EXECUTIVE SUMMARY
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On average, the anti-fraud and investigative unit of a health insurance company—often called the special investigations unit (SIU)—enabled its organization to realize combined fraud recoveries, savings and prevented losses totaling more than $59 million a year. This is a key finding of the NHCAA Anti-Fraud Management Survey Report for Calendar Year 2017, the tenth publication of this important industry benchmarking tool produced by the National Health Care Anti-Fraud Association. The median amount of combined fraud recoveries, savings and prevented losses across all respondents was nearly $18 million.

The NHCAA Anti-Fraud Management Survey was first administered in 2002, reflecting 2001 data. Each consecutive version thereafter has been improved and refined by the NHCAA Anti-Fraud Management Survey Committee, guided by input from the NHCAA membership. It was important to the committee to maintain comparability between the previous Survey editions while making necessary and useful modifications to reflect shifts and changes in health care fraud-fighting and the health insurance industry as a whole.

In addition to overseeing the updating, administration, and data collection of the Survey, the Anti-Fraud Management Survey Committee was also tasked with assembling the final Survey report. Throughout the survey process, the Committee remained mindful of the fundamental principles that have characterized the project from its outset. These include: relative simplicity in content and format; “apples to apples” comparability of the data; and strict confidentiality of survey data, not to be reported in any identifiable fashion.

In addition, the Survey must enable NHCAA Member Organizations to compare themselves not only to the industry at-large, but to companies of similar business volume and annual anti-fraud operating budgets.

Segmenting the Survey results in various ways enables NHCAA members to assess the structure, staffing, funding, operations and results of their anti-fraud and investigative efforts, making the Survey truly valuable as a benchmarking tool.

The 2017 Survey report reflects the input of 52 private insurers who account for nearly $856 billion of the health insurance benefits paid in the United States in 2017. The following graphs
illustrate the segmentation of the respondents who comprise the Survey base.

Dividing respondents into groups across 10 different segments in two different categories reveals how truly varied the respondent groups are. The overall Survey results are important, certainly. But to realize the full benchmarking benefits of the NHCAA Anti-Fraud Management Survey it is particularly useful for respondents to compare themselves to their peers.

The insurers that make up the Survey base represent the full array of health insurance business lines, including medical, dental, disability, health savings accounts, long-term care, pharmacy, vision and workers’ compensation. Investigative responsibility of the special investigations unit is wide-ranging, reaching well beyond traditional medical insurance to include all business lines listed above.

The Survey found that responding companies handled an average of 91.6 million health claims in 2017—which equates to an aggregate total of nearly 3.8 billion claims for all respondents.

To offer an alternate examination of respondents, the Survey also reports which health insurance products companies offer and the extent to which the SIU has benefit integrity responsibility for them. Respondents report a broad range of product offerings including: Commercial Group Private Health Insurance, Individual Private Health Insurance, FEHBP, Federal and State Health Insurance Marketplaces (Exchanges), Medicaid, Medicare Advantage, Medicare Part D, Medigap, Medicare-Medicaid Plan (MMP), SCHIP, Third Party Administrator/Administrative Services Organization products and TRICARE.

In addition, SIUs are often given responsibility for internal fraud matters with 51% of respondents reporting that this is an area that falls within the unit’s scope of duty.
The average number of full-time personnel that comprise an anti-fraud or investigative unit is 31.1 full-time equivalents (FTEs) according to the Survey data, while the median size of an SIU was 12 employees. Investigators and analysts together account for the majority of staff members working for anti-fraud departments, although information technology, auditing, administrative, legal, medical/clinical, management and supervisory professionals are also represented.

Regarding the unit’s location within a company’s organizational structure, the Survey shows that units most often report directly to either their Legal or Compliance department.

The annual operating budget of an SIU averages more than $3.58 million. In fact, when removing one especially large anti-fraud budget amount reported by a respondent, the average still exceeds $3.1 million. The median SIU annual budget was $1.49 million in 2017.

Budget averages vary quite a bit when looking at the respondent segment classified by business volume. SIU Budgets typically include an assortment of expenses, including salaries & benefits, training, travel, office space, anti-fraud software & systems, supplies and equipment, consultants, staff reward programs, HR-related costs and membership dues.

The Survey reveals that as of December 31, 2017, respondents had, on average, 512 open cases or investigations. The median number of open cases was 249. The vast majority of these investigations were provider fraud cases, although an SIU’s caseload also typically includes member/insured fraud, agent/broker fraud, internal fraud, employer group fraud, and third-party vendor fraud.

In addition to determining the average number of open cases that a company has on the last day of the year, the Survey also reports that the average number of total cases handled by an SIU in 2017 was 1,285. The average number of investigations initiated (opened, started, launched) by the SIU in 2017 is 727. On average, 136 cases were referred to law enforcement agencies, 18 to state licensing authorities and 25 to
in-house credentialing or network management departments. Respondents report that the average daily caseload of a health care fraud investigator is 29 cases.

