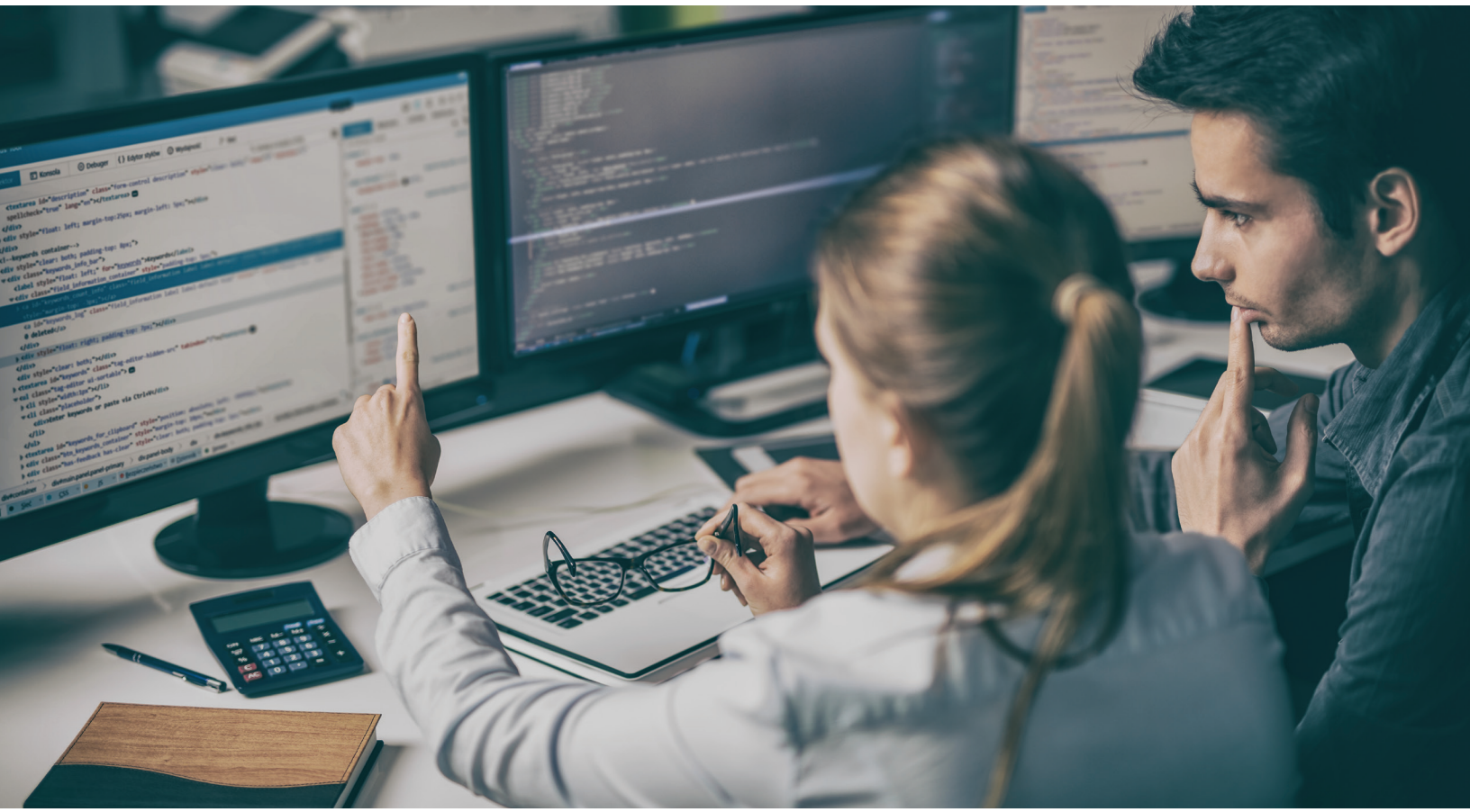
OPTUM®

Optum FWA solution: PayRite

Unlock the true value of your claims operations



Key challenges faced by Indian health insurance companies

With the growing penetration of health insurance in India, there is a surge in the number of claims being submitted and a corresponding increase in fraudulent claims. In addition to this, health insurance companies face the following challenges:

