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By

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Executive Summary

This report was prepared at the request of the Senate Insurance Committee, Senator Rosenthal, Chair. The objective of this report is to inform the committee and other policy makers about the different types of fraudulent activities that exist throughout the health care delivery system, both private and public. In particular, using information from various sources, it attempts to do the following:

- Provide a picture of the current structure of the health care market;
- Pinpoint the areas where the potential for fraud is the greatest; and
- Give an inventory of the major agencies involved in detecting, investigating, and prosecuting fraud and abuse.

Health care fraud has been on the front page of newspapers and magazines. According to the U.S. General Accounting Office (GAO), $1 of every $10 spent on public insurance programs is lost to fraud. Columbia/HCA Healthcare Corporation, owner of the largest chain of hospitals in the country, is under investigation for supposedly over-charging Medicare millions of dollars.

Although the media has brought the issue of health care fraud to the forefront, it often limits the discussion to public programs, ignoring fraudulent activities in the private sector, where the employer or the individual is the payor. Yet, the private sector accounts for the bulk of health care expenditures, 62 percent.

This report finds that the privately funded health care market operates mostly unchecked for fraud, especially the managed care side. The question for policy makers, then, is whether something should be done to protect this market from fraud. Not only does fraud affect costs, it affects the quality of care, particularly in managed care. Moreover, to the extent that fraud in the private side goes undetected or unaddressed, it may undermine the anti-fraud efforts in government-sponsored programs.

It is important to note that the majority of persons in the business of providing or receiving care are law abiding citizens. The aim of the report is therefore to bring focus to the estimated 2-4 percent of individuals involved in fraud.

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The Health Care Market in California

A person is more likely to cheat the system when one, there is money, and two, nobody is looking. Certain segments of the health care market happen to have a good dosage of both.

Health care is a huge industry in California and there are gigantic sums of money flowing through it. For instance, the revenues it earned in 1994, $116 billion[1], surpass the retail sales of 46 other states[2].

A person intending to defraud can also find the complexity of the health care market to their advantage. Behind the patient-doctor relationship exists a myriad of complex contractual and financial arrangements. A basic understanding of how the health care market functions is imperative to understanding the nature and types of fraud.

The objective of this section is to give the reader a basic understanding of the health care market. In this section we discuss both the market structure and the financial arrangements normally used between the players.

Below we provide a diagram that shows the category of players and where they generally operate within the market place. There are six different levels or categories of players.

Market Structure:

Layer 1: Original Purchasers

The first layer consists of the original purchasers of health care, of which there are three categories: employers, government, and individuals. If one assumes that private insurance is mostly employer paid, then employers in California pay about $43 billion for health care benefits or 37 percent of the total health care expenditures. The government (federal, state, and local) accounts for another 38 percent. Individuals account for the rest, 25 percent, through co-payments, premiums, and medical costs not covered by insurance[3].

1. Employer-Sponsored Insurance:

   In looking at employer-sponsored insurance, it helps to make the distinction between those employers that are "fully" insured and those that "self" insure. The difference is that the former passes the risk for medical care on to another party, while the latter remains at risk for those costs.

   - "Fully" insured employers are those that pay a monthly premium in exchange for medical insurance. When an employee becomes ill, the medical insurance, and not the employer, pays for the medical costs.
   - "Self" insured employers are employers or trade unions that set reserves aside and pay directly for the medical costs of their members. Very little is known about how

many employers are self-insured. Self-insured employers have to register with the U.S. Department of Labor and are exempt from many of the laws and regulations that govern health plans and disability insurers through ERISA (Employee Retirement Income Security Act).

2. Government as a Purchaser in Public Programs:

   The government plays a big role in purchasing medical insurance for three types of persons, the low income, the elderly, and the high risk. The two biggest public programs are Medi-Cal and Medicare.

   - Medi-Cal is a state and county administered program that is jointly funded by the state and the federal government. The program accounts for $16 billion or 14 percent of all health care expenditures in California. It purchases medical insurance for low income individuals and the medically needy.
   - Medicare is a federal program administered by the Health Care Financing Administration (HCFA). It accounts for $18 billion or 15 percent of all health care expenditures in California. Medicare is available to persons 65 years of age and older and certain disabled persons, regardless of income. Medicare Part A covers hospitalization, while Medicare Part B covers doctor bills.

