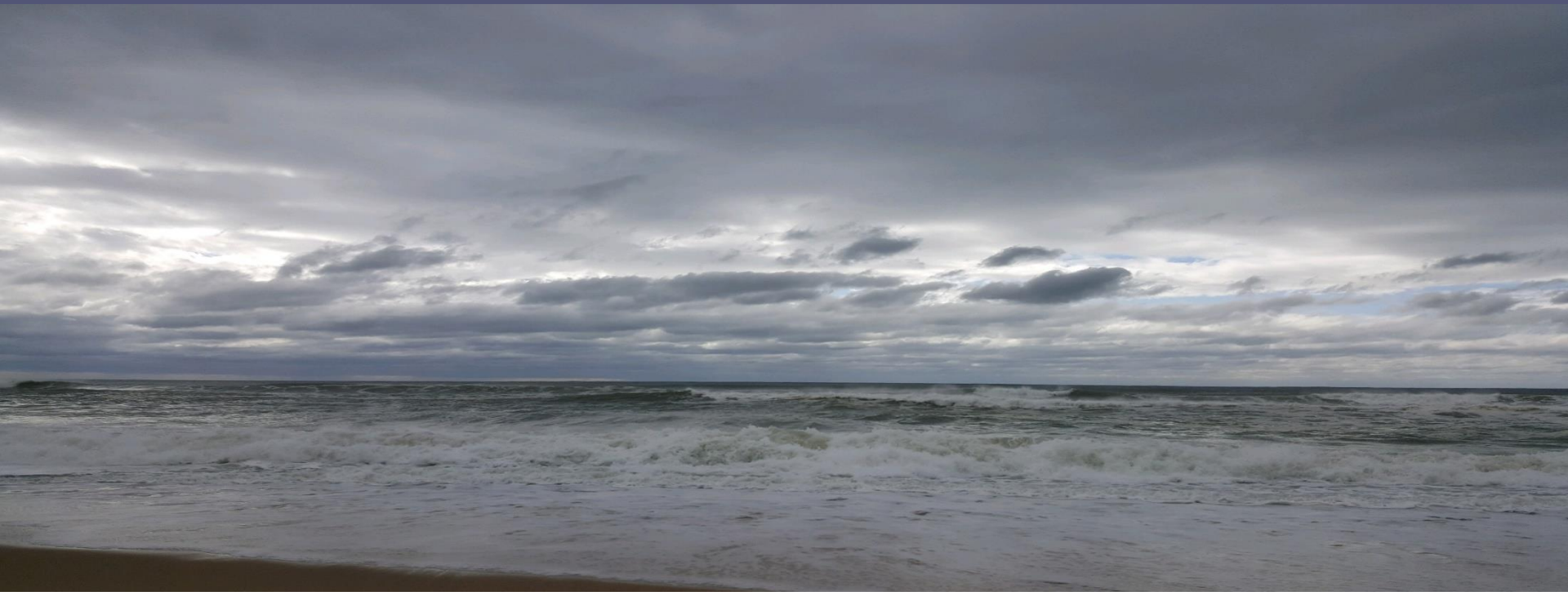
Trends in Health Insurance - Provider Billing, Technology, Fraud & Actuarial Ethics (New Perspective on Professionalism)

Michael L. Frank, ASA, FCA, MAAA



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ASNY Spring 2022 Meeting – June 27, 2022, 3:50pm to 4:40pm

Biography of Michael L. Frank

President & Actuary, Aquarius Capital

Actuarial and insurance/reinsurance consulting firm for US and International Organizations

Served as Adjunct Professor, Columbia University, M.S., Actuarial Science

Global Perspective of Health Insurance Market – Studies systems of US and 24 other countries
Employee Benefits, Retiree Health Valuations, Provider Contracting & Insurance/Reinsurance

Experience: Insurance/Reinsurance/Employee Benefits (30+ Years of Experience)

Appointed Actuary: Insurance Companies, HMOs, & Reinsurers
Consulted more than 500 municipalities & 100 private equity/hedge funds
Healthcare Provider & Managed Care Carve-Out Consulting
Consult other organizations serving the insurance industry (regulators, accounting firms, brokers, universities)
Expert Witness
Prior Employment: Prudential, Coopers & Lybrand, The Segal Company, Physicians Health Services, Coordinated Care Solutions/Careguide, Transamerica Reinsurance/MFC Re

Served as President, Actuarial Society of Greater New York (ASNY) and previously Chairperson for Continuing Education
Various Actuarial, Insurance, Reinsurance and Healthcare Reform Committees
Regular Industry Guest Speaker and Publisher of Articles

Interviewed on Healthcare Billing Practices (e.g., ProPublica/National Public Radio, Wall Street Journal, NBC, etc.)

