Thought Leadership Unit

2018 Case Study

Bending the Curve

Part 1: Tackling fraud, waste and abuse

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Fraud is everyone's business

Rising costs are driving inflation in the medical provision sector and, with it, member premiums.

Bending the Curve

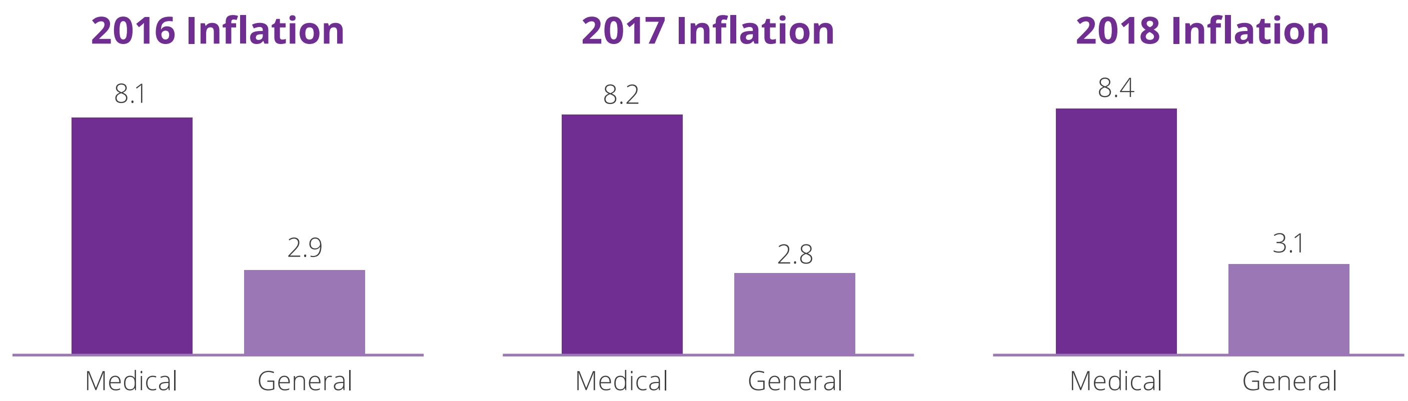
Part 1: Tackling fraud, waste and abuse

Annual health care spend is growing. This is due to rising drug costs (unit cost), lifestyle choices that contribute to noncommunicable diseases among a rising middle class, regulations that transfer the burden of costs to private plans and expansion of benefits (utilisation).

In 2008, the World Health Organization found that more than seven percent of all health care spending — a staggering U.S. $415 billion — was the result of fraud and error. The National Health Care Anti-Fraud Association (NHCAA) estimates that tens of billions of dollars of health care spending is lost to fraud each year.

Unnecessary spending directly affects both the financial performance of health insurers and the premiums employers — both private and government — and members must pay. It also results in higher out-of-pocket expenses for individuals and reduced benefits and coverage. It also means that money, care and resources that should be sustaining and improving global health is instead being rerouted towards greedy and immoral individuals and groups. That's why combatting fraud, waste and abuse is a major area of emphasis at Aetna International.

Fraud affects every single one of us — from small businesses to corporations, insurers, health care providers and doctors, as well as members.



Sources: Aon 2017 Global Medical Trend Rates, Aon 2018 Global Medical Trend Rates

Global health insurance fraud costs health care providers an astounding U.S. $260 billion (180 billion Euros) per year — approximately 6 percent of global health care spending. This equates to the GDP of a country like Finland or Malaysia being stolen on an annual basis.[1]

1 2010: http://www.ghcan.org/global-anti-fraud-resources/the-health-care-fraud-challenge

Defining fraud, waste and abuse

What constitutes fraud, waste and abuse (FWA)?

