

Research letter

An analysis of one potential form of health care fraud in Canada

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Abstract

HEALTH INSURANCE FRAUD is a potential source of expense, injustice and adverse events in medical care. We examined one type of such fraud: false claims for prescription benefits after the death of the beneficiary. Of 335 536 elderly people in Ontario who died between Jan. 1, 1991, and Jan. 1, 1997, we identified 113 for whom 1 or more prescription drug benefit claims (about 1 per 3000 deaths) were submitted more than 1 year after their death. Claims for expensive medications were rare, as were those for addictive medications. Our findings suggest that this type of health care fraud occurs infrequently and that countermeasures are unlikely to substantially reduce medication abuse in Canada.

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Health insurance fraud is of significant public concern. However, it is a difficult topic to study because of the complexities of informed consent and biases of self-report.¹ So far, the best available data come from case reports.²⁻⁵ These anecdotes, however, are often unreliable and may not be representative of the true extent of the problem.

A rigorous assessment of health insurance fraud is important because the findings could influence health care policy. If the volume of fraud is large, effort and expense may be required to remedy the situation. If the volume is small, it may be tolerated by policy-makers because the costs of corrective interventions could surpass the costs of fraud to the health care system. Indeed, a small volume of health care fraud could be life saving (e.g., antibiotics for a destitute child).

We undertook a study to examine one type of health insurance fraud: false claims for prescription benefits after the death of the beneficiary. Our goal was to establish whether fraudulent prescription benefit claims could be identified and evaluated. We did not attempt to address other potential types of health insurance fraud or possible corrective interventions.

The setting of the study was Ontario, which offers government-funded prescription benefits to people aged 65 years or more through the Ontario Drug Benefit (ODB) Program. We identified consecutive deaths that occurred in this age group between Jan. 1, 1991, and Jan. 1, 1997. We then identified claims for prescription benefits filed in the 12

months beginning 1 year after each patient's death that were underwritten by the deceased patient's health care card (denoted as "posthumous claims"). Prescription benefit claims filed within the first 12 months after a patient's death were not included to avoid the possible misclassification of claims as fraudulent that were late owing to processing delays.

For comparison, we consulted the ODB registry for prescription benefit claims submitted in the year immediately before each patient's death.

During the 6-year study period, about 11 million people were living in Ontario, about 1.3 million of whom were 65 years of age or older.⁶ A total of 335 536 people in this age group died. For 113 of them, 1 or more posthumous claims (about 1 per 3000 deaths) were submitted. The number of deaths increased marginally during the study period, from 51 244 in 1991 to 60 349 in 1996 ($p < 0.001$), whereas the frequency of posthumous claims showed no significant temporal trend.

For all categories of medications, the number of posthumous claims was lower than the number of claims submitted in the year before death (Table 1). Claims for medications of possible abuse were rare. The number of opioid

Table 1: Prescription benefit claims before death and fraudulent claims after death for 113 elderly patients, by category of medication

Category of medication	Interval;* no. (and %) of patients	
	Before death	After death
Cardiovascular	73 (65)	40 (35)
Respiratory	35 (31)	14 (12)
Gastrointestinal	61 (54)	27 (24)
Endocrine and metabolic	61 (54)	28 (25)
Eye drops	28 (25)	14 (12)
Topical	52 (46)	25 (22)
Antibiotic	68 (60)	31 (27)
Analgesic	62 (55)	27 (24)
Neurologic	60 (53)	18 (16)
All	99 (88)†	113 (100)

*Before death refers to the 1-year period before the patient's death; after death refers to the 1-year period beginning 1 year after the patient's death.

†Fourteen patients had not submitted claims during the year before their death.

claims fell substantially (14% v. 4%), as did the number for other analgesics, including NSAIDs (27% v. 9%), acetaminophen (22% v. 5%) and codeine preparations (22% v. 5%), and the number for tranquilizers (40% v. 9%). No claims were submitted for stimulants before or after death.

Most of the prescription benefit claims were for medications that could be considered potentially life-saving (81% of claims before death and 63% of posthumous claims) and rarely exceeded a monetary value of \$1000 over the year (21% and 12% respectively). Only 2 egregious cases of fraud were identified. The first involved 83 separate posthumous claims for Tylenol #2, for a total of 5216 tablets. The second case involved 137 separate posthumous claims for glucose monitoring strips, for a total value of about \$2000.

Our study provides a quantitative analysis of prescription benefit claims fraud. We found that about 1 case of fraud occurred for every 3000 deaths. Most of the posthumous claims were for medications used in the management of chronic medical problems. Posthumous claims for expensive medications or for medications of possible abuse were rare. Together, these findings suggest that the clinical and economic consequences of this type of health insurance fraud may be small.

We did not attempt to determine the full prevalence and duration of all health care fraud and its cost to society. Nevertheless, our findings suggest that fraudulent claims for prescription benefits after the death of a beneficiary are infrequent, that interventions to eliminate them may yield only small financial savings and that such efforts are unlikely to reduce medication abuse substantially.

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