3. Individuals as Purchasers:

   Individuals are the third biggest category of spenders. Following are three types of costs an individual can incur:

   - Premium Costs
   - Co-payments and Deductibles
   - Costs for medical services not covered by insurance

The California Healthcare Market

Layer 1:
Original Purchasers

1. Individuals
2. Employers
3. Government

$116 billion in purchases

Layer 2:
Purchasing Cooperatives

5 in California, representing 1.5 million persons or 5% of the population.

Layer 3:
Financial Intermediaries

117 Health Plans &
About 50 Disability Health Insurers

Layer 4:
Provider Organizations

1,800 + Provider Groups
6000 + Health Care Facilities

Layer 5:
Providers

Over 600,000 Licensed Providers
- 79,000 physicians
- 238,000 registered nurses

Layer 6:
Patients

32 million Californians
- 28% under 18
- 61% age 18 to 64
- 11% age 65 and over

Layer 2: Employer Purchasing Cooperatives

In the diagram above, purchasers, in particular employers, can opt to go through the second level of market activity, namely, a purchasing cooperative. These organizations negotiate the terms of the health care contract, such as premium and scope of benefits, on behalf of their client. There are five purchasing cooperatives in California. These are:

- The California Public Employees Retirement System (CalPERS),
- The Pacific Business Group on Health (PBGH),
- The Health Insurance Plan of California (HIPC),
- The California Smaller Enterprises Resource Services (CalSERS), and
- California Choice.

Some of these cooperatives cater to big employers (CalPERS and PBGH), while others to small employers (HIPC, CalSERS, and California Choice). These purchasing cooperatives currently negotiate the health care insurance for 1.5 million persons, or five percent of the total population in California[4].

Layer 3: Financial Intermediaries

The third level of market activity is with the financial intermediaries, normally known as insurers or health plans. Financial intermediaries are disability insurers, managed care organizations, preferred provider organizations, and point of service organizations. These organizations are in the business of taking risk. By enrolling large volumes of persons they can effectively spread the risk and pay for the medical claims as they occur.

1. Indemnity Health Insurers:

   In California there are approximately 50 disability or indemnity insurers transacting health insurance. Disability insurance indemnifies a person from a specified number of disabilities, illnesses, or injuries. Normally, a person with indemnity health insurance goes to the doctor of their choice for treatement on a covered medical condition. The doctor then bills the insurance company, who pays a fixed percentage, say 80 percent. The patient pays the remaining balance. In 1994 disability health insurers reported $2.1 billion in revenues, covering 1.5 million persons[5].

2. Health Plans (HMOs):

   As of August, 1997, the Department of Corporations, which regulates managed care organizations, listed 54 plans licensed to operate as full service plans and 62 as specialty plans. Full Service Plans are those that offer primary care, access to specialists, and general acute care as part of the same package. Specialty plans are organizations that offer only specialized medical services, such as vision, dental, chiropractic, psychological, or pharmaceutical. Health plans, unlike indemnity insurers, coordinate the delivery of care by arranging for health care providers for their insured. Also unlike indemnity insurers, they usually pay for services before they are rendered, usually on a contractual basis.

One source of confusion in this layer arises with regulatory oversight over these entities. Unlike most other states where the Department of Insurance regulates both disability health insurers and health plans, California is the only state where the Department of Corporations regulates Health Plans. The Department of Insurance regulates indemnity health insurers, which represents only a small segment of the market.

Layer 4: Provider Groups & Medical Facilities

In the fourth layer of the health care market are provider groups and medical facilities. These entities provide the medical care. The role of these medical groups and facilities, however, has shifted under managed care. They now provide the medical care under contract with the health plans. So, while the health plan is licensed by and accountable to the Department of Corporations, the subcontracting medical group or facility is carrying out the services. The subcontractor often takes risk because they receive a capitation payment.

According to a survey conducted by the American Medical Association, there are over 1,800 medical groups in California consisting of three physicians or more[6]. There are also 8,114 medical facilities in California, 5,996 of which are licensed[7]. The 1,851 unlicensed facilities are centers run by physical and occupational therapists. Among the licensed facilities, there are 498 general acute care hospitals, 751 community clinics, 1,196 skilled nursing facilities, 1,366 home health agencies, and 927 developmentally disabled habilitative-nursing centers.

