Fraudulent Claims and their Role in Increase of Health Insurance Premium in India

Internship Training
at
Accuratus Healthcare Bangalore

By
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Under the guidance of
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Post Graduate Diploma in Hospital & Health Management
2012–14

Institute of Health Management Research
Jaipur
2014

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr.Chetan V T** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at **Accuratus Healthcare Bangalore** from **3-2-2014 to 3-5-2014**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dean, Academics and Student Affairs

IIHMR, Jaipur

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The certificate is awarded to

Dr.Chetan V T

In recognition of having successfully completed her

Internship in the department of

Health Insurance Investigations

and has successfully completed his Project on

"Online Investigations platform"

3rd May 2014

at

Accuratus Healthcare Bangalore

He comes across as a committed, sincere & diligent person who has a

strong drive & zeal for learning

We wish him all the best for future endeavors

Training & Development

For Accuratus Healthcare

CEO- Accuratus Healthcare

Authorised Signatory

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Fraudulent claims and their role in increase of Health Insurance premium in India** and submitted by **Dr.Chetan V T** Enrollment No. 1304 under the supervision of **Maj Vinod Kumar** for award of Postgraduate Diploma in Hospital and Health/ Pharmaceutical / Rural Management of the Institute carried out during the period from 3rd February to 3rd May embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Signature

Acknowledgement

I would like to thank **Accuratus Healthcare Bangalore** for providing a great opportunity to learn the organization structure and allowing me to do project on **Fraudulent claims and their role in increase of Health Insurance premium in India**

I take this opportunity to heartly thank Dr.Deepak (Co-founder and Managing Director of Accuratus Healthcare) and Dr.B D Jain (Co-founder and CEO of Medverve, Bangalore) for their complete support and cooperation to conduct this study. And I would like to extend my thanks to all the employees of Accuratus healthcare, Investigating officers of Insurance companies and TPAs and also underwriters who gave extensive support to this study.

I would like to thank Maj.Vinod kumar (Associate Prof. IIHMR Jaipur), my mentor. This project could not be finished without the support of my mentor Maj.Vinod Kumar. Thank you for the continuous support and guidance sir.

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Abstract

Title: Fraudulent claims and their role in increase of Health Insurance premium in India

Name of Author : Dr.Chetan V T

Back Ground of Study:

Health insurance is a form of insurance that pays for medical expenses. If you are covered under health insurance, you pay some amount of premium every year to an insurance company and if you have an accident or if you have to undergo an operation or a surgery, the insurance company will pay for the medical expenses. With health insurance providing a world of benefits to people, fraudulent claims are on the rise. Frauds can be committed by anybody. It can be committed by a policyholder, a health insurance company or even its employees. Frauds committed by a policyholder could consist of members that are not eligible, concealment of age, concealment of pre-existing diseases, failure to report any vital information, providing false information regarding self or any other family member, failure in disclosing previously settled or rejected claims, frauds in physician's prescriptions, false documents, false bills, exaggerated claims, etc.

Rationale of the Study:

It is estimated that four-ten per cent of medical insurance claims may be fraudulent or exaggerated in some ways in Australia and the US. Insurance companies in the US lose over $30 billion each year to healthcare insurance frauds. In India, the statistics is also alarming. According to a survey conducted by one of the leading TPAs, the estimated number of false claims in the industry is estimated at around 10-15 per cent of total claims. One of the report suggests that the healthcare industry in India is losing approximately Rs 600 crore on false claims every year. Health insurance is a bleeding sector with very high claims ratio. So, to make health insurance viable, there is a need to focus on eliminating or reducing fraudulent claims.

Statement of Problem:

Increase in frauds indirectly drives up the premiums collected from policyholders as insurers ultimately recover the losses by increasing the prices The Indian insurance sector incurs a loss of more than 8% of its total revenue collection in a fiscal year, according to the. Further, studies indicate that the average ticket size of a single fraud ranges between Rs. 25,000 and Rs. 75,000. Increase in frauds indirectly drives up the premiums collected from policyholders as insurers ultimately recover the losses by increasing the prices. -

Research Question:

What are the dynamics of fraudulent claims in the insurance sector and how do they impact the change in premium amount?

Objectives:

- To understand the dynamics of Fraudulent claims in Health Insurance sector

- To do a preliminary assessment of current status of fraudulent claims
- To evaluate the role of fraudulent claims in increase of health insurance premiums.

Methodology

Type of study: Cross sectional Descriptive study

Location of Study: Bangalore

Study Population: Claim investigators and underwriters of TPA and Health insurance companies in Bangalore area in addition to secondary data.

Sample: List of insurance companies/ TPAs generated by applying **Simple Random Sampling** Claim investigators and underwriters can be selected from the identified insurance companies/ TPAs by **Systemic Random Sampling Method.**

Sample size: Estimated sample of 20 claims investigators and 5 underwriters.

Data collection: Basic for the study was secondary data, along with secondary data a research has been conducted through semi structured questionnaire. The key observations in secondary data are given below

Results

The trend of health Insurance premium which is being raised ten times from 2003-04 to 2011-12 and the claims ratio being constant with the national average of 15 percent fraudulent claims leading to loss of 500-700 crores of Rupees. These losses has to be beared by the insurer by the cost of Insurance premium.

Investigators opinioned among the cases received about 15 percent from preauthorization and 15 percent cases from claims have gone for investigation with the suspicious case of fraudulency.

The opinion of investigators that policy holders are more involved in initiation of fraudulent claims than providers. 60 percent of investigators felt that insurers are aware of these cases

The opinion of investigators shows OPD and surgical management cases are more prone for fraudulency. As there is less control over OPD cases it is very much difficult to monitor and control such frauds.

Data collected from Investigating Officers shows the number of cases handled, investigations done and the cases found to be fraudulent and also cases approved in doubt since past 1 year. There were 574 fraudulent cases found among 21956 cases when they conducted 6210 investigations. Few cases were approved in case of doubt and lack of proof to show fraudulent.

Impact of Fraudulent claims on policy holders and Insurers:

Policy Holders:

- Claim related delays
- Increased premiums

- Harassment in processing of payouts, free look cancellations, mis-selling, spurious calls
- Loss of trust in the industry

Insurers:

- Increased costs
- Decline in competitive advantage
- Erosion of profit margin
- reputation loss
- jeopardized customer relations
- loss of business
- regulatory issues

Conclusion

Health insurance industry is growing and being chanted about like the new mantra, but, still India is facing a huge loss in this sector because of the everyday increasing fraud claims. Fraudulent health insurance claim actually is a claim generated to cover or deform information which is designed to provide health care benefits. It seems that the educated people are more involved in fraudulent claims that the uneducated as per the opinion of Investigating officers, they also felt that fraudulent cases are more from stand alone hospitals and tier 1 cities. OPD cases and surgical cases have shown majority in fraudulent claims.

Yearly growth rate of Healthcare inflation is 8 to 12 percent and fraudulent claims holds average of 15 percent in India. Investigators also felt that the fraud claim ratio is growing day by day.

They have given suggestions to control the fraud through anti fraud squad, technological improvement in investigation, education of policy holders and proper training to employees.