- **Manual claims adjudication process** and 100% review of all claims
- **Obsolete Fraud, Waste & Abuse (FWA) systems** used to identify suspicious claims
- **High dependence on field investigation** to detect fraudulent activities before policy issuance and submission of fraudulent claims
- **Increasing health care costs** and narrow profit margins

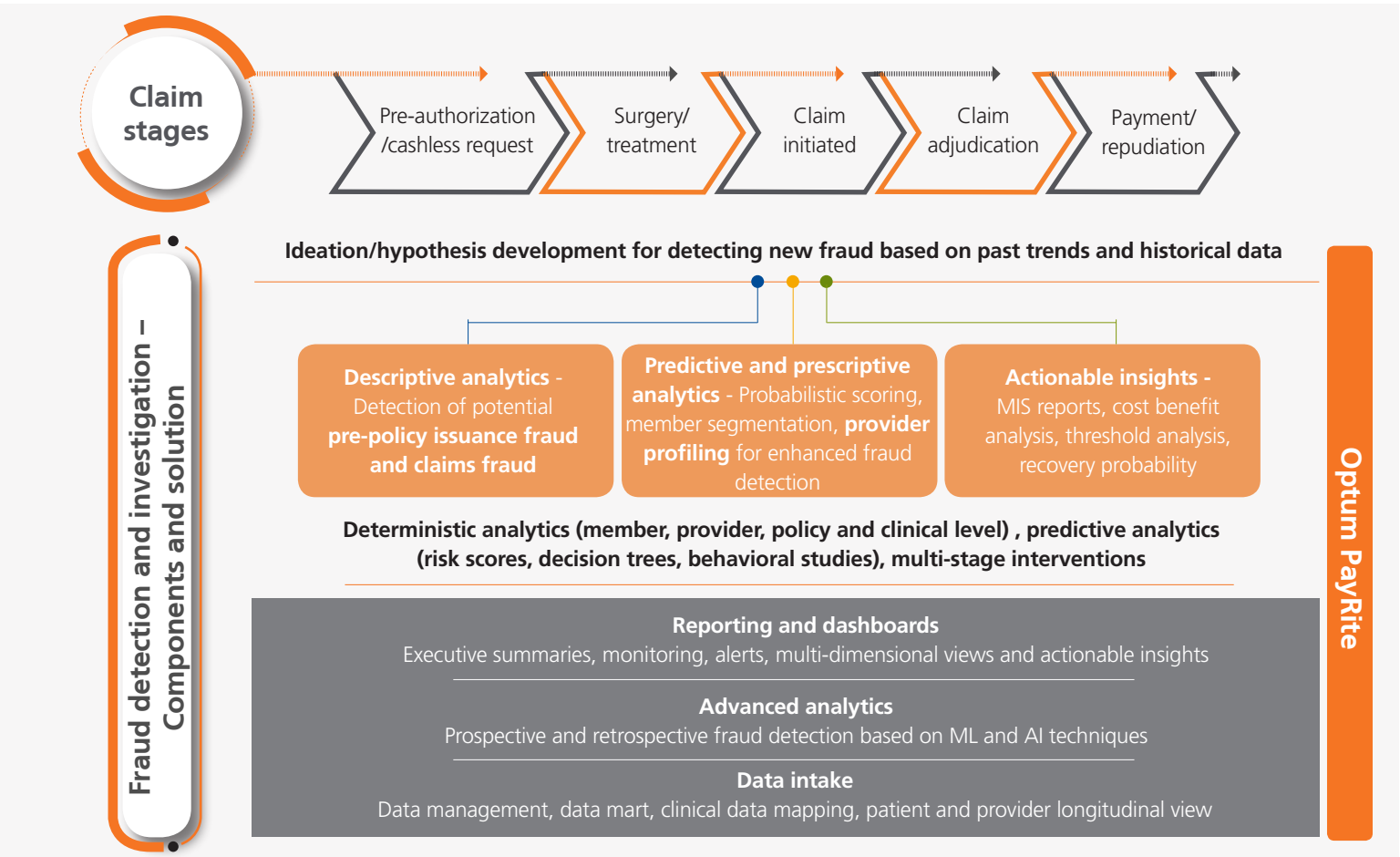
The Indian health insurance industry is contending with a high incurred claims ratio, at **101.05% (2016-17)** *- Insurance Regulatory & Development Authority (IRDA) Annual Report 2017*

A proactive and end-to-end approach to claims fraud intervention is a strategic investment that can help maximize claims accuracy and generate savings.

