Health care fraud

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According to the National Health Care Anti-Fraud Association (NHCAA), the financial loss due to health care fraud is in the tens of billions of dollars each year. The NHCAA also reports that a conservative estimate is 3 percent of total health care expenditures, while other government agencies place the loss at as high as 10 percent of annual outlay, which could also result in billions of dollars in financial loss.

So how does this affect you? Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premiums.

The NALC Health Benefit Plan has a dedicated department, the Special Investigation Unit, which focuses solely on investigating fraud waste and abuse and recovering plan funds. Over the last two years, the department has actively investigated and worked on approximately 1,000 cases per year. Each dollar recovered saves our members money.

Health care fraud is an intentional act, and can be committed by dishonest medical providers, patients/members of the Plan, or an individual who does not have any connection to the member but has intent to receive unauthorized benefits. Examples of fraud include: falsifying a claim to obtain FEHB benefits, trying to obtain or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.

So, how can we work together to protect the finances of your health plan?

- Never give your plan identification number to people you do not know or over the phone except for your health care provider, authorized health benefits plan or Office of Personnel Management (OPM) representative.
- Let only the appropriate medical professionals review your medical records or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill your insurance to get it paid.
- Carefully review each explanation of benefits statement you receive from the Plan. Although we understand that this can be an intimidating task, it is necessary to review the charges submitted.
- Periodically review your claim history for accuracy to ensure that you have not been billed for services you did not receive. Your review and confirmation are the only way the Plan has to verify you received the service submitted for payment.
- Never ask your physician to make false entries on certificates, bills or records in order to get the Plan to pay for an item or service.
- Ensure that only eligible family members are listed on your policy. Examples to review:
  - A former spouse after a divorce decree or annulment is final, even if a court order stipulates that you must carry their insurance, is no longer eligible.
  - Children age 26 or over (unless they are disabled and incapable of self-support prior to age 26) are not eligible as dependents on your policy

If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

Sometimes premiums are not paid, or other situations apply that result in a cancellation or termination of the policy. If this happens, you should discontinue using benefits, as you are no longer eligible for coverage. If your enrollment mistakenly remains active and benefits are paid, you will be responsible for refunding the Plan.

Fraud or intentional misrepresentation of material fact are prohibited under the Plan. Violators may be prosecuted or have other action taken against them.

What should you do if you suspect fraud, waste or abuse, such as charges by a provider for services you did not receive, double billing for the same service, or a belief that the provider misrepresented any information? First, call the provider and ask for an explanation. This could just be an error. If the provider does not resolve the matter, call the Plan at 703-729-4677 or 888-636-6252, and explain the situation so we can investigate the issue.

You also can report allegations directly to the Office of the Inspector General, which investigates all allegations of fraud, waste and abuse in the FEHB Program. The options for reporting are:

- Contacting the Health Care Fraud Hotline at 877-499-7295
- Completing an online complaint form at opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form
- Writing to the United States Office of Personnel Management Office of the Inspector General Fraud Hotline, 1900 E St. NW, Room 6400, Washington, DC 20415-1100

This is your Health Benefit Plan, and I encourage you to remain vigilant in the fight against health care fraud.