Dissertation Report on
Fraudulent claims and their impact on Health Insurance Premium

Under Guidance of Maj.Vinod Kumar

Prof. & Associate Dean

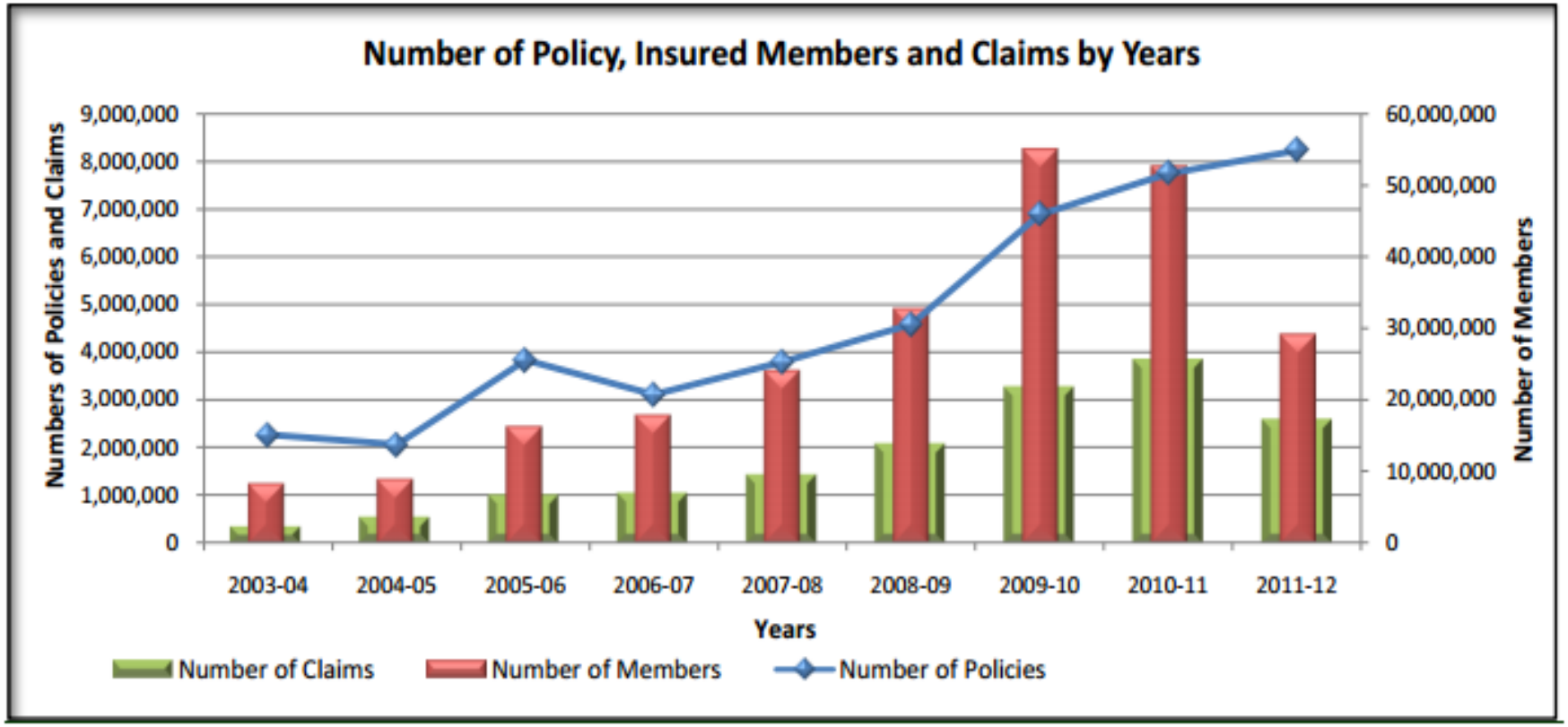
By Dr.Chetan V T
PGDHM 17th Batch
Health stream

Contents

- Introduction
- Research question
- Objective of study
- Methodology
- Results
- Conclusion
- Suggestions

- **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.



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.

Frauds 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

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

Research Question:

- To understand fraudulent claims and their impact on change in premium amount in health insurance sector.

Objective:

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

Literature Review

- Health insurance business premiums are expected to reach Rs 30,000 crore by 2015, (increase of 302 percent from 2011- IMS Health data).