The Optum PayRite solution

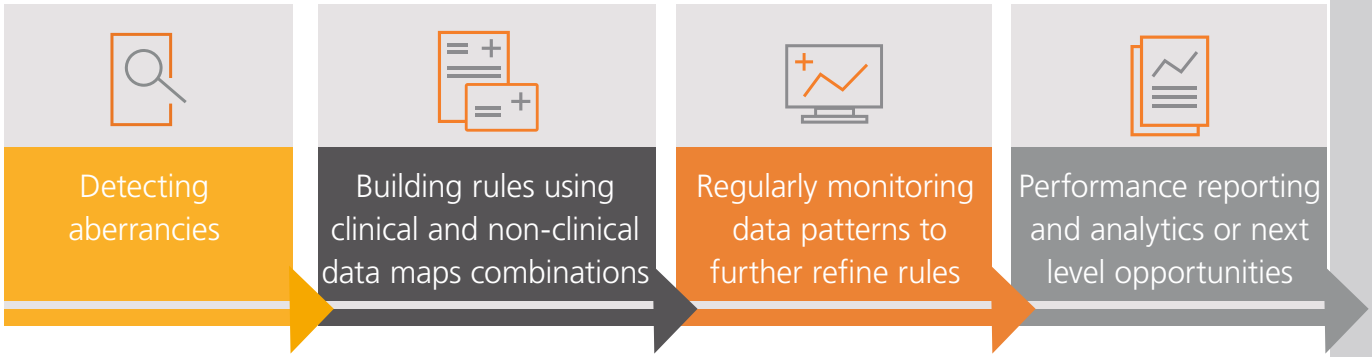
A comprehensive tool to enhance your existing FWA detection programs

From our first pre-payment predictive scoring model deployed eight years ago to our cutting edge provider education, Optum has continually invested in solutions that can help stay ahead of those committing fraud and to meet the growing needs of our clients. Our FWA tool, "PayRite" has been customized for the Indian market to help insurance providers power their existing anti-fraud investigation programs and unlock the true value of their claims operations. With **80+ rules and models** customized for the health insurance industry, PayRite has the ability to detect potential fraud before policy issuance, prevent payment errors, detect fraudulent claims and improve cash flow.



The Optum PayRite tool - Multi-stage implementations throughout the claim lifecycle

PayRite uses a 4-phased approach



Benefits: Helping you prevent, detect and investigate claim payment errors

With no disruption to your existing claims-review process, PayRite can rapidly apply analytics and insights to process 100% of incoming claims for fraud and improper payment risk. The tool can help insurers to:

- **Minimize revenue leakages** by identifying fraudulent claims from rightful claims
- Enable **faster insights and data-driven** decision-making
- **Increase accuracy of detection** to reduce false positive and re-work rates
- **Increase compliance** by ensuring full adherence to IRDA rules
- Improve **customer satisfaction and experience**

PayRite: Enabling sustainable growth for your claims operations

Scalable

Scalable solution to handle large amount of data

Modular functionality

Customized modules (Data management, rules management, analytics, and MIS etc.) to cater end user needs

New FWA opportunities

New leads identifications based on rules and models repository

Optimize current process

Automated fraud claims' flagging process with improvement in success ratio

Success stories

Profiling model helped detect malpractices for the biggest global player in the health care insurance industry

The client wanted to identify potential collusion behavior between a physician and pharmacy. Optum developed a scoring model using parameters like provider demographics and encounter data and analyzed claims data for 6 months to detect outliers.

~5% of physician-pharmacy combinations with suspected behavior were identified

---

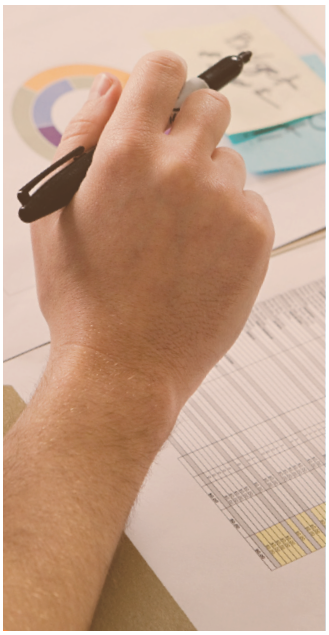
Fraud analytics for a Third Party Administrator (TPA) in Europe helped save significant cost

