iFHP 2023 FAWE RESILIENCE REPORT

Australia and New Zealand with insights from Europe and Africa

INTRODUCTION

This is the iFHP 2018 FAWE Resilience Report developed in collaboration with the University of West London [UWL]. Its purpose is to evaluate a range of indicators regarding fraud, error and waste in the healthcare insurance sector. These indicators will help all iFHP members understand current and future threats and issues that need to be addressed. It is the first report of this type ever undertaken.

The findings of this report are based on a survey distributed in late 2018 to five (5) member organisations of the iFHP. The survey was divided into four sections with headings that correspond with the structure of this report. The headings are: organisation, people, investment and technology - presented in that order.

This report consists of a two page executive summary highlighting the key findings and any associated observations and recommendations. Then there is a short section on the nature and limitations of the data, as the analysis so highly depends on the quality of data. Next there is a detailed breakdown of the survey results together with some comments.

These comments are further explored in the penultimate section entitled “observations and way forward”. Here there are more questions than answers but also a clear path to the next phase in the iFHP agenda to increase resilience amongst its members against fraud, abuse, waste and error. Lastly, there are some concluding words from the authors.

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1. EXECUTIVE SUMMARY

Text

2. NATURE OF THE DATA

This where we talk about the data and that we primarily have data from Australia
There are two other categories Europe and Africa for comparison
Each section ends with "the whole picture" including all categories.

This report is based on a survey of five (5) members of the iFHP. It is a snapshot of current practice in preventing and recovering funds lost to fraud, abuse, waste and error in the healthcare insurance sector. All values are presented in USD.

The results of the survey represent the data submitted by each organisation. From the data the most accurate assessment of current practice and recovery of assets lost to fraud, abuse waste and error is calculated. Given the sample size and variance in answer data density (i.e. the amount, detail and relevance of information provided in an answer), the limitations to data analysis are acknowledged. As a result exact calculations and **values on variance and standard deviation are not explicitly stated but rather qualitatively indicated when appropriate as low or high**.

Not all questions were answered by the organisations. Where data is absent this is highlighted in the report by indicating the number of organisations that responded and/or fail to respond. It is also worth noting that the answers to all questions where not delivered in the same format.

3. DETAILED ANALYSIS

3. ORGANISATION

3.1 Organisation base of operations

Australia & New Zealand	9
Europe	3
Africa	2
Total number of organisations	14

Note that this is largely a spotlight on ANZ with comparisons from other areas in the world

Several of the organisations operate worldwide but for this report the data has been limited to the country where the headquarters of the organisation resides. To maintain organisation anonymity these countries are not listed here.

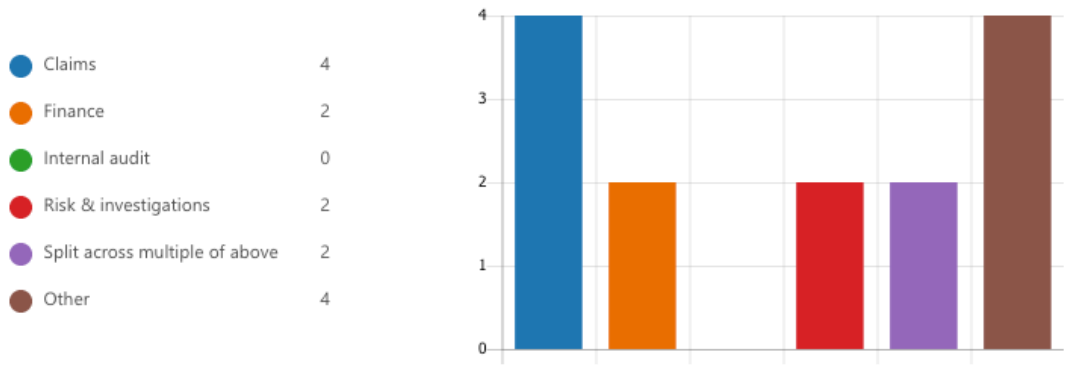
3.2 Number of lives covered

Category	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Total number of lives covered	15,521,589	5,689,142	4,000,000	25,210,731
Average number of lives covered	1,724,621	1,896,381	2,000,000	1,800,767

Comment on that overall, the organisations are comparable but that there are large variations

The total of numbers of lives covered by participating organisations range from 871.000 to 3.7 million, with an average of 1.4 million lives per organisation. Of the five (5) organisations three (3) have approximately one million lives, 870.000, 990.000 and 1.1 million. Two (2) organisations cover 2 and 3.7 million lives respectively. The total number of lives covered by these five (5) organisations is about 8.7 million.

3.3 Location of PIA unit



Should we divide this into three categories as well? Yes.

The positioning of the Payment Integrity Activities (PIA) varies and is located in;

- Risk and Investigations,
- Claims (special investigation unit) and Finance (data analytics),
- Governance,
- A dedicated function within a Healthcare and Strategy Division, and
- Claims and Commercial Department, across the five (5) organisations.

3.4 Internal and external PIA activity

The various stages that PIA are undertaken

Type	Stage	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
In-house	Pre-payment	8	3	2	13
	Payment	6	3	2	11
	Post-payment	9	3	2	14
Third-party	Pre-payment	2(2)	1	1	4
	Payment	2(1)	0	1	3
	Post-payment	4(1)	1	1	6

Numbers in cells indicate answering yes, number in bracket indicates number of non-replies

Add percentages to the analysis?

