Fla. 'Blues' face civil, criminal investigations

by Linda Everett

For years, the health insurance industry routinely blamed spiraling health care costs and crisis on Americans' overindulgence in "unnecessary" medical tests and procedures, advanced medical technology, greedy doctors, and too many hospital beds. But, given the Senate Permanent Subcommittee on Investigations' ongoing hearings on fraud and mismanagement in the insurance industry, and a recent Department of Justice (DOJ) lawsuit against Blue Cross and Blue Shield of Florida, we may find that the cause of the crisis may lie, at least partially, with the health insurance industry itself.

On July 9, the DOJ, on behalf of the Department of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA), filed a lawsuit against Blue Cross and Blue Shield of Florida (BC/BS) in U.S. District Court in Jacksonville, alleging the insurer violated the federal False Claims Act in its mishandling of tens of millions of Medicare claims a year since the mid-1980s. The civil suit follows a 1991 whistleblower complaint by former BC/BS employee Theresa Burr, who worked with the Jacksonville insurer in 1980-89. Besides overcharging the government, filing false claims for service, and violating its Medicare contract, Burr charges the insurer destroyed thousands of records. The last is the subject of a separate, ongoing criminal investigation by the Office of Inspector General for HHS.

The government's complaint alleges that, starting in 1988, BC/BS "knowingly engaged in a scheme to impair, impede, obstruct, and defeat the lawful governmental functions of the Medicare program." HCFA, the federal agency that oversees the Medicare and Medicaid programs, contracts with private insurers like Blue Cross and Blue Shield of Florida to process Medicare and Medicaid claims. BC/BS of Florida is the second largest Medicare processor in the country—30-40% of the insurer's business is in government contracts. Since 1986, HCFA contracted with BC/BS to process Medicare Part B claims that cover physician services, outpatient care, tests, and home medical equipment for the elderly and disabled.

BC/BS, like most insurers, subcontracts with data-processing firms for the computer services needed to administer the claims. In 1988, BC/BS recommended to HCFA that GTE Data Services be awarded the data-processing subcontract over another bidder who had the highest scoring proposal and who asked $5 million less. GTE, to get the contract, became a partner in a "joint venture" with a subsidiary of Pennsylvania Blue Shield. BC/BS of Florida concealed GTE's deficient data-processing system from HCFA by secretly inflating GTE's scores. BC/BS, knowing GTE lacked the capability to meet the required computer capability deadlines, then waived all data processing performance deadlines for GTE. BC/BS also created a false record of GTE's processing of claims for the government, and instructed its employees to keep quiet about the falsehood. BC/BS told employees to make widespread use of "force codes" to bypass Medicare audits used to prevent Medicare's payment for ineligible or duplicate claims. The suit alleges the insurer also created fictitious prescriptions with claims for medical equipment.

The deficiencies of GTE's data-processing system caused the insurer to wrongfully deny some claims outright. It also caused such a backlog in processing reimbursements for Medicare services, that initial claims for services were simply erased—leaving doctors, vendors, and clinics in financial jeopardy, forcing many to borrow to cover costs. In either case, part of BC/BS's scheme was to have the same claim submitted twice—thus, the insurer falsely inflated its administrative costs to HCFA and was reimbursed for processing two claims, not one. BC/BS also recycled a day's cycle of processed claims to inflate the aggregate statistic of the claims processed by GTE, and created a false record for HCFA of GTE's capability.

In another scheme, BC/BS had the Medicare program pay for claims for which BC/BS and other private insurers, as the primary payers, were responsible. In an audit of computer records for October 1989-March 1991, the Office of the Inspector General found that Florida BC/BS had illegally and knowingly had Medicare pay for nearly $19 million in claims on services that BC/BS and private insurers should have covered. This particular scam is used by other private insurers and Blue Cross and Blue Shield plans with HCFA contracts nationwide.

BC/BS of Florida also sells Medigap insurance to most of the state's elderly. Each subscriber pays a monthly premium to cover medical services that are approved but not completely covered by Medicare. Before the BC/BS Medigap payment kicks in, the claim must be processed and approved by Medicare. In another lucrative twist, BC/BS delays processing and approving these claims for months. The longer the delay in the approval process, the fewer Medigap reimbursements BC/BS pays out, but more Medigap monthly premiums elderly subscribers pay in.

Besides submitting false claims for services, knowingly producing false records to get false claims paid by the government, and causing payment of Medicare claims that were not properly reimburseable, the DOJ suit charges two other counts of breach of contract and unjust enrichment against the insurer. Given that Florida Blue Cross/Blue Shield "has been unjustly enriched at the expense of the United States," the suit demands the money be returned to the United States.