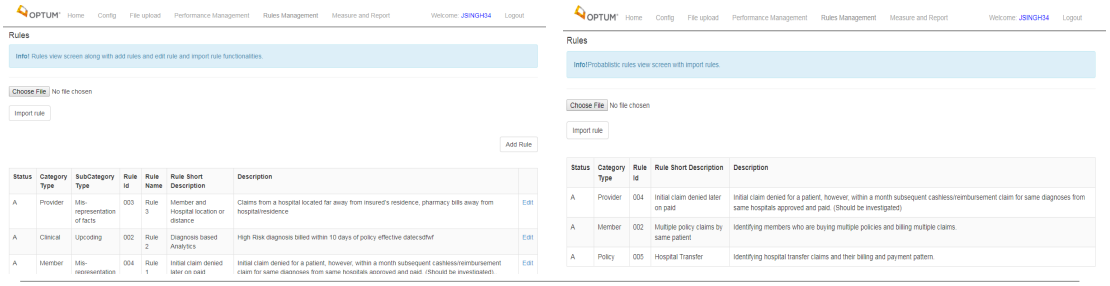
The client wanted to identify aberrancies at the claim, provider and member level. Optum analyzed historical FWA trends and developed a statistical rules-based, holistic, fraud capability infrastructure for an effective fraud management process.

~$25M of estimated saving using the fraud analytics framework

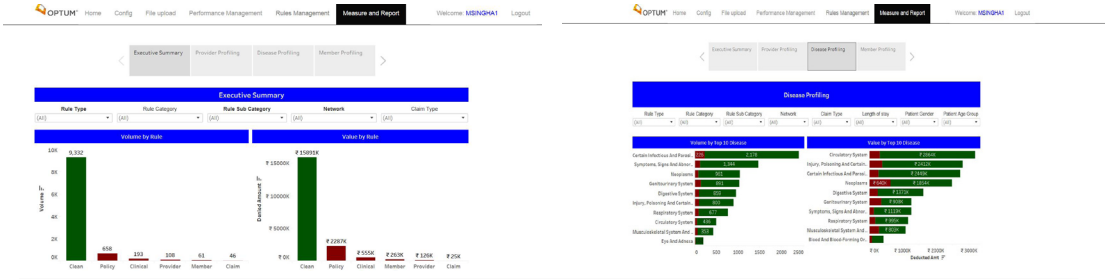
PayRite modules

- **Data management**
  - Clinical and non-clinical data maps
  - Analytics data mart (longitudinal view) and management
- **Rules performance and management**
  - Deterministic rules management
  - Probabilistic rules management
- **Analytics**
  - Pre-policy issuance fraud detection
  - Claims fraud detection
  - Member segmentation for fraud patterns and detection
  - Provider profiling
- **Performance reporting and dashboards (MIS)**
  - Executive dashboard
  - Performance analysis and monitoring
  - Benchmark analysis
  - Alerts
  - Drill-down functionalities and self-service capabilities
  - Ad-hoc reports





Comprehensive analytics and performance management solution for fraud detection and investigation



An illustrative view of the PayRite product component

About **Optum**

Optum is a leading health services and innovation company dedicated to **making the health system work better for everyone.**

- A team of **145,000+ health care experts** collaborating worldwide
- Serving **124M individuals**
- Invested **~3.3B** in technology and innovation annually
- Supporting customers' decision-making through predictive analytics, which is delivered via technology, domain expertise and expansive health care data (**claims data on 190M+ lives and clinical data on 100M lives**)
- **2B claims** processed annually
- **~4% to 7% claims** flagged annually for fraud, waste & abuse
- **$6B+ savings** identified from fraud, waste & abuse
- **5,000+ analytics resources**, including data scientists, data analysts, clinical coders, pharmacists, doctors and data engineers
- Developed **India's first ever meta data** and **data standards** for health care
- Enabling digital initiatives for **one of the largest state in India**

Contact Us

To request for your customized claims payment accuracy report, write in to us at **info_global@optum.com**

or scan the **QR code**

QR code instructions:
1. Download/open a QR reader app in your smartphone
2. Use the app to scan the QR code on the left.

OPTUM®

optum.com