Invalidity Pension

Fraud and Error Survey

Department of Social Protection

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Contents

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 first to be undertaken on the Invalidity Pension (IP) scheme, which is a weekly payment to people who cannot work because of a long-term illness or disability and are covered by social insurance (PRSI).[1]. The IP scheme is administered by the Invalidity Pension Claims Section of the DSP in Longford.

For the 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 IP 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 Invalidity Pension weekly expenditure, 28 November 2014[2]

	Gross rate	Appeals	Transferred claims	Net rate[3]
Fraud and Error as % of expenditure	**0.5**	**-**	**-**	**0.5**
As % of number of claims	*3.2*	*-*	*-*	*3.2*
Customer Fraud and Error	**0.5**	**-**	**-**	**0.5**
Customer Fraud	0.1	-	-	0.1
Customer Error	0.4	-	-	0.4
Departmental Error	**0.0**	**-**	**-**	**0.0**
Departmental overpayment	0.0	-	-	0.0
Departmental underpayment	-	-	-	-

In the last week of November 2014, there were some 55,000 recipients of IP, and total weekly expenditure was approximately €12 million. Extrapolating from the survey results, we therefore estimate the monetary value of total **scheme-wide fraud and error** in that week at **€0.06 million.**

Almost all identified cases of fraud or error centred on recipients' entitlement to additional means-tested or family circumstances-based allowances rather than on eligibility for the primary payment. This is in line with the results of the statistical risk analysis presented in Section 5 below, which identifies people with additional adult dependants as significantly more likely to have a fraud or error outcome than other scheme recipients.

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 4 below.

Table 2 – Estimated medical ineligibility as a percentage of Invalidity Pension weekly expenditure, 28 November 2014[2]

	Gross rate	Appeals	Transferred claims	Net rate
Medical ineligibility as % of expenditure	**2.3**	**-**	**1.3**	**1.0**
As % of number of claims	*2.3*	*-*	*1.7*	*0.7*

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 **€0.13 million** (net of transfers to other schemes). No cases with dual fraud/error and medical ineligibility outcomes were found.

[1] For a full description of the scheme, see http://www.welfare.ie/en/Pages/Invalidity-Pension.aspx

[2] 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, as well as 95% confidence intervals for the results.

[3] No successful appeals or inter-scheme transfers were observed, so the gross and net position is the same for all cases.

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 IP survey, the following approach was adopted:

- A random sample of 1,000 IP 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 IP cases were examined and decided by Deciding Officers within the Control Projects Team in Longford, 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

Outcome	No. of cases	% of total
Fraud & Error (gross and net)	**32**	**3.2%**
Total Customer Fraud & Error	31	3.1%
Customer Fraud	8	0.8%
Decrease qualified adult allowance	*4*	0.4%
Terminate free fuel allowance	*1*	0.1%
In employment without informing DSP[4]	*2*	0.2%
Special investigation ongoing[5]	*1*	0.1%
Customer Error	23	2.3%
Decrease qualified adult allowance	9	0.9%
Terminate free fuel allowance	5	0.5%
Terminate Living Alone allowance	4	0.4%
Terminate free fuel and Living Alone allowances	4	0.4%
Terminate claim	1	0.1%
Departmental Error	1	0.1%
No fraud or error detected	**968**	**96.8%**
No change following review	946	94.6%
Normal Movement	15	1.5%
Deceased	*3*	0.3%
Returned to Work	*1*	0.1%
Transferred to State Pension (Contributory) at age 66	*8*	0.8%
Transferred to Widow(er)'s Pension	*2*	0.2%
Transferred to Partial Capacity Benefit	*1*	0.1%
Found medically ineligible in separate 300-case review	7	0.7%

Fraud and Error cases

The low rates of fraud and error observed in the survey are consistent with similar results for other long-term non-means tested schemes[6]. In the case of IP, not only is the number of affected claims low at 3.2%, but the average overpayment per claim is very low—€36.43 per affected claim or €1.14 on average across all claims.

This reflects the fact that almost all identified fraud and error outcomes relate to means-tested payments for qualified adults, the means-tested free fuel allowance, and the Living Alone Allowance. In line with these findings, analysis of the survey results identifies a claimant having a qualified adult dependant as the most important predictor of a fraud/error outcome (see Section 5 below).

[4] In these cases a period of undeclared employment, contrary to the scheme rules, has been determined to be Fraud. However, there is no change between the pre- and post-survey weekly payment rates in these cases, so that they result in an increase in the number of Fraud cases but not a change to the Fraud rate as a percentage of expenditure.

[5] This investigation has not yet completed, but the case has prudentially been assigned to the Fraud category.

[6] The DSP 2014 survey of Widow/er's / Surviving Civil Partner's Contributory Pensions (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) found a net Fraud and Error rate of 0.5% of expenditure.

No successful appeals or transfers to other DSP payments were recorded for the identified Fraud and Error cases, so that the Gross and Net rates of Fraud and Error are the same. This again reflects the fact that almost all of the affected people remained in payment on the IP scheme with an unchanged primary payment rate.

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)[7].

