

# Illness Benefit

## Fraud and Error Survey



Department of Social Protection

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## 1. Introduction

The Department of Social Protection (DSP) undertakes fraud and error surveys to establish baseline fraud and error levels for social welfare schemes. The purpose of such surveys is to identify the level of risk associated with particular schemes and areas with a view to designing processes and control measures specifically targeted to minimise the level of future risk.

This survey is the second to be undertaken on the Illness Benefit (IB) scheme, which is a short-term weekly payment to people who cannot work because of illness or injury and are covered by social insurance (PRSI)<sup>1</sup>. The first survey of the scheme, in 2006, found a net fraud and error rate of 0.4% but did not incorporate a medical eligibility review.

For the present survey, 1,000 randomly selected cases in payment on the last week of November 2014 were reviewed to assess recipients' compliance with the rules of the IB scheme. The key results of this assessment are shown in Table 1, and further analysis is given in section 3 below.

**Table 1 – Estimated Fraud and Error as a percentage of Illness Benefit weekly expenditure, 28 November 2014<sup>2</sup>**

	Gross rate	Appeals	Transferred claims	Net rate
<b>Fraud and Error as % of expenditure</b>	<b>0.5</b>	0.0	0.1	<b>0.4</b>
<i>As % of number of claims</i>	<i>1.1</i>	-	<i>0.1</i>	<i>1.0</i>
<b>Customer Fraud and Error</b>	<b>0.5</b>	0.0	0.1	<b>0.4</b>
Customer Fraud	0.3	-	-	0.3
Customer Error	0.1	-	0.1	0.0
<b>Departmental Error</b>	<b>0.0</b>	0.0	0.0	<b>0.0</b>
Departmental overpayment	0.0	-	-	0.0
Departmental underpayment	-0.1	-	-	-0.1

In the last week of November 2014, there were some 58,000 recipients of IB, and total weekly expenditure was approximately €11.3 million. Extrapolating from the survey results, we therefore estimate the monetary value of total **scheme-wide fraud and error** in that week at **€0.04 million** (net of transfers to other schemes).

A sub-sample of 300 cases was selected for detailed medical review. The results of this process are shown in Table 2, and more detailed analysis is presented in Section 0 below.

**Table 2 – Estimated medical ineligibility as a percentage of Illness Benefit weekly expenditure, 28 November 2014<sup>2</sup>**

	Gross rate	Appeals	Transferred claims	Net rate
<b>Medical ineligibility as % of expenditure</b>	<b>12.9</b>	<b>5.0</b>	<b>2.3</b>	<b>5.6</b>
<i>As % of number of claims</i>	<i>13.7</i>	<i>5.3</i>	<i>2.0</i>	<i>6.3</i>

Based on these results, we estimate the total monetary value in the last week of November of claims which, if examined, would be found to be **medically ineligible** at some **€0.63 million** (net of transfers to other schemes). No cases with dual fraud/error and medical ineligibility outcomes were found.

A risk analysis of both the Fraud and Error and Medical Ineligibility results is presented in Section 5. No statistically significant predictor variables were found for the low number of customer fraud and error outcomes found, while for medical eligibility non-Irish nationality and certain incapacity categories have been tentatively identified as predictor variables for a higher probability of a medical ineligibility determination.

<sup>1</sup> For a full description of the scheme, see [http://www.welfare.ie/en/Pages/345\\_Illness-Benefit.aspx](http://www.welfare.ie/en/Pages/345_Illness-Benefit.aspx).

<sup>2</sup> Figures may not add due to rounding. Table 4/Table 5 (Fraud and Error) and Table 8/Table 9 (Medical Ineligibility) below show these results rounded to two decimal places, along with 95% confidence intervals for the results.

## 2. Methodology

### *Survey criteria*

The Department agreed the following criteria with the Comptroller & Auditor General (C & AG) for the successful implementation of baseline fraud and error surveys:

- All cases for inclusion in the survey must be selected randomly from the population of cases in payment at a specific time;
- The sample size must be sufficiently large to yield reasonably reliable estimates;
- The reviews should be carried out as promptly as possible;
- Cases should be tested fully for all possible breaches of regulations;
- The monetary values of any changes as a result of the review together with the monetary value of the sample should be captured so that the results can be extrapolated to draw conclusions about the estimated value of the loss; and
- The results of the survey should be capable of being audited.

During the course of 2013, the C&AG audited previous surveys and the fraud and error survey process in the DSP. The findings of the audit were published by the C&AG in September 2013, and DSP has undertaken to incorporate the findings into future surveys as appropriate.