Society of Actuaries LEARN Program – Instructor, Reinsurance for Insurance Regulators (e.g., NYSDFS December 2017)
Other Credentials & Designations

Associate Society of Actuaries, Member American Academy of Actuaries, Fellow Conference of Consulting Actuaries, International Actuarial Association, Caribbean Actuarial Association
Licensed life, accident & health broker and reinsurance intermediary
Board of Directors, Capstone Healthcare Econometrics Research Foundation
Advisory Board, University of Michigan, Actuarial Department

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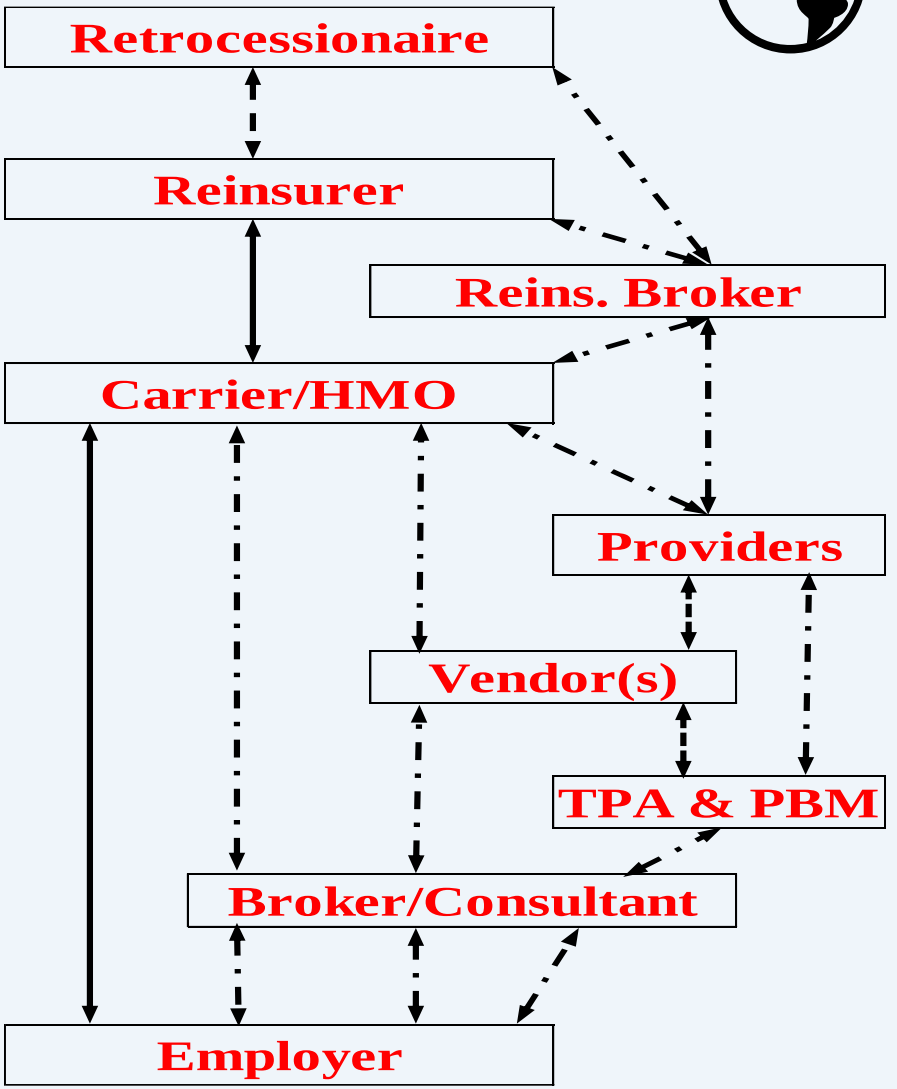
Overview

- Recent Trends with Insurers and Healthcare Providers
- Identify Areas of Excessive Billing and Fraud
- Impact on the Healthcare Professional and Insurance Industry
- Impact on Consumer Rights
- Sample Cases and Considerations on Actuarial Professionalism

Health Insurance "Food Chain" – Employer Model

- Traditional health insurance arrangement with medical provided by the member's employer.
- *The TPA is responsible for processing claims to the healthcare provider (e.g., physician, hospital, radiology, lab, etc.) and PBM for pharmacy*
- Each may be responsible to provide information in order for the employer to be reimbursed for a specific or aggregate claim.
- Require proof of eligibility, covered services/plan summary, and copies of adjudicated claims and specific medical management pre-certifications.
- May be multiple party signoffs (reinsurers/retrocessionaires) or "lead" reinsurer signoff for more complex, high-cost and catastrophic medical claims.
- Many of these organizations have investors behind them.
- Definitions: HMO (Health Maintenance Organization-a health insurance company), TPA (Third Party Administrator managing claims and eligibility), MGU (Managing General Underwriter)



Sample Provider Reimbursement Methods

Physicians

- Resource-based relative value scale (RBRVS) Fee Schedule
- Procedure Code: CPT (Current Procedural Terminology) code or HCPCS (Health Care Common Procedure Coding System)
  - Sample CPT Codes - Primary Care Visits (e.g., code 992XX)
  - Ears Nose Throat (ENT): Code 31231-Diagnostic Exam of Nasal Passages Using a Scope
- Withholds
- Capitation

CPT Code	Description of Code	Billed Charges	Insurance Network Discount	Amount After Discount	% Discount
99203	Office Visit or Other Non-Hospital Visit with a Provider	$ 330.00	$ 79.14	$ 250.86	24.0%
31231	Diagnostic Exam of Nasal Passages Using a Scope	$ 651.00	$ 273.27	$ 377.73	42.0%
Subtotal		$ 981.00	$ 352.41	$ 628.59	35.9%

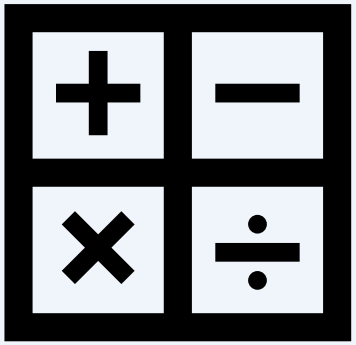
Hospitals

- Inpatient: Diagnostic Related Groups (DRGs)/Case Rates or Per Diems
  - Reimbursements impacted by hospital re-admissions (e.g., Medicare)
- Outpatient: ASC (Ambulatory Surgical Codes)

