A Study on Health Insurance Fraudulent Cases

Name: Deepesh Varma

Roll No.: 1492

University Mentor: Dr Nutan P Jain

BACKGROUND

- Fraudulent health insurance practice remains an enormous threat to insurers and their reputations.
- A significant portion of claims received are fraudulent, adding unnecessary costs and legal complications.
- An audit of XYZ Company established that between 10-15% of the submitted claims are fraudulent.
- As per Insurance Regulatory and Development Authority of India(IRDAI), insurance fraud is ‘an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties.’
- The rising trend of litigation cases highlights the need for a comprehensive analysis to identify the root causes and develop strategies to improve the outcomes of these cases.

OBJECTIVE

- The main study objective here is to undertake an investigation into the various fraudulent health insurance cases in XYZ Company.
- To Review the pattern, trends, and outcomes of fraudulent health insurance cases.
- To Analyze the types of frauds and their possible reasons.
- To Suggest alternative ways to reduce frauds.
- By addressing these issues of health insurance fraud, this study holds significant implications for cost savings, improved operational efficiency, enhanced reputation and trust, and better risk management within the health insurance industry.

LITERATURE REVIEW

AUTHORS	YEARS	STUDY LOCATION	SAMPLE SIZE	SAMPLING TECHNIQUES	SALIENT FEATURES
Xu et al.	2024	China	828	Online survey, snowball sampling	Investigated differences in willingness to report health insurance fraud in familiar vs. unfamiliar healthcare settings among young and middle-aged adults.
Liu et al.	2023	China	Theoretical Study	Not specified	Explored the governance path of health insurance fraud using evolutionary game theory, considering moral hazard, fraud cost, reward, punishment, bribes, and doctor-patient collusion.
Katrice Bridges Copeland	2023	United States	Theoretical Study	Not specified	Discusses the importance of trust in healthcare, the government's role in promoting trustworthy conditions, and the need to address fraud risks in value-based reimbursement to maintain public trust.
Deloitte	2023	India	10+ C-suite stakeholders/senior management	Not specified	Insights on insurance fraud trends, challenges, and mitigation strategies
Amponsah et al.	2022	Ghana	1323 health insurance claims	Not specified	Used decision tree algorithms to extract fraud detection rules from claims data and implemented the rules in a blockchain smart contract for fraud prevention in healthcare claims processing.
José Villegas-Ortega	2021	United States	67 Studies	Random Sampling	The paper identifies six different definitions of health insurance fraud from the literature. Based on their analysis, the authors propose a concise definition: "Health insurance fraud is an act of deception or intentional misrepresentation to obtain illegal benefits concerning the coverage provided by a health insurance company.
Ramesh Kumar Satuluri	2021	India	Theoretical Study	Not specified	Examines the digital transformation in the Indian insurance industry and its impact on various aspects like sales, underwriting, claims processing, product pricing, and fraud detection. Highlights the potential cost savings and improved profitability through digital innovation
Mackey et al.	2020	United States	Theoretical Study	Not specified	Proposed a blockchain framework for combating healthcare fraud and abuse, with a focus on patient-centric claims validation and consensus mechanisms involving providers, payers, and patients. Developed a prototype using the Ethereum blockchain platform.

METHODOLOGY

- The study will focus on the company's Operations - Fraud, Waste & Abuse department, which is responsible for identifying, investigating, and managing fraudulent health insurance claims.
- Study Population:
  Health insurance cases which comes under legal notice, ombudsman forum and consumer forum at XYZ Company during the period from November 2023 to May 2024. These cases were analyzed to understand the patterns, trends, and outcomes of fraudulent activities.

- Study Procedure:

1. Data Collection:
Collect relevant data for all legal cases lost/won at the legal, ombudsman and consumer forums during the specified period.

2.Data Preparation:
Organize and clean data
Remove any identifying information

3.Quantitative Analysis:
Conduct descriptive statistical analysis to examine the patterns and trends.

4.Root Cause Analysis:
Ishikawa (fishbone) diagram was used to identify the root causes that contribute.