Layer 5: Individual Providers

At the fifth level are the providers who either have their own patient base or have a contract with a provider group or medical facility. Providers are a very diverse group. In California the Department of Consumer Affairs licenses over 600,000 health professionals. Among this group are physicians, nurses, pharmacists, psychologists, physical therapists, dentists, chiropractors, optometrists, and a host of other types of providers. In addition, the Department of Health Services certifies over 400,000 other providers as nurse assistants, home health aides, and hemodialysis technicians.

Layer 6: Patients

The sixth level in the health care market are the consumers of health care or the patients. In 1996 there were 32.2 million persons in California[8]. Of these

- 11% are age 65 and over;
- 28% are under 18; and
- 61% are 18 to 64 years of age.

Financial Arrangements in Health Care

So far we have shown that the health market is very complex, both because it has many layers and many players. We now present a discussion about the two most popular financial arrangements in health care: fee-for-service and capitation.

In a fee-for-service system, one party charges the other as the services are incurred. A doctor, for instance, would charge the insurance company after the services were rendered. The individual or the patient in such cases ends up paying what the insurance does not pay. The doctor might charge $60 dollars for the visit, the insurance pays $40, and the patient pays $20. In a fee-for-service environment, the provider has no set budget. The income of the provider depends on the frequency and the types of services rendered. Obviously, the more the patient visits or the more complicated the diagnostic and treatment, the more the provider gets.

Unlike fee-for-service, the system of capitation is more akin to having a fixed budget. Take the case of the doctor above and suppose that he or she is now going to be paid on a capitated basis. Suppose the doctor has a contract that pays $20 per person per month. If the doctor has a patient base of only 200 then he or she makes gross revenues of $48,000 per year to pay clerical staff, purchase medical equipment, and also earn an income. If instead the doctor has 1,500 patients, the gross revenues escalate to $360,000 per year. Under this system, the more patients the provider has, the larger the gross revenues. The provider, however, is at risk of costs exceeding income anytime the expenses of treating patients exceed the gross revenues.

Neither one of the two systems above is perfect. The first gives providers the incentive to schedule more examinations than are medically necessary. The second has incentives to curtail medical care to stay within the budget.

Health Care and the Nature of Fraud

The previous section gave a basic overview of the health care market, dividing it into six layers. It placed participants according to their role in the delivery of health care. More importantly, the diagram developed serves as a guide of how the $116 billion are channeled through.

With so much money flowing through the system, somebody is bound to find a way to steal some. The General Accounting Office estimates that nationally $1 of every $10 in health care is lost to fraud. The 1992 Resolution on Health Care Fraud adopted by National Association of Attorneys General estimated the health care fraud in government and private insurance programs to be $80 to $100 billion each year.

If the GAO's estimate of the cost of fraud, namely $1 of every $10, holds true for the private health care sector in California, the cost to private payors could be over $4 billion. The California Department of Insurance (CDI) estimates it could be higher. Over the past five years, CDI has received about 8,000 reports of health insurance suspected fraudulent claims from disability health insurers alone. CDI also notes that significant percentages of the suspected fraudulent claims reported in auto insurance and workers' compensation deal with suspected fraud by health care providers, drug suppliers, or claimants receiving some form of health care paid through the auto insurance or workers' compensation coverage.

What forms is fraud likely to take? This section will address this issue in the following four ways:

1. First it will define fraud and abuse;
2. Then it will list some of the various forms fraud is likely to take;
3. It will also give case examples; and
4. Lastly, it will give two reasons why capitation is not a wonder drug for health care fraud.

Defining Fraud and Abuse

Fraud and abuse can occur at any of the six layers depicted earlier. It could be

- the original purchaser supplying false information;
- an employee in a purchasing cooperative being bribed;
- an executive of a health plan submitting false documentation on the number of physicians contracted to serve a given patient base;
- several individuals setting up a phony provider company to get capitated payments for a few months and then disappear;
- a particular provider that falsifies utilization or cost data to receive a higher share of the risk funds set aside by the health plan; or
- a beneficiary that goes to two or three different providers to get prescription drugs at a discount and then turns around and sells them for a profit.

