Shift

SHIFT TECHNOLOGY FRAUD INSIGHTS

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EXECUTIVE SUMMARY

Welcome to Fraud Insights Vol. 2. In our inaugural volume and a subsequent special edition, we covered provider fraud in the world of auto insurance and fraud trends linked to the COVID-19 pandemic respectively. In Vol. 2 we switch gears to address Fraud, Waste, and Abuse (FWA) trends impacting the global healthcare payer market.

It is estimated that FWA costs insurers and payers more than $600 billion (500 Billion Euros) globally. And while we recognize that healthcare systems, and thus how patients and providers interact with payers, operate differently based on the country in which they exist, we can still identify FWA trends that extend beyond national borders. We strongly believe that shedding light on these universal schemes and scenarios can help insurers around the world better focus premiums on impactful care.

In this issue, we will take a closer look at multiple aspects of healthcare FWA. Our analysis will begin with provider fraud and abuse — more specifically, abusive activities perpetrated by unscrupulous opticians. These are particularly interesting scenarios that rely on maxing out benefits to drive undeserved profits for providers. We then turn towards the trend of providers colluding to build up unnecessary services connected to each other and referring shared patients for services. We will also explore how FWA is impacting the world of international health for travelers and expatriates and why these scenarios may be so difficult to spot.

It is incredibly important to understand that while "waste" in the healthcare payer system is typically not fraudulent, it absolutely influences the ability to focus premiums on impactful care. As such, we will explore issues related to subrogation and coordination of benefits opportunities, specifically how they are being detected either prospectively or retrospectively. Finally, the report will investigate the impact of fraud in the policy underwriting and renewal processes.

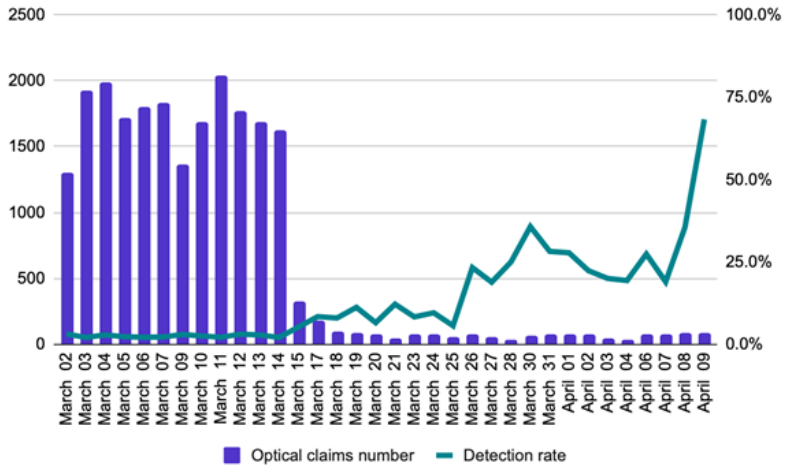
OPTICAL PROVIDER FRAUD TRENDS

Health insurance is a system based on trust, where the vast majority of claims are routinely reimbursed with little or no supporting documentation beyond a claim form or invoice. As such, health insurance has the highest volume of claims and pay-outs per any line of insurance and arguably the most complex coverage and payment guidelines. Within this report, we will explore how providers, and in our example specifically optical providers, are exploiting this system.

Understanding how fraud impacts optical providers is not always straightforward. Optical claims not only represent a high average value, but also are difficult to investigate without negatively impacting relationships between providers, customers, and payers. Further, for many consumers, vision care represents a predictable healthcare expense.

For this report, we have elected to explore optical fraud trends directly related to the COVID-19 pandemic. Since global lockdowns and the closing of non-essential business should have reduced the opportunity for consumers to buy new eyeglasses using insurance benefits, we would have expected to see decreased claims in this area. However, we have seen that some optical retailers did not experience a decrease equivalent to that of the industry at large. The theory being that some optical retailers are attempting to mitigate their losses by sending fake claims to payers.

We can see this theory play out in France during the first lockdown from March 17 to May 11, 2020. During this period most optical retailers were closed. Only a handful were included on the "on-duty list" making them available to meet the most urgent needs. As expected, claims volumes related to consumers purchasing new eyeglasses dropped noticeably. However, and as we can see in the following chart, while there was a significant reduction in the number of claims, a greater number of claims were identified as potentially fraudulent. In fact, the detection rate increased to more than 50 percent on multiple days. The value attached to the potentially fraudulent claims was more than 300,000 Euro.