Introduction

Health insurance is a form of insurance that pays for medical expenses. If you are covered under health insurance, you pay some amount of premium every year to an insurance company and if you have an accident or if you have to undergo an operation or a surgery, the insurance company will pay for the medical expenses. With health insurance providing a world of benefits to people, fraudulent claims are on the rise.

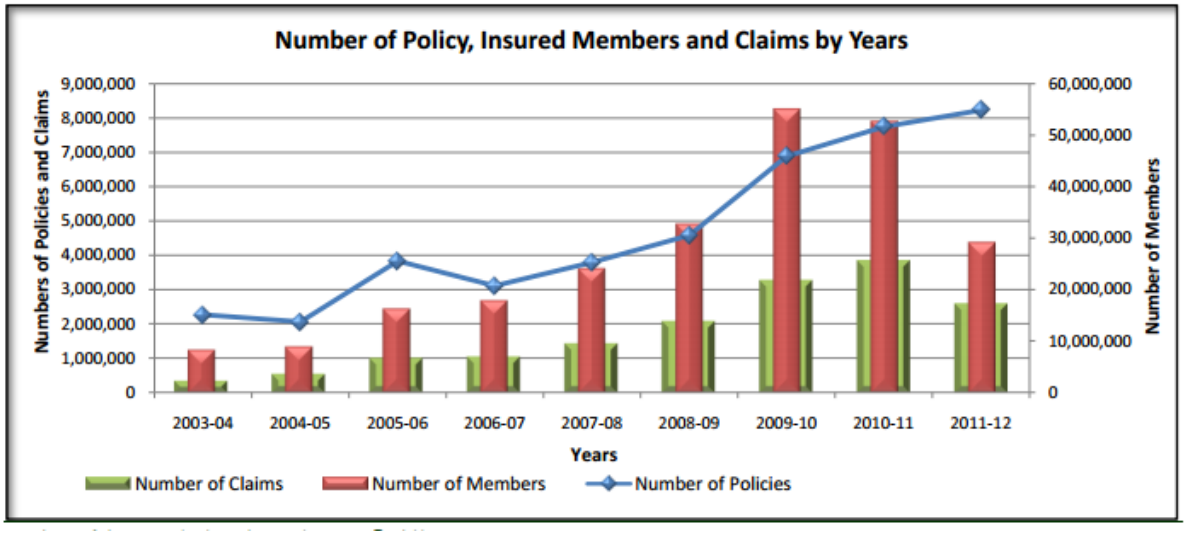
Table1. Macro Indicators on (Non-Life) Health Insurance Data – 2003-12

Policies, Insured Members and Claims

Year	Number of Policies	Number of Members	Number of Claims
2003-2004*	22,65,451	83,61,629	3,60,088
2004-2005*	20,59,449	89,87,239	5,55,273
2005-2006*	38,28,495	1,63,45,575	10,16,785
2006-2007*	31,10,475	1,79,07,430	10,60,047
2007-2008*	37,90,838	2,41,21,625	14,36,998
2008-2009*	45,75,725	3,27,10,604	20,81,297
2009-2010**	68,84,687	5,48,93,453	32,63,597
2010-2011**	77,42,076	5,25,08,111	38,43,285
2011-2012***	82,25,112	2,91,34,940	25,91,781#

NB: 1. * Policies serviced by TPAs only.
2. ** Figures of Policies serviced by TPAs and directly serviced by Insurers
3. *** Data submitted online by PVT insurers and offline by PSU insurers.
4. # - Inclusive of Claim Records where Claim Paid Amount >₹ 20 lakh

Figure1. Number of Policy, Insured Members and Claims by Years- Health Insurance Data – 2003-12



Inference: Number of Policies issued in 2011-12 have increased by 6% whereas number of insured members and number of claims paid in the year 2011-12 have reduced by 45% and 33% respectively when compared with those of 2010-11 which could be attributable to data omissions/errors in member and claim data sets.

Health insurance fraud is described as an intentional act of deceiving, concealing, or misrepresenting information that results in healthcare benefits being paid illegimately to an individual or group. The main purpose of fraud is financial gain. However, it not

only creates a hole in the insurance companies' pocket, but affects all the stakeholders. It not only invites higher premiums, but also leads to restricted benefits, higher insurance co-payments, potential of denial for future coverage, higher service taxes and also impacts on the quality of care.

Frauds can be committed by anybody. It can be committed by a policyholder, a health insurance company or even its employees. Frauds committed by a policyholder could consist of members that are not eligible, concealment of age, concealment of pre-existing diseases, failure to report any vital information, providing false information regarding self or any other family member, failure in disclosing previously settled or rejected claims, frauds in physician's prescriptions, false documents, false bills, exaggerated claims, etc.

Frauds by health insurance companies or its employees include preparation of bogus claims by fake physicians, billing for products or services not rendered, exaggerated claims submission, billing prepared for higher level of services, modifications or alterations made in submission of health insurance claims, change in diagnosis of the patient, fake documentation, and fraud committed by the employees of a hospital or any other healthcare product or service provider in order to make a quick buck. Fraudulent and dishonest health insurance claims are a major morale and moral hazard not only for the health insurance industry but even for the entire nation's economy. Concrete proof as evidence including documentation, statements made by the policyholder and his family members and even neighbors are taken into consideration.

The essential components of fraud include intention to deceive, derive benefits from the health insurance industry, preparation of exaggerated or inflated claims or medical bills and an intention to induce the firm to pay more than it otherwise would. Devising innovative methods and tactics including pressure tactics, favoritism and nepotism form a part of fraud which is a hazard growing by leaps and bounds since the last decade. To establish that a fraud has been committed requires furnishing of relevant proof. An in-depth analysis of the health insurance policyholder's intention may also be taken into consideration.

It is estimated that the number of false health insurance claims in the industry is approximately 15 per cent of total claims. The report suggests that the healthcare industry in India is losing approximately Rs. 600 to Rs. 800 crores incurred on fraudulent claims annually. Health insurance is a bleeding sector with very high claims ratio. Hence, in order to make health insurance a viable sector, it is essential to concentrate on elimination or minimization of fake claims**.**

It is estimated that four-ten per cent of medical insurance claims may be fraudulent or exaggerated in some ways in Australia and the US. Insurance companies in the US lose over $30 billion each year to healthcare insurance frauds. In India, the statistics is also alarming. According to a survey conducted by one of the leading TPAs, the estimated number of false claims in the industry is estimated at around 10-15 per cent of total claims. One of the report suggests that the healthcare industry in India is losing approximately Rs 600 crore on false claims every year. Health insurance is a bleeding sector with very high claims ratio. So, to make health insurance viable, there is a need to focus on eliminating or reducing fraudulent claims.

Literature Review

This chapter surveys previous literature and studies relevant to the field of study. The literature review should be comprehensive and should include recent publications.

- As per the IMS Health data, health insurance business premiums are expected to reach Rs 30,000 crore by 2015, registering an increase of 302 per cent from 2011. It is encouraging to note here that health insurance coverage grew about 445 per cent between 2004 and 2011 in India.

- Quiggle, James. "Health Fraud" Scam Alerts. Coalition Against Insurance Fraud, 2011 .According to The Coalition Against Insurance Fraud, health fraud depletes taxpayer-funded programs like Medicare, and may victimize patients in the hands of certain doctors..