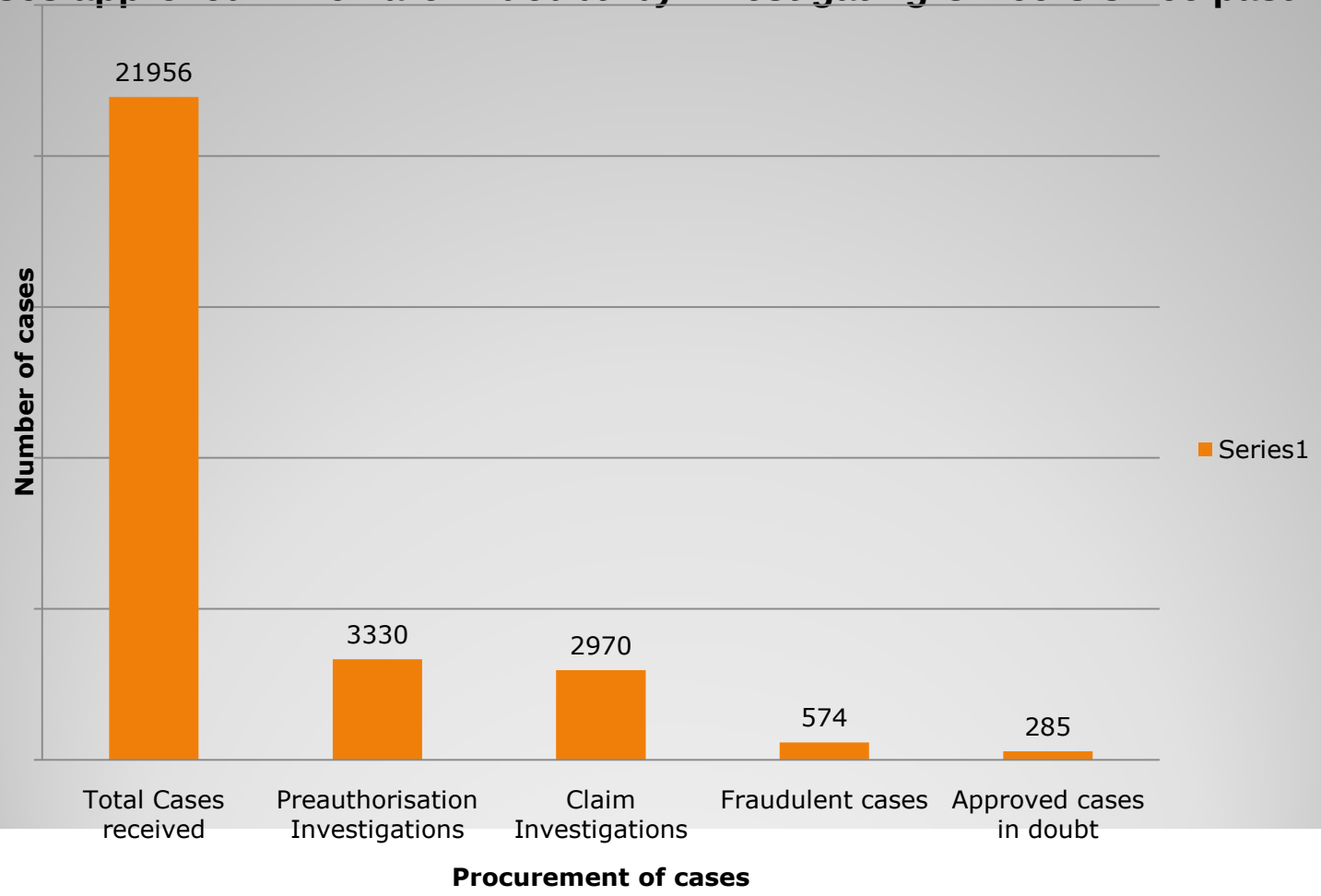
- Indian insurance companies have collectively lost Rs.30,401 crore due to various frauds (nine per cent of the total estimated size of the insurance industry in 2011- Indiaforensic state).

Methodology

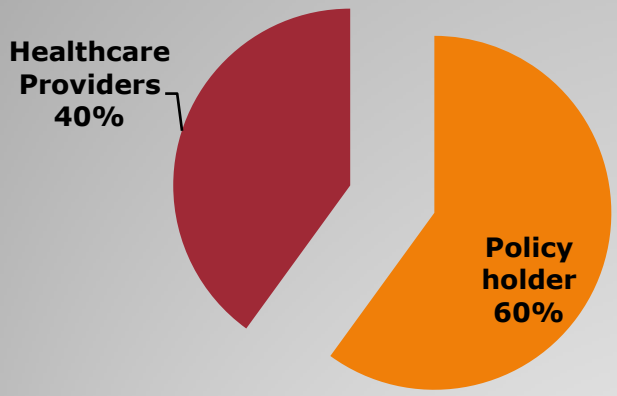
- **Type of study**: Cross sectional Descriptive study
- **Location of Study:** Bangalore
- **Study Population:** Claim investigators and underwriters of TPA and Health insurance companies in Bangalore area in addition to secondary data.
- **Sample:** List of insurance companies/ TPAs generated by applying **Simple Random Sampling** Claim investigators and underwriters can be selected from the identified insurance companies/ TPAs by **Systemic Random Sampling Method.**
- **Sample size:** sample of 20 claims investigators and 5 underwriters.
- **Data collection:** secondary data and Semi structured questionnaire.