As the examples above show, fraud can occur in a wide range of environments. Unfortunately, most of the discussion of fraud centers around a very narrow definition of fraud, namely claims fraud. Fraud in health care is seen by many as a provider or a medical facility submitting a false claim, resulting in payment for services not rendered.

How one defines fraud is very important because it ultimately determines what activities are fraudulent and thereby reportable. Needed is a definition that can encompass the different types of fraud that can occur within the six layers of the market. Following are definitions of fraud and abuse that can potentially meet such a need.

Fraud *occurs when somebody* ***intentionally*** *"attempts to obtain something of value that the party is not entitled to under the statutory, regulatory, or contractual rules that govern the relationship."*[9] This definition, although a long one, is general enough to encompass fraud schemes throughout the health care system, including those in managed care.

The definition of abuse is very similar to the one for fraud. ***Abuse*** *occurs when somebody* ***recklessly or negligently*** *"attempts to obtain something of value that the party is not entitled to under the statutory, regulatory, or contractual rules that govern the relationship."*[10] In practice, it is difficult to distinguish fraud from abuse, but the main difference lies in that fraud requires "intent," while abuse does not.

The words "statutory" and "regulatory" are very important in the definitions above. They encompass state and federal laws regarding theft, false statements, false claims, mail fraud, breach of fiduciary relationship, and conspiracy to defraud the government.

It is important to also note that the above definitions allude to the "contractual rules that governs the relationship." Inclusion of such a phrase is especially important within a managed care environment that makes heavy use of contracts.

Types of Fraud and Abuse:

Despite the fact that fraud can take on various forms and sometimes occurs under unique conditions, various efforts have been made to categorize it by types. Unfortunately, these categories are not consistent from one source to another in their labeling or in how they define categories of fraud. Moreover, these categories are usually in the context of the more limited definition of fraud that looks only at providers and beneficiaries.

Needed are categories of fraud that can encompass fraudulent schemes occuring in any of the six layers of the market. Following is an attempt to create more universal categories of fraud.

1. False Statement

The first universal category of fraud is perhaps the most common and it occurs when somebody supplies false information for a personal or collective gain. This can happen in any of the six market layers. It could be when

- an individual lies in the application to get better rates;
- an employee in a purchasing cooperative misrepresents information about the different plans to channel business in one direction or another;
- the sales person of a health insurance company promises benefits that he or she knows that the plan does not provide;
- the director of a provider group misrepresents its utilization data;
- a physician bills for services not rendered; or
- a patient lies about his medical condition to get costly prescription drugs to sell on the black market.

One type of false statement fraud, claims fraud, gets a lot of media attention. A false claim can be submitted in a variety of ways and the discussion usually centers around providers, provider groups, and medical facilities. Following are three different types of false claims fraud:

- *Unbundling*
  This occurs when a provider submits separate claims for a service that normally requires only one. The provider makes more money by billing for the procedure in parts.

- *Upcoding*
  Upcoding happens when a provider submits a claim for a procedure that is more expensive than the one performed.

- *Billing for Services not Provided*
  A provider can submit a claim for a service he or she did not perform.

There are many other types of false statements, but they are not as well known. Following is a partial list of such cases

- *Exclusion of Covered Benefits*
  Exclusion of covered benefits occurs when a provider tells the patient that the medical procedure is not covered by the insurance, when in fact it is. The provider then offers to perform the medical services at a discount. If the provider receives a monthly capitation payment for that person, then the provider is in essence charging twice, to the insurer and to the patient.

- *False Coverage*
  False coverage happens when an individual or employer buys health insurance from a "fly-by-night" insurance company. Operators of these schemes take the premium, but then fail to pay the claims when they are due.

- *Credentials Falsification*

Credentials falsification happens when either a medical facility or provider misrepresents their credentials and renders services that they are not qualified to perform.

2. Bribery & Self-Referrals

Bribery and self-referrals requires the involvement of two or more parties. Bribery usually takes one of two forms. In the first form, the first party, for a fee, passes on valuable information that will help the second party negotiate a better contract. In the second form, fraud occurs because one party channels business in the direction of the second party for a specified fee or a "kickback." Such patient referral activities are also referred to as "capping" or "steering." "Self-referral" occurs when the first party refers a patient to another medical facility partly owned by the first party.