Pharmacy

- Discounts off average wholesale price (AWP), manufacturer rebates

Minimum Permissible Loss Ratios



Minimum Permissible Medical Loss Ratios

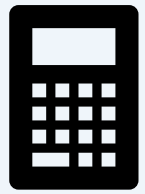
- 85% large group
- 80% small groups/individuals
- Established nationally (federal law)
  - Variations by states (e.g., New York is 82% instead of 80%)

Formula for Medical Loss Ratio Calculation:

$$\frac{\text{(Claims + Loss Adjustment Expenses + Activities to Improve Health Care)}}{\text{(Earned Premium – State Fees)}}$$

Minimum Permissible Loss Ratios (Continued)

Impact:



Encourages insurance companies to lower administrative costs

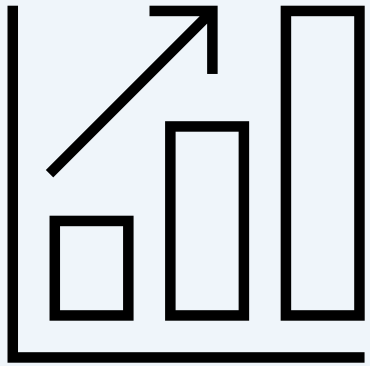
- Potential Impact No.1: Insurers employ less personnel (e.g., claims dept., etc.) to review claims and rely on artificial intelligence (AI) to manage claims
  - May potentially be less aggressive in claims management due to the rebate triggering
- Potential Impact No.2: Insurers pay claims faster to healthcare providers
- Encourage increase claims volume processed w/ higher "first pass rate" without human intervention (Electronic Data Interchange).
  - Many provider contracts have fast turnaround requirements for claims reimbursement (e.g., 80%+ paid within ten days)
  - Third party administrator (TPA) contracts may also have service guarantees to ensure fast turnaround times
  - Impact of COVID-related claims has impacted "first pass rate"

Rebates driven by loss ratio pools

- Rebates would be returned by insurance companies to policyholders if loss ratios fall below the minimum permissible levels
- Will reversing claims trigger potential policyholder rebates based on the formula?

Components of Healthcare Trend

- Components:
  - Price Inflation (e.g., fee schedules)
  - Utilization
  - Deductible Leveraging
  - Technological Advances
  - Malpractice Claims
  - Cost Shifting
  - Aging
  - Impact of COVID-19 on the above



- Fraud: How much of the above costs are due to fraud and excessive billing?

Ten Common Healthcare Provider Fraud Schemes (Association of Certified Fraud Examiners, 2013)

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Misrepresenting dates of service
- Misrepresenting locations of service
- Misrepresenting provider of service
- Waiving of deductibles and/or co-payments
- Incorrect reporting of diagnoses or procedures (includes unbundling)
- Overutilization of services
- Corruption (kickbacks and bribery)
- False or unnecessary issuance of prescription drugs

Note: Excluded above is identity theft, which is a growing problem.

Excessive Healthcare Provider Bills in the News (4 Examples)

Sample #1: A Texas hospital that charged a teacher $108,951 for care after a 2017 heart attack told the patient Thursday it would slash the bill to $332.29. This is after insurance paid the hospital nearly $56,000 for his four-day hospitalization and the procedures to clear his blocked artery. (Source: National Public Radio, 2018)

Sample #2: Oklahoma patient gets bill for $15,076 for 4 Tiny Screws. Total bill was $115,527 for a three-day hospital stay, including $15,076 for four tiny screws. (National Public Radio, 2018)

Sample #3: Individual has three-hour neck surgery in New York City for herniated disks and received significant bills from $56,000 from hospital, $4,300 from the anesthesiologist and $133,000 from his orthopedist. Individual then receives $117,000 from an "assistant surgeon" that individual never met. (Source: NYTimes, 2014)

Sample #4: NY Post highlighting a $1 billion scam with one patient highlighted in the article receiving more than $1.2 million in hospital bills, including out of network claims and balance billing. (Source: NY Post, 2018)

Sample #5: Hospital Bill: Large Claim for Discussion (2015)

Patient had one-night hospital stay for partial hip replacement (resurfacing) at NYU-Langone

- Admit Day: Friday, December 11, 2015
- Discharge Day: Saturday, December 12, 2015
- 2 Hour Procedure: Billed Charges: $138,000+; Approved Charges: $76,000+

All services were billed as in-network and services were pre-authorized.

- Patient Coverage: $4,000 deductible, 10% coinsurance, $12,000 out of pocket limit.
- Small group fully insured policy

Patient disputed bills with hospital and insurance company for multiple reasons:

- Specific services identified as not provided (6 PT/OT visits, infusion drugs);
- Specific services identified upcoded (10 of 11 items inappropriately billed as implantable devices);
- Bill had visible errors (e.g., services listed had names of other patients on it, bills had incorrect services coded, etc.);
- Bills were not transparent (e.g., no units, etc.) and appeared very excessive.