Units receive referrals in a number of ways, including from customers and insureds; directly from law enforcement; via NHCAA information-sharing; from other insurers or outside third parties; through non-law enforcement organizations other than NHCAA; from providers or provider employees; through regional information sharing; from the media; and even anonymous tips. However, most referrals that an SIU receives are either internal, supplied by employees and departments of the company itself, or revealed through the use of anti-fraud technology (i.e. analytics programs).
Survey respondents were asked to identify the most prevalent types of substantiated allegations their SIU faced in 2017. Topping the list were:

1. Billing for Services Not Rendered
2. Improper Coding – upcoding
3. Aberrant Billing
4. Performing medically unnecessary procedures
5. Misrepresenting a non-covered service as covered
6. Excessive Billing of Units
7. Improper Coding – unbundling
8. Improper Coding – improper use of modifiers
9. False claims
10. Enrollment, Application, Eligibility Fraud

The Survey demonstrates that SIU employees are committed to professional excellence. Fifty-four percent of those surveyed indicate that a fixed number of annual training hours are required for each unit employee. Of the 46% that do not require training, 96% report that unit personnel still acquire an average of 32 hours of training a year, which is approximately 13 hours more than the average training requirement of 19 hours.

Information-sharing is a frequently used investigative tool, according to the Survey. Venues through which respondents formally disclose information on active investigations to other companies’ units and law enforcement include: NHCAA-sponsored programs such as SIRIS, Law Enforcement Requests for Investigation Assistance (RIA), and Case Discussion Roundtable Meetings, as well as non-NHCAA regional anti-fraud meetings, the Healthcare Fraud Prevention Partnership (HFPP), and law enforcement-sponsored task force meetings. Several respondents also report that they share information through the BCBS Association’s National Antifraud Advisory Board and through Medicaid program integrity meetings.
Software-based fraud detection products and systems represent another important fraud-fighting tool that 82% of investigative units depend on. Survey results show that most units using fraud-detection software employ either a commercial system or a combination of commercial and proprietary systems.

To detect and combat health care fraud, respondents use numerous devices. The vast majority of NHCAA members surveyed employ a broad range of fraud detection tools that include: maintaining a fraud-reporting hotline and e-mail inbox, receiving and reviewing written leads, using data-mining and other software applications, attending information sharing meetings, searching SIRIS for possible leads, conducting internet and media searches and performing in-house as well as field investigative activities.

Respondents also employ an array of fraud awareness and prevention measures. These include offering a fraud-reporting hotline and e-mail inbox, hosting a fraud-focused section on the corporate Website, including fraud notices and hotline information in Explanation of Benefits statements, distributing consumer brochures, sponsoring public awareness advertising, providing provider education as well as corporate anti-fraud training.

The quantifiable financial results of the work of SIUs are generally divided into three categories: recoveries, savings and prevented losses. Recoveries typically represent recouped claims payments attained through criminal restitution, civil judgment, civil settlement, collection vendors and direct recovery by the anti-fraud unit. For purposes of the Survey, savings are claims not paid due to the intervention of the anti-fraud or investigative unit. Prevented loss is the financial representation of claims that were never submitted as a result of actions taken by the SIU.

The documented value that SIUs bring to their respective organizations, and in turn to their enrollees and insureds, is undeniable. The Survey reveals that in 2017, an anti-fraud unit showed average recoveries of nearly $5.5 million, average savings of $31 million, and $37 million in average prevented losses.
Prevented loss consists of two sub-categories—change in behavior and process improvement. Change in behavior means the dollars a company did not pay as a result of changes in provider billing patterns, where the “change” was the result of or attributable to actions of the SIU. Process improvement represents the dollars a company did not pay as a result of modification(s) made to internal policies, edits or processes, where again, these changes were made as a direct result of actions taken or recommendations made by the SIU.

When combined, the recoveries, savings and prevented losses generated by the efforts of anti-fraud investigative units are substantial. The survey asked respondents to report their SIU’s return on investment, based upon the parameters used internally by their company. This inquiry resulted in an average ROI of 13.7 to 1, where the annual SIU budget is represented by “1.” Respondents were also asked to describe in detail the categories, elements and variables that are included in their SIU’s return on investment calculation. The broad variability of respondent explanations of ROI is remarkable and sheds light on why it is so challenging to report industry-wide SIU anti-fraud outcomes.

The National Health Care Anti-Fraud Association published a white paper in conjunction with this year’s Anti-Fraud Management Survey titled, “The ROI of Fighting Health Care Fraud: The Impact of Methodological Variability,” that examines the scope of responsibility of health insurer SIUs and how they calculate return on investment within their organizations. The paper can be accessed at https://www.nhcaa.org/media/144051/roi_nhcaa_whitepaper.pdf.

The NHCAA Anti-Fraud Management Survey for Calendar Year 2017 is a unique look at the inner workings of the health care anti-fraud units operating within our nation’s health insurance companies. The work they perform to detect and investigate health care fraud saves their organizations hundreds of millions of dollars each year, while protecting the integrity of health insurance for everyone.

The results of the Anti-Fraud Management Survey demonstrate how well-aligned NHCAA members are to the ideals and mission of the National Health Care Anti-Fraud Association, “To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse.”

The National Health Care Anti-Fraud Association is very pleased to be able to present the results of the NHCAA Anti-Fraud Management Survey Report for Calendar Year 2017.