All organisations conduct PIA **pre-payment internal** with only one (1) organisation conducting **external** assessment. The level of detail on what internal processes are used differs. One organisation has an internal automated and manual pre-approval decision and mutual claim adjudication. A second organisation has Internal Business Rule Engine controls for the adjudication of all claims. This ensures the medical necessity of length of stay of patients in hospitals, has special adjudication of illnesses and procedures to ensure medical appropriateness and accuracy of claims, targeted prepayment audits and an audit programme communicated in advance to medical providers to influence behaviour and support integrity of billing and track changes in behaviour. The remaining three (3) organisations provided no details as to internal procedures. The one organisation that has **external** PIA provided details that indicated that it sought undertakings from members/legal representatives in third party recovery, prepayment querying with medical providers and customers education with all policyholders regarding benefit entitlements.

Post-payment internal and external PIA activity

All organisations conduct PIA **post-payment internal** with four (4) organisations conducting both **internal and external.**

Two (2) organisations provided **details on internal post payment systems.** For one organisation these consisted of quality assurance claims adjudication, fraud detection, investigations and recovery of fund. A second organisation had targeted clinical and billing audits and investigations into claims that have been paid that came from informed leads or identified by the organisation. In addition, this organisation also employed data analytics to conduct post payment checks to billing outliers in providers'

claiming behaviour, with dedicated staff to deal with enquiries from members regarding statements of benefit received post payment of a claim, and contract and schedule compliance to checks to ensure that the correct benefits were claimed.
Four (4) of the five organisations have an **external post payment system** but an only detail provided by one organisation was periodic external audit.

3.5 Claims lines targeted by PIA

Area	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Hospital Claiming (e.g., care centre, clinic)	9	3	2	14
Medical claiming (e.g., professional)	9	3	2	14
Ancillary claiming (e.g. dental, physiotherapist, chiropractor)	9	3	2	14
Member/customer claiming (e.g. company/individual)	9	3	2	14
Staff/employees (e.g. internal/in-house)	6	3	1	10
Third-party (e.g. sub-contracted employees/consultants)	2(1)	2	1	5

Numbers in cells indicate answering yes, number in bracket indicates number of non-replies – how should we deal with the non-replies?
Add percentages to the analysis?

All organisations target hospital, medical, ancillary, members/customers claims lines. All target staff/employees claims lines save for one organisation that has outsourced this type of claim with only three (3) organisations targeting **third party** claim lines. One noticeable point here is that the organisation that assessed staff/employees claims lines externally also claimed it has no third party claim lines.

3. PEOPLE

3.6 Percentage of paid out claims recovered

Of the annual total paid out claims recovered for the last three years inclusive (2019-2022), what is the percentage recovered through PIA FAWE activity?

Awaiting clarification of question

The annual total paid out claims recovered for 2016-2018 for fraud is 1-2 %. One organisation claimed 33 % for all fraud, abuse and waste with no information on error whilst a second organisation had no breakdown between claims with 3 % across all claims. Therefore, calculating data across all four (4) organisations:

Table 1 - Percentage range and average of paid out claims recovered

Area	Range [%]	Average [%]
Fraud	1-2	1
Abuse	13-20	17,5
Waste	52-70	60,5
Error	8-35*	21

*Based on three (3) organisations

The reason for this breakdown is that one organisation claimed no breakdown of data was possible as subjective and dependent on intent of the claimant, with a second organisation stating it had no practical way to measure error. A third organisation also claimed that it did not record data in specific descriptive units as above but completed an external review of claims with a focus on leakage, which encompassed all of the elements above and concluded that approx. 2.7-3.7% of benefits paid were lost due to leakage.

Note that fraud is significantly lower than the other areas and that waste is the biggest area, at about three times the size of either abuse or error. This distribution is further considered in relation to other questions as well as explored in section 4 Observations and way forward.

3.7 a) What proportion (%) of individual practitioners that provide services to your customers – have a contractual arrangement with your fund?

b) What proportion of hospitals who provide services have a contractual arrangement with your fund?

3.8 a) How many claims on average does you member make each year?

Awaiting clarity on what this question means

b) What is your average claim cost?

Type	ANZ (8)	EUR (3)	AFR (1)	ALL (12)
Total claim cost	9,876	1,848	410	12,134
Average claim cost	1,235	616	410	1,011

Awaiting clarity on currency

3.9 Dedicated employees in the areas of payment integrity

How many dedicated employees (i.e. specialists, primary responsibility, etc.) does your organisation have in total, working across the areas of payment integrity? Excludes consultants and third parties

Category	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
How many dedicated employees (i.e. specialists, primary responsibility, etc.) does your organisation have in total, working across the areas of payment integrity? Excludes consultants and third parties	21	30	42	26
How many further people are engaged on a third party or consultant basis	2	3	0	2
The total headcount of those working in the healthcare line of business	446	2,273	1,757	1,025

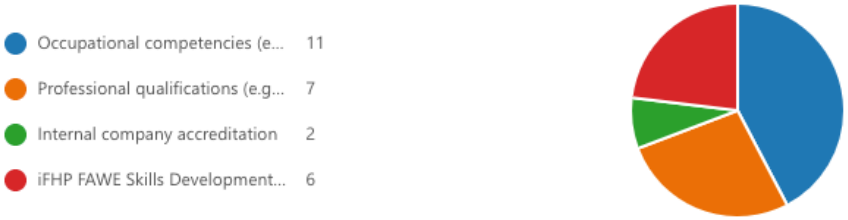
The numbers are averages
Discuss the range of answers (i.e. standard variation but in practitioner terms)
Because one ANZ organisation uses 10 third party people
Add percentages to the analysis?