Hospital In-Network Bill – Partial Hip Replacement (Resurfacing) for One Day Hospital Stay

Hospital Billed Amounts for One Day Length of Stay (December 2015)

	Hospital Service Category	Hospital Reported Units	Hospital Billed Charges
1	0121-MED-SURG-GY/2 BED	1	$ 4,564.00
2	0270-MED-SUR SUPPLIES	2	$ 300.61
3	0272-STERILE SUPPLY	1	$ 185.37
4	0278-SUPPLY/IMPLANTS	11	$ 70,456.48
5	0279-SUPPLY/OTHER	15	$ 6,789.92
6	0301-LAB/CHEMISTRY	1	$ 106.00
7	0305-LAB/HEMATOLOGY	1	$ 97.00
8	0320-DX X-RAY	1	$ 288.42
9	0360-OR SERVICES	1	$ 21,890.00
10	0370-ANESTHESIA	170	$ 1,024.85
11	0420-PHYSICAL THERP	4	$ 1,118.00
12	0424-PHYS THERP/EVAL	1	$ 734.00
13	0434-OCCUP THERP/EVAL	1	$ 785.00
14	0636-DRUGS DETAIL CODE	395	$ 5,574.27
15	0710-RECOVERY ROOM	1	$ 3,506.94
16	Private Duty Room	Not Available	$ 390.00
17	Surgeon (Hospital Employee)	Not Available	$ 17,500.00
18	Anesthesiology (Hospital Employee)	Not Available	$ 3,200.00
19	Lab (Hospital Lab)	Not Available	$ 245.00
20	**GRAND TOTAL**	**606**	**$ 138,755.86**

HMO Adjudicated Claims and Calculation of Member Cost

HMO Paid Claims	Patient Billed Amount (Cost)	Hospital Approved Payment
$ 33,944.01	$ 3,771.56	$ 37,715.57
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ 25,721.41	$ 2,857.93	$ 28,579.34
$ 2,478.78	$ 275.42	$ 2,754.20
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ 1,649.99	$ 183.33	$ 1,833.32
Part of Case Rate	Part of Case Rate	Part of Case Rate
$ -	$ 390.00	$ 390.00
$ 2,305.84	$ 256.21	$ 2,562.05
$ 1,930.50	$ 214.50	$ 2,145.00
$ -	$ 122.50	$ 122.50
$ 68,030.53	**$ 8,071.45**	**$ 76,101.98**

HMO Approved Payment Amount as a % of Billed Charges ==>	54.8%
HMO % Discount off of Billed Charges ==>	45.2%

Note: Costs for a one-day length of day. Excludes pre-op expenses and DME costs, plus invoices that included services for other patients.

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Question: Why is the case rate higher than its associated billed charges? 9% higher (28% higher excluding lines 11-13)

Sample #5 Hospital Bill (Rev Code 278) - Implantable Device Cost for Hip Surgery Adjudicated by Insurer (December 11, 2015 Procedure)

		1	2	3	4	5	6
Line No.	Description	Implantable Device Units	NYU-Langone Hospital Billed Charges	Insurance Company Approved Cost as Implantable Device at $2,600 per Device Rate	Member Cost Share @ 10%	Insurance Company Cost
1	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
2	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
3	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
4	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
5	SUT FIBER WIRE BRD BLU W/NDL NO 2	1	$ 173.90	$ 2,600.00	$ 260.00	$ 2,340.00
6	MIXER CEMENT BONE EVAC III	1	$ 531.66	$ 2,600.00	$ 260.00	$ 2,340.00
7	DRILL BIT QC STER 3.2*145MM	1	$ 874.20	$ 2,600.00	$ 260.00	$ 2,340.00
8	CEMENT BONE SIMPLEX RADIOPAQUE	1	$ 957.30	$ 2,600.00	$ 260.00	$ 2,340.00
9	TISSEL FROZEN 10 ML	1	$ 4,290.82	$ 2,600.00	$ 260.00	$ 2,340.00
10	*IMPACTOR BHR 54MM	1	$ 28,697.45	$ 2,600.00	$ 260.00	$ 2,340.00
11	*HEAD BHR 48 MM	1	$ 34,235.55	$ 2,600.00	$ 260.00	$ 2,340.00
12	Subtotal	11	$ 70,456.48	$ 28,600.00	$ 2,860.00	$ 25,740.00
13	Insurance Company Explanation of Benefits Calculated Discount 1 - [Column (4), Line (12)] / [Column (3), Line (12)]			**59.4%** off billed charges		
14	Ratio of Total to Amount Paid (True Cost) by Hospital (Hospital Markup) (12) / $1,500		4697% ←	1907%	191%	1716%

**Note* : *Per Hospital staff and the manufacturer, lines 10 and 11 cost Hospital less than $1,500 combined and hospital also received rebates for the device. Hospital bill charges to the consumer is $62,933.00 for lines 10 and 11 combined.*

Top 10 Medical Device Technologies Market worth above $400 Billion by 2020 (Source: MarketsandMarkets, November 15, 2018)

- The global top 10 medical device technologies market is fragmented in nature.
- Prominent players in this market include:
  - Johnson & Johnson (U.S.), GE Healthcare (U.K.), Siemens Healthcare (Germany), Medtronic (U.S.), Philips Healthcare (Netherlands), Roche Diagnostics (Switzerland), Abbott Laboratories Inc. (U.S.), Smith & Nephew plc (U.K.), Stryker Corporation (U.S.), Boston Scientific Corporation (U.S.).
- The growth in the top 10 medical devices industry is mainly driven by the rising prevalence of chronic lifestyle diseases like cardiovascular, diabetes, hypertension, cancer, and respiratory problems.
- Similarly, the rising acceptance of newer technologies by physicians & hospitals and growing geriatric population are also driving the overall growth of the top 10 medical devices market.
- However, factors such as uncertainty in reimbursement and the imposition of the medical device excise tax in the U.S. are restraining the growth of this market.