5.Interpretation:
Interpret the findings of the study

6.Recommendations:
Formulate recommendations based on the study findings

Results

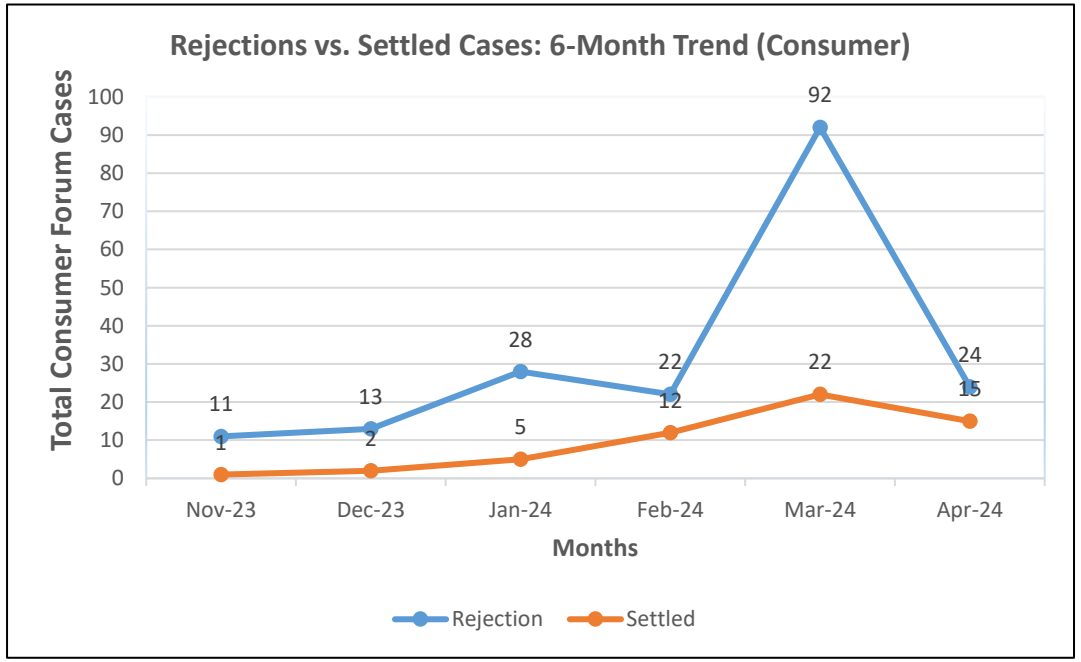
- From November 2023 to May 2024, a total of 712 health insurance litigation cases were analyzed across all three forums.
- The distribution of cases was as follows:

Litigation Cases	Number of cases (n)	Percentage of cases
Consumer Forum	302	42
Legal Forum	71	10
Ombudsman Forum	339	48