NETWORK PROVIDER TRENDS

Unfortunately, provider fraud is not limited to individual practitioners seeking to pad their bottom line during an economic downturn. As noted in our analysis of optical provider fraud in France, the industry is becoming much more adept at identifying individual provider fraud. By examining variables describing their specific activities, number of services, number of patients, ratio of each specific service and comparing these to similar providers to identify outliers, it is becoming increasingly difficult for providers to cheat on insurers.

To better disguise their activities towards the insurers and better justify the medical journey of their patients, providers are colluding to build up unnecessary services connected to each other and sending each other their patients. Not only is this behavior harder to track but it also allows medical providers to significantly increase potential revenue by gathering more patients from other providers' referrals. Such activities have been observed for quite some time all over the world. For example, Shift Technology uncovered networks involving general practitioners who agree to either prescribe unnecessary or increased amounts of medication which is then filled by participating pharmacies.

In certain situations, pharmacies were discovered to have provided fake invoices for patients who never had the prescription filled. We have also observed general practitioners who are sending excessive numbers of their patients to the same physiotherapists and then receiving kickbacks.

And finally, we have detected a major network involving various specialists including orthopedists, Ear, Nose, and Throat specialists, gynecologists, cardiologists, and ophthalmologists. These providers have been investigated for potentially sending clients to each other and/or forging claims related to patients they have never seen. And while it appeared after investigation that they were not aware of previous visits from their patients to other practitioners the investigation did lead, however, to a dedicated third-party individual who was helping the insured plan a full medical journey. This individual is very knowledgeable of all insured's plans and was able to help them orchestrate all the visits and ensure that all treatments were covered by their plans.

While it is difficult to prove that the providers were not aware of this behavior, the ability to identify such patterns and make it known to the providers is an incredibly valuable deterrent. Simply knowing that connections between providers can more readily be identified may lead them to a change behavior in a way that will benefit insurers.

FRAUD, WASTE & ABUSE CHALLENGES IN INTERNATIONAL HEALTH

Due to the regulatory and/ or contractual obligations to process claims promptly, it is understandable that health insurance, and especially international health policies, has the highest instances of fraud, waste, and abuse (FWA) among all lines of insurance business.

International health Insurance typically provides worldwide healthcare benefits for individuals and families living abroad for a period of at least one year. These benefits are often employee sponsored and tend to be robust and flexible (e.g. any provider, private hospitals over public hospitals, etc.). Policy costs are significantly higher, as are customer service expectations. Naturally, this implies the need for a fast and efficient service, where extra checks for FWA should be as transparent to the client as possible. Wrongly inquiring about received medical services could have a negative impact on the insurer's image and reputation. Thus, accuracy and precision on FWA alerts becomes crucial as fraudsters rely on the discretion associated with these types of policies to perpetrate fraud.

A key challenge of managing these risks associated with FWA for international healthcare is applying the same controls across multiple markets that are both large and varied. For example, the simple act of validating a provider may quickly become a challenge. What we often observe is that claim handlers are given limited time to check if the provider exists, if they provide the services claimed and if the bill received actually comes from the provider before reimbursing large amounts of money that the customer has already paid. As a result, we see numerous examples of phantom providers, where groups of policyholders have created completely fabricated providers and submitted claims for reimbursement. There are also examples of "legitimate" providers that routinely bill for services for multiple family members on the same date of service where oftentimes some, or all of the services, were never provided or not medically necessary. Extra complexity is added by the fact that bills come in a wide variety of formats, languages, and quality levels. This alone makes it almost impossible for insurers to determine if there is something wrong with the claim within a given timeframe. In addition, claims are either handled regionally or even by thirds parties. This makes it challenging for insurers to apply a unified claim assessment policy, FWA detection guidelines and to avoid internal fraud or collusion.

We also find that establishing customary and reasonable pricing for services is challenging as these can fluctuate depending on region, type of provider and other factors. Frequently, insurers end up paying overbilled costs due to the lack means to determine the correct reimbursement amount. In addition, providers around the world who are used to working with these insurers are aware of this, and regularly take advantage of it.

Even checking the patient's identity can be surprisingly difficult, opening the door to potential card sharing between friends and family, as well as internationally to non-related persons. This difficulty in conducting anything more than basic checks makes it easier for patients to collude with providers to hide non-covered services (such as cosmetic surgery), unnecessary treatments or upcoding. We are also beginning to see increasing incidences of health tourism, where a "patient" travels to an exotic location and stays in a luxury hospital suite while receiving basic checks or small interventions, all while enjoying the vacation destination.