Sample Emergency Room Visit (2021)

	Description of Service	Adjustment Code	Hospital Billed	Insurance Approved	Plan Paid	Member Responsibility	Member Observation
1	Dress/Debrid P-Thick Burn M (16025)	PPO008	$ 563.23	$ -	$ -	$ -	
2	Emergency Dept Visit (99283-25)	DED003, PPO008	$ 1,479.99	$ 2,632.00	$ -	$ 2,632.00	
3	Unclassified Drugs (J3490)	PPO008	$ 0.70	$ -	$ -	$ -	Bacitracin
4	Dress/Debrid P-Thick Burn M (16025)	PPO008	$ 544.23	$ -	$ -	$ -	Duplicate of Line 1
5	Emergency Dept Visit (99283-25)	PPO008	$ 698.87	$ -	$ -	$ -	Duplicate of Line 2
6	Subtotal: (1) + … + (5)		$ 3,287.02	$ 2,632.00	$ -	$ 2,632.00	
7	Reported Discount by Insurance Company in EOB		19.9%	Discount off Billed Charges			
8	Remove Duplicates: (1) + (2) + (3)		$ 2,043.92	$ 2,632.00			
9	Reported Discount by Insurance Company if Removing Duplicates		28.8%	Load off Billed Charges			

Notes:

A. Two Hour Emergency Room Visit with less than 10 minute visit

B. Adjustment Code PPO008 means provider accepted "contracted rates" and DED003 means applied to members deductible

C. EOB talks about surprise bill laws for out of network claims. This claim was in-network.

You be the "Judge" on Fraud (Samples)

- Primary Care Visits (e.g., code 992XX) billed at higher intensive and more expensive code than the service actually provided
- Specialty Services billed additional services (samples)
  - Pulmonary: Code 94060-Respiratory Test Measuring Air Speed w Medicine
  - Cardiology: Code 93015-Stress test with additional physician office charge
  - ENT: Code 31231-Diagnostic Exam of Nasal Passages Using a Scope
- Hospitalization:
  - Sample Procedures with Billing Abuses: Infusion, Implantable Supplies, Rehabilitation (Physical Therapy/Occupational Therapy)
- Durable Medical Equipment:
  - Is equipment being used? Medically necessary? Kickbacks to Providers?
- Home Care: Providing services to individuals that don't meet the requirements to get care.
- Lab and Blood Work
  - Bills greater than $2,000 that are considered paid in full for less than $50.
  - Potential impacts of physicians referring to labs that they have ownership in.

Sample ENT Office Visit (5 Minutes)

Summary of Costs before Application of Member Cost Sharing

CPT Code	Description of Code	Billed Charges	Insurance Discount	Amount After Discount	% Discount
99203	Office Visit or Other Non-Hospital Visit with a Provider	$ 330.00	$ 79.14	$ 250.86	24.0%
31231	Diagnostic Exam of Nasal Passages Using a Scope	$ 651.00	$ 273.27	$ 377.73	42.0%
Subtotal		$ 981.00	$ 352.41	$ 628.59	35.9%

Note: Healthcare provider is a large Accountable Care Organization in Rye, NY (Zip Code 10580). Bill was mailed from Boston, MA address.

→ ***Fraud increased the cost from $250.86 to $628.59, or $377.73 (or 150.6% increase)***

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Adverse Impact on Consumers

Business Insider (3/10/22)

- The Kaiser Family Foundation found 3 million Americans owe over $10,000 in medical debt.
- It estimated total medical debt in the US is $195 billion, and it unevenly falls on patients of color.
- The debt can cause patients to skip needed doctor's visits, along with hurting credit reports.

Kaiser Family Foundation (1/5/2016)

- Four out of 10 Americans (actually 37%) say they are saddled with active debt from medical and dental polls, according to a new KFF Health Care Debt Survey.
- Among the Insured with Medical Bill Problems, 63% Report Using Up Most or All Their Savings and 42% Took on an Extra Job or Worked More Hours
- Half of People Without Health Insurance Report Problems With Medical Bills, and They Face Similar Financial and Personal Consequences As Those With Insurance
- Among people with health insurance, one in five (20%) working-age Americans report having problems paying medical bills in the past year that often cause serious financial challenges and changes in employment and lifestyle, finds a comprehensive new Kaiser Family Foundation/New York Times survey.
- As expected, the situation is even worse among people who are uninsured: half (53%) face problems with medical bills, bringing the overall total to 26 percent.

False Claims Act

- Referred to as the “Lincoln” Law (1863)

- Criteria
  - Services not rendered;
  - Services performed on non-existing or phantom patients;
  - Upcoding: Procedures more expensive than those actually performed (“up-coding” or “code creep”);
  - Unbundling: Itemizing billing services that should be bundled (e.g., Medicare);
  - Non-medically necessary services being performed;

- Individuals can be prosecuted for violating this (e.g., Department of Justice, State Government)

- “Qui Tam” Action:
  - Private individuals known as “relators” could pursue this remedy through a “qui tam” action
  - “Whistleblowers” are also entitled to financial remedy

Should the False Claims Act apply to all members of all plans?

Other Laws Regarding Fraud & Excessive Billing

- **1872 (Approximately):** Mail Fraud Laws
- **1914 (and Updated 1938):** The Federal Trade Commission Act to prohibit unfair/deceptive acts and practices in commerce.
- **1970:** Racketeer Influenced and Corrupt Organizations (RICO) Act of the Organized Crime Control Act
- **1995:** Stark Act prohibited physicians from referring Medicare/Medicaid patients to providers (initially labs) that the physician owned or had a family member.
- **2015 (NY):** Protection from Surprise Bills and Emergency Services
  - Protects consumers from surprise bills when services are performed by a non-participating (out-of-network) doctor at a participating hospital or ambulatory surgical center in your HMO or insurer's network or when a participating doctor refers an insured to a non-participating provider.
  - The new law also protects all consumers from bills for emergency services.
  - Law only addresses out of network claims, not excessive or fraudulent billing for in-network claims.