The number of dedicated employees working for an organisation on fraud, abuse, error, and waste range from 7-51, based on five (5) organisations. Broken down one organisation stated it has 51 dedicated employees (no details), a second twenty–one (21) employees (excluding error), a third nine (9) (but increasing to 15) employees and fourth a detailed breakdown with 26 in Special Investigation Unit (SIU), 2 in claims and 3.5 in personal recovery injury, and the last seven (7) dedicated employees.
Note that there is a high variance between values. Calculated against lives covered this equates to **10 dedicated employees per 1 million lives covered**.
This last highlighted part is an interesting number that we could add.

3.10 Professional qualifications

Type	ANZ (8)	EUR (3)	AFR (2)	ALL (13)
Occupational competencies (e.g. police/law enforcement, nursing, clinical, law, etc.)	7	1	2	10
Professional qualifications (e.g. Accredited Counter Fraud Specialist [ACFS], Professional Certified Investigator [PCI], etc.)	6	2	2	10
Internal company accreditation	1	0	1	2
iFHP FAWE Skills Development Course;	3	2	0	5

24. Do your team members have professional qualifications?



Nature and composition of investigation teams

All organisations have employees with occupational competencies and professional qualifications. Three (3) of the five organisation provided details of the composition of the investigative teams but only two (2) provided explicit data. One organisation employees four (4) Health Information Managers, (two of which were also nurses), one (1) coder and one (1) with a background in law enforcement. A second organisation has two (2) former Police Detectives, two (2) Claims management, two (2) Clinical Nurses, seven (7) Health Information Managers, two (2) Clinical Coders and six (6) Financial employees for (benefit recoveries and reassessment). All three (3) organisations have clinical employees such as a nurse.

The key roles in terms of competencies, in no order of significance, are: health information management, nursing, coding, law enforcement and claims management. Note that several organisations combine more than one of the various competencies in the same person.

Four (4) organisations have employees with professional qualifications. These are diverse: certified Counter Fraud Specialists, Certificates in Security Investigations, risk management, Quality Auditing, Diploma in Investigations, Health Information Management degree, and ACFS.

It is clear that formal qualifications are relevant and valuable, thus given the size (number of employees, turnover etc.), scope (number of lives covered, societal inclusion, etc.) and reach (global coverage, movement of customers, goods and services, etc.) of the of health insurance sector, it could be considered developing a **sector specific qualification**.

3.11 Estimated return on investment from claim lines

In absolute numbers (i.e. not relative other values) what is your estimated return on investment from units claim lines in (as noted if possible please quote in €'s across the three years data period (2019 - 2021):

Type	ANZ (9)	EUR (3)	AFR (1)	ALL (12)

Awaiting clarity on why this question seems to be asked multiple times with different answers

3.12 Number of cases per year

Type	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Average of cases reviewed yearly	24,854	1,918	1,815	16,648
Average number of cases handed over to regulators, third party review, or criminal investigation (by the police)?	14 (0.08%)	8 (0.03%)	8 (0.40%)	48 (2,62%)

3. INVESTMENT

3.13 Payment of claims

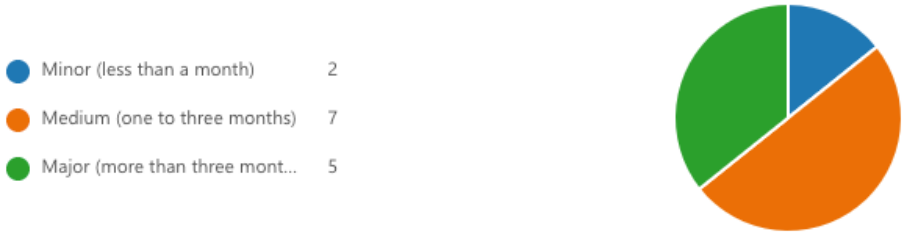
Ratio of PIA undertaken	ANZ (9)	EUR (3)	AFR (1)	ALL (13)
Pre/post payment of claims	48/52	66/34	25/75	50/50

Ratio split of PIA undertaken pre/post payment of claims
Pre-payment ratio split of PIA ranges from **15-80%** and **post payment 20-85**% across all organisations. These ratios are currently under assessment and subject to change. Organisation one (1) had a 80/20 split, organisation two (2) 35/65 split, organisation three (3) 40/60 split, organisation four (4) 15/85 split (but pushing to 80 % pre-payment), and organisation five (5) 20/80 split.
Currently only one organisation has a pre-payment PIA above 50 % but there seems to be a **movement towards an emphasis on pre payment PIA**. This move corresponds with research findings and empirical data pointing clearly towards prevention of fraud being more cost effective than post payment activities (e.g. investigation and litigation).