3. Underutilization

Another form of fraud and abuse comes in the form of repeated poor quality of care. This is perhaps the hardest form of fraud to prove since it requires that the diagnostic and treatments rendered be evaluated in light of current medical practices. Underutilization refers not to one medical mishap, but to a systematic pattern of substandard medical treatment.

Case Examples

False Statements: The Case Against Columbia/HCA Healthcare Corporation

In July of 1997, FBI agents raided 35 Columbia facilities and indicted three executives of Columbia/HCA Healthcare Corporation. The individuals indicted were a reimbursement executive at the company's corporate headquarters in Nashville, Tennessee, a chief executive officer of Columbia's Southwest Florida division, and a chief financial officer of the division in Jacksonville, Florida. Each is charged with conspiracy and four counts of false statements—the equivalent of submitting false or inflated claims. The government is looking for possible Medicare violations in Columbia's blood-lab testing, home health care, and hospital billings. So far the facilities in California do not seem to be part of the investigation.

Bribery & Self-Referral: United Home Health Agency of California

John Watts and Gene Woods, owners of United Home Health Agency, plead guilty in 1995 of defrauding Medicare of up to $2.5 million dollars. In addition to submitting false claims and falsifying medical records, they were charged with paying kickbacks for the referral of Medicare patients.

Underutilization: The Case of Western Dental Services of California

Western Dental, with some 115 dental centers serving 350,000 Californians, was accused early in 1997 by the Department of Corporations of being in violation of the Knox-Keene Act (body of laws governing the licensure and operation of health plans in California). In addition, Western Dental is being investigated by the FBI for alleged insurance fraud[11].

Medical audits conducted by the Department of Corporations revealed a repeated pattern of undertilization. Procedures that normally would take two or three visits, such as multiple root canals, were done in one sitting. Poor quality materials were also used. At the core of the problem seems to be Western Dental's method of compensating managing dentists at the different centers. The Department of Corporation notes that quarterly bonuses ranged from $0 to $36,000[12].

Two Reasons Why Fraud Will Continue Despite Capitation

Currently, it is well accepted that fraud exists in a fee-for-service environment. Not as well accepted is that fraud can occur in a capitated arrangement. Some argue that fraud is not possible under capitation since the provider no longer has to file a claim, and medical services are prepaid according to the contract.

Yet, following are two important reasons why fraud is likely to continue, despite capitation.

1. *There is a lot of money flowing through managed care*
   The first reason why fraud is likely to still exist in a capitated environment is simply because there is a lot of money flowing through the managed care system. It is estimated that the Department of Corporations is overseeing an industry worth more than $30 billion.

2. *Capitation passes the function of insurance to invidual providers*
   The other reason why capitation will not stop fraud is more subtle in nature, but it gives providers the incentive to reduce the quality of care. What many people do not realize is that capitation passes on the insurance function, namely the risk, to the person or entity who receives the capitation and provides the medical service. Take the analogy of the employer who pays a monthly premium to an insurance company for providing health care services to its employees. If a certain employee becomes ill, spends two days in the hospital, and the bill comes to $4,000, the insurance pays the bill, not the employer. The insurance takes the risk. The same happens to a provider being capitated. The capitated provider bears the risk for providing certain medical services to a patient. Like the insurance company, the provider can spread the risk by having a large patient base. This then becomes a double-edged sword. On one side, the provider can bear the risk the larger the patient base. Yet the more patients, the less time and resources the provider can dedicate to them. On the other side, if the provider does not have a large patient base, then he or she bears a high amount of risk anytime a very sick patient walks in. Either way, the provider is put in a difficult situation. Fraud can then occur when a provider attempts to make money by cutting corners in the delivery of medical care.

Health Care and Fraud Control Units in California

The previous chapter defined fraud and organized it into three very general categories. Fraud, thus, can occur through a false statement, a kickback or self-referral, and repeated underutilization. Moreover, fraudulent activities can take place in any of the six layers of the health care market presented in chapter one.

This chapter hopes to further contribute to the discussion by describing the fraud control units in California. More than that, however, it hopes to find the gaps or sections of the market where fraud control units are almost non-existent.