### *Sample selection*

The Department's Statistician oversees the fraud and error surveys at design and reporting stage. At design stage an appropriate sample structure is identified to fit the scheme's profile of recipients.

In terms of the IB survey, the following approach was adopted:

- A random sample of 1,000 IB claims in payment at 28 November 2014 ('the Fraud and Error sample') was selected.
- The sample of 1,000 was examined by the statistician and found to be representative as required by reference to age, location, gender etc.
- A representative sub-sample consisting of 300 of these cases was then randomly selected for medical assessment ('the medical sub-sample').

### *'Gross' and 'net' rates of Fraud and Error and Medical Ineligibility*

Fraud and error rates are calculated based on the decisions of the deciding officer (DO) in each case included in the survey sample.

- **Fraud or suspected fraud** arises where it appears to the DO that the claimant knowingly gave false or misleading information or wilfully concealed relevant information.
- **Error** cases are primarily due to inadvertent customer, third party or departmental error.

Fraud and error rates may be quoted either as a *percentage of total scheme expenditure* (in the week the survey was initiated) or as a *percentage of the number of claims in payment* on that date.

- The **gross** rate refers to the position after account is taken of decreases or increases in weekly rate (including terminations of payment), but before transfers to other DSP schemes and the position post appeals of any cases affected. (Cases with an unchanged weekly rate but where a historical overpayment is identified only affect the *number of claims* rate.)
- The **net** rate of Fraud and Error is the rate after taking account of transfers to other DSP payments and the post-appeals position of affected cases.

A similar distinction is made between the gross and net rates of the impact of medical eligibility reviews—i.e. the net rate of **medical ineligibility** takes account of those cases ruled eligible on appeal and those where a customer transfers to another scheme.

### 3. Results of full sample review for Fraud and Error

The full sample of IB cases were examined and decided by Deciding Officers, so that results for all 1,000 cases are included in this report.

The results of this exercise are summarised in Table 3 below.

Table 3 - Full sample results summary

<b>Outcome</b>	<b>No. of cases</b>	<b>% of total</b>
<b>Fraud &amp; Error (gross)</b>	<b>11</b>	<b>1.1%</b>
<b>Fraud &amp; Error (net)</b>	<b>10</b>	<b>1.0%</b>
Total Customer Fraud & Error (net)	5	0.5%
Customer Fraud (gross/net)	4	0.4%
<i>Decrease qualified adult allowance</i>	2	0.2%
<i>Terminated: In employment while claiming IB</i>	1	0.1%
<i>Terminated: unable to contact client</i>	1	0.1%
Customer Error (net)	1	0.1%
<i>Decrease qualified child allowance</i>	1	0.1%
Departmental Error (gross/net)	5	0.5%
Overpayment	1	0.1%
Underpayment	4	0.4%
<b>Transferred to other schemes</b>	<b>1</b>	<b>0.1%</b>
Customer Error (gross only)	1	0.1%
<i>To Inv. Pension (qualifying child allowance terminated)</i>	1	0.1%
<b>No Fraud or Error</b>	<b>989</b>	<b>98.9%</b>
No change following review	754	75.4%
Normal Movement	190	19.0%
<i>Deceased</i>	2	0.2%
<i>Closed - medical eligibility expired<sup>3</sup></i>	120	12.0%
<i>Closed - benefit entitlement expired<sup>3</sup></i>	26	2.6%
<i>Change in Qualifying Adult circumstances</i>	2	0.2%
<i>Change in Qualifying Child circumstances</i>	3	0.3%
<i>To Disability Allowance</i>	2	0.2%
<i>To Invalidity Pension</i>	11	1.1%
<i>To Jobseekers Allowance</i>	1	0.1%
<i>To Jobseekers Benefit</i>	2	0.2%
<i>To Maternity Benefit</i>	10	1.0%
<i>To State Pension (contributory)</i>	2	0.2%
<i>To Partial Capacity Benefit</i>	1	0.1%
<i>Other</i>	8	0.8%
<b>Found medically ineligible in separate review</b>	<b>45</b>	<b>4.5%</b>
<i>As a result of separate 300-case medical review</i>	41	4.1%
<i>As a result of other routine medical reviews</i>	4	0.4%

<sup>3</sup> These cases were closed with no transfer onto other DSP schemes. Cases where medical or benefit eligibility for IB expired but where the recipient then transferred to another DSP scheme are shown in the 'To [name of DSP scheme] lines below.