3.14 Average time spent on investigations

Category of time spent	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Minor (less than a month)	2	0	0	2
Medium (one to three months)	4	1	2	7
Major (more than three months)	3	2	0	5

34. What is the average time spent on an investigation (from opening it to closing it)?



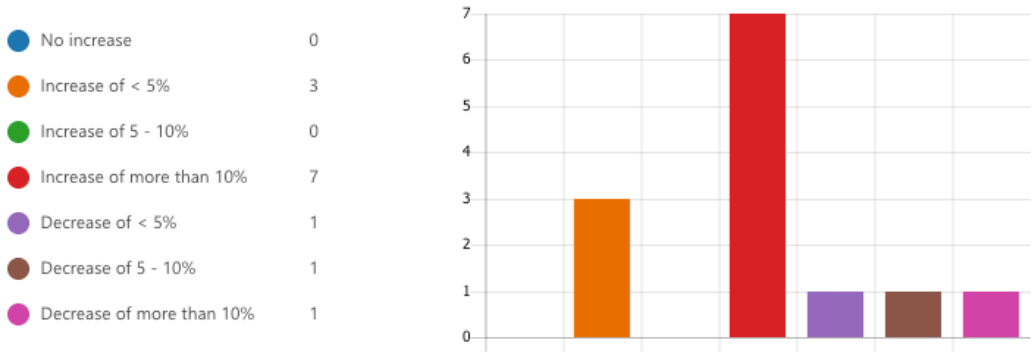
Three (3) organisations indicated time spent on investigations; two (2) organisations responded that most cases are medium (one to three months) with one (1) more than three (3) months. To add context to this a minor investigation can be completed in one day with major investigations lasting two (2) years. Furthermore, desktop audits and claims verifications (pre and post payment) can be dealt with in less than a month; DRG audits between 1-3 months and clinical audits are more than 3 months. Thus, **there is no set time for investigations** but instead depends on 'factors' associated with the case. Further analysis is required to assess the average time spent on investigations (breakdown of time intervals) and specific investigations (type of case under investigation).

3.15 Savings as a result of claims PIA

Since the establishment of your PIA unit have you experienced an increase or decrease in the level of recoveries year on year for the last three years (2019-2021)?

Category of time spent		ANZ (8)	EUR (3)	AFR (2)	ALL (13)
No increase		0	0	0	0
Increase	<5%	1	1	1	3
	5-10%	0	0	0	0
	>10%	5	1	1	7
Decrease	<5%	1	0	0	1
	5-10%	1	0	0	1
	>10%	0	1	0	1

35. Since the establishment of your PIA unit have you experienced an increase or decrease in the level of recoveries year on year for the last three years (2019-2021)?



All five (5) provided answers that indicate relatively similar results. The total gross benefit identified as **savings from PIA is 0.8-3 %.** The average is 1.7%.

3.16 Claims pay-out avoided/recovered annually due to PIA

What percentage of your total claims pay-out is avoided and/ or recovered annually due to PIA activity?

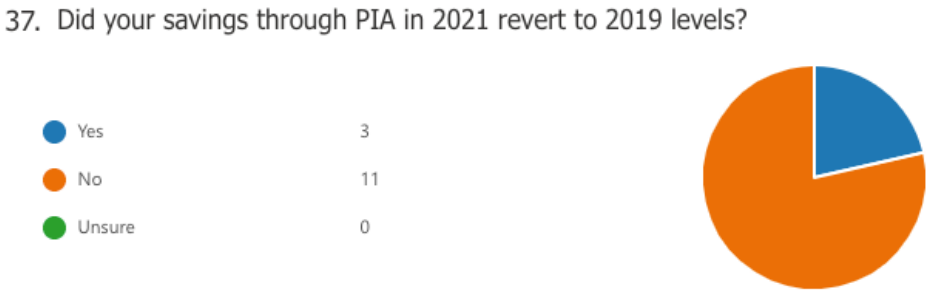
Claims pay-out avoided/recovered annually	ANZ (9)	EUR (3)	AFR (1)	ALL (13)
Average percentage	3%	2%	11%	3%

Awaiting clarity on how the percentages are reported.

As with question 16, all five (5) organisations provided answers. Two (2) of the organisations referred back to question 16, stating same value. The percentage of **claims pay-out avoided/recovered annually is 0.8-5%.** The average is 2.3%.

3.17 Did your savings through PIA in 2021 revert to 2019 levels?

Claims pay-out avoided/recovered annually	ANZ (9)	EUR (3)	AFR (1)	ALL (13)
Yes	1	1	1	3
No	8	3	1	12



3. TECHNOLOGY

3.18 Claims processing

What % of your claims are "straight through" (auto) processed?

What % of your claims are submitted digitally?

Average percentage of claims	ANZ (8)	EUR (3)	AFR (1)	ALL (13)
"Straight through" (auto) processed	79%	71%	79%	77%
Submitted digitally	59%	65%	89%	65%

Given these percentages it seems as if claims can be processed in both ways.

3.19 PIA Software

Do you have an external sourced electronic software system to facilitate your PIA in the identification and investigation process?

Do you have an internally built electronic software system to facilitate your PIA in the identification and investigation process?