Here are definitions and examples:

	Definition	Examples
Fraud	Intentional deception or misrepresentation	• Billing for services that were never rendered • Misrepresenting who provided services • Altering claim forms or medical documentation • Falsifying a patient's diagnosis to justify tests or surgeries
Waste	Overutilisation of services or other practices	• Medication and prescription refill errors • Failure to implement standard industry waste-prevention measures
Abuse	Actions that result in unnecessary costs improper payments, or payments for medically unnecessary services	• Misusing billing codes on a claim • Performing a large number of laboratory tests on a patient when the standard of care indicates that only a few tests should have been performed • Billing for items or services that should not be paid for by a health plan

1 2010: http://www.ghcan.org/global-anti-fraud-resources/the-health-care-fraud-challenge

Potential perpetrators of fraud

Red flags of fraud

- Unusual/inconsistent billing practices
- Discrepancies between billed services and patient records
- Unusually high volume or percentage of the same services
- Pressure to pay claims quickly
- Provider advertisements for “free” services or other incentives

- Misspelled or misused medical terminology on claims forms
- High-dollar member reimbursement claims
- Alterations on claims submissions or enrolment forms
- High incidence of prescriptions that do not coincide with medical claims history

- Use of a post-office box or hesitancy to provide a physical address
- Frequent changes in providers
- A disinterest in rehabilitation or job services
- A history of self-employment or ability to easily work for cash while receiving disability benefits

Mistaken beliefs that lead to fraud, waste and abuse

FWA are allowed to continue because many believe fraud is a victimless crime and a number of other mistaken beliefs:

1. Health services should be provided at all costs
2. More is always better
3. Expensive is always better
4. The professional integrity of health care providers cannot be challenged[2]

What Aetna International does to combat fraud, waste and abuse

Pursuit	Our International Special Investigations Unit (ISIU) vigorously pursues those involved in suspicious activity. We devote the time and resources necessary to tackle fraud, waste and abuse and to protect ourselves, our plan sponsors and our members.
Collaboration	We are members of the European Healthcare Fraud & Corruption Network (EHFCN), which is dedicated to preventing and detecting fraud within the health care and insurance industry. We also collaborate with other fraud entities and agencies around the world.
Expertise	Our ISIU is regularly called upon by our industry peers and broker partners to consult on live cases and FWA processes. By sharing our expertise, we enable others to more effectively pursue their own investigations.
Results	Our efforts help keep premium increases low while protecting our members from identity theft.

Our mission is to aggressively pursue allegations of fraud and our approach is clear: **zero tolerance.** Aetna does not tolerate or passively accept health care FWA.

2 Source: *Healthcare Fraud, Corruption and Waste in Europe* by Paul Vincke, Managing Director of the European Healthcare Fraud and Corruption Network (EHFCN)

The International Special Investigations Unit (ISIU)

Each year our ISIU saves and recovers more than $3 million USD related to fraud, waste and abuse.

- Our dedicated ISIU is populated with accredited counter fraud specialists and a dedicated analyst.
- The team comprises a tightly-knit group of professionals working behind the scenes who fight fraud. The team also works with internal medical directors, nurses, information technology (IT) specialists, field claims analysts and administrative staff to prevent and investigate FWA.
- Stringent pre-set policies, procedures and preventative measures are in place to prevent FWA.

The team's tasks include:

- **Prevention** — Prepayment claims reviews to avoid fraudulent payments.
- **Detection** — Analysis of provider data to identify suspicious behaviour.
- **Investigation** — exploration of all provider billing and practice behaviour, not just a single issue.
- **Recovery** — Aggressive pursuit of money lost to fraud, waste or abuse.
- **Reporting** — Suspected fraud, waste and abuse is reported to state and federal agencies.
- **Compliance** — Acting as the liaison with insurance fraud bureaus, attorney generals, law-enforcement agencies and other third parties.
- **Protection** — Maintaining a database of individuals with a proven record of conducting FWA.

Working with our international network, and independent anti-fraud and corruption bodies such as the EHFCN is an important part of our fraud, waste and abuse model. Such bodies present an opportunity for us to share our expertise on investigating and reporting on all fraud referrals including financial recoveries and savings.

The European Healthcare Fraud & Corruption Network (EHFCN)

Aetna International's ISIU works hand in glove with the European Healthcare Fraud & Corruption Network.