Improper Medicare Payments Hit Lowest Level in Nearly a Decade (Source: Modern Healthcare 11/16/18)

- More targeted enforcement actions by CMS has led to the lowest improper payment rate for Medicare in nearly a decade, according to new federal data.
- The CMS doled out an estimated $31 billion in improper payments in fiscal 2018, which is around 8.12% of all claims paid during that period, according to a report issued Friday.
  - That's down from $36.2 billion or 9.51% of Medicare claims in fiscal 2017.
- Improper payments include fraudulent claims, payments distributed to the wrong recipient or for the wrong amount, payments with insufficient documentation, and those when the recipient uses the funds improperly.
- The CMS calculations include all claims incorrectly paid between July 1, 2016, and June 30, 2017. This is the lowest rate of improper payments for Medicare fee-for-service since 2010 and the second time since 2013 that the rate fell below 10%.

Question:

How many more fraud claims would be filed and reported if members had material cost sharing (e.g., no Medicare supplement policy, etc.)?

Provider Collection Process

- With members having higher cost sharing (e.g., larger deductibles, higher coinsurance, etc.), healthcare providers have had to increase their collections process.
- Multiple Collection Agencies – Internal (subsidiary) vs. Third Party
- Unbundling Bills with Each Procedure Code being a Different Collection Letter or Organization
- Filing Claims in Court without Due Process or Notification (e.g., people sued without receiving a subpoena, etc.)
- Certain types of claims are triaged to the Bad Debt Pool
  - 1983: New York established a Hospital Bad Debt and Charity Care Pool for hospital losses associated with uncompensated care. Renamed the Hospital Indigent Care Pool (1997)
  - Became a series of subpools initially funded by payer add-ons to regulated inpatient hospital rates and an assessment on hospital inpatient revenues.

What is the New York State Bad Debt/Indigent Pool?

1996: Health Care Reform Act (HCRA) replaced these inpatient payer add-ons with a more comprehensive system of payer surcharges on both inpatient and outpatient hospital services Indigent care awards reflect write offs of bad debt and charity care.

- Each hospital's amounts are currently reported in the aggregate based on hospital charges. Not tied back to a related rendered service or to a patient, much less a patient's insurance or income status.

2018: Community Service Society (CSS) reports that the indigent care pool continues to provide windfalls to non-safety net hospital. (Source: www.cssny.org)

- Delay in full implementation of reforms to the allocation of scarce Indigent Care Pool (ICP) funding have resulted in unintended consequences.
- A new Community Service Society study of New York's ICP found that hundreds of millions of dollars actually flowed away from struggling safety-net hospitals serving large numbers of uninsured and low-income patients to hospitals with healthier bottom lines.

Question #1: What percentage of submitted claims to the indigent pool are fraudulent?

Question #2: Are billed charges high so that hospitals can capture more dollars from the state indigent pool?

Question #3: What is the reporting and auditing requirements of these pools?

How does the Law and Insurance Apply?

- **"Account Stated"**
  - When a provider sends a bill, you are obligated to object in writing within a reasonable time if you are to dispute or believe in error (e.g., 30 days).
  - When a provider refers you to an insurance company, then is the provider waiving their rights to enforce this requirement?
  - It is not consistent with the appeals process for medical plans (fully insured or self-funded).

- **Sample Fully Insured Claim Denial Language**
  - "If you do not agree with the final decision, you have the right to bring civil action under Section 502(a) of ERISA within two years of the decision."
    - Does this mean federal laws <u>trump</u> state laws for insurance disputes?
    - 1945: McCarran–Ferguson Act, a federal law exempted the business of insurance from most federal regulation, so states became responsible for regulating insurance.

Special Investigations Unit (SIU)

- Target health care-related fraud and abuse, including internal fraud, electronic transaction fraud and external fraud.
  - Sample Brochure of a Sample SIU - http://www.aetna.com/data/fraud2.pdf
  - Sample Services
    - Unusual provider billing practices.
    - Discrepancy between the submitted diagnosis and the treatment.
    - Diagnoses or treatments that are outside the practitioner's scope of practice.
    - Many other fraud related items.
- Potential Issues – *Is the Insurance Industry Enabling Fraud?*
  - One insurance company's SIU confirmed that it will not share results with the member (the one filing the complaint) nor adjust the adjudicated cost sharing.
    - How does member know the complaint was reviewed or decided on?
    - Why would member's cost sharing not be adjusted if fraud is correctly identified and codes/services are to be adjusted? Wouldn't deductibles, copays, coinsurance, out-of-pocket maximum costs change?
    - Why would SIU withhold pertinent information to a patient (especially one defending itself in potentially a wrongful litigation) or put up "road-blocks" in the investigation process?