- Fraud is a significant issue that must be addressed by all insurance companies. There has been a 70 percent rise in frauds in General Insurance in past five years and frauds in life insurance sector have more than doubled. Insurance companies have borne a loss of Rs.30,000 crores due to frauds in 2011-12 (Source: the economic Times, 4 March 2012)

- U.S. Attorney's Office (2011-07-26). "Salisbury Cardiologist Convicted of Implanting Unnecessary Cardiac Stents". FBI Some scams involve double-billing by doctors who charge insurers for treatments that never occurred, and surgeons who perform unnecessary surgery.

- Hyman, David A. "Health Care Fraud and Abuse." p. 541. The most common perpetrators of healthcare insurance fraud are health care providers. One reason for this, according to David Hyman, a Professor at the University of Maryland School of Law, is that the historically prevailing attitude in the medical profession is one of “fidelity to patients”

- Hyman, David A. "Health Care Fraud and Abuse." p. 547. This incentive can lead to fraudulent practices such as billing insurers for treatments that are not covered by the patient’s insurance policy. To do this, physicians often bill for a different service, which is covered by the policy, than that which was rendered.

- Fraudulent Health Insurance Claims | Medindia. Fraudulent and dishonest claims are a major morale and a moral hazard not only for the insurance industry but even for the entire nation’s economy.

- Indian insurance companies have collectively lost a whopping Rs.30,401 crore due to various frauds which have taken place in the life and general insurance segments during the year, according to a study. The losses work out to about nine per cent of the total estimated size of the insurance industry in 2011, the study carried out by Pune-based company Indiaforensic states said.

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Sample size: Estimated sample of 20 claims investigators and 5 underwriters.

Data collection: Basic for the study was secondary data, along with secondary data a research has been conducted through semi structured questionnaire. The key observations in secondary data are given below

Results

The total premium income of the insurance industry, comprising life, non-life and health, is around Rs.3.5 lakh crore, according to the figures by Insurance Regulatory and Development Authority (IRDA).
The company has identified collusion between employees of insurance companies and beneficiaries furnishing false documents, and manipulation in citing the cause of death as part of the modus operandi adopted by fraudsters to claim undue insurance benefits. Indiaforensic carries out regular studies in examining frauds, security, risk management and forensic accounting and claims to have assisted the Central Bureau of Investigation (CBI) in the multi-crore Satyam scam.
The life insurance segment accounted for as much as 86 per cent of the frauds while remaining 14 per cent took place in the general insurance sector, which includes false claims for cars, houses and accidents, the report showed. The study also highlighted that the frauds in the life insurance segment had more than doubled in the last five years while those related to general insurance sector increased by 70 per cent.
In 2007, insurance firms had lost as much as Rs.15,288 crore, of which life insurance accounted for `13,148 crore while the general insurance segment lost Rs.2,140 crore. The insurance sector is susceptible to various frauds in the country. However, insurance experts assert that while it is true that insurance companies are cheated, the quantum of losses is not as high as the study claims.

Table 2. Table of premium, claims paid, ratio of fraud claims and loss to insurer.

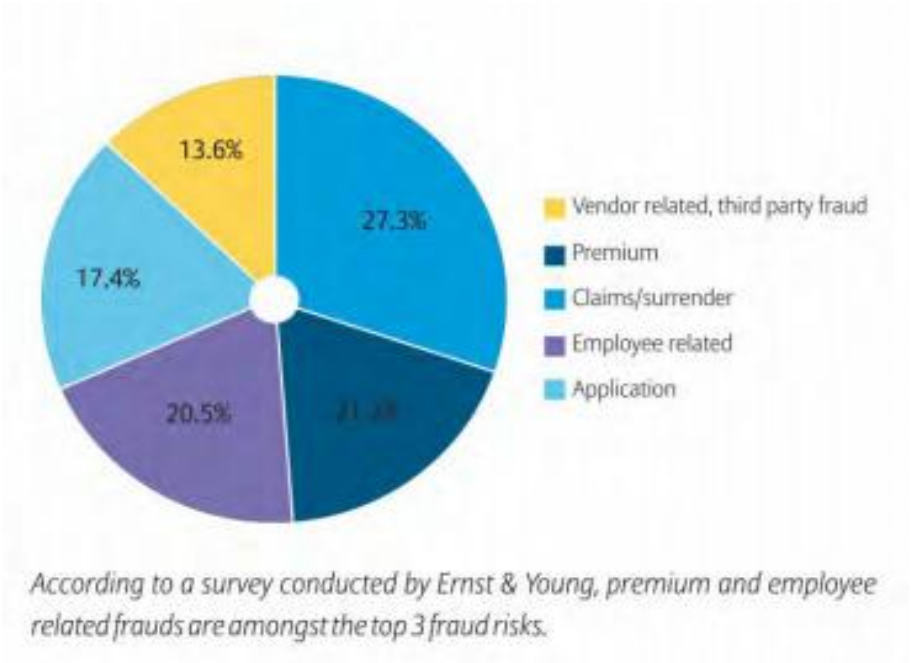
Period	Premium(in Crs.)	claims paid (in Crs.)	Claims paid ratio (in Crs.)	Fraud claims national Average	Loss to insurer (in Crs.)
2003-2004	944	785	83%	14%	56
2004-2005	987	948	96%	14%	68
2005-2006	1,947	1,777	91%	14%	127
2006-2007	2,820	2,198	78%	14%	157
2007-2008	2,758	2,904	105%	14%	207
2008-2009	3,976	4,087	103%	15%	272
2009-2010	7,803	7,456	96%	15%	497
2010-2011	10,932	10,797	99%	15%	720
2011-2012	10,942	8,499	78%	15%	567

.
Table 2 shows the trend of health Insurance premium which is being raised ten times from 2003-04 to 2011-12 and the claims ratio being constant with the national average of 15 percent fraudulent claims leading to loss of 500-700 crores of Rupees. These losses has to be beared by the insurer by the cost of Insurance premium.

The internal laws are not so lax." The study said that clients were defrauding the insurance companies by not disclosing existing diseases. This was being done by manipulating the empanelled doctors while applying for the policy. False age certificates are also being submitted to become eligible for insurance. The forging of medical bills are the most common fraud that affect the health insurance sector. In as many as 31 per cent of the total falsified documentation, medical bills were the common target of the frauds by external parties.

Travel abroad for surgery without disclosing it, or getting a damaged vehicle insured without disclosing the accident are some of the common methods of cheating insurance companies, the report states as examples of frauds in the general insurance sector.

Figure 2. Survey by Earnst & Young on premium and employee related frauds.



According to a survey conducted by Ernst & Young, premium and employee related frauds are amongst the top 3 fraud risks.

Figure 3:Data collected from Investigating Officers shows the number of cases handled and investigations done since past 1 year.

