare providers that commit the frauds count on the fact that the system is very complicated and use that to its advantage.

I share this story to alert regulators and government officials of dishonest practices that unfortunately are very common. Even with thirty years of experience as an actuary in the insurance industry, it took me a year to figure this out. The average consumer or better yet, 99% of consumers, would be helpless and defenseless in this matter. My hope is that healthcare reform introduces checks and balances to encourage transparency and punish fraud. I wonder how many people out there have been financially damaged because of unethical billing practices? I would bet millions. If the government wants to spend dollars to reduce healthcare costs, then consider spending it on fraud prevention initiatives, including funding advocacy groups that can help consumers on these matters. Also, spend money to prosecute fraud.

In President Trump's election campaign, he highlighted the needs of the forgotten man. This should carry to the healthcare consumers as well. To illustrate the need for regulation, consider the following points raised by the hospital's medical director in a letter addressed to me pertaining to their bills:

- J "...consistent with the hospital's methodology which takes into account costs, market rates..."
- J "All patients are advised that anticipated out of pocket expense is only an estimate and does not necessarily reflect a complete amount."
- J "Your patient responsibility of \$ <DOLLAR AMOUNT> represents your inpatient stay coinsurance in relation to the rate contracted for <INSURANCE COMPANY> to pay <HOSPITAL> and how benefits are applied."

Can the estimate be so inaccurate that instead of billing for one device at a cost of \$1,500 plus a reasonable margin the charge was for eleven of them (for one person at one given point in time) at a cost of \$70,456.48, or 47 times the cost to the hospital? Is it reasonable to hold the patient responsible for services not rendered? I asked for a copy of the contracted rates between the health insurer and the healthcare provider to verify if claims are appropriately processed; it was not provided. Should the consumer not be allowed to examine contracted amounts, especially if the consumer must pay a significant expense (e.g., deductible, coinsurance)? What about the transparency preached by the industry? I even asked for an estimate prior to surgery, and none was provided.

The consequence of the lawsuit that I must defend is that the insurance company will have to explain to the courts and to the public why fraudulent claims have been deemed valid and why they are used to justify rate increases, and in the process, why they are an "enabler" of fraud. On a personal note, the hospital forced me to spend time learning about the negatives that people experience in the legal system through unethical tactics, and caused me and my family many unpleasant moments through this process. Unfortunately, I am not alone in this matter. Each

time, I share my story with someone, they, in turn, share a similar story that has happened to them or a friend/family member. Clearly, this is a big problem and a country-wide issue.

Quoting the movie “Network” from 1976 (our country’s 200th anniversary), “I am mad as hell, and not going to take it anymore.” Fraud is a crime and the legislators and regulators need to help fight this crime.

Although this is only one of many cases, I hope my decision to fight fraud will make a difference for everybody. The reader can contribute to this cause by contacting local, state and federal agencies to let them know that fraud should be fought aggressively.

About the Author

Michael L. Frank, ASA, FCA, MAAA is President & Actuary of Aquarius Capital. He is also an adjunct professor of the actuarial department at Columbia University as well as an instructor of the Society of Actuaries’ LEARN program, designed for insurance regulators. He previously served as President of the Actuarial Society of Greater New York, and consults insurance companies, HMOs, employers, healthcare providers, municipalities, large corporations, and regulators in the insurance industry.

Michael can be contacted at Michael.Frank@AquariusCapital.com or (914) 933-0063. Please feel free to share your own personal stories with the author. More importantly, please share it with regulators and legislators. The committers of fraud are banking on your silence, so speak out.