Steps to Increase Fraud Prevention

- Laws on Transparency – Unfortunately, consumer inability to audit insurance company-provider contracts.
- Redesign health insurance plans so individuals have more "skin in the game" through member cost sharing to provide incentives to validate claims.
  - Unidentified Fraud: Medicare fraud identified is approximately 10% and would be higher if members had more cost sharing (note cost sharing is low for individuals with Medicare and Medicare Supplement policies)

- Technology to survey individuals to confirm care.
  - Validate services provided, including duration and healthcare provider name
  - May pick up fraud through identify theft
- Tracking member utilization with providers including volumes and proximity.
  - Analytics to track utilization patterns of physician and pharmacy dispensing of drugs and other services (e.g., physical therapy)
  - Aggregating data to track patterns and anomalies in data
  - "Common Sense" analytics

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Source: https://www.actuary.org/sites/default/files/files/code_of_conduct.8_1.pdf

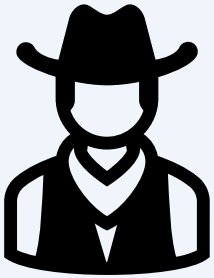
Hypothetical Question #1 on Actuarial Ethics

Question #1 - Premium Rate Development: Should actuaries assume some level of responsibility for including extraordinary amounts of fraudulent claims in premium rate filings (e.g., Precept 1-"profession's responsibility to the public")?

If claims include fraudulent claims and a target loss ratio for pricing is used, then the potential for administrative loads and profit margins to include an additional amount ("mark up") for such fraudulent claims.

Is the insurance industry preventing or enabling fraud by including the costs of fraud in premium rate development (e.g., putting an administrative/retention load on top of each fraudulent claims dollar)?

Minimum Permissible Loss Ratios



Minimum Permissible Medical Loss Ratios

- 85% large group
- 80% small groups/individuals
- Established nationally (federal law)
  - Variations by states (e.g., New York is 82% instead of 80%)

Formula for Medical Loss Ratio Calculation:

$$\frac{\text{(Claims + Loss Adjustment Expenses + Activities to Improve Health Care)}}{\text{(Earned Premium – State Fees)}}$$

Question: How much additional premium is received above claims due to the inclusion of fraudulent claims?

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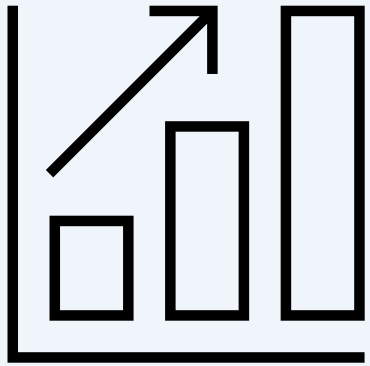
Fraud Education & Regulation

- Member education to recognize the signs of fraud
- Enforce laws that are currently in existence and prosecute those committing the crimes.
  - High profile healthcare providers are not prosecuted or publicized in the news.
- Regulators should require more transparency and follow up by insurance companies receiving complaints of fraud.
  - Currently consumers do not receive follow ups or results to fraud investigations by insurance company fraud units.
  - Insurance policies currently have little information to assist a covered member in reporting or identifying fraud.
    - Members generally do not know what to do when a victim of abusive billing or fraud.
  - Potentially modify loss ratio calculations to make fraud investigation a favorable part of the permissible medical loss ratio calculation.
  - Have premium rate approval decisions be contingent on insurance companies having effective.
  - Regulators are spending more resources on cybercrime.

Components of Healthcare Trend

- Components:
  - Price Inflation (e.g., fee schedules)
  - Utilization
  - Deductible Leveraging
  - Technological Advances
  - Malpractice Claims
  - Cost Shifting
  - Aging
  - Impact of COVID-19 on the above



- Fraud: How much of the above costs are due to fraud and excessive billing?

Sample Rate Increase Notification (Dated 6/3/22)

- Proposed Premium Rate Changes - 20.7%
- Premium = $2,200+ per month ($26.4k+ per year); deduction $7k single/$14k family
- Why We Are Requesting a Rate Increase
  - The requested increase is due to our view of projected claims. Rising medical expenses are the main reason for the requested increase.
  - A number of factors contribute to these rising costs, including increase in the cost of medical services and increases in the amount of services used.
  - A part of the medical costs includes a pooling technique established under the Affordable Care Act (ACA) called Federal Risk Adjustment. The 2023 risk adjustment amount will be 14% lower due to a Centers for Medicare & Medicaid Services (CMS) modification. This reduction increases our requested rates by 0.3%.
  - We have prepared a narrative summary that provides a more detailed explanation of the reasons why we are seeking a premium rate adjustment.
  - This summary will be posted on our website and the DFS website. Our rate application will also be posted on the DFS website.
    - https://www.dfs.ny.gov/consumers/health_insurance/health_insurance_premiums
    - https://www.uhc.com/content/dam/uhcdotcom/en/Legal/PDF/Ex-13B-OHI-SG-2023-Narrative-Summary.pdf

Morris Report & Impact on Actuarial Ethics

- 2004: UK Government asked Sir Derek Morris to undertake a wide-ranging independent review of the actuarial profession driven by one insolvent insurance company in the UK. (https://www.frc.org.uk/actuaries/oversight-of-the-actuarial-profession/morris-review)

- Focus of Review:
  - The extent of competition and choice in the market for actuarial services;
  - The regulatory framework for members of the actuarial profession; and
  - The future role of the Government Actuary's Department (GAD).

- 2005: Proposed introduction of a new regime of independent oversight of the regulation of the profession by the FRC.
  - Independent standard setting;
  - oversight of compliance with technical and ethical standards;
  - actuarial training and CPD;
  - more effective scrutiny of actuarial advice;
  - clearer lines of accountability of actuaries to regulators, to the profession and to clients and employers;
  - address the potential conflicts of interest that surround the role of the Scheme Actuary to pension schemes

- Recommendations were accepted by the Government, the Financial Reporting Council (FRC) and the Institute and Faculty of Actuaries (IFoA).