As international insurers look to develop a more standardized approach to managing the entities and claims, today's data scientists are taking a much more generic approach in evaluating those same entities and claim data. Effective approaches require advanced technologies such as AI and ML to be able to gain insights from unstructured data in different languages, as well as the identification of high risk entities (providers/members/groups) based on data outside of claims, such as sanctions, news reports and social media.

SUBROGATION TRENDS

Healthcare and disability subrogation are something that tends to be underutilized in the marketplace, yet it can be a very useful tool to keep premiums or contributions low. It is also crucial to remember that identifying subrogation opportunities is not typically about rooting out fraud, but rather about eliminating or reducing waste in the claims process.

Subrogation opportunities in healthcare most often occur when a claimant is hurt or suffers a serious illness as a result of something outside their control. In these situations, it is not uncommon for a third party to have caused the injury or illness. As such, one would expect also that the third party would be responsible to pay for the care received by the insured. In such instances, the injured person's health plan will pay for the medical care initially, with an understanding that if a third party is found responsible for the injury or illness the health plan will be entitled to reimbursement. This can occur either by the health plan pursuing reimbursement directly from the liable third payer, or reimbursement to the health plan from the patient, after the patient receives funds from the liable third-party payer.

Typical situations where health insurance subrogation may be used to coordinate payment with other payers includes car accidents (where the automobile insurance policy may be primarily responsible for payment), work injuries (where workers' compensation may be primarily responsible), slip and falls (where the property owner's liability insurance may be responsible), or toxic torts, product recalls, and other scenarios where a court has decided someone needs to pay damages, including amounts already paid by a consumer's health plan.

To make the most of subrogation opportunities, health payers must first know they exist. At the time of treatment, it may not be clear what or who caused the accident or illness. The patient is treated, and claims are submitted by the providers for services. Since the insured is often removed from the claims process itself, there is little opportunity for the payer to interact with the insured to understand the exact nature of their injury or illness.

Forward thinking health payers are increasingly turning to artificial intelligence to help them identify those claims likely to be the responsibility of a third party. For example, machine language (ML) algorithms based on structured data (such as beneficiary's the medical history, addresses of the beneficiary and hospital, prescribed treatments, etc.), as well as unstructured data (such as accident reports, phone call notes or practitioner notes) can all be useful in identifying likely subrogation cases.

UNDERWRITING FOR HEALTH FRAUD TRENDS

More and more health plan members now view their health benefits as a consumable. They feel they are paying for nothing if they do not use their coverage to its full benefit. While some providers may remind members to claim their maximum benefits, we have also observed a growing trend of members spontaneously seeking services and treatments just prior to their policy renewal date. This trend has been even stronger so far in 2020 with the economic downturn associated with the COVID-19 pandemic.

Although the typical pattern is quite simple, it may not always be easy to spot. The insured needs to be quite knowledgeable on their various benefits and the policy's limits. For example, if a member knows they are entitled to receive up to 20 physiotherapist treatments per year, yet did not require those services, the member may be tempted to simply use them. They would then go to a physiotherapist clinic to receive "massages" which are then paid by the health plan. What is interesting in this abuse of health benefits is that the type of services sought out may be influenced by location: eyeglasses in France, traditional Chinese medicine in Hong Kong and Singapore, and physiotherapy treatment in Canada, Singapore, and Hong Kong.

These abuse patterns may also apply to entire families. Much like the physiotherapy example illustrated above, we have observed claims activity that show whole families requiring physiotherapy treatments in the period immediately preceding renewal.

Being able to build a link between the underwriting team in charge of contract renewals and the team handling the claims is key in assessing such cases. Several actions have been taken by the underwriting teams following these behaviors. In some cases (and where it is legal) policyholders with a proven history of abuse have been rejected for renewal. In other situations, the insurer contacts the policyholder directly to renegotiate service limits and premiums. This kind of discussion has led to a major change in behavior from these policyholders who are now more careful about abusing their benefits.

And as we have discussed before, the insured is not always acting alone. Network analysis indicates that several providers are directly influencing their patients to max out benefits prior to contract expiry.

CONCLUSION

The world of healthcare fraud, waste, and abuse is complicated and often very subjective. Insurers want to maintain good relationships with their customers and their provider networks, while at the same time knowing that the majority of claims they pay out are legitimate. Working with healthcare payers around the globe, Shift is able to see how negative policyholder and provider behavior is impacting the system and how those behaviors can best be identified, investigated, and rectified.

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