Institute of Actuaries of India

Session C1.1 - Data and Standards, Fraud & Abuse Management

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Waves of Reforms…Oceans of Opportunities

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Agenda

Part 1

- Introduction to data in India
- Data standards

Part 2

- Fraud and abuse management

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Data in India (Overview)

- Although far from optimum, data quality in India is improved steadily in past 3-4 years. Significant difference in claims data quality of “in-house”, top 3-5 TPA’s and rest.

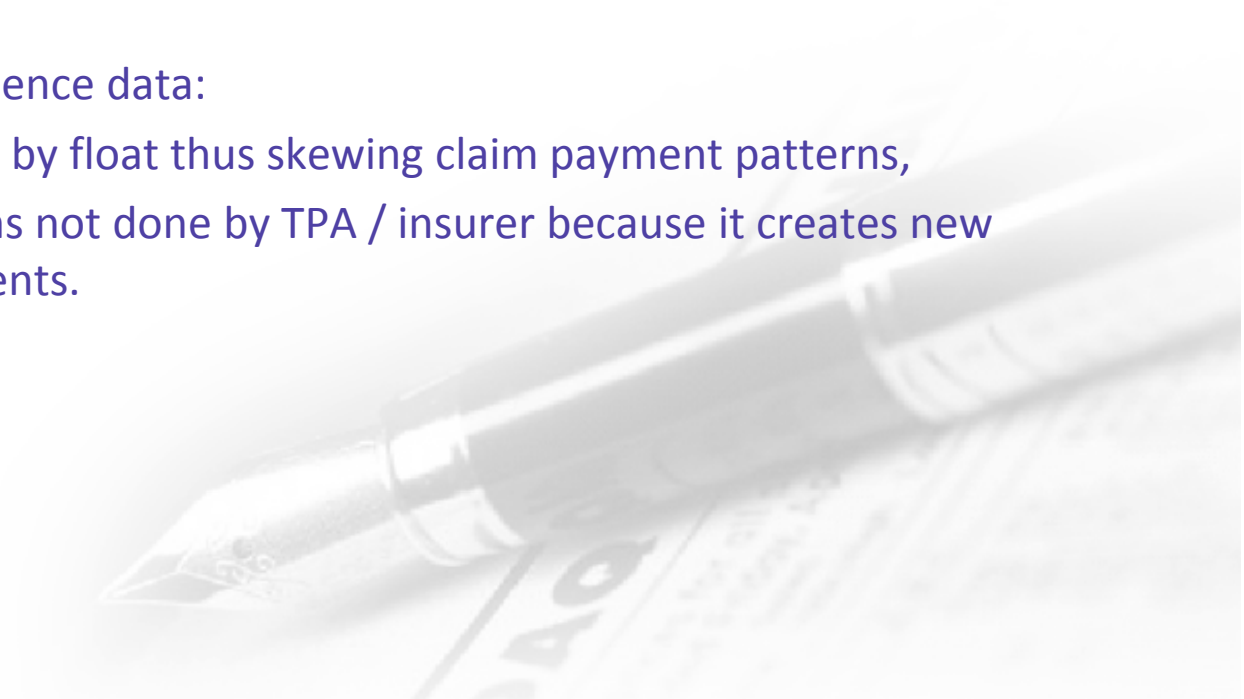
- Main issues can easily be remedied thru minor IT improvements, financial incentives & education of data entry staff (ages of 150+ plus, date of admission prior to policy start, etc.).

- Insurers at varying level of analytics capacity. “Old school” insurers still think in terms of MIS and query. Progressive insurers creating data warehouses, in-house analytical teams, predictive models etc.

Data quality (Quality Issues)

- Lack of focus on proper ICD coding:
  - all applicable ICD codes frequently listed randomly – not in order of primary ailment / other or existing ailment (i.e. diabetes / fracture of femur etc.),
  - ICD codes applied randomly (i.e. joint replacement & removal of implant coded same but huge cost difference),
  - procedure codes usually missing.

- Functional processes influence data:
  - paid dates influenced by float thus skewing claim payment patterns,
  - tagging of fraud claims not done by TPA / insurer because it creates new paperwork requirements.



Data in India (Regulatory Aspect)

- Table A, B & C format is comprehensive but it needs to continuously evolve to meet industry changes. Structural improvement and long term vision, i.e. create unique customer identifier (to facilitate longitudinal data analysis or portability analysis) can enhance value significantly.

- IRDA seeks much more data than other regulators in South East Asia, none seek similar levels of granularity. IIB repository rich data source, very well positioned thru it's unique mandate. Need to leverage for common data service i.e.:
  - declined lives database for health,
  - required check for portability,
  - facility to independently verify a corporate's claim experience etc.

- IRDA currently seeking vendor to implement fraud analytic solution

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Data Standards

Various industry groups have deliberated issue, multi-prong approach.