Software system to facilitate PIA		ANZ (8)	EUR (3)	AFR (2)	ALL (13)
Internally built	Identification (Analytics)	6	2	1	9
	Investigation (Case management)	3	1	1	5
Externally sourced	Identification (Analytics)	7	1	1	9
	Investigation (Case management)	3	1	0	4

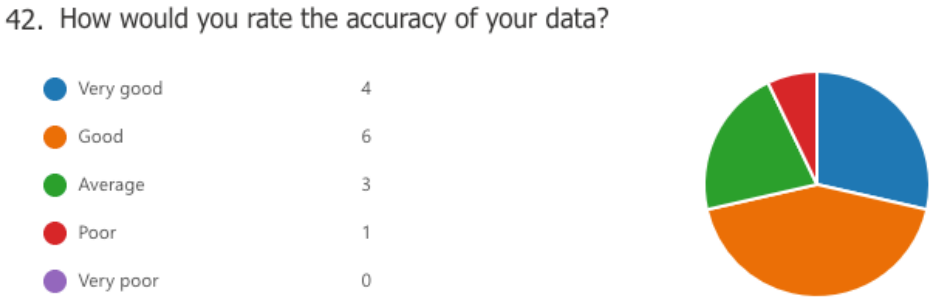
The numbers don't add up as organisations can have both identification and investigation internal software, and both internal and external software.

Two (2) of five organisations have **proprietary** software systems for i**nformation analytics** PIA process. Two (2) organisations have **adapted** systems for PIA process. One (1) organisation has developed (imed) and adapted (bespoke machine learning capability) in place.
Two (2) organisations have **dedicated investigation (case management)** systems with one explaining that it uses proprietary electronic software system for its rules engine on pre-payment adjudication of claims. The second organisation to have a **developed case management investigation** uses base SAS and SAS enterprise to identify FWA, triage cases and produce evidence, and has built its own system in-house (CHAIN) to manage cases which are held electronically.

No organisations have **developed case management investigation software** as part of a suite but one has adapted a bespoke SAP solution.
Two (2) organisations use Lorica (HIBIS) claims solution for the purpose of post payment review of claims and alerts but neither had a developed investigation case management system but one had the adapted bespoke SAP solution mentioned above. There is **no clear software solution** for analytics or case management across these five (5) organisations.
The detailed analysis of how the different software systems work and are applied is arguably a project in and by itself. It is, however plausible to identify a number of key functions that are considered essential for effective management and investigate to what extent these are fulfilled.

3.20 Accuracy of data

Data accuracy	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Very poor	0	0	0	0
Poor	1	0	0	1
Average	2	1	0	3
Good	3	1	2	6
Very good	3	1	0	4



3.21 Integrated system coverage

Do you have an integrated system that covers all claims, providers and member data?

Do you use this technology to address pre-payment issues?

Integrated system	ANZ (9)	EUR (3)	AFR (2)	ALL (14)
Covering all claims, providers, and member data	7	3	2	12
Used to address pre-payment issues	7	3	2	12

3.21 Past, present, and future threats

Threats	ANZ (9)	EUR (3)	AFR (2)	ALL (14)

What are the biggest threats and issues to your organisation in relation to:

Hospital claiming (e.g., care centre, clinic)
Medical claiming (e.g., professional)
Ancillary claiming (e.g. dental, physiotherapist, chiropractor)
Member/customer claiming (company/individual)
Staff/employees (internal/in-house)
Third-party (sub-contracted employees/consultants)
Covid-19 or other global health emergency
Other

Fraud, Abuse (upcoding) and error, Medicare does not have sufficient controls in place, Upcoding and Overservicing, Increase in financial crime due to recession / improved cyber criminal attacks;

The table below is a consolidation of the diverse responses to past, present and future threats to different claim lines. All five (5) organisations provided answers that are summarised in the table, highlighting key threats.

Table 2 - Consolidation of past, present and future threats to claim lines. Each threat was recognised by two or more of the participating organisations.

Claim lines	Past	Present	Future
Hospital	Consumption of resources	Manipulation of coding and pricing	Psychiatric claims
Medical	Upcoding of episodes, cosmetic treatment and unsupported specialist billing		
Ancillary	Billing for services not provided and limit swapping	Billing for services not provided and alternative treatments	Alternative treatments
Member/customer	Fictitious or altered claims for services not provided and collusion	Same as for past + organised crime	
Staff/employees	Processing and adjudication of claims claiming via an externally facing platform		
Third party	No clear threats identified.		

The biggest threats (based on four (4) organisations) to **hospital claiming in the past, present and future** are as follows:
PAST

Accommodation (referred to by one (1) organisation), psychiatric and rehabilitation services (referred to by one (1) organisation), up-coding (referred to by one (1) organisation), and incentive for referrals (referred to by one (1) organisation)
PRESENT
Accommodation (referred to by one (1) organisation), psychiatric services (referred to one (1) organisation), review claims and re-coding by hospitals (referred to one (1) organisation), and up-coding, and unbundling of packages, unnecessary pathology and imaging, manipulation of pricing (expensive medication and delivery modes), miss-billing of prosthetic devices and unnecessarily expensive prostheses manipulation of prices (all referred to one (1) organisation).

FUTURE
Accommodation (referred to one (1) organisation), psychiatric claims and ICU, and pathway referrals (rehabilitation), low value care (**referred to by three (3)** organisations with one (1) also claiming that the move towards more services provided outside of the hospital environment potentially reduced fees for service cost, increases the opportunity for volume of services and lack of clarity regarding delivery methods (referred to one (1) organisation).

