Control by the Estonian Health Insurance Fund over the funding of health services

Are the control systems of the Health Insurance Fund capable of preventing and detecting misuse?

Summary of the audit results

What did we audit?

During the audit, the National Audit Office assessed whether the Health Insurance Fund

- is able to prevent or detect the misuse of health insurance funds;
- reacts accordingly, in case of suspicion or detection of the misuse of funds and imposes sanctions where required.

Why is this important to taxpayers?

The Estonian Health Insurance Fund pays for the medical bills presented by healthcare providers if an insured person has been to an appointment and/or received treatment. The purposeful and efficient use of the healthcare budget presumes that the Health Insurance Fund has built control systems which allow for the prevention or detection of misuse.

The budget for healthcare services of the Health Insurance Fund in 2020 amounted to nearly 1.2 billion euros. Compared to the previous year, there has been an 8% increase.

What did we find and conclude from the results of the audit?

According to the National Audit Office, the Health Insurance Fund is unable to systematically prevent or detect the misuse of health insurance funds with its controls. The improvement of the control is hindered by the fact that it is not possible to automatically compare whether a medical bill and the medical file set out the same services. Furthermore, patients have not been provided a convenient option for giving feedback to the Health Insurance Fund on the correctness of the medical bills. In certain cases, the correctness of a bill can only be verified with help from the patient.

The Health Insurance Fund must be acknowledged for the course taken in the past years towards strengthening the control systems – a new channel for sending medical bills has been introduced and methods for machine learning and statistical analyses have been developed in order to make control planning more efficient.

- **The Health Insurance Fund only started identifying risks of fraud in 2017 when the first cases of fraud appeared in media.** In 2017, the Health Insurance Fund ordered two external audits as a result of which, potential risks of fraud were identified for the first time, and recommendations were made to alleviate the risks. Based on these, the management of the Health Insurance Fund approved the measures for alleviating major risks related to health insurance benefits and compensation for medical devices. The implementation of these measures has been monitored on an ongoing basis. However, the risks specified in external audits have not been reassessed so far, neither has the time for the reassessment been agreed

upon (e.g. a risk may become more important over time). At the same time, new risks might have emerged since the assessment.

- **The Health Insurance Fund has not issued a clear signal to the healthcare sector that any fraud is followed by a contractual penalty and/or termination of the contract.** Upon detecting fraud and systematic errors, the Health Insurance Fund may impose a contractual penalty. Even though fraud was detected in several occasions, the two largest contractual penalties so far have been 5,000 euros each. So far, the proportion of the largest contractual penalties has been modest, making up 0.22% and 0.0076% of the turnover of the service providers fined. Therefore, the contractual penalties may not necessarily have the desired effect on the behaviour of those who commit a fraud, or a warning effect on other market participants. Furthermore, the Health Insurance Fund has not terminated contracts in all cases of detected systematic errors or fraud. The National Audit Office is of the opinion that in case of fraud, the Health Insurance Fund must impose a larger fine and terminate the contract, to give the healthcare providers a clear message that such behaviour is unacceptable.
- **Some of the misuse can only be detected if the patients confirm there was incorrect information on the medical bill.** The Health Insurance Fund has stated that if the medical file (epicrisis or health record) and medical bill match, the further correctness of the medical bill can only be verified with help from the patient. Since 2016, patients have had access to their medical bills in the patient portal and can see the services provided as well as the funds spent. So far, not many people have accessed their medical bills: in the first half-year of 2019, an average of approximately 8,900 people per month, i.e. 1.9% of the people who received healthcare services in the same period.
  At the same time, the Health Insurance Fund has identified several major breaches thanks to complaints submitted by patients. Even though the Health Insurance Fund admits that the inspection of medical bills and medical files alone does not suffice to ascertain that the health insurance funds have not been misused, the Health Insurance Fund has not provided patients with an opportunity to conveniently provide feedback on the service.
- **Automatic inspection helps prevent mistakes and simpler fraud, but data from registers outside the Health Insurance Fund is not used in these inspections.** Therefore, some of the misuses cannot be detected. It should be acknowledged that in 2020, the Health Insurance Fund implemented a new electronic channel for sending medical bills, which allows for more automatic controls than so far. These controls help prevent simpler misuse, but do not involve data from registers outside the Health Insurance Fund. For example, the existence of the activity licence of a healthcare provider is not verified because this register is maintained by the Health Board. The existence of activity licences is verified by the Health Insurance Fund in the register case by case and generally, once a year. Therefore, the Health Insurance Fund cannot be aware of any cases where a service provider's activity licence has been declared invalid in the meantime. During the audit, the National Audit Office discovered a case like that.
- **The comparison of medical bills and files is an efficient control measure, but involved 0.04% of the medical bills in 2019.** The most thorough control measure in detecting misuse is target selection, which is the only one to analyse and compare medical bills and files. However, the number of medical bills and files involved in it has been small so far. For example, in 2019, target selection was used to examine 4,000 medical bills. In total, there were 10,7 million medical bills that year. This entails a risk that regardless of the right focus, major misuse cases may remain undetected due to the small sample. For example, target selection was used in 2015 and 2016 to verify both the prescription and sale of orthoses, and as a result, financial reclaims were also made. Nevertheless, in 2017, the media spoke about possible fraud related to the prescription and sale of orthoses, which was notified to the media by patients. As a result of the investigation that followed, the Health Insurance Fund confirmed that those were cases of fraud.
- **In planning control activities, including the assessment of risks, the Health Insurance Fund has no overview of the law compliance of its contractual partners** because it does not take into account the results of the (internal) controls conducted by the Health Board, the State Agency of Medicines or hospitals. The Health Insurance Fund, the Health Board and the