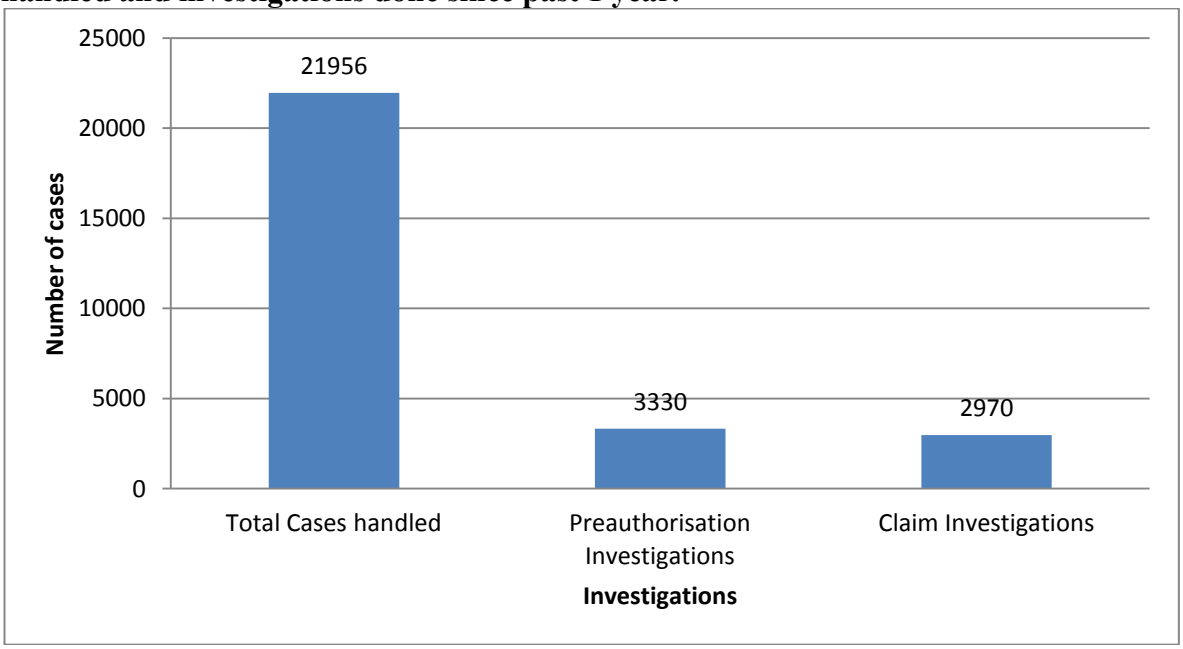


Figure 3 shows among the cases received about 15 percent from preauthorization and 15 percent cases from claims have gone for investigation with the suspicious case of fraudulency.

Figure 4: Cases handled by investigators since past 1 year

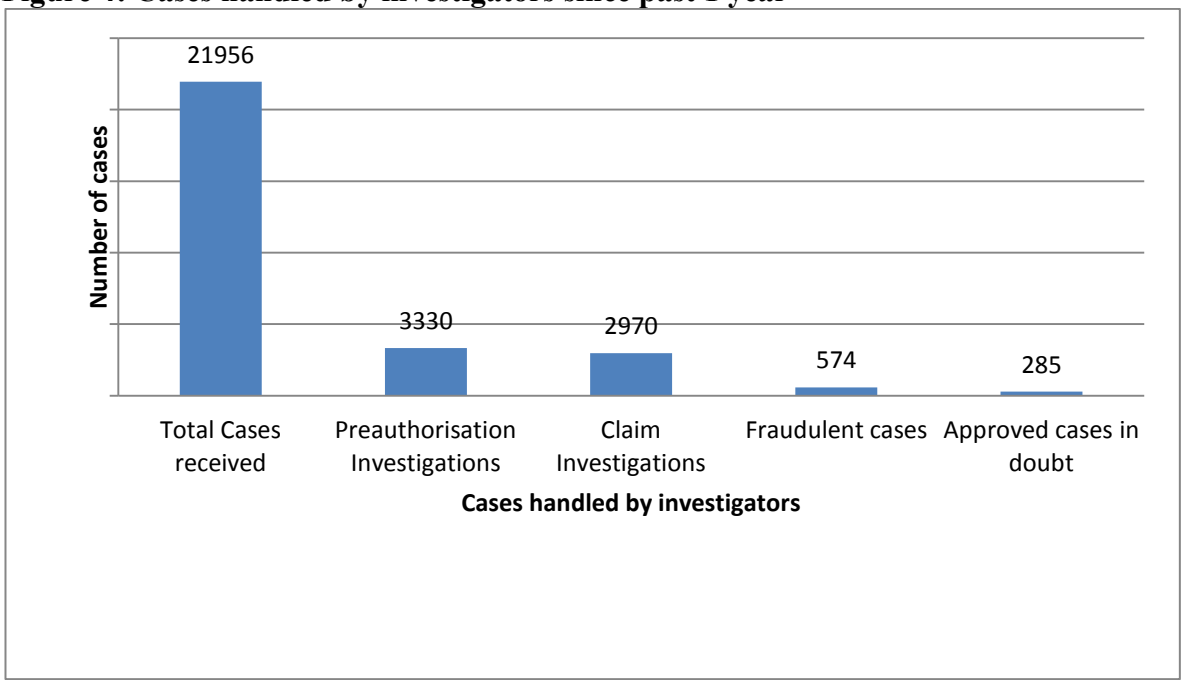


Figure 4 shows Data collected from Investigating Officers shows the number of cases handled, investigations done and the cases found to be fraudulent and also cases approved in doubt since past 1 year. There were 574 fraudulent cases found among 21956 cases when they conducted 6210 investigations. Few cases were approved in case of doubt and lack of proof to show fraudulent.

Figure 5: Opinion of Investigating Officers on initiation of fraudulent cases.