For **medial claiming** based on four (4) organisations **past, present and future threats** are as follows**:**
PAST
Up-coding (referred to by two (2) organisations), plastic, reconstructive surgery (referred to by two (2) organisations), cosmetic procedures present as necessary medical interventions (referred to by one (1) organisation), duplicate billing of tests, unbundling of codes, misrepresenting ineligible treatment and unnecessary or low value treatment for financial benefit (referred to by one (1) organisation).
PRESENT
Up-coding (referred to by two (2) organisations), plastic, cosmetic surgery (referred to by two (2) organisations) documented as medically necessary, orphan claims and specialist billing not support by hospital records (referred to by one (1) organisation), and duplicate billing of tests, unbundling of codes, misrepresenting ineligible treatment and unnecessary or low value treatment for financial benefit (referred to by one (1) organisation).
FUTURE
The threats are the same as the **PRESENT** with the exception of one mention of dubious qualifications of medical professional and healthcare providers.

For **ancillary claiming** based on four (4) organisations **past, present and future threats** are as follows:
PAST
Dental surgery (referred to by one (1) organisation) with one (1) organisation referring to cosmetic dentistry masquerading as dental treatment, up-coding (referred to by one (1) organisation), billing for services not provided **(referred to by three (3)** organisations), limit swapping (referred to by two (2) organisations), and exaggerating length of treatment (referred to by one (1) organisation).

PRESENT
Alternative treatments (referred to by one (1) organisation), use of natural therapy (untrained/registered masseurs) a delivery of sexual services (referred to by one (1) organisation), billing for services not provided (referred to by two (2) organisations), over-servicing (referred to by one (1) organisations), and exaggerating length of treatment (referred to by one (1) organisation).
FUTURE
Alternative treatments (referred to by one (1) organisation), organised crime (referred to by one (1) organisation), changes within PHI reforms and confusion in services covered/excluded depending on provider(s) delivering service, and how physios are still potentially able to deliver Pilate and reflexology despite it being a natural health removed from rebates (referred to by one (1) organisation), billing for treatment not provided, exaggerating length of treatment and cosmetic surgery presented as dental treatment (referred to by one (1) organisation).

For **members/customers** claiming the threats based on four (4) organisations the **past, present and future** are as follow:
PAST
Fictitious/altered claims/claims for services not provided (**referred to by three (3)** organisations), with specific mentioned of the presentation of forged invoices and fake corporate accounts (referred to by one (1) organisation), with collusion with providers, limit swapping referred to by one (1) organisation).
PRESENT
Fictitious/altered/false claims/claims for services not provided (referred to by two (2) organisations), collusion (referred to by two (2) organisations), organise crime (referred to by two (2) organisations), including the presentation of forged invoices and fake corporate accounts (referred to by one (1) organisation), and multiple memberships in false names (referred to by one (1) organisation).
FUTURE
It is broadly the same as the **PRESENT** fictitious/altered/false claims/claims for services not provided (referred to by two (2) organisations), collusion (referred to by two (2) organisations), organise crime (referred to by two (2) organisations), including the presentation of forged invoices and fake corporate accounts (referred to by one (1) organisation), and multiple memberships in false names (referred to by one (1) organisation) but with one specific mention of identity theft across the global landscape.

For **employees (Internal in-house)** based on four (4) organisations the **past, present and future** threats are as follows:
PAST
Processing/adjudication of claims (referred to by one (2) organisation), false membership via external platforms (referred to by one (2) organisation), and false cash claims (referred to by one (1) organisation), with theft of assets, money, customers' identity/banking details, company data and collusion with insured person/providers (all referred to by one (1) organisation).
For the **PRESENT AND FUTURE** the threats are the same as the **PAST** with the exception of one mention of procurement fraud.

For **third party/sub-contracted** based on three (3) organisations: the **past, present and future** are as follows:
PAST
High value contracts and compliance issues (referred to by one (1) organisation), false membership via external platforms (referred to by one (1) organisation), with specific reference to recovering money from third party with lawyers seeking to make arrangement(s) that reduce settlement but maintain quantum for client that break the recovery into specific values (referred to by one (1) organisation).
For the **PRESENT AND FUTURE** the threats are the same as the **PAST**.

4. OBSERVATIONS AND WAY FORWARD

This report is based on the partially complete responses to the survey. It has provided some useful information and data but from this limited data we can only draw clear conclusions on a discrete number of issues that are relevant to fraud, abuse, error and waste in the healthcare sector.

Section 4 of the report highlights the need for detailed research based on the data obtained in the survey. For clarity each section is broken down into organisation, people, investment and technology. We offer analysis of the key issues raised in this survey and end each section with three (3) recommendations. These recommendations are all based on data (or lack of it) and specific comments made by iFHP members.

In total we offer 12 recommendations in this section of the report. Below, however, are three (3) key recommendations that require attention based on the data and comments in the survey. These recommendations are achievable. These are:

1. Develop a sector specific qualification in order to establish a common approach and understanding; for knowledge transfer through publications, seminars, and workshops, etc.

2. Identify software solutions that help all members of the iFHP to evaluate and streamline working practice(s); and

3. Clarify and define the use of DRG or similar system to benchmark best practices across the iFHP membership.

4. ORGANISATION

Whilst the organisations are vulnerable to fraud, abuse and error and waste, and have made some progress in dealing with these issues, unless systematically addressed these issues will have an effect on the types and level of service organisations can offer to the numbers of lives covered. Further investigation is needed to address organisational processes and procedures so investment in people – employees and customers' service – increase organisational competiveness and help future proof systemic shortcomings now and in the future.