## ***Fraud and Error cases***

The low rates of fraud and error observed in the survey are consistent with similar results for other non-means tested schemes<sup>4</sup>. Moreover, the overall net fraud and error rate of 0.4% is identical to that found in the 2006 Fraud and Error survey of the Illness Benefit scheme.

Because of the low Fraud and Error rate in the scheme coupled with the 1,000 case sample size, 95% confidence intervals for a number of the key survey outcomes as shown in Table 4, Table 5 and Table 6 are rather wide and in some cases include negative values (marked in red)<sup>5</sup>.

Nonetheless, the survey is powerful enough to give meaningful results at the 95% confidence level for gross and net Customer Fraud, total Customer Fraud and Error, and total Fraud and Error, as a percentage of expenditure and hence in terms of estimated scheme-wide monetary value.

The total Fraud and Error rate as a percentage of the number of cases is also significant at the 95% confidence level, while the estimated gross and net Customer Fraud, Departmental Underpayment, and Customer Fraud and Error rates (as a percentage of spending), as well as the Departmental Underpayment rate (as a percentage of the number of cases), are all significant at the 90% confidence level.

**Table 4 - Confidence interval (95%) for Fraud and Error as percentage of total expenditure**

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Fraud and Error (% of expenditure)</b>	0.04	<b>0.48</b>	0.91	0.01	<b>0.36</b>	0.71
Customer Fraud and Error	0.06	<b>0.48</b>	0.90	0.03	<b>0.36</b>	0.70
Customer Fraud	0.00	<b>0.34</b>	0.67	0.00	<b>0.34</b>	0.67
Customer Error	-0.11	<b>0.14</b>	0.40	-0.01	<b>0.03</b>	0.06
Departmental Error	-0.11	<b>0.00</b>	0.10	-0.11	<b>0.00</b>	0.10
Departmental overpayment	-0.04	<b>0.05</b>	0.14	-0.04	<b>0.05</b>	0.14
Departmental underpayment	-0.11	<b>-0.05</b>	0.00	-0.11	<b>-0.05</b>	0.00

**Table 5 - Confidence interval (95%) for Fraud and Error as percentage of number of cases**

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Fraud and Error (% of cases)</b>	0.40	<b>1.10</b>	1.80	0.33	<b>1.00</b>	1.67
Customer Fraud and Error	0.01	<b>0.50</b>	0.99	-0.04	<b>0.40</b>	0.84
Customer Fraud	-0.04	<b>0.40</b>	0.84	-0.04	<b>0.40</b>	0.84
Customer Error	-0.15	<b>0.10</b>	0.35	-0.05	<b>0.00</b>	0.05
Departmental Error						
Departmental overpayment	0.01	<b>0.50</b>	0.99	0.01	<b>0.50</b>	0.99
Departmental underpayment	-0.15	<b>0.10</b>	0.35	-0.15	<b>0.10</b>	0.35

<sup>4</sup> The DSP 2014 survey of Widow/er's / Surviving Civil Partner's Contributory Pensions ([http://www.welfare.ie/en/downloads/wcp\\_survey.pdf](http://www.welfare.ie/en/downloads/wcp_survey.pdf)) found a net Fraud and Error rate of 0.7% of expenditure, and the DSP 2013 survey of Child Benefit ([http://www.welfare.ie/en/downloads/cb\\_survey\\_13.pdf](http://www.welfare.ie/en/downloads/cb_survey_13.pdf)) found a net Fraud and Error rate of 0.5% of expenditure.

<sup>5</sup> Negative values here mean that we cannot claim to have identified with 95% confidence a population-wide outcome that is different from the null hypothesis of a zero rate of fraud and error.

Table 6 - Confidence interval (95%) for estimated monetary value of population Fraud and Error in survey week

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Fraud and Error (monetary value)</b>	€4,937	<b>€53,795</b>	€102,653	€644	<b>€40,391</b>	€80,138
Customer Fraud and Error	€6,961	<b>€54,305</b>	€101,649	€3,031	<b>€40,901</b>	€78,772
Customer Fraud	€337	<b>€37,997</b>	€75,657	€337	<b>€37,997</b>	€75,657
Customer Error	-€12,466	<b>€16,308</b>	€45,083	-€1,191	<b>€2,905</b>	€7,000
Departmental Error						
Departmental overpayment	-€12,571	<b>-€510</b>	€11,551	-€12,571	<b>-€510</b>	€11,551
Departmental underpayment	-€5,070	<b>€5,282</b>	€15,633	-€5,070	<b>€5,282</b>	€15,633

### ***Normal Movement cases***

The number of Normal Movement cases was relatively high, consistent with the short-term nature of the Illness Benefit scheme.