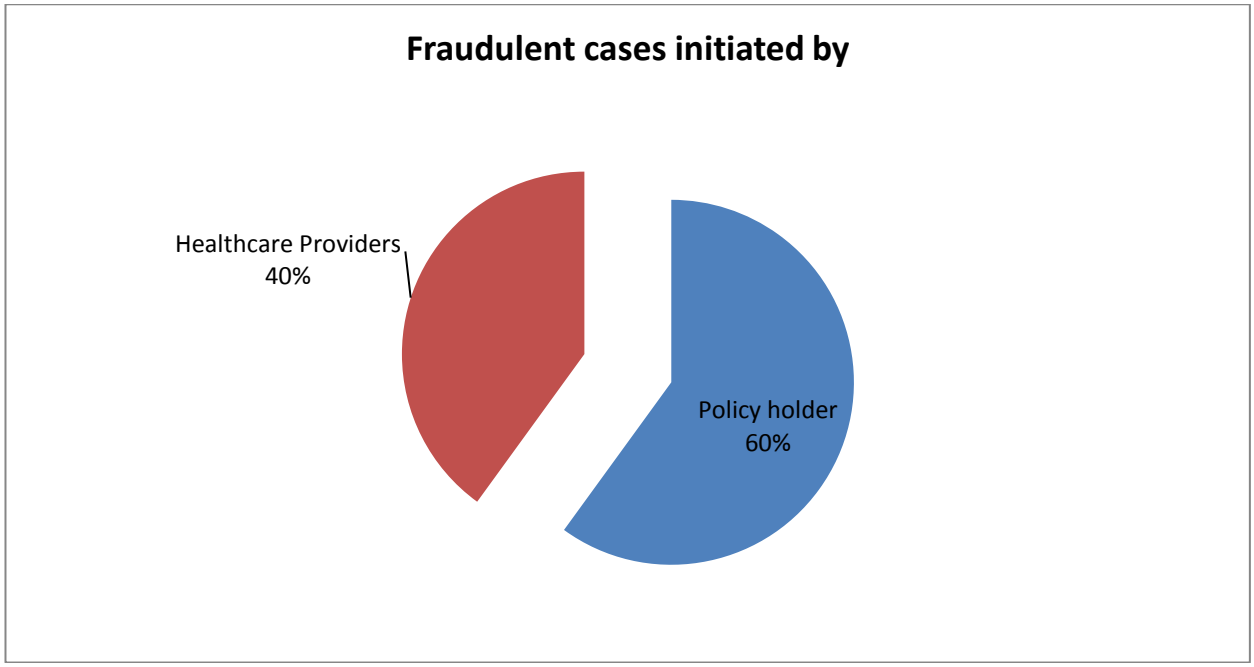


Figure 5 shows the opinion of investigators that policy holders are more involved in initiation of fraudulent claims than providers. 60 percent of investigators felt that insurers are aware of these cases

Figure 6: Opinion of Investigating Officers and underwriters on distribution of fraudulent cases among cities.

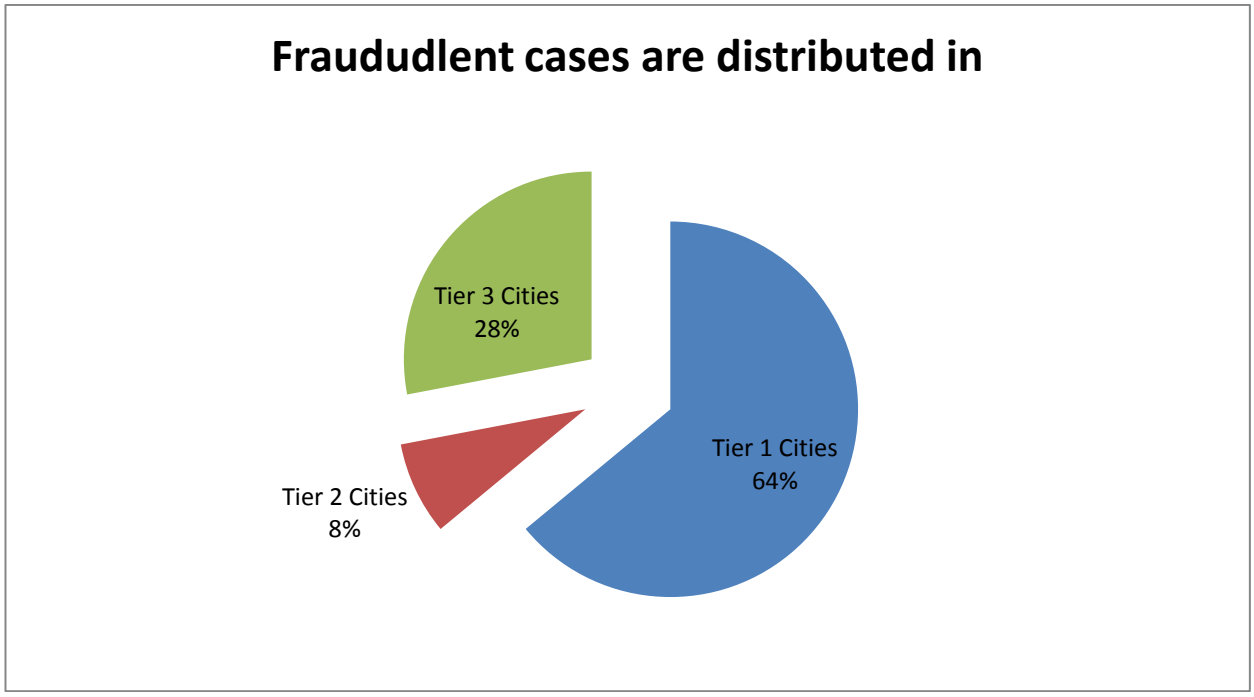


Figure 6 shows around 64 percent of the investigators feel that the fraudulent claims are more in tier 1 cities followed by tier 3 cities. It also suggested that the people who are educated and lives in tier 1 cities are involved more in such activities.

Figure 6: Opinion of Investigating Officers and underwriters on healthcare providers involved in fraudulent claims.

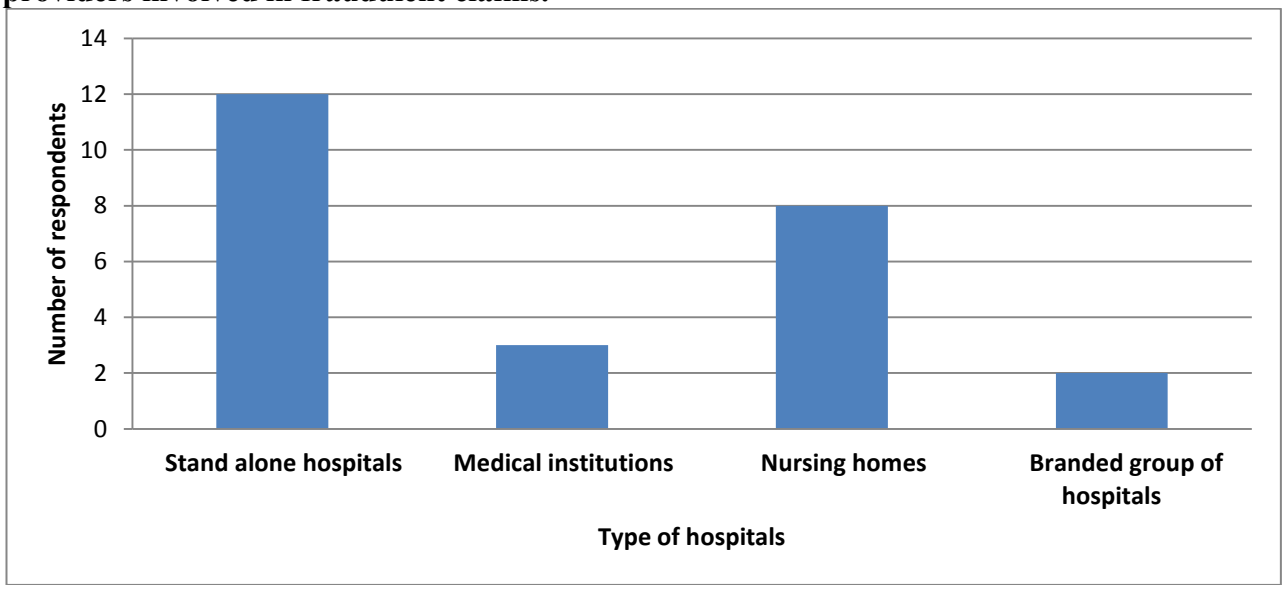


Figure 7 shows that the stand alone hospital which are in tier 3 cities and also in tier 1 cities are more involved in fraudulent activities. It suggests that the top management to end users might be involved as it is controlled by that centre only.

