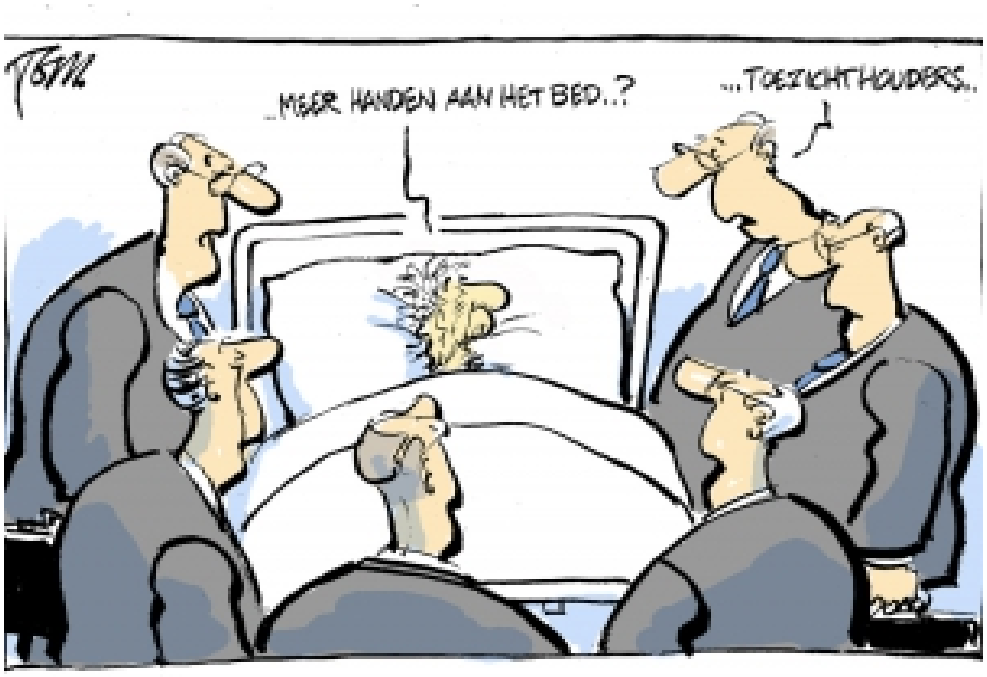
Regulators in the fight against fraud

Nederlandse Zorgautoriteit

Ladies and gentlemen, good morning,

There is no easy solution to the problem of wrongful financial claims by health care providers, whether they are honest mistakes or just plain fraud. Enormous amounts of money are spent in the health care sector, and that forces us to make sure that these funds are spent wisely. In that context, close cooperation with our fellow regulators within, what we call, the chain is essential. And that chain is long; in the Netherlands, we have six regulators fighting against fraud.

I would like to show you this cartoon. The text is in Dutch, but I will translate it for you:
The patient lying in bed asks the men standing around him: more nurses at my bedside? And their reply is: regulators.



Ladies and gentlemen, today's speech is about the power and challenges of cooperation. By joining forces, we as regulators are able to do more to prevent mistakes before they happen, and to improve the inspections afterwards. This will help everyone stop wasting money. The money that we are able to save in this way can be used towards improving health care.

Allow me to use a football analogy or soccer, for the Americans among us. In order to be able to win, a football team has good players for each position.

But that is not enough. All players on the team must have a common objective, and they have to make rules amongst themselves, and then stick to them. In short, players on a football team must both have individual qualities *and* be good team players.

Back to health care, and let's look back on the year 2006. A new health care system was introduced in the Netherlands back then. Health insurers were given a key role in the new system. They are private companies with a public task.

Health insurers are given a leading role in the claims assessment process. The rationale behind it is that having health insurers with a statutory duty and that bear risk themselves will guarantee lawfulness. The government takes a step back, and will only institute criminal proceedings in extreme cases. This approach is based on ideology: market forces are leading.

At this stage, the NZa, too, as well as law-enforcement authorities do little. Fraud prevention looks at isolated cases, is incident-driven, and is not effective.

At the same time, the number of reports about abuses keeps on growing.

I would like to play a video to show you what can happen if a regulator fails to take swift and decisive action after receiving reports about abuses.

The video is about the Bernard Madoff case. Mr. Madoff was arrested in 2008 by the FBI for fraud. He had swindled the customers of his business out of approximately 65 billion US dollars. Despite the information that the US Securities and Exchange Commission (the SEC) had received from a whistle-blower years before the eventual arrest, the SEC failed to take any action. I will show you a segment from the public hearing in 2009.

www.youtube.com/watch?v=oGaVIS_3h8I

This was a painful lesson for the US regulator. But we, too, can learn from it.

In 2011, the NZa concluded that the approach that had been followed until then yielded too little result.

That is why the NZa started using a new approach: an integrated approach that consisted of looking at the system, and carrying out concrete investigations. It first employed this approach in the dental care industry. A detailed investigation into the checks among dentists revealed that health insurers failed to get the most out of them. In our annual inspections of health insurers, too, it turned out that nearly all of them, allocated too few people, capacity and time in these checks. That is why we started forcing health insurers to carry out stricter checks.

In addition, the NZa launches investigations itself, seeks to influence the sector's perception of the norms, imposes sanctions, and helps to track down abuses. In 2011, the NZa carried out three investigations into the dentistry sector. These cases have led to several substantial fines (between 100,000 and 300,000 euros).