- Other Correspondence
  - Morris Review (Final Report): https://webarchive.nationalarchives.gov.uk/ukgwa/20120704150545/http://www.hm-treasury.gov.uk/d/morris_final.pdf
  - AAA Submitted Information: https://www.actuary.org/sites/default/files/pdf/prof/morris_sept04.pdf
  - BBC Article on Historical Events of Insolvent Insurer: https://www.bbc.com/news/business-10725923

Hypothetical Question #2 on Actuarial Ethics

Question #2 - Solvency: Should an insolvent insurance company or pension plan trigger an evaluation by the ethics board if financial ruin is an important aspect of the Code of Professional Conduct (e.g., Precept 1-"profession's responsibility to the public")?

- From 2009 to 2021 (YTD), 15 actuaries were disciplined by the SOA. Only 1 actuary during 2019-2022 through today.
- Few if any were disciplined due to an actual insolvency case.
- Certain regulatory and government agencies would evaluate the actual insolvencies depending on the jurisdiction.
  - *Should the ethics board also be involved in the review based on the responsibility to the public?*

Insolvent Insurance Companies (Sample Companies - 82)

(Source: National Organization of Life and Health Insurance Guaranty Associations)

American Chambers Life Insurance Company
American Educators Life Insurance Company
American Integrity Insurance Company
American Life Assurance Corporation
American Medical and Life Insurance Company
American Network Insurance Company
American Standard Life & Accident Insurance Company
American Western Life Insurance Company
AMS Life Insurance Company
Andrew Jackson Life Insurance Company
Bankers Commercial Life Insurance Company
Bankers Life Insurance Company
Benicorp Insurance Company
Booker T Washington Insurance Company, Inc.
Centennial Life Insurance Company
Coastal States Life Insurance Company
Colorado Bankers Life Insurance Company
Confederation Life Insurance Company (CLIC)
Consolidated National Life Insurance Company
Consumers United Insurance Company
CoOportunity Health
Diamond Benefits Life Insurance Company/Life Assurance Company of Pennsylvania
EBL Life Insurance Company
Executive Life Insurance Company
Executive Life Insurance Company of New York
Family Guaranty Life Insurance Company
Farmers and Ranchers Life Insurance Company
Fidelity Bankers Life Insurance Company
Fidelity Mutual Life Insurance Company
First Capital Life Insurance Company
First National Life Insurance Company
First National Life Insurance Company of America
Franklin American Life Insurance Company
Franklin Protective Life Insurance Company
George Washington Life Insurance Company
Golden State Mutual Life Insurance Company
Guarantee Security Life Insurance Company
Imerica Life and Health Insurance Company
Inter-American Insurance Company of Illinois
International Financial Services Life Insurance Company
Investment Life Insurance Company of America
Kentucky Central Life Insurance Company
Legion Insurance Company
Life & Health Insurance Company of America
Lincoln Memorial Life Insurance Company
London Pacific Life & Annuity Company
Lumbermens Mutual Casualty Company
Medical Savings Insurance Company
Midwest Life Insurance Company
Monarch Life Insurance Company
Mutual Benefit Life Insurance Company
Mutual Security Life Insurance Company
National Affiliated Investors Life Insurance Company
National Heritage Life Insurance Company
National States Insurance Company
New Jersey Life Insurance Company
North Carolina Mutual Life Insurance Company
Northwestern National Insurance Company of Milwaukee Wisconsin
Old Colony Life Insurance Company
Old Faithful Life Insurance Company
Old Standard Life Insurance Company
Old West Annuity & Life Insurance Company
Pacific Standard Life Insurance Company
Pavonia Life Insurance Company of Michigan
Penn Treaty Network America Insurance Company
Reliance Insurance Company
SeeChange Health Insurance Company
Senior American Insurance Company
Senior Health Insurance Company of Pennsylvania
Southland National Insurance Company
Standard Life Insurance Company of Indiana
States General Life Insurance Company
Statesman National Life Insurance Company
Summit National Life Insurance Company
Supreme Life Insurance Company of America
Time Insurance Company
Unison International Life Insurance Company
Universal Health Care Insurance Company, Inc.
Universal Life Insurance Company
Universe Life Insurance Company
Villanova Insurance Company
Western United Life Assurance Co.

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Failed CO-Ops – 21

CO-OP Plan	State	Estimated Close Date
Meritus Health Partners	Arizona	2015
Colorado HealthOP	Colorado	2015
HealthyCT	Connecticut	2016
Land of Lincoln Health	Illinois	2016
CoOportunity Health	Iowa & Nebraska	2015
Kentucky Health Care Cooperative	Kentucky	2015
Louisiana Health Cooperative Inc.	Louisiana	2015
Minuteman Health Inc.	Massachusetts and New Hampshire	2017
Evergreen Health Cooperative Inc.	Maryland	2017
Consumers Mutual Insurance of Michigan	Michigan	2015
Nevada Health Cooperative	Nevada	2015
Health Republic Insurance of New Jersey	New Jersey	2016
New Mexico Health Connections	New Mexico	2020
Health Republic Insurance of New York	New York	2015
InHealth Mutual	Ohio	2016
Health Republic Insurance of Oregon	Oregon	2016
Oregon's Health CO-OP	Oregon	2016
Consumer's Choice Health Insurance Company	South Carolina	2016
Community Health Alliance Mutual Insurance Company	Tennessee	2015
Arches Mutual Insurance Company	Utah	2015
New Mexico Health Connections	New Mexico	2020

https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/

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Questions? Thank You

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Interesting Math Problem: Calculate (13,837) x (Your Age) x (73) = ????????