The European Healthcare Fraud & Corruption Network (EHFCN)

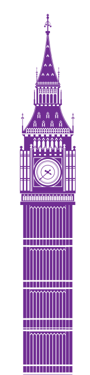
Learn more at **www.ehfcn.org**.

- A consortium of health care and counter-fraud, counter-corruption and/or counter-waste organisations in Europe
- Public and private health insurances and health funds, ministries of health, counter-fraud units specifically focusing on The Fraud Triangle health care; 19 members in 14 countries
- A not-for-profit organisation whose mission is to improve health care systems for the benefit of every patient by creating a real fraud-proof and corruption-proof culture within health care systems across Europe

Accountability and international cooperation

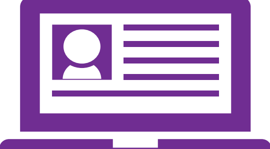
Countries each have their own approaches to combatting FWA. For example:

In the U.S. **The National Health Care Anti-Fraud Association** (NHCAA) has SIRIS (Special Investigations Resource and Intelligence System.) This allows authorised users to effectively share critical information about suspected fraudulent activity throughout the country.



In the UK, the **Insurance Fraud Enforcement Department** (IFED) is maintained by the City of London Police. Aetna International is a member of the Association of British Insurers (ABI) which is entitled to access IFED resources.

High-tech and high touch



- We review all reimbursement invoices at a certain threshold level.
- We use advanced business intelligence software to identify providers whose billing, treatment or patient demographic profiles differ significantly from those of their peers.
- We enlist members and providers in helping to combat fraud by educating them and publicising high-profile cases.
- Our frontline claims and customer service professionals receive intensive, ongoing training in fraud detection.
- Fraud champions within our claims teams around the world participate in monthly calls and are updated on the latest scams and fraud, waste and abuse in their regions.

A FWA case study: 2011 – 2017

What we found	• A routine review of claims for members who had received more than $10,000 US in reimbursements turned up two questionable claims from “Maia*”, a member of an Aetna International group plan in Singapore. • Red flags: - Unusually high costs (e.g., a procedure that typically costs $75 – $150 was billed at $475) - Inconsistent invoice formatting and numbering - Incorrect tax amounts
What we did	• Local fraud champions contacted the providers involved. One confirmed costs had been altered; the other could find no record of Maia in their system. • The ISIU investigated all of Maia’s claims for the year. Again, providers confirmed either alteration or forgery of claims. • When Maia submitted additional claims, we suspended and flagged them. • Additional research back to 2011 revealed more than 400 individual claims from Maia, most of which had been altered or fabricated based on a template invoice from 2011. The total value of fraudulent claims: $450,000 US. • We forwarded our findings to our client, Maia’s employer, who interviewed Maia and terminated her employment. • Aetna International’s legal team engaged local solicitors, who demanded Maia repay the fraudulent claims or face civil action.
The results	• Maia repaid the money in full; $450,000 over a six-week period. • Besides recovering the $450,000, our actions saved $30,000 in claims that had been suspended and an estimated $100,000 in future fraudulent claims.