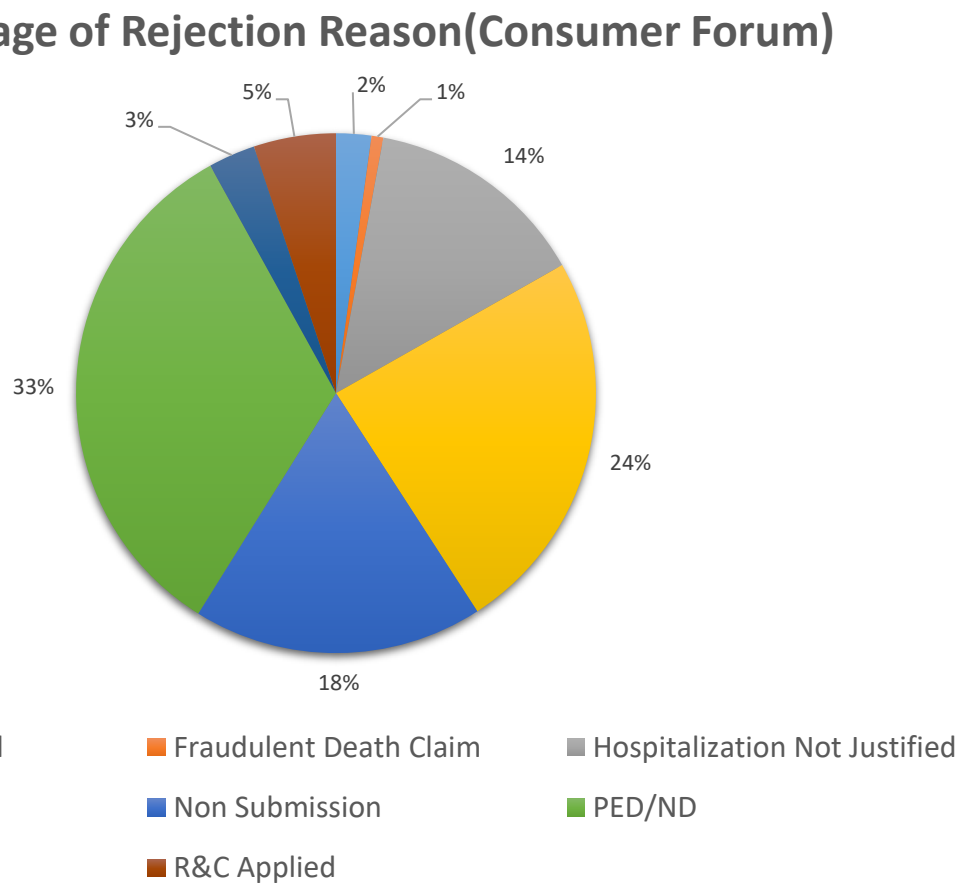
Consumer Forum Cases

Among 302 cases, 232 (76. 8%) were rejected and 70 (23. 2%) were settled.

The success rate in the Consumer Forum cases was higher on the side of Insurance company which stood at 74%.

