



Master of Business Administration(MBA)
in
Pharmaceutical Management
2024

**Detection of fraud in
the Health Insurance
Industry**

Name : Vishal Uppal

Mentor – Dr. Rahul Sharma



Introduction

- **Health Insurance** – Health Insurance is the legal agreement between an insurer and insured in which insured pays some premium, against which insurer provides medical security to the insured.



Fraud in Health Insurance

Fraud is a crime which mostly occurs for the purpose of gaining financial gain and can be defined as a crime in general terms.

Health insurance fraud is the deliberate deception or misrepresentation of information to obtain unauthorized benefits from a health insurance program.

Key Element of Health Insurance Fraud



DECEPTION: INVOLVES INTENTIONAL FALSEHOODS OR MISREPRESENTATIONS.



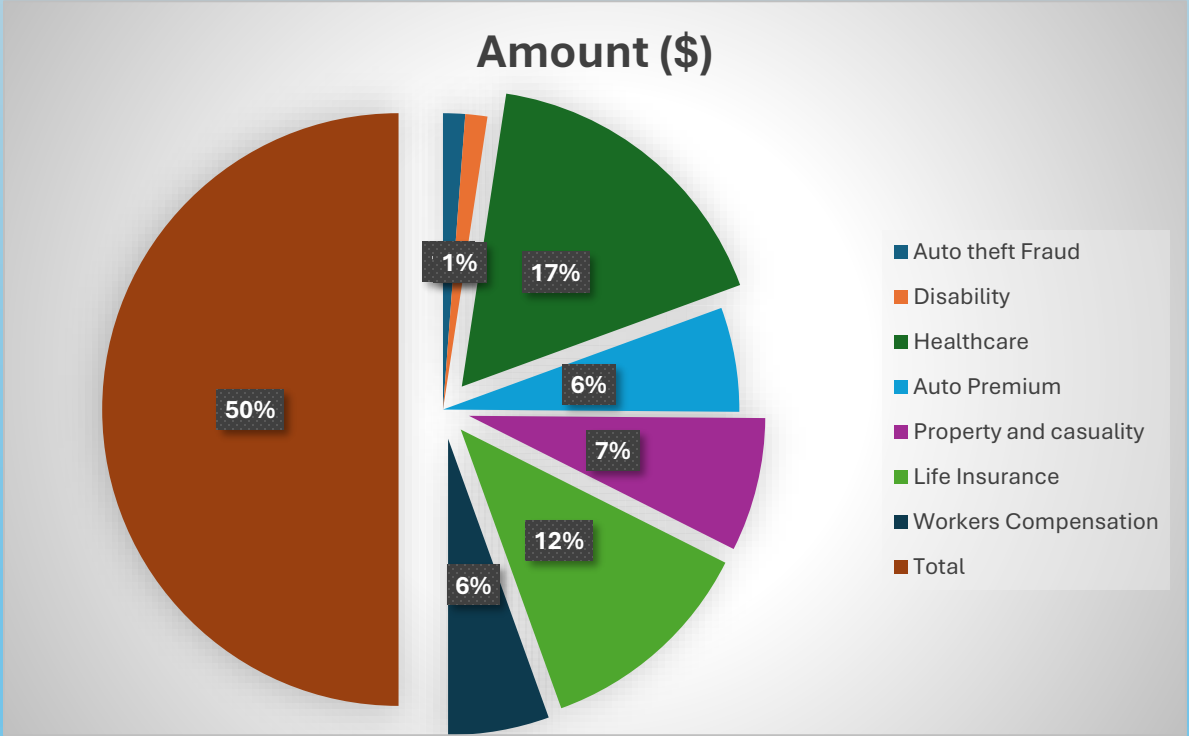
UNAUTHORIZED BENEFITS: THE GOAL IS TO RECEIVE PAYMENTS OR SERVICES THAT ARE NOT LEGITIMATELY EARNED OR COVERED.



PARTIES INVOLVED: CAN INCLUDE HEALTHCARE PROVIDERS, PATIENTS, OR INSURANCE COMPANIES.