- Encourage alignment between payor & provider systems. Eventual goal is seamless EDI.
- Create a collaborative environment so IT vendors can join hands and develop / adopt common standards for data capture, storage & transmission.
- Encourage all existing data exchange platforms to become standard compliant & interoperable
- Engaged with NADHO and NIC to assess what existing standards and other resources can be leveraged
- Ensure output is aligned to Table A B and C, other initiatives like MoH& FW (EMR) and Acord initiative underway at IRDA

Goal is to encourage the IT vendors to create and abide by standards, industry groups can assist but not create standards. Standards evolve so a durable and on-going approach needed.

Data Standards

Way forward

- Identification of data elements, defining data types & size, standardizing data elements
- Standardize key forms & formats : proposal, enrolment, policy, claim, cashless authorization request, cashless approval, discharge summary, final hospital bill.
- Main master's required for first round of standardization. Some already in use.

1	Insurer Master	11	System of Medicine Code Master
2	TPA Master	12	Industry Type Code Master
3	Relationship Master	13	Frequently Claimed Disease Master
4	Occupation Master	14	Frequently Claimed Procedure Master
5	Claim Rejection / Deduction Master	15	Claim Status Master
6	Endorsement Type Master	16	Hospital code Master
7	Product Type Master	17	Hospital type Master
8	Policy Type Master	18	Claim Type Master
9	Hospital Selection Type Master	19	PIN Code Master
10	Claim Payment Type Master	20	City Master

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Fraud & abuse management

Defining fraud & abuse

- **Fraud** is willful and deliberate, involves financial gain, done under false pretense and is illegal.

- Health Care Anti-Fraud Association defines fraud as: “intentional deception or misrepresentation that the individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity, or to another party”

- **Abuse** generally fails to met one or more of these above criteria, subtle difference. Treatment that is not a usual medical practice or of marginal utility is abuse. If it is medically necessary, it should be supported by case notes.

Fraud & abuse management

Examples of fraud:

- **Customer**: claims for a hospitalization which never happened, non-disclosure, impersonation or collusion during PPC, claiming from multiple coverage's etc.
- **Provider**: unnecessary surgery (ie: hysterectomy), billing for services not provided, inflating cost of services or consumables, consultations by unrelated specialists, unbundling, upcoding etc.
- **Distribution**: broker misrepresenting group experience, fabricating groups, agent not forwarding premium to insurer, facilitating non-disclosure, creating factious people etc.

Examples of abuse:

- **Provider**: excessive diagnostic tests, extended LoS, conversion of day procedure to overnight admission, admission limited to diagnostic investigations etc

Fraud & abuse management

Estimates of fraud

- US estimates range widely, reasonable estimate at 6% or USD 120 billion out of USD 2 trillion annual healthcare expenditure. Certain segments, such as Medicare more fraud prone. Can be highly sophisticated, larger scams conducted by organized crime rings, ie:
  - 115 people, 9 cities, USD 240 million in false billings
  - 91 people, 8 cities, USD 290 million in false billing

- In India, HI fraud not really regarded as a criminal act, more tolerated socially. No strong deterrent for abuse either. Various people estimate impact in the 10-12% range.

Common methods of detecting potential fraud

- **Distribution**: multiple policies from single address, vague address, income / premium inappropriateness, selective purchase in family, agent with track record of fraud

- **Claim**: site visit raises suspicion, reimbursement claims from an in-network hospital, distance between policy holder & hospital, suspicious documents (ie: MSWord printed bills, no lab reports or surgical notes, no telephone number for hospital, same handwriting on all bills, etc), repeated admissions / admissions in same family, claim in last month of policy etc

What can you do

Distribution & underwriting

- Profile agents by monitoring individual portfolios
- Identify fraud “hot zones” for more rigorous monitoring of proposals
- Monitor labs who conduct PPC’s
- Regularly analysis underwriting impact and refine underwriting rules / guidelines

Provider contracting & claims

- Strengthen contracting and limit provider network. Shift to package rates
- Claim processing system should have in-built administrative and clinical alerts
- Invest in training, shift from detection by intuition to detection thru processes

Other thoughts

Create zero tolerance environment for fraud or abuse facilitated by agents or employees

Dedicate team to investigate frauds and to assist law enforcement in prosecution.

Way forward

What can a insurer do:

- Create a internal culture of information sharing so processes and guidelines evolve
- Provide regular training to sales, underwriting and claims employees
- Invest in data analysis
- Offer whistleblower rewards

What can the industry do:

- Should have a mechanism to share case studies, tools and training
- Should create data standards that facilitate analytics, ie: unique provider code
- Should collaborate in data analysis
- Collectively engage policy makers and consumer bodies, illustrate impact on consumers
- Collaborate with media to increase public awareness that fraud will not be tolerated
- Demand tougher laws and facilitate prosecution

Collaborate, it is everyone's problem.

Thank you

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