No evidence was found of fraud or error in these cases, and accordingly the Department does not consider that the fraud and error results for the survey need to be adjusted upwards based on the lower effective sample, net of movement cases.

## 4. Results of medical sub-sample review

Alongside the fraud and error analysis outlined above, medical reviews were conducted on the 300-case medical sub-sample. Again, results from all 300 cases are included in this report, as summarised in Table 7 below.

Table 7 - Summary of medical sample results

<b>Outcome</b>	<b>No. of cases</b>	<b>% of total</b>
<b>Medically ineligible (gross)</b>	<b>41</b>	<b>13.7%</b>
<b>Medically ineligible (net)</b>	<b>19</b>	<b>6.3%</b>
<i>No appeal, no transfer to other DSP scheme</i>	17	5.7%
<i>Disallowed on appeal</i>	2	0.7%
<b>Allowed on appeal</b>	<b>16</b>	<b>5.3%</b>
<b>Transferred to other DSP schemes</b>	<b>6</b>	<b>2.0%</b>
<i>To Jobseekers Assistance</i>	2	0.7%
<i>To Jobseekers Benefit</i>	4	1.3%
<b>Medically eligible</b>	<b>259</b>	<b>86.3%</b>
No change following review	183	61.0%
Normal Movement	69	23.0%
<i>Closed - claim expired</i>	51	17.0%
<i>Change in Qualifying Adult circumstances</i>	3	1.0%
<i>Change in Qualifying Child circumstances</i>	1	0.3%
<i>To Disability Allowance</i>	2	0.7%
<i>To Invalidity Pension</i>	5	1.7%
<i>To Jobseekers Allowance</i>	1	0.3%
<i>To Jobseekers Benefit</i>	1	0.3%
<i>To Maternity Benefit</i>	4	1.3%
<i>To State Pension (contributory)</i>	1	0.3%
Medically eligible but Fraud/Error in separate 1000-case review	7	2.3%
<i>Customer Fraud</i>	2	0.7%
<i>Customer Error</i>	1	0.3%
<i>Departmental Error - Overpayment</i>	1	0.3%
<i>Departmental Error - Underpayment</i>	3	1.0%

### **Medical ineligibility cases**

When a case is determined to be ‘medically ineligible’, this means that the claimant has been determined not to meet the medical criteria required for payment eligibility under the scheme on the date of examination. It is important to note that in all such cases, a deciding officer had previously determined that the client was medically eligible for Illness Benefit based on all the medical evidence available at that time. Moreover, payment eligibility for the scheme lapses as soon as a recipient ceases to supply weekly or monthly medical certificates confirming that their illness or injury continues to render them unfit for work. In the absence of other evidence, a ‘medical ineligibility’ determination cannot then be categorised as fraud or error. Instead, it generally reflects changes in medical circumstances over time.

As a medical ineligibility determination removes the primary criterion for payment under the IB scheme, all forty-one cases thus identified lost their IB entitlement entirely. However, full payment entitlement was restored on appeal in sixteen cases, and six of the remaining twenty-five recipients are now in payment in other DSP schemes, as shown in Table 7 above.



Table 8, Table 9 and Table 10 below show that despite the smaller medical sample size (300 cases) and low ineligibility rate in the survey, we can nonetheless be confident at the 95% level (and indeed at the 99% level) that our estimate of the Gross Medical Ineligibility rate for the population is meaningful.

The highly resource-intensive nature of these reviews means that any increase in sample size in order to increase the power of the survey would have a significant negative impact on survey timeliness and availability of limited medical review resources for their ongoing work, and so we believe a right balance has been struck in the survey design between timeliness, cost/resource use, and power.

