MANAGED HEALTHCARE EXECUTIVE®
FOR DECISION MAKERS IN HEALTHCARE

FRAUD Finding

It's what isn't there that will cost you

by **Julie Miller**

KNOWLEDGE IS power. In an effective underwriting process, the more information about an applicant's historical health status the better. Particularly for individual policies, fully identifying costly conditions up front helps organizations better assign risk and avoid potentially damaging rescission situations when costly claims arise.

Douglas M. Mertz, vice president of membership services and sales for e-Services Corporation, a subsidiary of the MIB Group, Inc., based in Westwood, Mass., has seen the financial effects that occur when applicants fraudulently or otherwise omit relevant health status information from their application. As a not-for-profit trade association, MIB Group provides its members with access to an exclusive historical database of brief coded medical information, created by and available to authorized member company underwriting, medical and claims personnel for the purpose of identifying applicant fraud, omissions or misstatements.

Mertz says each year applicant fraud takes a bite out of company profits, and health insurers could cover their risks with greater precision by using fraud detection tools at initial underwriting.

Q Plans would all agree that any type of fraud takes money out their pockets. What are the critical issues with applicant fraud?

Doug Mertz, VP, membership services and sales, e-Services Corporation, an MIB Group, Inc. subsidiary

A In the health insurance market, 'fraud' typically means provider fraud, where hospitals, doctors and labs tend to be the focus. Clearly there is a large dollar value to uncovering this type of fraud. With applicant fraud, applicants don't disclose everything necessary for an underwriter to make an informed decision about placing the risk—in other words, errors, misstatements and omissions. Whether intentional or unintentional, they can result in an underwriter making an incorrect or uninformed decision. Depending on the treatment or therapy that's required for that early claim, the cost to the company on a block of new policies can result in millions of dollars, inflating a company's actual claims costs and endangering coverage for honest policyholders.

Accurate numbers for new health policies issued across the industry are difficult to get agreement on, but according to Reden and Anders Consulting, there's more than 15 million individual health insurance policies issued annually in the United States. The potential for applicant fraud with a large dollar amount is significant. In studies

AT A GLANCE

HEADQUARTERS:
160 University Ave.
Westwood,
Massachusetts

YEAR FOUNDED:
1902

NUMBER OF EMPLOYEES:
170

NUMBER OF MEMBERS:
About 500 insurance companies in the U.S. and Canada selling health, life, disability and long term care insurance products

PRODUCTS OFFERED:
MIB Checking Service; Applicant fraud detection data exchange; Plan-F Follow-up Service

MHE Source: MIB Group Inc.

we've done, we believe that on an industrywide basis, applicant fraud amounts to probably between $500 million and $1 billion. That's significant when you consider the margins health insurers' operate under.

Q How often does applicant fraud occur and what are the immediate costs?

A After searching our database for impairments associated with nonrated policies, we discovered that 12 out of every 1,000 health insurance policies issued would have been declined if the information that is in the MIB database would have been available at underwriting. This data was based on the sample companies' actual underwriting guidelines. Another 29 of the 1,000 had undisclosed conditions serious enough that an underwriter would have requested further information had they been aware of it at the time, which could have resulted in ratings, exclusions or declinations. Based on today's margins, that could turn a profitable book unprofitable in a hurry.

Some of the conditions identified in this study were chronic obstructive pulmonary disease, diabetes, hepatitis C and coronary artery disease. For example, undisclosed coronary artery disease has first-year excess claim costs between $33,000 and $41,000 [according to Milliman USA]. If you go back to the example of 12 out of every 1,000, then a company that issues 5,000 policies could be expected to have 60 cases approved with declinable conditions. Conservatively speaking, if you assume five of those 60 had coronary artery disease, you're talking upwards of $200,000 in excess first-year plan costs right on the bottom line just from five of those 60 members.

Q Other than the unpredictable treatment costs for those particular members, are there other reasons to screen for applicant fraud?

A Our members tell us that individual health insurance has one of the highest incidences of adverse selection. One reason is because customers tend to remain uninsured to avoid the expense of costly premiums until they have a medical condition that requires treatment. At that point, they apply for coverage and neglect to disclose information, so the company is left with paying a claim or rescinding it, which means extensive investigative costs to determine if the condition manifested itself prior to the issuance of the policy. Typically, unless it's an excessive claim, companies tend to pay it to maintain their image in the community. We know of companies that have full-time rescission underwriting departments. That means they're catching it at the back end when in fact, there's great potential to catch it up front.

> "Applicant fraud amounts to probably between $500 million and $1 billion."

Q Why do individual policies require extra attention in the underwriting process?

A One of the challenges of the individual market is that policies don't have high persistency. They tend to be of short duration. If you make a mistake in underwriting an individual policy, it's almost impossible to recover the costs.

It seems the only people who stay on board when premiums go up are those who have conditions so severe they're forced to maintain your policy. In talking to CEOs of leading companies, they say the duration of an individual policy is less than three years on average. People pick it up as short term coverage when they're out of work, then go back to work and are on the company plan. Under that scenario, there's virtually no chance to recover if underwriting mistakes are made.

Q Will applicant fraud increase or decrease with the rise of consumer directed healthcare and its high-deductible plans?

A If a plan requires a $5,000 deductible, for example, an underwriter should not be fooled by the high deductible. If I'm attempting to commit fraud, and I've got coronary artery disease, you're still going to pay $36,000 of my $41,000 expense. And I saved the $5,000 in an HSA. So I think it just opens the door for more applicant fraud. I don't think there is great comfort in higher deductibles. That's a good deal if the care only costs me $5,000 and you $36,000. The worst thing that can happen is that I get caught, but usually I'm not.

Q It seems that there is a high percentage of applicant fraud. Are that many people really trying to hide their health status?

A Of course not. I'm not trying to imply that all applicants withhold the truth. Sometimes it's quite unintentional. For example, an application can ask whether or not you have a certain condition, such as hypertension. An applicant might answer 'no' because his or her doctor has prescribed medication, and now the applicant's blood pressure reading is below 140/90.

So to them, they don't have hypertension. But it could be very important for the underwriter to know the condition is being controlled through drug therapies, which is absolutely a factor in underwriting.

Some companies use a percentage of monthly premium that would apply to cover current medication as a factor in making underwriting decisions. If it exceeds say 25%, the case is declined.

The people who said they don't have high blood pressure because they take medication weren't lying. They just don't understand the underwriting implications. MHE

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