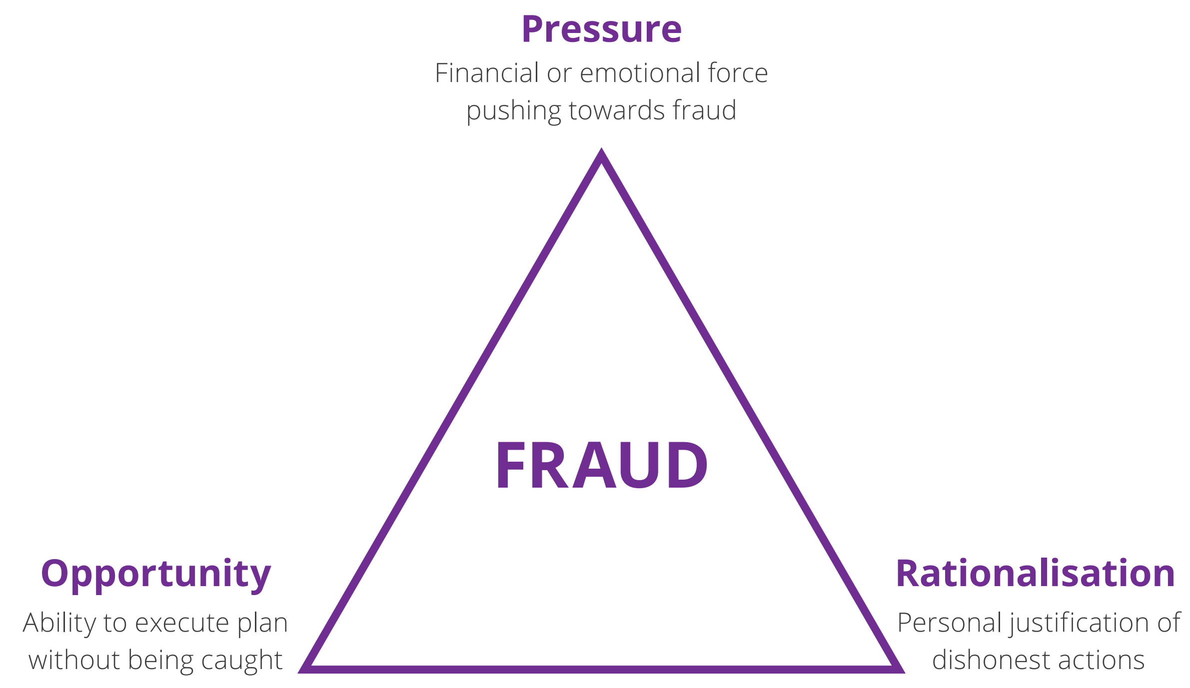
*Name changed to protect the identity and privacy of the individual

Aetna is working to build a culture of health and well-being within our communities to transform the member experience and address many of the acute challenges facing health care today. Our zero-tolerance approach to fraud, waste and abuse underpins this mission.

The Fraud Triangle

A framework for spotting high-risk fraud situations

- Theory developed by American criminologist, Donal Cressey.
- The theory explains the factors that lead to fraud and other unethical behaviour.
- When businesses and organisations understand the Fraud Triangle, they can more effectively combat criminal behaviour that negatively impacts their operations and their employees.



1. Pressure	2. Opportunity	3. Rationalisation
This can include money problems, gambling debts, alcohol or drug addition, overwhelming medical bills. Greed can also become a pressure, but it needs to be associated with injustice. "The company has not been paying me what I'm really worth", for instance.	In the case of fraud, usually a temporary situation arises where there is a chance to commit the act without a high chance of being caught. Companies that are not actively working to prevent fraud can present repeated opportunities to individuals who meet all three criteria of the Fraud Triangle.	The individual must be able to justify what he or she is about to do. Some may think they are just going to borrow the stolen goods, or that they need the money more than the 'big' company they are stealing from.[3]

3 Source: http://www.brumellgroup.com/news/the-fraud-triangle-theory/

Taking responsibility

Here are some simple ways you can protect against health care fraud, and keep health care costs down for everyone.

Advice for employers

- **Protection:** Protect your corporate health insurance policy information. Be careful about disclosing any policy or group scheme information over the internet or telephone.
- **Education:** Inform your employees of the impact of fraud, waste and abuse. FWA increase the cost of providing health insurance benefits and put company and government schemes at risk. Refer employees to further reading — or in Aetna International's case — our member handbooks which outline the implications and costs of health care fraud, waste and abuse.
- **Diligence:** Select your broker partners and health insurance company with care. Ask questions about their FWA processes and policies.
- **Report:** If you suspect your organisation may be the victim of insurance fraud, call your insurance company.