**Table 8 – Confidence Interval (95%) for medically ineligible cases as a percentage of weekly scheme expenditure**

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Medical Ineligibility (% of expenditure)</b>	9.06	<b>12.91</b>	16.77	2.88	<b>5.60</b>	8.33

**Table 9 - Confidence Interval (95%) for medically ineligible cases as a percentage of total cases**

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Medical Ineligibility (% of cases)</b>	9.61	<b>13.67</b>	17.72	3.41	<b>6.33</b>	9.26

**Table 10 - Confidence Interval (95%) for estimated monetary value of medically ineligible cases**

	<i>Lower bound (gross)</i>	<b>Gross</b>	<i>Higher bound (gross)</i>	<i>Lower bound (net)</i>	<b>Net</b>	<i>Higher bound (net)</i>
<b>Medical Ineligibility (monetary value)</b>	€1,023,776	<b>€1,459,772</b>	€1,895,767	€325,339	<b>€633,244</b>	€941,150

## ***Appeals***

Of the 41 recipients who received a first-instance decision of medical ineligibility for IB, a high proportion (18 or 44%) pursued an appeal against the decision. At the time of survey completion, ten of these appeals were complete—in all of these cases the appeal was successful and scheme payment was restored.

A further eight appeals are currently under consideration: based on a detailed examination of each of these cases, *for the purposes of this survey* we have recorded six out of eight cases as likely to be restored to payment on appeal (marked ‘allowed on appeal’ in Table 7), and the remaining two cases as likely to have their initial ineligibility determination confirmed (marked ‘disallowed on appeal’ in Table 7)<sup>6</sup>.

<sup>6</sup> This assignment has been made purely for statistical purposes, to give as realistic a set of survey results as is possible given the publication timeframe, and does not in any way inform or prejudice the actual appeal outcomes, which may differ.

We note, however, that our assignment of these cases is in line with the scheme-wide average success rate for non-withdrawn appeals of 75%.

### ***Normal Movement cases***

The number of Normal Movement cases was relatively high. However, this is not unexpected given that Illness Benefit is a short-term scheme where a high percentage of claimants may be expected to resume employment after a period of illness or injury.

Moreover, no evidence was found of medical ineligibility in these cases—rather, the vast majority showed clear evidence of compliance by sending final medical certificates confirming that they were fit to resume work—so that the Department does not consider that the survey results need to be adjusted upwards based on a lower effective sample net of movement cases.

### ***Medically eligible cases where Fraud/Error was detected in the 1000-case survey***

As shown in Table 7, a number of cases (7 out of the total medical sample of 300) were separately determined by Deciding Officers, in reviewing the status of the full sample of 1,000 cases as detailed in Section 3 above, to reflect Fraud or Error on the part of the claimant.

However, no cases with both Fraud/Error and medical ineligibility outcomes were recorded.

## 5. Risk category analysis

### *Fraud and Error risk analysis*

In order to ascertain which claim attributes, if any, were more likely to occur in claims that were found to be in error (either by fraud or customer error), the results from the sample were analysed for two categories of claims<sup>7</sup>: those claims that had a resulting change in their payment and those that had no change in their payment (after the subsequent investigation). This analysis was based on the gross level of customer fraud and error in the full sample of 1,000 cases.

However, because of the very low rate of customer fraud and error (six cases out of 1,000, on a gross basis before transfers to other schemes), no statistically significant predictor variables were detected for the 'customer fraud or error' outcome.

### *Medical eligibility risk analysis*

A similar analysis was conducted in respect of the medical eligibility outcome in the medical sub-sample<sup>8</sup>. In this case—

- Clients with a nationality code other than 'Irish' were found to be somewhat more likely to show a medical ineligibility outcome (significant at the 95% confidence level).
- A significant association (at the 90% confidence level) was also found between the medical incapacity code corresponding to 'Back/Neck/Rib/Disc injury' and an increased likelihood of a medical ineligibility determination<sup>9</sup>.

## 6. Conclusions and recommendations

The overall net cost of fraud and error for Illness Benefit in November 2014 is estimated at 0.4% of expenditure, while the overall net cost of medical ineligibility at the same point in time is estimated at 5.6% of scheme expenditure.

This is a low risk scheme, with an effective control policy centred on periodic medical reviews. The statistical associations found with certain predictor variables for 'medical ineligibility' outcomes could be taken into account as the scheme control policy evolves.

We will continue to use the results of this and other surveys to refine our methodology for future surveys. In the case of the present survey, given the low rates of fraud, error, and ineligibility found, we believe that an appropriate balance was struck between sample size/power, timeliness, and use of resources.

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<sup>7</sup> Chi-square analysis was used to identify initial risk groups and regression and probit models were used to determine strength of association for the initial variables.

<sup>8</sup> This was done on a 'post appeals' but 'pre-transfer to other DSP schemes' basis, as this best reflects the target group of cases for risk analysis.

<sup>9</sup> Suggestive relationships, with  $p < 0.05$ , were also found for several other incapacity codes, but the small number of cases observed for each code means that this result must be treated with caution as false positives are to be expected.