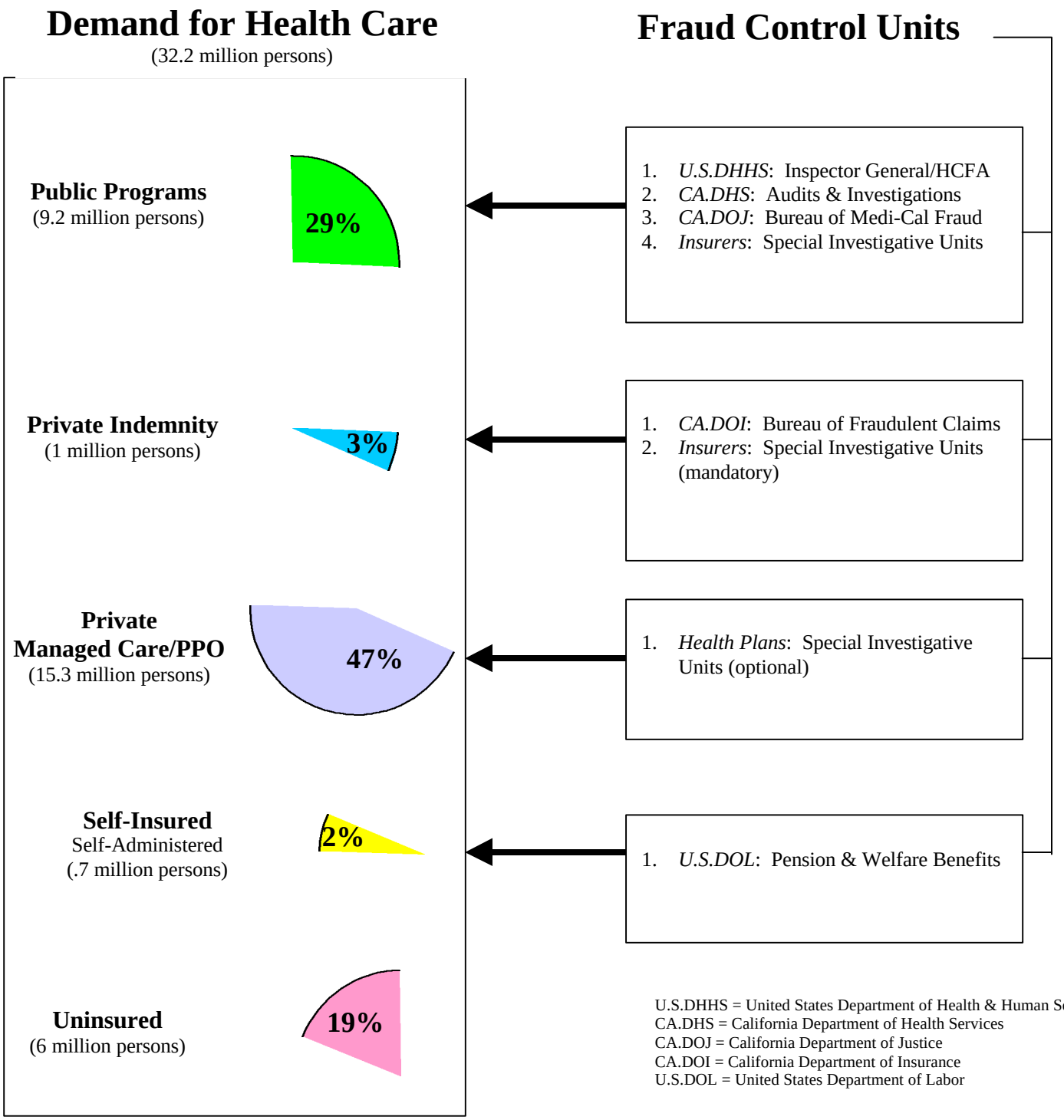
To this end, we constructed the following diagram to show the involvement of the different fraud control units by segments of the market. The left side divides the market according to its demand. Of the approximately 32.5 million persons in California, 26% are enrolled in public programs, 5% in private indemnity insurance, 45% in private managed care, 6% in purely self-insured programs, and about 18% are uninsured[13].

The right side of the diagram shows the fraud control units operating in each segment of the market. In the "Public Programs" market, for instance, there are at least four different fraud control units operating in California. The "Private Indemnity" side has at least two, the "Private Managed Care" one, and the "Privately Self-Insured" has one.