Advice for individuals

- **Protection:** Protect your health insurance membership or ID card as you would a credit card. Keep your policy number and personal insurance information private from telephone solicitors or over the internet. Be careful about disclosing your information.
- **Report:** If you suspect you may be the victim of identity theft or insurance fraud, call your insurance company. Medical identity theft is on the rise. Thieves use personal health insurance information to steal expensive medical services, equipment and drugs.
- **Diligence:** Keep a close eye on your medical reports, the services and invoices you receive, and all your medical care records.
- **Informed:** Read your policy, benefits statements, Explanation of Benefits (EoB) statements and any paperwork you receive from your insurance company carefully. Make sure the treatment dates, details, charges and expenses are correct to the best of your knowledge.
- **Integrity:** Be aware that sharing medical coverage with uninsured family members or friends is against the law. This can lead to tainting electronic medical records and incorrect diagnoses for the insured, amongst other negative fallout.
- **Eyes open:** Be wary of offers for 'free' health care services, tests or treatments. These could be fraudulent schemes designed to bill you and your insurance company illegally for thousands of dollars you have never received.[4,5]

At Aetna International, we provide access to quality health care — locally and virtually — focusing on health outcomes while containing costs and keeping premiums in check. Our FWA actions contribute to U.S. $ millions of savings per year. This helps us to combat medical inflation and keep premiums in check for the benefit of our broker partners, clients and customers alike.

4 https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud.aspx

5 https://www.consumerreports.org/medical-identity-theft/medical-identity-theft/

Further reading

Bending the Curve: Addressing rising costs in health care

In this white paper, we outline the main influencers of medical inflation — utilisation and unit cost — and share some of Aetna International's medical cost containment (MCC) strategies, which temper the impact of fast-growing health care burdens.

At Aetna International, we are transitioning from being a health insurance provider to a health and wellness partner. We are using value-based approaches — centred around the individual — to address rising health care costs, clinical inefficiency and duplication of services. Value-based care is simply the idea of improving quality and outcomes for patients by ensuring our customers can access quality care, whether preventative, chronic or acute.

Appendix

Cost containment

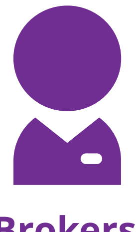
Effective cost containment is holistic, not reactive.
Here's Aetna International's three-pronged approach:

- We leverage our worldwide networks to understand the variance in cost and quality around the globe.
- We provide new tools like vHealth by Aetna to connect patients and providers.
- We reach out to at-risk members through our In Touch Care program.
- We offer condition-management and support programs.
- We ensure members are getting the appropriate screenings.

- We use precertification to ensure that easy-to-prescribe procedures are not overprescribed.
- We publish Clinical Policy Bulletins that provide guidance on the medical necessity of medical technologies, experimental treatments and other services.
- We use concurrent review and discharge planning to ensure members are getting the right service in the right setting.
- We coordinate services when members are seeing multiple providers for multiple conditions.

- We ensure claim validity through reactive and proactive fraud, waste and abuse processes.
- We ensure that charges are correct and are reasonable and customary for the setting.
- We ensure that claims are paid by the right carrier, a process known as subrogation.

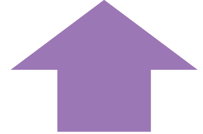
Rising costs have significant impacts for several key stakeholders



Brokers

Deductibles are rising faster than premiums

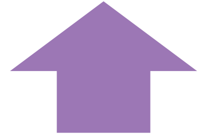
63%
rise from
2010 – 2016



Plan Sponsors

Premiums are rising faster than earnings

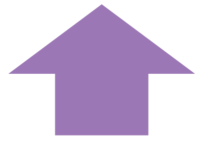
19%
rise from
2011 – 2016



Members

Earnings aren't keeping up

11%
rise from
2011 – 2016



Top 3 employer goals: 2018

Short term (next 12 – 18 months)	Long term (next 5 years)
1 Managing overall cost of health care benefits	**1** Managing overall cost of health care benefits
2 Maintaining current level of benefits offered	**2** Maintaining current level of benefits offered
3 Maintaining productivity of all employees	**3** Attracting high-quality new talent