Further analysis is needed on the role(s) and objectives of the PIA. The location of PIA units seem to vary but the objective of the PIA appears to be the same. Analysis is needed though on **what** and **how** a PIA is used to determine the importance of organisational objectives as the level of detail differs on what internal process is used. This could outline the most effective internal system will reduce fraud, abuse, error and waste. Also, only one (1) organisation claimed to conduct **external pre-payment** and explained that it sought undertakings from members/legal representatives in third party recovery, pre-payment querying with medical providers and customers education with all policyholders regarding benefit entitlements: this we suggest is an approach that all organisations should consider as a preventive mechanism for fraud, abuse, error and waste.

The survey provides information and details regarding PIA i**nternal post payment systems** from two (2) organisations with one (1) organisation on **external post payment systems.** Data is therefore limited on these important systems that help reduce fraud, abuse, error and waste. In particular more detailed data is needed to conduct detailed assessment. In addition the only information secured in the survey regarding **external post payment system** claimed the organisation conducted a periodic external audit. The periodic nature of the audit, by whom, why and on what organisation is unclear. Assessment of **pre-payment** is clearly understandable but organisations should perhaps conduct external assessment beyond periodic audit.

Recommended way forward:

4. Further investigation is needed to address organisational processes and procedures to increase competiveness and future proof systemic shortcomings;

5. Develop an approach (official statement/policy) that all organisations should consider as a preventive mechanism for fraud, abuse, error and waste, and

6. Outline and assess how the pre- and post-payment systems help reduce fraud, abuse, error and waste.

4. PEOPLE

Losses to fraud are difficult to recover but the percentage range is close across the organisations based on the responses in the survey. This distribution across only a few organisations is substantial. What is needed is a detailed understanding of what these organisations are doing and systems of measurement, if any, that are in place before informative analysis can be conducted. This would be invaluable to help disseminate best practice across the IFHP members.

Technology can enable the assessment of claims but the employment of counter fraud specialists, however, are considered a necessary investment rather than a cost for all organisations in preventing and recovering organisational profits from fraud, abuse, waste and error.

There is a range of occupational/professional qualifications in use across the organisations. This in itself is not a problem; but there is no indication here that these are transferable across the sector. The survey highlights a range of people employed but a detailed mapping of competence and qualifications across the sector is needed. Further, one could consider a sector specific qualification that could be accredited by the iFHP. This should help IFHPs other members that perhaps lack the knowledge and experience of members in this survey to establish set/similar criteria across the sector leading to internationally recognised skills/competence and qualifications.

The estimated return on investment from claim lines is wide ranging. A shift has occurred to assess attributed savings/behavioural change. The one organisation that is currently not calculating attributed savings/behavioural change will do so in the future. A second organisation claimed that it did not estimate (sentinel effect) in any systematic way and considered the data provided an under estimation of savings made. It appears that whilst a shift has occurred in trying to estimate attributed savings/behavioural change there is no clear method employed in the sector to make such an assessment. This should be something that is possible to design and could be used sector wide to the benefit of all iFHP members.

Recommended way forward:

1. Detail and disseminate what organisations are doing in terms of systematic measurement of fraud, abuse, error and waste;

2. Develop a sector specific qualification accredited by the iFHP; and

3. Deliver certified iFHP qualification training that aligns with national qualifications (e.g. ACFS), thus allowing participants to multi-certify.

4. INVESTMENT

Four (4) organisations claim to have a Diagnostic Related Grouping (DRG) for package price and per item, but only two (2) claim to have a **DRG system**. Further clarification is needed here as to whether organisations have a **system** in place or DRG is used in a selective manner based on the internal procedure/priority such as package price and item(s). From the data in the survey it is currently difficult to come to a detailed and specific conclusion.

The percentage of PIA pre and post payment is: **pre-payment 15-80 %** across all organisations and p**ost payment 20-85 %** across all organisations**.** There is a wide variation here: one (1) organisation had an 80-pre/20-post payment split, with another 15-pre/85-post payment split. From the data in this survey it is impossible to determine the reasons for this variance. The organisation that has the 15-pre/85-post payment split, however, indicated that it is moving towards 80 % pre-payment method. Pre-payment is useful method to reduce fraud, abuse, error and waste without hurting customer satisfaction. Trying to reclaim funds lost to fraud and abuse in particular is difficult to recover and prepayment percentage should be in excess of the post-payment threshold.

There are no clear criteria or routes that lead to investigation across all organisations. Internal procedures seem to be in place but these are vague with no systematic approach clearly stated. There is ample room here to design a clear system based on set criteria. This can still be flexible in that the system is reviewed to establish cases that it catches and excludes, nonetheless a set system leads to consistency and measurability creating informative and useful best practices across organisations and for IFHP members.

All organisations report an increase in funds recovered (2016-2018) since establishment of PIA. The percentage total claims pay out avoided/recovered per annum based on PIA is 1-5 % based on all organisations and as such PIA in a positive approach to reducing fraud, abuse, error and waste.

Recommended way forward:

1. Investigate, develop and establish clear criteria for opening an investigation;

2. Clarify and define the use of DRG or similar system to benchmark best practices across the iFHP membership; and

3. Consider an optimal distribution for pre- and post-payment activities, with a clear rationale activates in terms of cost/resource effectiveness.

4. TECHONOLOGY

Two (2) of the five organisations have a **dedicated analytic (identification)** software system for PIA and two (2) of five organisations have **dedicated investigation (case management**) systems in place, with one (1) organisation a **dedicated analytic (identification**) as part of a suite but no organisations have a **dedicated investigation (case management**) as part of a suite.