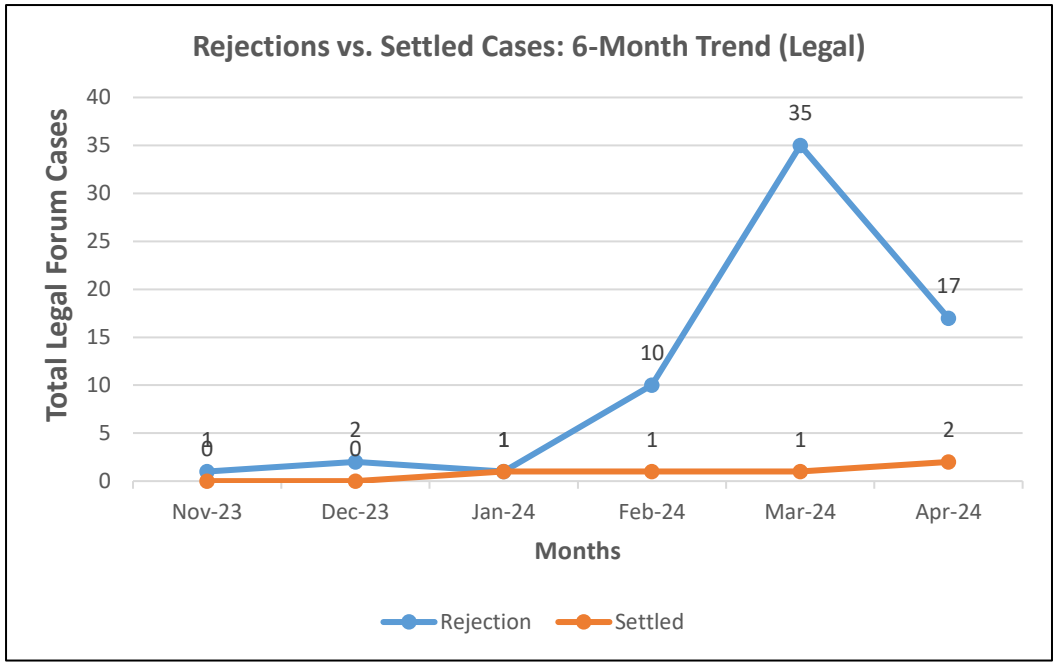


Consumer Forum Cases

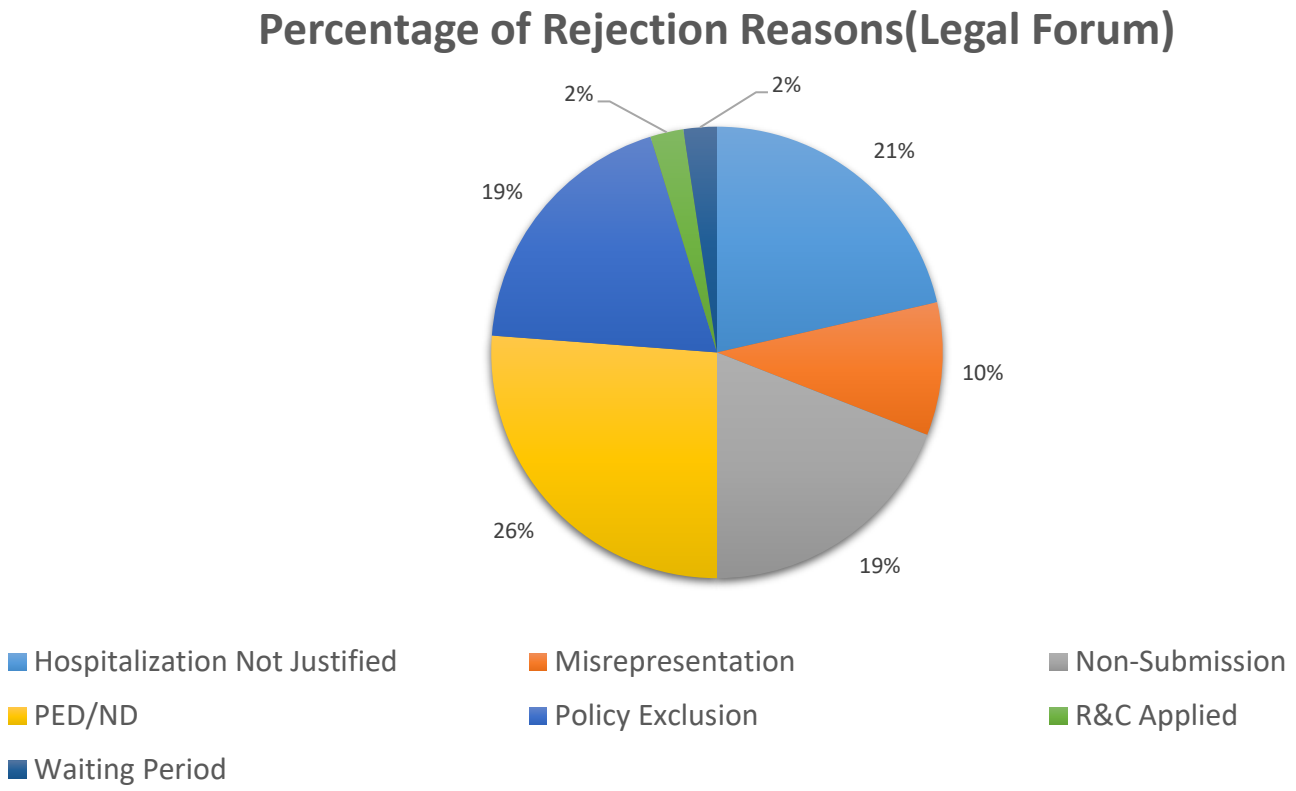


Legal Forum Cases

- Among 71 cases, which 66 (93. 0%) were rejected whereas 5 (7. 0%) of the cases were settled.
- The Insurance Company's overall win percentage for the Legal Forum cases were at 87%.