Figure 7: Opinion of Investigating Officers and underwriters on fraudulent cases related to type of Hospitalization

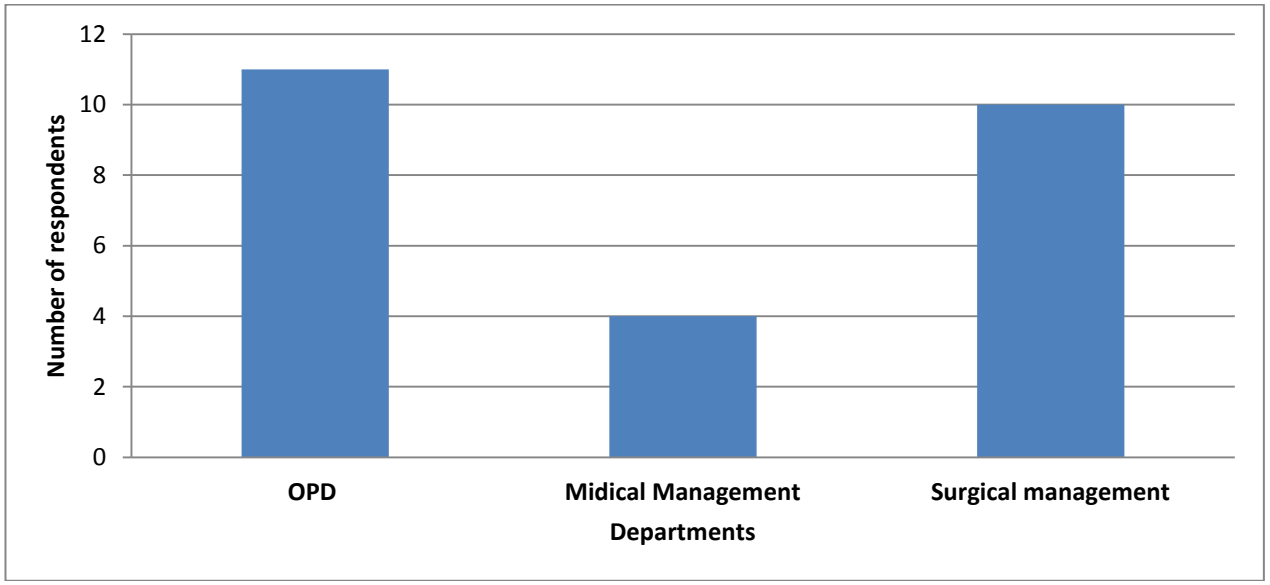


Figure 8 shows OPD and surgical management cases are more prone for fraudulency. As there is less control over OPD cases it is very much difficult to monitor and control such frauds.

Figure 8: Opinion of Investigating Officers and underwriters on Literacy level of people involved in fraudulent claims

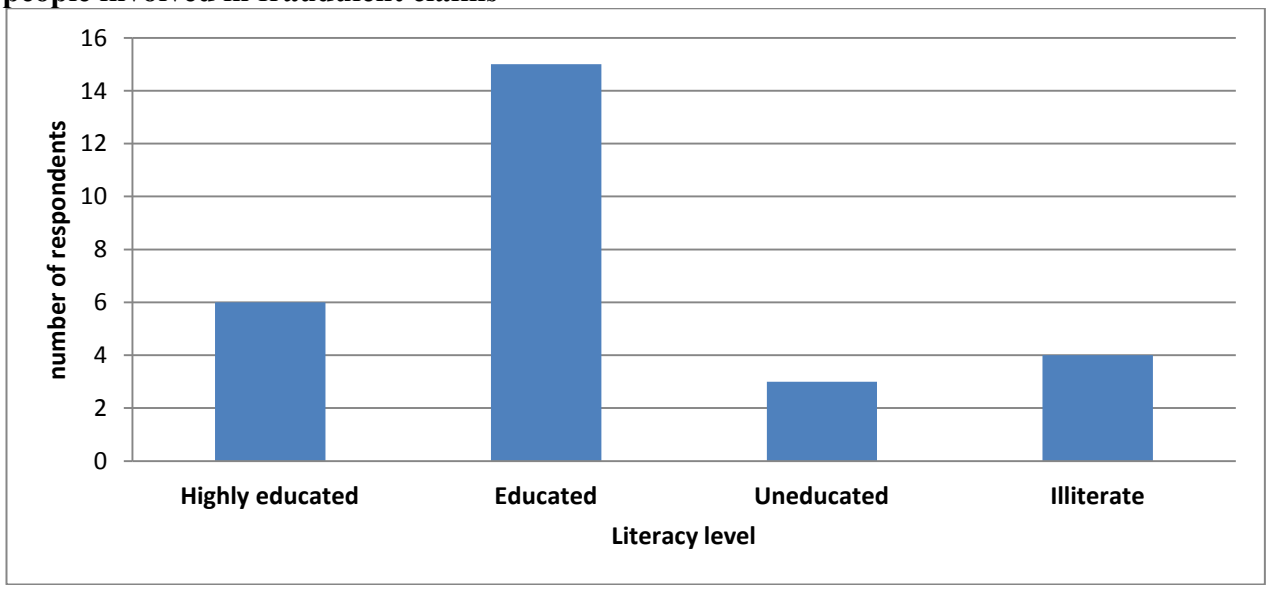


Figure 6 shows around 64 percent of the investigators feel that the fraudulent claims are more in tier 1 cities followed by tier 3 cities. Figure 9 suggests that the people who are

educated and lives in tier 1 cities are involved more in such activities. Educated people involved with such claims shows the loop hole in the insurance sector.

Figure 9: Opinion of Investigating Officers and underwriters on Awareness among people about involvement of hospital in fraudulent claims