Results

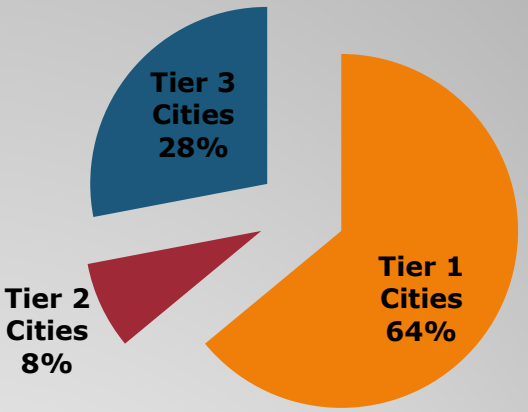
Number of cases handled, investigations done, cases found to be fraudulent and also cases approved which are in doubt by Investigating Officers since past 1 year.



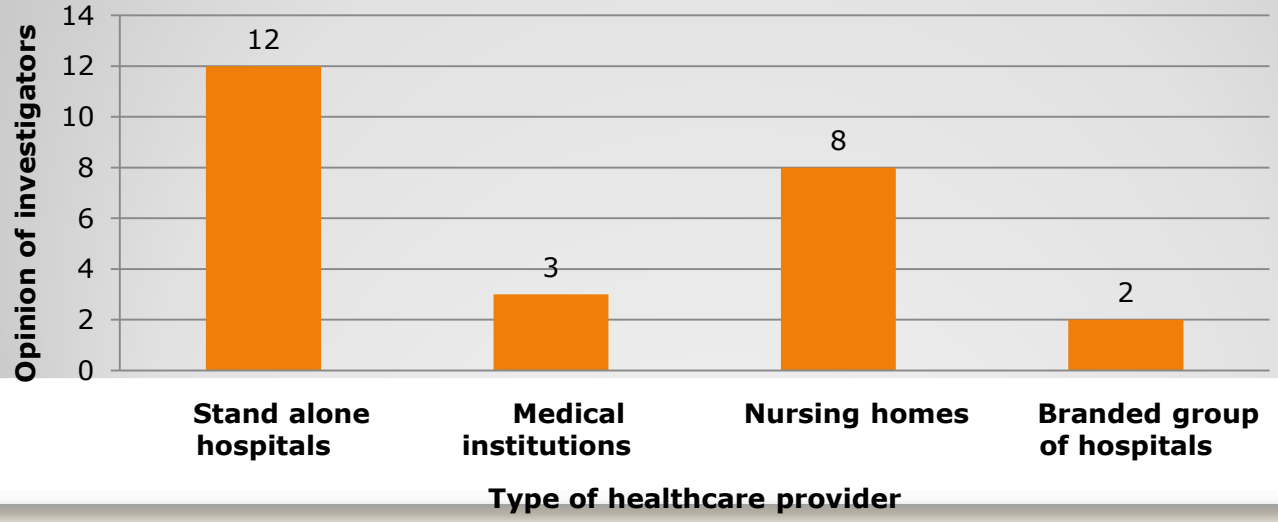
Opinion of Investigating officers on initiation of fraudulent cases