Source: Wells Fargo survey

Cost drivers: 2018

	Americas	Europe	Asia-Pacific	Middle East and Africa
Top cost drivers	• Hospital costs • Physician services • Prescription drugs	• Hospital costs. • Physician services • Clinics/labs	• Hospital costs • Clinics/labs • Preventative care	• Hospital costs • Prescription drugs • Physician services
Top health conditions (minus maternity)	• Cardiovascular disease • Cancer • Musculoskeletal/ back conditions	• Cancer • Cardiovascular disease • Musculoskeletal/ back conditions • Mental health issues	• Cancer • Cardiovascular disease • Musculoskeletal/ back conditions	• Cardiovascular disease • Cancer • Respiratory illness
Top risk factors	• Obesity • Physical inactivity • Poor nutrition	• High blood pressure • Physical inactivity • Smoking	• Physical inactivity • High cholesterol • High blood pressure	• High blood pressure • High cholesterol
Typical cost sharing approaches	• Annual deductibles • Member coinsurance • Premium cost sharing by employees • Annual limits on out-of-pocket expenses	• Annual deductibles • Annual limits on out-of-pocket expenses • Premium cost sharing by employees • Member coinsurance	• Annual deductibles • Member coinsurance • Premium cost sharing by employees • Annual limits on out-of-pocket expenses	• Annual deductibles • Annual limits on out-of-pocket expenses • Member coinsurance • Premium cost sharing by employees
Cost mitigation methods	• Plan changes (U.S. and Canada) • Cost sharing (U.S. and Latin America)	• Provider networks • Plan changes • Cost sharing	• Cost sharing • Service limits • Provider networks	• Cost sharing • Service limits • Provider networks

Sources: Aon survey[6]

6 http://www.aon.com/russia/files/2018-global-medical-trends-report.pdf

About Aetna International

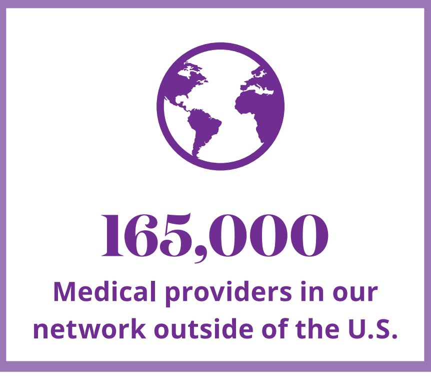
Aetna International is re-shaping health care across the globe by developing solutions to improve the quality, affordability and accessibility of health care. To this end, we raise awareness of critical health challenges facing the world and examine potential solutions that could help combat and prevent the worsening of some of the world's most serious health care problems.

Global expertise with local touch:

16
Countries where we have employees

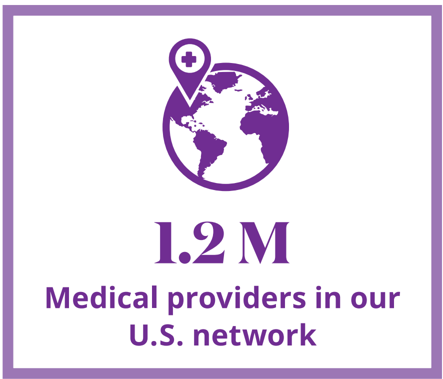
160
Year heritage

1,600
Aetna International employees



165,000
Medical providers in our network outside of the U.S.

800,000
Aetna International members worldwide



1.2 M
Medical providers in our U.S. network

Aetna International white papers:

2016 Volume I: Cancer in the developed world

2017 Volume I: Globesity: Tackling the world's obesity pandemic

2017 Volume II: Striking the right balance: Global caesarean delivery rates in an era of controversy

2017 Volume III: Expatriate mental health: Breaking the silence and ending the stigma

2017 Volume IV: Diabetes: The world's weightiest problem

2017 Volume V: The Forgotten Killer: Cardiovascular Disease

2017 Opinion Paper 1.0: Pandemic: Controlling infectious diseases before they spread

2017 Opinion Paper 2.0: Endemic infectious diseases: Focusing the world's attention on neglected killers

2017 Volume VI: The ticking bomb: Ageing population

2017 Volume VII: Bending the curve: Addressing rising costs in health care

2017: Volume VIII: Antibiotic resistance: Toward better stewardship of a precious medical resource

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