Healthcare Authorization Systems (HAS)

Protecting your people & resources with verified, real-time information you can trust

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HAS Executive Summary

HAS is an easy-to-use, patent-pending, health IT startup that is **over 10 times more effective than all current healthcare fraud solutions**. HAS will prevent 60% to 80% of all transactional healthcare fraud nationwide…versus the 1% to 5% prevented by predictive modeling and other solutions. HAS provides real-time, inexpensive, convenient, and incorruptible location-, personality-, and time-stamped electronic documentation of healthcare encounters that providers link directly to each claim. This creates immediately available, reliable, chain-of-evidence proof of what occurred, when, where, for how long, and who was involved, which enables payers to authenticate every claim before paying it. **This is the most cost-effective way to prevent healthcare fraud before money is lost…and only HAS can do it.**

HAS is the only system that documents **each healthcare transaction** and creates inexpensive and convenient **proof** that **a real patient** and **a real provider actually participated**. Healthcare purchasers (HAS' customers)—for a service fee of 1%—will save 4% to 10%. Providers, patients, and payers will receive the HAS service **free**, along with financial incentives to use it.

Healthcare providers, identity thieves, and imposters commit 90% of healthcare fraud. HAS will be an integral and normal part of delivering health care and will **a)** eliminate all imposters from health care's payment system; **b)** document and authenticate all U.S. healthcare encounters before claims are paid; and **c)** immediately link documentation to claims. **This has never been done before**. HAS is expected to grow safely—at record pace—to an **annual revenue of $20 billion and a value of $60 billion.**

Competition – **The Center for Medicare and Medicaid Services (CMS) spends approximately $800 billion a year on health care.** CMS' new, 18-minute video explaining their fraud-prevention strategy is at http://www.youtube.com/watch?v=5q5RvPwER08. HHS reports 2011 fraud/abuse recovery efforts yielded $4.1B, of which $1.6B was pharma marketing settlements, leaving $2.5B, at most, from other fraud.

Predictive modeling is the newest healthcare fraud detection technology. No current healthcare fraud detection competitor **has ever** detected more than 1% to 5% of the accepted estimates of healthcare fraud. **HAS is over 10 times more effective.** Predictive modeling healthcare fraud detection competitors are: Emdeon, Truven Health Analytics (formerly Thomson Reuters Healthcare), Verisk Health (formerly HealthCare Insight), Northrop Grumman, HP Enterprise Services, CSC, ACS (Xerox), Perot Systems (Dell), IBM, Accenture, CGS Administrators, General Dynamics IT VIPS, SAS, Brighterion, EDIWatch, Fortel Analytics, and LexisNexis Risk Solutions. **Northrop Grumman will develop a fraud prevention system for CMS under a four-year task order worth $77 million (6-30-11).**

Zone Program Integrity Contractors (ZPICs): SafeGuard Service (Zones 1 & 7), Health Integrity (Zone 4), AdvanceMed Corp./NCI (Zones 2 & 5), and Cahaba Safeguard Administrators (Zone 3). **AdvanceMed was awarded a $107 million five-year contract for Zone 5.**

Other competitors: CMS' Center for Program Integrity, Health Care Fraud Prevention and Enforcement Action Team (HEAT), Medicaid fraud prevention bureaus and Audits & Investigation departments, and special investigation units.

Market – The National Health Care Anti-Fraud Association (NHCAA) estimates U.S. healthcare fraud at $75 to $250 billion a year (3% to 10% of all healthcare spending). The Government Accountability Office (GAO) estimates Medicare fraud at $60 to $90 billion a year. This could make the nationwide total for all healthcare fraud much higher than the NHCAA estimate.

$2.5 trillion was spent on U.S. health care in 2009 and $2.2 trillion in 2007. Of that, 33% to 54% was waste, according to PricewaterhouseCoopers' *The Price of Excess*. HAS is a tool that will **inexpensively verify facts on 100% of claims before they are paid**—instead of the practice of **reviewing just 3%** of Medicare's 4.4 million claims a day. This verification will deter and detect fraud before claims are paid and money is lost. HAS will also cut investigation costs and the need for prosecution and incarceration.

Business Model – By making HAS free for providers, patients, and payers, **adoption is virtually automatic.** HAS customers **1)** ensure that their providers, patients, and payers have the tools they need to eliminate unnecessary costs and **2)** can expect to save 4 to 10 times the HAS service fee. HAS annual revenue from service fees is projected at 1% of customer healthcare spending. Nationwide, this 1% equals about $20 billion a year. Every part of HAS will be proved on paper and in prototype before substantial costs are incurred. To ensure customer loyalty and service at a fair price, all customers will be minor shareholders in HAS, if allowed by law.

Customers – Prospective HAS customers are employers, state Medicaid agencies, Medicare, and all organizations that purchase healthcare coverage. Medicaid agencies are prime candidates to be founding customers, because **1)** together they spend over $400 billion a year on health care, **2)** each state is responsible for its own program, and **3)** many states have huge financial problems. Five state Medicaid agencies have expressed interest in HAS when it is ready to begin providing services. **These five agencies spend a total of over $116 billion a year on health care, which represents over $1 billion in HAS annual revenue.**

Management Team – HAS' management team will be selected by HAS' founders and initial partners.

The next step is to read the *HAS Confidential Snapshot* (two pages) and HAS' other confidential documents.

To obtain these confidential documents, contact Jim Wigney at (916) 760-4477 or jim.wigney@hasnet.us.