

Combating Fraud in Prescriptions and Health Insurance Billing

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SUMMARY

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At the Prime Minister's request, the General Inspectorate of Finance (IGF) and the General Inspectorate of Social Affairs (IGAS) have carried out a review of expenditure relating to prescription fraud and fraudulent claims against the health insurance scheme, with expenditure under the general scheme amounting to €244 billion in 2024. **Health insurance fraud, with detected fraud totalling €628 million in 2024, stems mainly from healthcare professionals or individuals impersonating others or falsifying their identity.** Such fraud accounts for nearly 70 per cent of the total amount of fraud detected and prevented by the health insurance system. This fraud results from the billing of fictitious procedures, the inappropriate coding of procedures on invoices, or the forgery of prescriptions.

Health insurance fraud has arisen against a backdrop of **the widespread adoption of third-party payment since 2016** and the introduction of '100% healthcare' schemes in recent years, combined with reduced vigilance on the part of the insured and **rapid reimbursement by the health insurance scheme** (within 4.4 days by 2025), creating vulnerabilities in a payment chain that is insufficiently secure.

Consequently, the health insurance scheme has implemented a deliberate anti-fraud strategy based primarily on checks carried out after payment. The fight against fraud is now one of its priority objectives under the Objectives and Management Agreement (COG) binding it to the State for the period 2023–2027, as demonstrated by an increase in dedicated resources (a 27 per cent rise in staff numbers between 2020 and 2024). Its current administrative structure for combating fraud – with the primary health insurance funds (CPAMs) playing a key role and strong national oversight by the National Health Insurance Fund (CNAM) – appears satisfactory. It has been strengthened by the roll-out of six inter-regional centres for judicial investigators, which appears promising for handling high-stakes fraud cases, although it is too recent to assess its effectiveness.

Consequently, the health insurance system is showing positive results in terms of fraud detection, with the amounts recovered having tripled since 2021 and the targets set by the COG having been exceeded. **The picture is more mixed when it comes to the recovery of overpayments**, with only around half of the sums concerned being recovered. Furthermore, the CNAM's estimate of fraud does not cover the full scope of expenditure and is not used to guide anti-fraud measures: yet one must understand the problem in order to combat it. In this regard, the gap between detected and estimated fraud suggests **the existence of pockets of undetected fraud.**

Two major projects relating to the digital transition in the healthcare sector offer the prospect of scaling up the fight against health insurance fraud, in that they represent a strategic shift from downstream to upstream controls, through enhanced payment security: the METEOR project, which aims to integrate built-in controls into the health insurance payment software, and the digital prescription scheme. The former will enable the rejection of undue payments before they are made and will therefore drive efficiency gains, in line with the principle that 'a rejection is better than an undue payment'. The second will help guard against fraudulent prescriptions and secure the prescription and billing chain, by eventually reconciling prescription and dispensing data.

These two projects, which are currently underway but have undefined or distant deadlines, must be more closely managed by the CNAM in order to speed up their implementation. The 2030 deadline for the full roll-out of METEOR appears to be very late: the task force recommends increasing the resources allocated to this project. As for digital prescriptions, the deadline set by law for the end of December 2024 has not been met, which calls for the adoption of a roadmap aimed at implementing them as soon as possible.

At the same time, several measures must be put in place to step up the fight against fraud.

Firstly, **the targeting of audits using statistical analysis must be improved.** In particular, **the intensity of audits varies between categories of healthcare professionals, and some remain under-audited.** Several audit criteria could be applied systematically to all professions, and targeting would benefit from drawing on the potential of data science (*data mining* or *machine learning*) to identify potential new fraudulent patterns. Strengthening cooperation with partners, including supplementary health insurance organisations and government departments, is also likely to improve targeting. Furthermore, the balance between the volume of audits for cases involving low and high financial stakes should be shifted in favour of the latter, with the aim of maximising the amount of fraud detected and optimising the allocation of human resources. **Indeed, cases involving losses of less than €1,000 account for 30 per cent of cases processed, but less than 1 per cent of the total loss,** with most of these cases relating to fraud by insured persons, whilst the greater the loss per case, the more fraud by healthcare professionals is over-represented.

Secondly, **the process of billing by healthcare professionals and reimbursement by the health insurance scheme exhibits a significant imbalance between the two parties.** Whilst the health insurance scheme is subject to a seven-day payment guarantee, with penalties for non-compliance, healthcare professionals benefit from very favourable billing terms (long submission deadlines, the option of unsecured submissions without supporting documents). The balance of constraints needs to be restored by requiring healthcare professionals to:

- ◆ improve their billing practices: whilst the law provides for the principle of direct payment by the insurer upon presentation of the insured person's Vitale card, the rate of 'degraded transactions' – i.e. those without a Vitale card – is projected to reach 16 per cent of treatment forms by 2024: this principle must be made fully operational by providing for the necessary flexibility (for example, by setting a tolerance level for the rate of 'degraded' claims that must not be exceeded);
- ◆ Faster invoicing: the regulations must be amended to reduce the statutory time limit for invoicing the health insurance scheme from two years and one quarter to four months.

Thirdly, **a key lever for improving litigation efforts lies in better coordination between the CPAMs and the public prosecutor's offices,** to align administrative and judicial action as early as possible in the case process. Defining a common litigation strategy for high-stakes fraud cases would enable these to be combated effectively and make use of the judicial authority's powers regarding seizures, thereby facilitating recovery.

Furthermore, **the range of sanctions available to the health insurance scheme is diverse and potentially dissuasive, but remains underutilised.** Consequently, many cases of fraud result in no sanctions whatsoever, as only 20,000 legal proceedings were initiated in 2024 out of a total of 36,000 cases. Changes to certain procedures, notably the harmonisation of the rules governing the withdrawal of accreditation and the streamlining of procedures for financial penalties, would help to improve the enforcement actions taken by the CPAMs.

To implement all these measures, **a strategic review of the staff dedicated to combating fraud must be carried out.** Further increases in staffing levels and the strengthening of certain skills, particularly in statistics, may be necessary as part of the shift in the focus of the fight against fraud from downstream to upstream.

The proposals put forward by the task force aim to step up fraud prevention and the fight against fraud. Beyond its contribution to controlling health insurance expenditure, this action forms part of the social contract in that it strengthens citizens' support for the social protection model. As such, it is an objective of constitutional significance, which the task force has found is now widely

shared.