Nonetheless, the survey is powerful enough to give meaningful results at the 95% confidence level for Customer Error, total Customer Fraud and Error, and total Fraud and Error (as a percentage both of expenditure and number of cases). Additionally, the estimated Customer Fraud rate (as a percentage of spending) is significant at the 90% confidence level, with an interval from 0.0% to 0.2% of expenditure.

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

	Low	Centre	High
Customer Fraud	-0.01%	**0.08%**	0.17%
Customer Error	0.15%	**0.42%**	0.68%
Total Customer Fraud and Error	0.22%	**0.50%**	0.78%
Departmental Error	-0.02%	**0.01%**	0.04%
Total Fraud and Error	0.23%	**0.51%**	0.79%

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

	Low	Centre	High
Customer Fraud	0.20%	**0.80%**	1.40%
Customer Error	1.32%	**2.30%**	3.28%
Total Customer Fraud and Error	1.98%	**3.10%**	4.22%
Departmental Error	-0.15%	**0.10%**	0.35%
Total Fraud and Error	2.06%	**3.20%**	4.34%

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

	Low	Centre	High
Customer Fraud	-€1,060	**€9,917**	€20,895
Customer Error	€18,628	**€50,687**	€82,745
Total Customer Fraud and Error	€26,775	**€60,604**	€94,433
Departmental Error	-€2,740	**€1,084**	€4,907
Total Fraud and Error	€27,800	**€61,688**	€95,576

Normal Movement cases

The number of Normal Movement cases was low, consistent with the long-term nature of the Invalidity Pension 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 a lower effective sample net of movement cases.

[7] 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.

4. Results of medical sub-sample review

Alongside the fraud and error analysis outlined above, medical reviews were undertaken 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

Outcome	No. of cases	% of total
Medically ineligible (gross)	**7**	**2.3%**
Medically ineligible (net)	**2**	**0.7%**
Transferred to other DSP schemes	5	1.7%
Jobseekers Allowance	*2*	0.7%
Supplementary Welfare Allowance	*2*	0.7%
Partial Capacity Benefit	*1*	0.3%
Medically eligible	**293**	**97.7%**
No change following review	277	92.3%
Normal Movement	6	2.0%
Deceased	*1*	0.3%
Returned to Work	*1*	0.3%
To State Pension (Contributory) at age 66	*2*	0.7%
To Widow(er)'s Pension	*1*	0.3%
To Partial Capacity Benefit	*1*	0.3%
Medically eligible but Fraud/Error in separate 1000-case review	10	3.3%
Customer Fraud	*3*	1.0%
Customer Error	*7*	2.3%

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 decided that the client was medically eligible for invalidity pension based on all the medical evidence available at that time. 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 medical ineligibility removes the primary criterion for payment under the IP scheme, all seven cases thus identified lost their IP entitlement entirely. However, five out of seven 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 of our estimate of the Gross Medical Ineligibility rate for the population.

However, the estimate of the Net Medical Ineligibility rate (as a percentage of spending) is significant only at the 90% level (with a 90% confidence interval from 0.1% to 2.0 percent equivalent to an estimated scheme-wide weekly monetary value ranging from €0.015 million to €0.241 million).

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

	Low	Centre	High
Gross (before transfer to other schemes)	*0.58%*	***2.33%***	*4.08%*
Net (after transfer to other schemes)	*-0.04%*	***1.04%***	*2.13%*

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

	Low	Centre	High
Gross (before transfer to other schemes)	*0.46%*	***2.33%***	*4.21%*
Net (after transfer to other schemes)	*-0.42%*	***0.67%***	*1.75%*

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

	Low	Centre	High
Gross (before transfer to other schemes)	€69,961	**€286,699**	€503,437
Net (after transfer to other schemes)	**-€5,240**	**€127,968**	**€261,175**

Normal Movement cases

The number of Normal Movement cases in the medical sample was low, and no evidence was found of medical ineligibility in these cases, 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

As shown in Table 7, a number of cases (10 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: 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 fraud and error in the full sample of 1,000 cases.

Statistical analysis[8] revealed that the variables with the strongest influence on the likelihood of a case being in fraud or error were—

- The claimant's family circumstances – specifically, whether the claimant was in receipt of additional allowances in respect of qualified adult dependants. This relationship was highly significant (at a greater than 99.9% confidence level), and would seem to reflect the large number of such cases where the reduction in payment was due to a change to Qualifying Adult or Free Fuel allowances.
- The claimant's location—specifically, claimants with an address in Dublin had a somewhat higher probability of fraud or error compared to claimants in other counties. This result was significant (at a 95% confidence level).

Medical eligibility risk analysis

A similar analysis was conducted in respect of the medical eligibility outcome in the medical sub-sample. Here, no variables with a statistically significant influence on the observed pattern of medical ineligibility determinations were detected.

6. Conclusions and recommendations

The overall net cost of fraud and error for Invalidity Pension in November 2014 is estimated at 0.5% of expenditure, while the overall net cost of medical ineligibility at the same point in time is estimated at 1.0% of scheme expenditure.

This is a low risk scheme, with an effective control policy centred on periodic medical reviews. In addition, the main identified risk group for fraud and error outcomes—cases with additional qualified adult dependants in the scheme control policy—is already prioritised in the scheme control policy.

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.

[8] 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.