Note that in the diagram we do not list the FBI, U.S. Attorney General, and District Attorneys. These agencies play an important role in investigating and prosecuting fraud. Their mandate is very broad, however, and not specific to any one segment.

The significance of this diagram is that the segment of the market that has the biggest number of enrollees, the managed care segment, gets the least amount of attention with respect to fraud.

The Demand for Health Care and Fraud Control Units in California, 1996[14]



U.S.DHHS = United States Department of Health & Human Services
CA.DHS = California Department of Health Services
CA.DOJ = California Department of Justice
CA.DOI = California Department of Insurance
U.S.DOL = United States Department of Labor

What follows is a brief description of the different fraud control units.

Federal Units

At the federal level, efforts to curb health care fraud have been underway for a considerable period. In 1995, California was one of four states chosen to pilot Operation Restore Trust (ORT) to examine the nature and extent of fraud in Medicare. The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 and went further by making fraud in health care, both public and private, a federal crime and by increasing civil and monetary penalties. HIPAA also increased the resources of various federal departments to deter, investigate, and prosecute fraud in health care. Moreover, it directed the Department of Health and Human Services (DHHS) to coordinate federal, state, and local anti-fraud efforts and to set up a national health care data bank.

In California, there are at least **five** federal agencies actively fighting fraud.

- *Department of Justice--U.S. Attorney*

The U.S. Attorney in California has four offices, two in the south and two in the north. Although they have jurisdiction to prosecute private payor health care fraud, they focus mostly on cases related to federal sponsored programs, such as Medicare. In prosecuting Medicare fraud cases, they work closely with investigators of the Office of the Inspector General (OIG) and the Federal Bureau of Investigation.

- *Department of Justice--Federal Bureau of Investigation (FBI)*

The Federal Bureau of Investigation is one of the few agencies that can take cases from any segment of the market, private or public. They sometimes help the Office of the Inspector General with their cases.

- *Department of Health and Human Services--Office of Inspector General (OIG)*

The Office of Inspector General, with the passing of HIPAA, has a broad jurisdiction in the cases they can take on. Because of limited resources, however, they take only cases involving Medicare fraud.

- *Department of Health and Human Services--Health Care Financing Administration (HCFA)*

The Health Care Financing Administration administers Medicare and oversees Medi-Cal state agencies. They design policies to make the programs of Medi-Cal and Medicare less subject to fraud and abuse. In California, they are the lead coordinators of Operation Restore Trust.

- *Department of Labor—Pension and Welfare Benefits (PWB)*

Fraud within ERISA (Employee Retirement Income Security Act) type plans can be reported to the Pension and Welfare Benefits office of the Department of Labor. The Department of Labor has two offices in California, one in the north and one in the south. In cases where fraud is apparent, PWB opens an investigation and can impose administrative and civil sanctions.

State Units

Unlike their federal counterparts, state efforts to combat fraud in health care have not been as comprehensive. For instance, there is no California equivalent of the Health Insurance Portability and Accountability Act, both in terms in the augmentation of resources and its directive.

Nevertheless, following is a description of the state operated fraud control units.

- *California Department of Justice--Bureau of Medi-Cal Fraud (Attorney General)*

The Bureau of Medi-Cal Fraud, with a staff of 132, both investigates and prosecutes providers that defraud the Medi-Cal program.

- *Department of Health Services--Audits and Investigations*

The aim of the Audits and Investigations agency within the Department of Health Services is to curb losses in Medi-Cal. To this end, and to assure that the health plans are in compliance, they conduct financial and medical audits.

The branch also investigates beneficiary fraud through its Investigations Branch (IB). It has 174 staff in 17 field offices throughout California.

- *Department of Insurance—Bureau of Fraudulent Claims (Fraud Branch)*

The Insurance Commissioner is mandated to pursue all lines of insurance fraud, including fraud committed in disability health insurance. Basic funding for the investigation and prosecution of insurance fraud is derived from a $1,000 per-carrier assessment. The funding supports a law enforcement effort staffed by police officers who investigate the fraud and file cases with district attorneys.