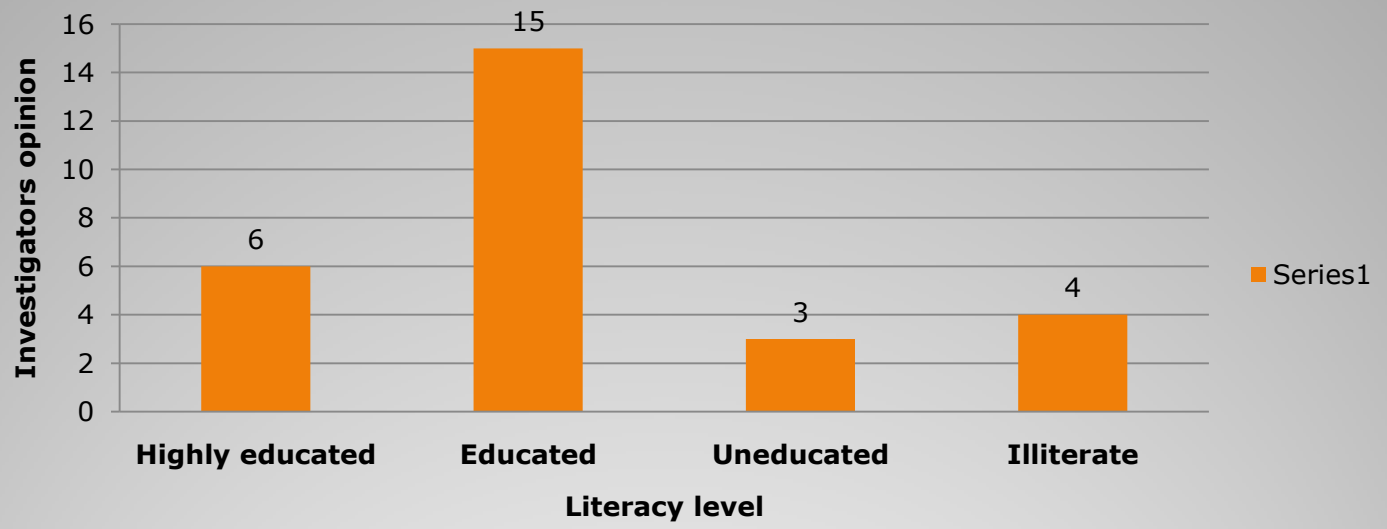
Investigators opinion on distribution of fraudulent cases in cities



Opinion of investigators on Type of healthcare providers involved in fraudulent claims.



Literacy level of people involved in fraudulent claims



Awareness among people about involvement of hospital in fraudulent claims

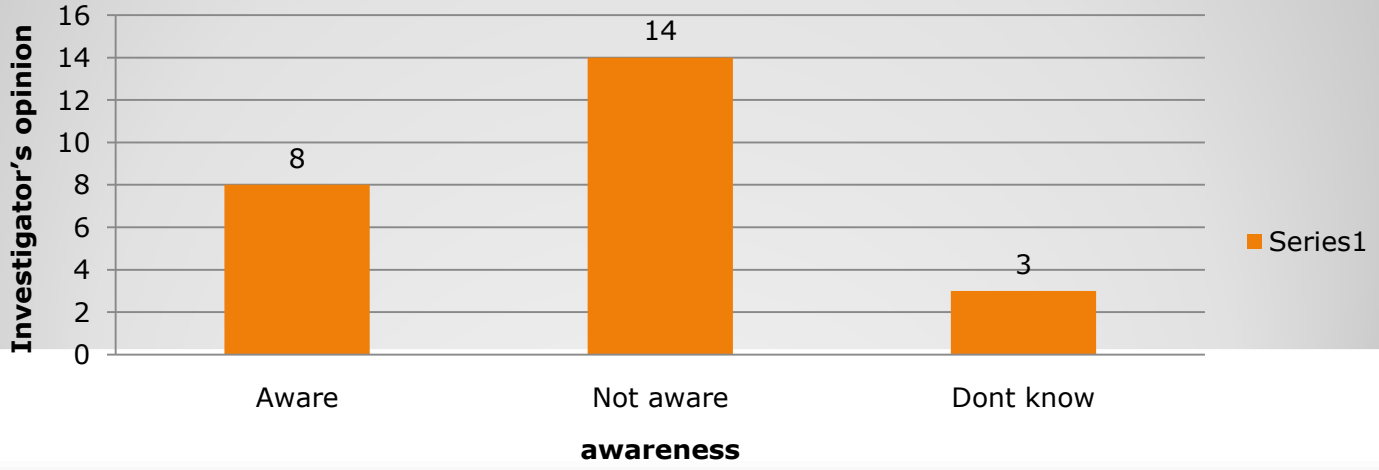


Table of premium, claims paid, ratio of fraud claims and loss to insurer period wise.

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

- Number of false health insurance claims in the industry is approximately 15 per cent of total claims
- Healthcare industry in India is losing approximately Rs. 600 to Rs. 800 crores incurred on fraudulent claims annually.
- The inflation rate of health Insurance premium is increasing from 8-12% every year.

Conclusion:

How does fraud impact policy holders and insurers?

- 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

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

Suggestions on

Countering Insurance frauds given by Investigating Officers and medical Underwriters of Insurance companies and TPAs :

- Anti-fraud units. actively fight fraud with Special Investigation Units — or SIUs.
- Anti-fraud software. 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.

- Train employees. Most insurers train employees such as adjusters and claims staff how to spot fraud.
- Sponsor national effort. National Insurance Crime Bureau (NICB), whose agents help investigate suspected schemes and refer the suspects for prosecution.
- Investigations recoup. Health insurers save more than 22 percent money from fraudulent cases

Thank You