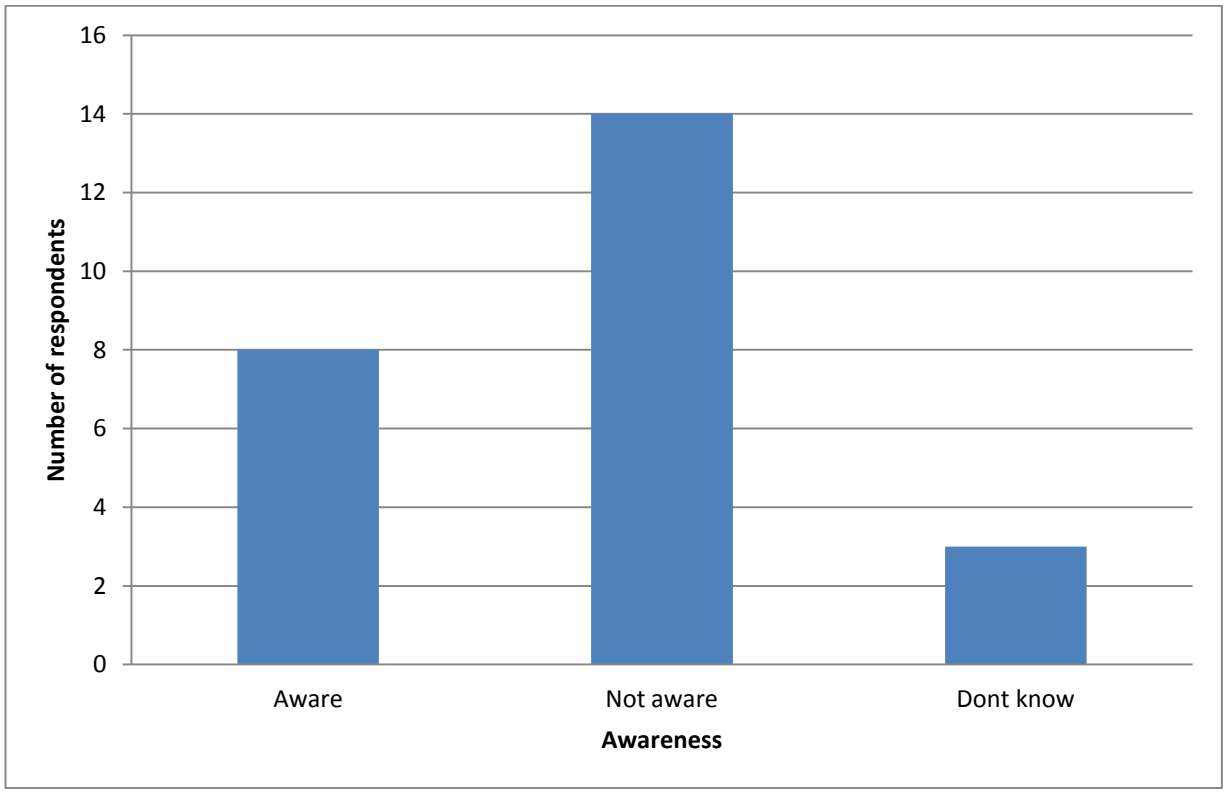


Figure shows the opinion of investigators that policy holders are more involved in initiation of fraudulent claims than providers. 60 percent of investigators felt that insurers are aware of these cases

Figure 10: Opinion of Investigating Officers and underwriters on Trend of fraudulent claims since years.

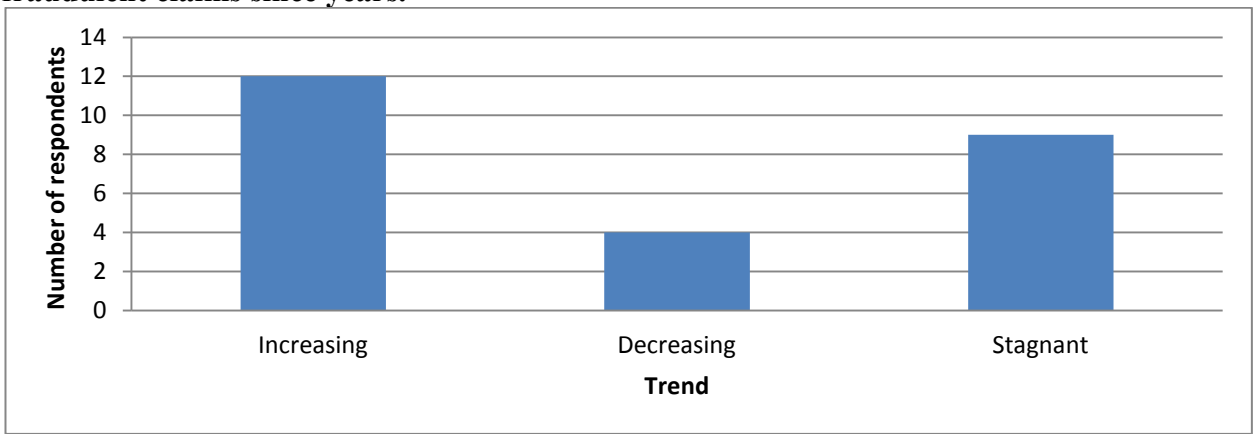


Table 4. Periodic table of premium, claims paid, ratio of fraud claims and loss to insurer.

Period	Premium(in Crs.)	claims paid (in Crs.)	Claims paid ratio (in Crs.)	Fraud claims national Average	Loss to insurer (in Crs.)
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2011-2012	10,942	8,499	78%	15%	567

As per figure 10 the investigation officers feel that the trend of fraudulent claims increasing that can be seen in Table 4 that along with the premium claims paid ratio also increasing with the national average of 15 percent fraudulent cases. This increasing trend shows how our Health Insurance companies are draining money in fraudulent claims.

How does fraud impact policy holders and insurers?

Investigating officers and underwriters shared their views on impact of fraudulent claims on insurers as well as policy holders. It is a myth that insurance fraud is a victimless crime. Any kind of insurance fraud impacts policy holders or insurers or both. The key impacts of fraud on insurers and policy holders are:

Policy Holders:

- Claim related delays
- Increased premiums
- Harassment in processing of payouts, free look cancellations, mis-selling, spurious calls
- Loss of trust in the industry

Insurers:

- Increased costs
- Decline in competitive advantage
- Erosion of profit margin
- reputation loss
- jeopardized customer relations
- loss of business
- regulatory issues

2.2.5 Discussion

Health insurance industry is growing and being chanted about like the new mantra, but, still India is facing a huge loss in this sector because of the everyday increasing fraud claims. Fraudulent health insurance claim actually is a claim generated to cover or deform information which is designed to provide health care benefits. Frauds can be of many types and committed by insurer or the insured. Let's understand them –

Deliberate and Opportunity Fraud –

Deliberate fraud is purposeful act of presenting accident or loss which is covered under the policy. Whereas, opportunity fraud is created by a policyholders by over stressing a genuine claim or providing wrong information related to the pre-existing diseases etc. to get the underwriting done in their favor.

Figure 6 shows around 64 percent of the investigators feel that the fraudulent claims are more in tier 1 cities followed by tier 3 cities. Figure 9 suggests that the people who are educated and lives in tier 1 cities are involved more in such activities. Educated people involved with such claims shows the loop hole in the insurance sector.

External and Internal Fraud –

External fraud is claimed by either an individual or entities like policyholder, beneficiaries, medical service providers or vendors against a company. Internal fraud on the other hand is carried out against a policyholder or its company by other employees like manager, executive or agents.

Policyholder's Fraud –

Now-a-days, consumers have become aware of the norms, features and rules of the insurance and have started getting benefited by being involved in frauds. Policyholder frauds are divided into 3 categories – eligibility fraud, claim fraud and application fraud.

Figure 5 shows the opinion of investigators that policy holders are more involved in initiation of fraudulent claims than providers. 60 percent of investigators felt that insurers are aware of these cases

Eligibility Fraud -

This fraud generally constitutes the falsification of the information provided about the insured's employment status, pre-existing diseases or information concerning the dependent. Here, the beneficiary is paid benefits illicitly, for example, if a person submits claim for the dependent or relative who is not covered under the policy. Another case is when a part-time employee is not covered under some health plan provided by the company for full-time employees but, my generating false records with any HR employee he is successful in receiving the benefits.

Application Fraud -

It is generally committed in the health insurance sector where the consumer knowingly enters forged information in its application related to the pre-existing diseases, claim or important dates. For instance, a policyholder might not enter the details related to his

pre-existing diseases or serious medical conditions in order to get an extensive cover and have problem free claim filing. Even, at times, the employer plays with the joining date of the employee by getting things approved from the insurance company.