To the extent of available resources, the Department has investigated health insurance fraud cases. During the past 5 years, the Department has investigated 435 health care fraud cases, resulting in the arrest of 56 individuals. As noted above, the Department has also pursued health care fraud in auto insurance and workers' compensation cases.

Local Government Units

Local law enforcement in Los Angeles has been active in pursuing insurance fraud, including health care fraud. The Los Angeles Police Department has a unit that investigates insurance fraud. Their investigations have uncovered health care fraud connections with organized crime. Local district attorneys have prosecuted health care fraud cases filed with them. Like the Department of Insurance, a significant number of local prosecutions of health care fraud have been as part of auto insurance or workers' compensation fraud cases. The 1991 health insurance fraud legislation discussed above also included a component for district attorney prosecution that was never implemented.

Private Sector Fraud Control Units

The first line of defense against health care fraud lies with the insurer or health service plan. In recognition of the key role of the insurer in this effort, the Legislature mandated all insurers to set up anti-fraud units by July 1992. These units are called Special Investigative Units or SIUs. These units are required to work with claims examiners to detect fraud, to investigate possible fraud, and report suspected fraud to the California Department of Insurance. The Department of Insurance oversees the insurer SIUs and works with SIUs in the investigation of fraud. SIUs also work with local district attorneys in the prosecution of health insurance fraud.

Many Managed Care Organizations (MCO) also maintain anti-fraud units, however there is no requirement to establish an SIU. Since they do not report suspected fraud to the California Department of Insurance, they work directly with local law enforcement and prosecutors if they find fraud.

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Endnotes

[1] California Health Care Fact Book, Summer 1996, p. 9.

[2] Retail sales taken from the California Statistical Abstract, 1996, p. 189.

[3] California Health Care Fact Book, 1994, p. 9.

[4] The State of Health Insurance in California, 1996, p. 62.

[5] Jerry Turem, "Small Group Risk Rates Results: The First Year of AB 1672," California Department of Insurance.

[6] Medical Groups in the US, 1996.

[7] Department of Health Services, Licensing and Certification Program, 1997.

[8] Current Population Survey, March Supplement, 1997.

[9] Davies & Jost (1997), *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, Georgia Law Review, p. 374.

[10] Davies & Jost (1997), *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse?*, Georgia Law Review, p. 374.

[11] Los Angeles Times, Sept. 16, 1997.

[12] Department of Corporations, *Report of Dental Survey: Western Dental Services, Inc.*, June 27, 1997, p. 16.

[13] Public programs offer both indemnity and managed care type of coverage. Enrollees covered through public programs are not included in the private sector side. The numbers presented are the best estimates available.

[14] The enrollment figures by health insurance coverage were developed as follows:

Total California Population
Estimates from the 1996 Current Population Survey put the total number of persons in California to about 32.2 million.

Public Programs

▪ Medicare	HCFA, San Francisco Office	3.8 million, Dec. 1996
▪ Medi-Cal	CA DHS, Medical Care Statistics	5.4 million, 1996

Private Managed Care/PPO
Private Managed Care/PPO refers to those covered through a Health Plan or Preffered Provider Organization regulated through the Department of Corporations. It excludes managed care enrollees covered through Public Programs above. For March 1996, the Department of Corporations reported 17.9 enrollees. Of these, we subtracted out 2.6 million managed care enrollees getting coverage through Medicare or Medi-Cal.

Uninsured
Estimates from the Current Population Survey put the number of uninsured to about 6 million.

Self-Insured, Self-Administered

According to the Hay/Huggins Benefits Report, 1996, 9% of employers offer Self-Insured (Self-Administered) plans in the Mountain and Western area of the United States. These figures are based on a survey of 126 employers. If we are looking at all the employers in California, the percentage will likely go down. We offer a conservative estimate of 4.5%.

Employers in California provide health care benefits to about 50 percent of the population. This amounts to about 16 million individuals (employees and their dependents). Four percent of 16 million is therefore 0.7 million.

Private Indemnity Insurance

Enrollment for indemnity health insurers is the left-over portion. This amounts to about 1 million persons. This is probably a good estimate, especially with the health care market shifting to managed care coverage. A study conducted by the Department of Insurance estimated that indemnity health insurers covered about 1.5 million persons in 1994. (See Jerry Turem, "Small Group Risk Rates Results: The First Year of AB 1672," California Department of Insurance.)