Two (2) of five organisations have **proprietary** software system for i**nformation analytics** PIA process and two (2) organisations have **adapted** systems for PIA process. There is no clear software solution for analytics or case management based on these five (5) organisations. It appears that **identification** and **investigation** systems have developed in an ad hoc fashion and there is potential for a dedicated software system to be designed and utilised across the healthcare sector and for iFHP members.

There is detailed information on past, present and future threats in section 3 across all claim lines with common themes such as up-coding, unbundling of packages, unnecessary pathology, manipulation of pricing (expensive medication and delivery modes), miss-billing etc. These are perhaps disappointedly expected and an ongoing problem in the healthcare sector. PIA has helped tackle these as indicated above but analysis is needed to help prevent **future** threats from services provided outside of the hospital environment, alternative treatments, use of dubious qualifications by healthcare employees, internal frauds such as false membership, theft of client personal details, and organised crime. The current PIA systems in place are unable to deal with all of these issues and employment of ex-law enforcement professionals and/or close working relationships with national and international law enforcement bodies could be further established.

Recommended way forward:

1. Identify key functional requirements for software in support of identification and investigation that would allow all members of the iFHP to evaluate and streamline their software solutions;

2. Collate and consider future threats and develop an action plan for various items including an information exchange system allowing for experience and advice to be shared across members as new threats materialise; and

3. Develop and nurture relationships with both national and international law-enforcement agencies and professionals, e.g. co-hosting an annual international conference.

5. CONCLUSION

ABOUT THIS REPORT

This report provides information on five (5) healthcare insurance providers. No individuals or organisations are identified. Instead the report provides a snapshot analysis of healthcare organisations approach to fraud, abuse, error and waste.

The authors of this report are committed to analyses such as this making a real difference. We are grateful to the iFHP and participating organisations for helping us gather the data upon which this report was based.

By expanding the extent of knowledge that member organisations of the iFHP hold about not only their own arrangements but also their peers, we can help ensure better quality decisions are taken in the pursuit of countering fraud, abuse, waste, and error, for a competitive advantage.

This report is providing the basis for developing a database of healthcare insurance resilience information for all members of the iFHP.

ABOUT THE AUTHORS

Prof. Graham Brooks

Prof. Graham Brooks' research specialises in how corruption threatens the security of criminal justice, business and health systems in an international context.

Prof. Brooks has been invited to present at the Cabinet Counter Fraud Conference 2012, the European Health Fraud and Corruption Network 2015, in The Hague, the Cabinet Office Round-Table on Anti-Corruption in 2016. Prof. Brooks presented a paper on 'Democratization of the police in the Republic of Korea: Decentralization, Accountability and Legitimacy' in Korean Parliament 2017, and is now recognised as an Official Advisor to the Police Reform Group in South Korea. Prof. Brooks has also been Assistant Director Centre for Counter Fraud and Corruption and Secretariat of Counter Fraud Accreditation Board in his career so far.

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Peter Stiernstedt is the Deputy Head of School of Human and Social Sciences at the University of West London. He is also pursuing a PhD in Social Sciences on the Perception of Corruption with a fully funded bursary from the University of Portsmouth. Previous academic achievements are a BSc in Physics from the University of Gothenburg in Sweden, followed by an MSc in Security Management from the University of Portsmouth.

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ABOUT THE PUBLISHING ORGANISATIONS

iFHP

The International Federation of Health Plans was founded over 45 years ago in Sydney, Australia by a small group of chief executives of health insurance businesses. Our membership base now has over 70 member organisations from across the world covering in excess of 200 million lives across multiple continents.

Our member only events allow exchange of information between peers in a friendly, open and trusted environment. The connections established during these meetings are invaluable for executives in creating long-lasting relationships and solidarity across the industry.

Around the world there are huge challenges across numerous sectors of health insurance, and with an alliance of organisations the opportunity to effect positive influence and change is all the greater. We aim to engage our members in discussion on critical real-world scenarios and possible solutions.

University of West London

The University of West London is ranked as the top modern university in London, 8th modern university in the UK and ranked as the 50th university nationally by the Guardian University Guide 2019.

Research at the University of West London spans a broad range of fields across the arts, STEM, health, education and more. We focus on research that has an impact on real-world problems, drawing on our close ties with businesses and industry as well as the expertise of our staff.

Our law and criminology courses, with their distinctive focus on law in action, are delivered by highly qualified staff and designed to provide you with a well-rounded, skills-based and professionally relevant qualification.

98% of our graduates are in employment or further study within six months of graduation and they achieve the second highest starting salaries of all the London modern universities.

iFHP 2018 FAWE RESILIENCE REPORT

INITIAL SAMPLE CURRENT STATE ANALYSIS

The evidence in this report shows that losses to fraud, abuse, error and waste can be reduced. A reduction in unwanted expense is to be welcomed and the evaluation of the data in this report is a clear indication that analysis of systems, processes and procedures work in preventing and reducing losses to fraud, abuse error and waste. This report highlights key issues that need attention in the healthcare insurance sector and makes realistic and achievable recommendations that make a difference to company profits and customer service.
Losses that can be prevented must be. This report is the basis on which to build a series of detailed, instructive and informative reports for current and future threats that need to be addressed in the healthcare insurance market.

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