Figure 9 shows the opinion of investigators that policy holders are more involved in initiation of fraudulent claims than providers. 60 percent of investigators felt that insurers are aware of these cases

Claim Fraud –

When a consumer enters an illegal claim for whose benefit he is not entitled for, the fraud is called claim fraud. He can ask for a false claim which is especially seen under maternity covers. In such intentional cases, the provider and member are seen to go for collusion and thus, benefiting the physician. These kinds of groups are also known as fraud rings. Another case - a policyholder can even turn to create an insurance speculation, wherein, he purchases several health insurance policies without letting the insurance companies know this fact and enjoy claim settlement from all.

Moreover, the agents or hospitals generate higher medical bills related to hospitalization, treatment etc. to cheer their pockets.

Conclusion

Health insurance industry is growing and being chanted about like the new mantra, but, still India is facing a huge loss in this sector because of the everyday increasing fraud claims. Fraudulent health insurance claim actually is a claim generated to cover or deform information which is designed to provide health care benefits. It seems that the educated people are more involved in fraudulent claims that the uneducated as per the opinion of Investigating officers, they also felt that fraudulent cases are more from stand alone hospitals and tier 1 cities. OPD cases and surgical cases have shown majority in fraudulent claims.

Yearly growth rate of Healthcare inflation is 8 to 12 percent and fraudulent claims holds average of 15 percent in India. Investigators also felt that the fraud claim ratio is growing day by day.

They have given suggestions to control the fraud through anti fraud squad, technological improvement in investigation, education of policy holders and proper training to employees.

Table 4. Periodic table of premium, claims paid, ratio of fraud claims and loss to insurer.

Period	Premium(in Crs.)	claims paid (in Crs.)	Claims paid ratio (in Crs.)	Fraud claims national Average	Loss to insurer (in Crs.)
2003-2004	944	785	83%	14%	56
2004-2005	987	948	96%	14%	68
2005-2006	1,947	1,777	91%	14%	127
2006-2007	2,820	2,198	78%	14%	157
2007-2008	2,758	2,904	105%	14%	207
2008-2009	3,976	4,087	103%	15%	272
2009-2010	7,803	7,456	96%	15%	497
2010-2011	10,932	10,797	99%	15%	720
2011-2012	10,942	8,499	78%	15%	567

The above table clearly shows the loses occurring to insurers since years which definitely impacts on the premium to be collected.

The inflation rate of health Insurance premium is increasing from 8-12% every year. These fraudulent claims will definitely impact on policy holders as well as insurers.

Investigating Officers and medical Underwriters of Insurance companies and TPAs feel that fraudulent claims will lead to:

Premiums stay high. Insurance prices stay higher because insurance companies must pass the large costs of insurance fraud to policyholders.
People lose their savings. Trusting consumers are bilked out of thousands of dollars, often their entire life savings, by insurance investment schemes. Seniors are especially vulnerable.

Local businesses lose money. Fraud increases the costs for business and makes it more expensive to provide health coverage and other insurance benefits for employees.

Consumer goods and services cost more. Prices of goods at your department or grocery store keep rising when businesses pass higher costs of their health and commercial insurance onto customers.

Schemes kill & injure. Doctors perform dangerous and invasive operations on healthy patients to inflate their insurance billings.
Workers lose jobs. People lose jobs and careers when insurance companies go bankrupt after being looted by company insiders. Dishonest businesses also lie to illegally lower their workers compensation premiums. The swindlers thus can underbid honest competitors for contracts or prices of goods and services. Victimized competitors may have to lay off workers, freeze wages or even move out of state.

Victims feel violated. People feel shame, despair and a sense of violation that can last a lifetime. Fraud schemers also expose their own families to embarrassment in their communities. Jail time and fines also can tear apart families of convicted schemers.

Actions taken along with suggestions on Countering Insurance frauds given by Investigating Officers and medical Underwriters of Insurance companies and TPAs :

Anti-fraud units. Most insurers actively fight fraud with Special Investigation Units — or SIUs. The investigators typically have strong law enforcement backgrounds, or come from elsewhere in an insurer such as the claims department.

Anti-fraud software. Many SIUs use sophisticated software to identify schemes, especially large and complex fraud rings. One of the most powerful programs, predictive analytics, even can forecast the likelihood of certain schemes happening in the future.

Educate consumers. Insurers educate consumers how to protect against being scammed. Insurers also often sponsor toll-free fraud hotlines accept tips through their websites.

Train employees. Most insurers train employees such as adjusters and claims staff how to spot fraud.

Sue swindlers. Some insurers aggressively sue swindlers in civil court. These insurers seek to bankrupt the swindlers and send a strong message to other cheaters that cheating that insurer isn't worth the risk. Staged accident and health fraud rings are frequent targets.

Sponsor national effort. Property-casualty insurers sponsor the National Insurance Crime Bureau (NICB), whose agents help investigate suspected schemes and refer the suspects for prosecution. NICB also runs a national consumer fraud hotline. Health insurers formed the National Health Care Anti-Fraud Association, which offers training and data for investigating fraud.

Investigations recoup. Health insurers save more than 22 percent money from fraudulent cases

Instrumentation

Schedule

Survey conducted by
DR.CHETAN V T, PGDHM student, IIHMR Jaipur.

Instructions: This questionnaire is developed to assess the Role of fraudulent claims and moral hazard in increase of Health Insurance Premium. Kindly read the questions carefully and answer promptly. The given information is for study purpose only and name of persons and institutes will be kept ammoniums. Your expertise and feedback will help our study, thank you.

Name: _____ Date:
Age:_____
Gender:_____
Name of insurance company/TPA:_____
Role:_____
___
Work experience in Health Insurance Industry:_____

1) Number of claims received since 1 year_____
2) Net worth of the claims received_____
3) Number of investigations done since past 1 year
4) Preauthorization investigations:_____ Percentage_____
5) Claims investigations:_____ Percentage_____
6) Number of fraudulent cases detected since past 1 year_____
7) Net worth of the fraudulent cases _____
8) Number of suspicious cases approved when in doubt _____
9) Percentage of the insurance premium increased compared to last year_____

8) Usually fraudulent cases initiated by
a)patients/insurance policy holder
b)hospitals

9) As per your knowledge from which area you have found more fraudulent cases?

a) Tier 1 cities
b) Tier 2 cities
c) Tier 3 cities

10) Which type of hospitals involved more in fraudulent activities

a) Stand alone hospitals
b) Medical institutions
c) Nursing homes
d) Branded group of hospitals

11) Which claims do you get more number of fraudulent cases related to

a) OPD
b) Medical management
c) Surgical management ----------

12) People doing fraudulent claims majorly are

a) Highly educated
b) Educated
c) Uneducated
d) Illiterates

13) Are patients aware of the fraud in case of initiation of fraudulent claim done by hospital?

a) Yes
b) No
c) Don't know

14) Do you agree the role of moral hazard and fraudulent cases in increase of insurance premium?

a) Definitely Yes
b) Yes
c) Don't know
d) No
e) Definitely no

15) Trend of moral hazard and fraudulent cases

a) Increasing
b) Decreasing
c) Stagnant

16) Suggestions to control fraudulent claims and moral hazard. _____

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The information given is true as per my knowledge… Name:

Signature:

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