Insurance Fraud Costs

Category	Amount (\$)
Auto theft Fraud	7.4
Disability	7.4
Healthcare	105
Auto Premium	35.1
Property and casualty	45
Life Insurance	74.4
Workers Compensation	34
Total	308.3





AIM AND OBJECTIVES

AIM :-

- To evaluate the various techniques employed for identifying the fraud in the health insurance sector.

OBJECTIVES :-

- To assess various techniques utilized for detecting fraud in the health insurance industry
- To assess financial impact of fraud in health insurance industry

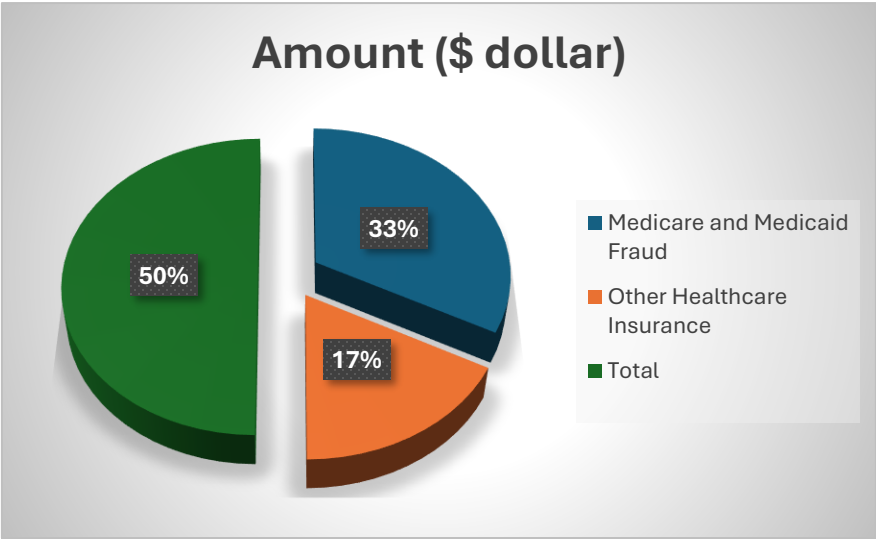


1. To assess financial impact of fraud in health insurance industry

- Acc. To Forbes -
- 20% of insurance claims are fraudulent.
- It is the second most costly white-collar crime.
- Healthcare fraud accounts for \$105 billion in Insurance losses annually
- In 2020, \$3.1 billion of health care claims were recovered by the Office of Inspector General.

Healthcare Insurance Statistics

Category	Amount (\$ dollar)
Medicare and Medicaid Fraud	68.7
Other Healthcare Insurance	36.3
Total	105





2. To assess various techniques utilized for detecting fraud in the health insurance industry.

- Various techniques could be used like –
 - Statistical Analysis
 - Machine Learning
 - Text Analytics

Results and Discussions



. THE MOST EFFECTIVE WAY TO DETECT THE FRAUDS IN INSURANCE CAN BE BY USING- DATA ANALYTICS AND STATISTICAL METHODS TO IDENTIFY UNUSUAL PATTERNS OR OUTLIERS IN THE DATA



SOCIAL NETWORK ANALYSIS CAN BE USEFUL TO UNCOVER FRAUDULENT ACTIVITIES SUCH AS COLLUSION, WHERE MULTIPLE PARTIES WORK TOGETHER TO DEFRAUD THE INSURANCE COMPANY.



ACCORDING TO THE ECONOMIC CONTRACTUAL THEORY OF FRAUD, PARTICIPANTS TO THE INSURANCE CONTRACT, SUCH AS CLIENTS, INTERMEDIARIES, EMPLOYEES, AND THIRD PARTIES, ARE TYPICALLY RESPONSIBLE FOR INSURANCE FRAUD.



RECOMMENDATIONS



This paper suggests future research to investigate the impact of four distinct components of the insurance fraud (the Customer, the Intermediary, the Employee, and the Third Party) on both the financial & the non-financial performance metrics within the insurance industry.



Achieving this goal would require implementing a robust fraud risk framework. This framework should encompass rigorous underwriting processes, effective claims validation procedures, intermediary scrutiny, fostering a culture of integrity among employees, and conducting thorough evaluations of third-party involvement.