State Agency of Medicines exchange information if data is needed from another institution during supervision or any other inspection. At the same time, the abovementioned institutions or hospitals do not exchange information on the results of the (internal) audit systematically. As the contractual partners of the Health Insurance Fund are inspected by the State Agency of Medicines and the Health Board as well, it is very important for the better planning of the controls that their supervision and other inspection results be known to the Health Insurance Fund. Also, the consideration of the results of the audits by the boards, including the complaints received and observations made, would allow for a more integral view for identification of risks and more information for planning the controls.

- **To detect the misuse of health insurance funds, the Health Insurance Fund has decided to develop more efficient analysis methods.** Since 2019, the Health Insurance Board has been aiming to analyse medical bills by machine learning and the detection of differences. Based on previous control results, machine learning allows developing a model which predicts the services listed on the incoming medical bills, which may also have been charged incorrectly. In the detection of differences, the institutions and services are identified where deviations from the limits specified have appeared and are explored in more detail.

What did we recommend as a result of the audit?

The main recommendations by the National Audit Office:

- implement a solution according to which a person is notified (e.g. via text message or e-mail), regularly or under certain conditions (e.g. in case of certain services, if a certain amount is exceeded), if his/her medical bills for the appointment are available in the patient portal. After reviewing the medical bills, the patient should be given the opportunity to provide feedback on whether he/she went to a doctor and used the services provided on the medical bills. At that, it should be decided whether the description of the service as provided on the medical bill should be made more comprehensible for the patient. Also, patients should be provided an opportunity to opt out of notifications;
- an information technology workspace should be developed, which would help assemble the results of the supervision by the Health Insurance Fund and external partners (e.g. the Health Board, the State Agency of Medicines) as well as complaints by patients into one environment. This would allow for more comprehensive information according to institutions and services, in planning control activities;
- opportunities should be found for implementing new automatic controls, including linking automatic controls of medical bills to registers outside the Health Insurance Board (e.g. the Health Board's register of the activity licences of healthcare providers);
- establish, in the future, an opportunity for automatic verification of the compliance of a medical bill with the information provided in the health information system. Until the respective technical opportunities are developed, the compliance of medical bills and files should be verified during target selection by placing more importance than so far on the detection of potential fraud;
- use, as a sanction in case of fraud, more efficient contractual penalties and termination of the contract.

Responses of the audited: The Minister of Social Affairs and the chairman of the board of the Health Insurance Fund mostly agreed with the recommendations given in the audit, but pointed out that the reporting of medical bills could be made available for those patients only who have given their consent.

The chairman of the board of the Health Insurance Fund promised to convene a steering group involving the representatives of the Estonian Health Insurance Fund, the Health Board and the State

Agency of Medicines. The aim is to jointly develop, by the end of 2021, a common information technology workspace for the three institutions to use. This would assemble the controls conducted by the three institutions on the healthcare providers, and the results of such controls.

The chairman of the board of the Health Insurance Fund added that termination of the contract and imposition of contractual penalties as a sanction are the last resorts for impacting a partner. The Health Insurance Fund uses a flexible approach. The reason for this is the need to preserve a balance between service availability and quality. Fast and large contractual penalties compromise service continuity and availability for the insured.