Investigations by the NZa into several agencies for so called PGB personal care (Personal Budget Scheme) revealed that they completely failed to keep any records of their clients. As a result, high periodic penalty payments were imposed. This case was one of the reasons behind the decision to handle more cases from the pool of tracked-down cases. Furthermore, an old investigation into a hospital from 2008, which was the first investigation into possible fraud, was completed in 2011 with the imposition of a fine of 500,000 euros.

As a result of these investigations, a realization has sunk in that, in various health care markets in the Netherlands, serious problems concerning the correctness of claims may be occurring. The number of

reports that the NZa received about such problems started to increase rapidly from 2011, from 500 back then to 2,000 last year. The attention that our investigations attract makes people realize that they are able to contact someone with their reports about abuses.

Cases such as these lead to increased attention within the NZa for this problem, and also lead to the desire to generate public and political attention for it. Yet, the NZa at that moment is a very small organization, with only 38 regulatory employees who are charged with oversight of 100,000 health care providers, and 9 health insurers. Making tough choices and priority setting is what makes a regulator effective and decisive.

Then, a big breakthrough happened in 2013;
The NZa carried out dawn raids in two hospitals. The Dutch media were on it: they reported extensively on 'how easy it is to file false claims'. A new controversy (in the Netherlands and abroad) erupted when a Dutch newspaper managed to register itself as a rehabilitation clinic without any problems at all, was accepted, was assigned a claim code, and was thus able to file false invoices.

Everyone was outraged. As a result, fraud prevention was placed at the top of the political agenda. All interested parties promised to put more effort and capacity into the fight against fraud and mistakes in health care. Investments would be made in staff and time.

Many different actors are involved in the fight against fraud. Yet, a single, simple cause does not exist, neither does a simple solution. We call this a "wicked problem".

If I may use the football analogy again: in our playing field, we also have different players, with different roles and tasks, and, sometimes, also with different objectives and interests.

- Lawmakers decide on the system (currently a free-market system), create the incentives, and also determine how much room there is for incorrect claims;
- Consumers have their roles with regard to choice and checks;
- Providers file claims, maintain certain ethical standards when doing so, and they check these claims themselves;
- Insurers purchase health care services, and check these services. They may claim back;
- Regulators conduct investigations, and take action using formal or informal instruments;
- Criminal law enforcement authorities take legal action in several severe cases.

It is not easy to settle on effective interventions for all of these points. A lot of cooperation and convincing is needed for that. One issue that is tricky, for example, is the question of what should be solved through criminal law, and what should be solved through administrative law. This process of coordination has been laid down in a clear protocol.

In a regulatory investigation into a hospital, the latter issue (so criminal law versus administrative law) triggered a political and public debate. The NZa completed the case, and the hospital was imposed the highest fine ever. However, the case was so big that, afterwards, many thought that the Public Prosecution Service should have instituted criminal proceedings against the hospital.

Besides joining forces as fellow regulators, it is also necessary to cooperate with partners in the sector. Trade associations sometimes deny or play down the waste of money by mistakes or fraud. Generally speaking, they see health care professionals as a special category of people, who, unlike 'normal people,' do not need any oversight. And it's in their DNA that they always do the right thing for patients.
Unfortunately, that is not the case. Health care professionals, too, make mistakes (consciously or unconsciously) when filing a claim for the care they provided. And, like in other industries, there are health care providers that are mainly interested in making a lot of money in any way possible, including in not-so-legal ways. In order to separate the wheat from the chaff, we need monitoring and checks, which is also in the interest of the profession's standing.
Providing good health care to patients also means ensuring that correct claims are filed.

Trade associations are able *and should* play a major role in that process by setting the bar high in terms of what the social norm should be. Integrity is an element of the health care provider's professional attitude. Wrongful behavior should not be swept under the carpet, but should be acknowledged and be dealt with, for example by reporting it to the police or other authorities. That is how we are able to get a grip on the problem, which is in the interest of ensuring high-quality health care for patients. After all, that is our shared ambition.

On the one hand, health insurers are our allies in the fight against wrongful claims. Yet, on the other hand, health insurers are sometimes also the object of investigations. Insurers compete with one another, fighting for customers. That is why they do not always share all the information about risks and how to deal with those risks, which would help find the best approach.

Any indications of possible fraud are important. We just saw the video about the SEC, an example of a regulator that fell short.

The NZa operates an information desk that consumers, health care providers and insurers can call when they have questions about funding or access to health care services. People can also report possible violations they might encounter.

A lot of people know how to find our information desk. We get approximately 19,000 questions per year, and 2,000 of which are about possible abuses.

Over the next few months, we will enhance our information desk so that it will become even easier for people to find. In addition, we will also be able to respond to questions and indications faster.

Ladies and gentlemen, I'm stating the obvious here. Eleven individual football players will never achieve great results if they do not explicitly learn how to play as a team.
Creating a high-performance team requires stamina, discipline, and perseverance. And everyone will experience ups and downs before reaching the top.

In order to take the fight against fraud to the next level, we need to take the next, major steps together;

- All regulators and insurers should design a common strategy, a common objective;

- Health insurers would have to share information about possible fraud cases with law enforcement authorities sooner;
- The Dutch Tax Administration, the Inspection, health insurers, and the NZa should link their data where possible;
- We should speed up criminal proceedings by making it possible to check medical files in those instances where it is necessary;
- Trade associations should actively work together in order to rid the industry of the bad apples.

This will prevent the waste of money. The money that we save in this way can be used to realize high-quality and affordable health care.