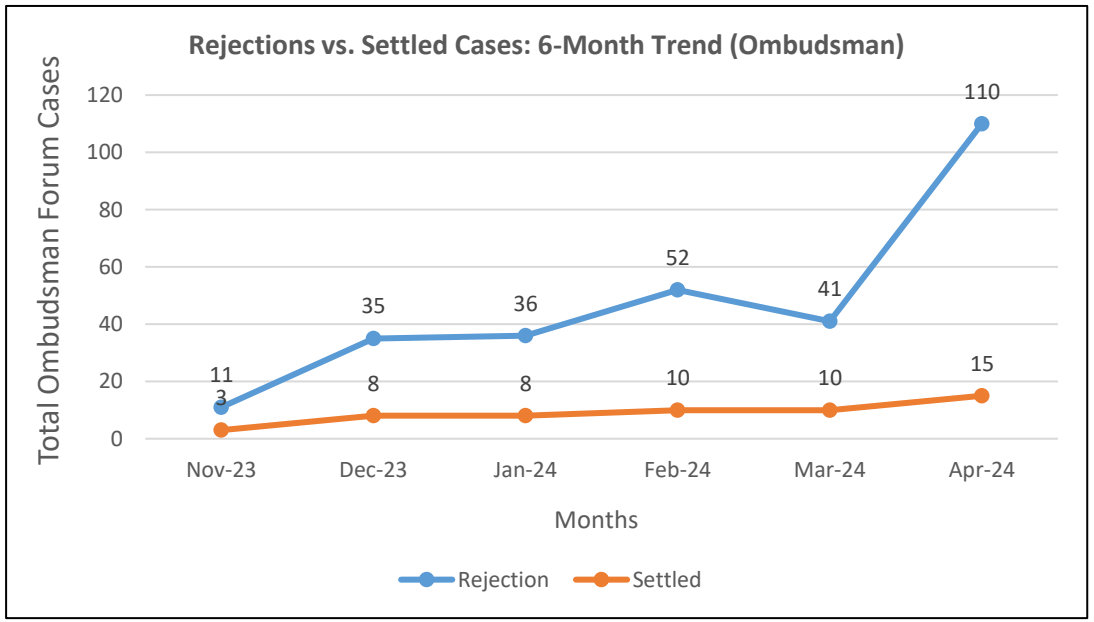


Legal Forum Cases

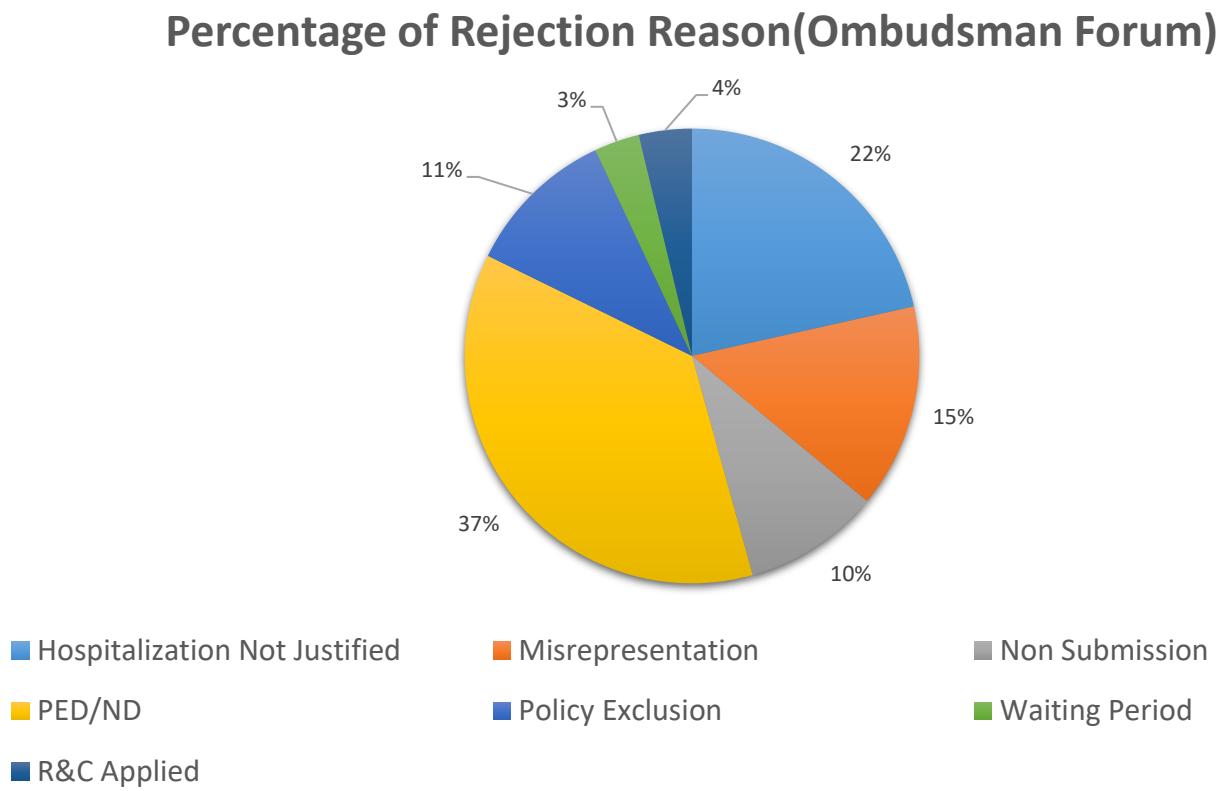


Ombudsman Forum

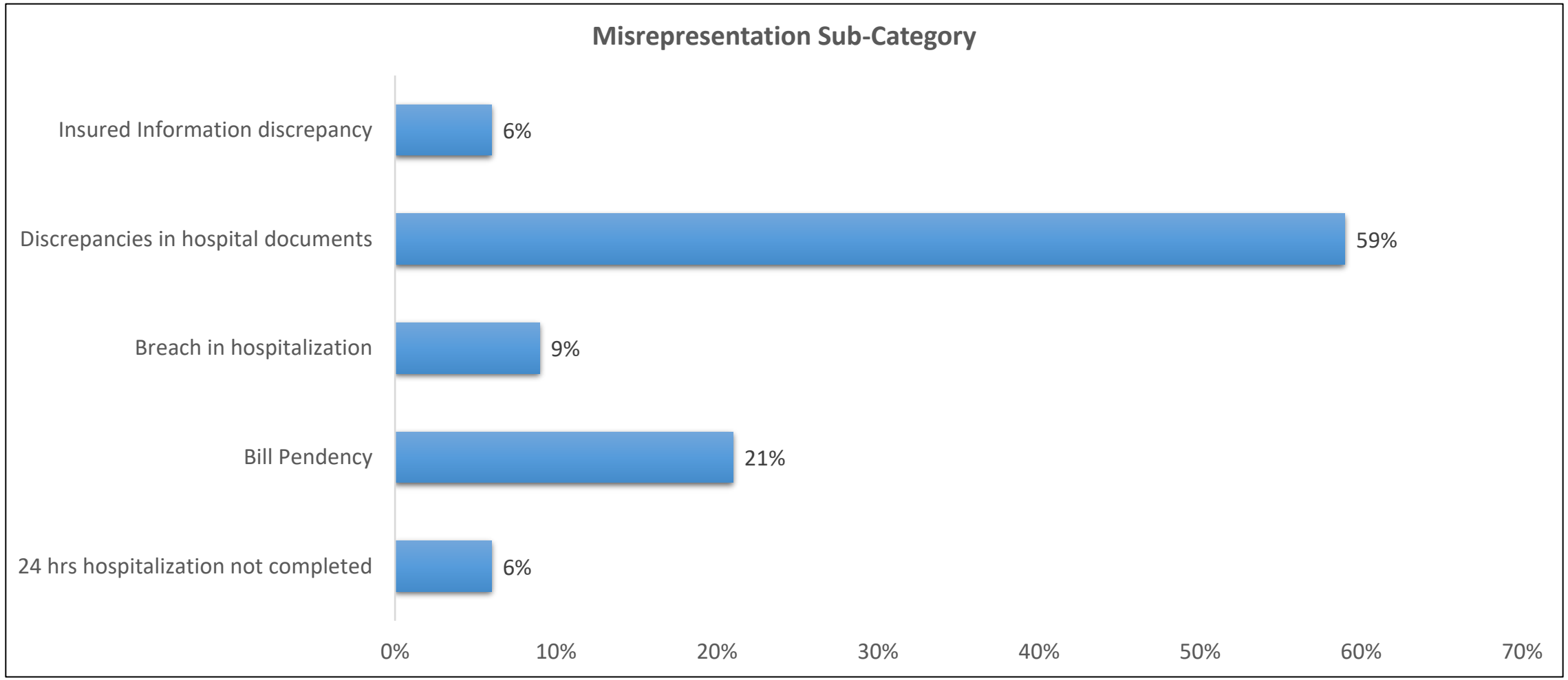
- Out of 339 cases, 285 cases (84.1%) were rejected while 54 cases (15.9%) resulted in settlements.
- The company demonstrated a strong performance in this forum, achieving an average success rate of 82.34%.



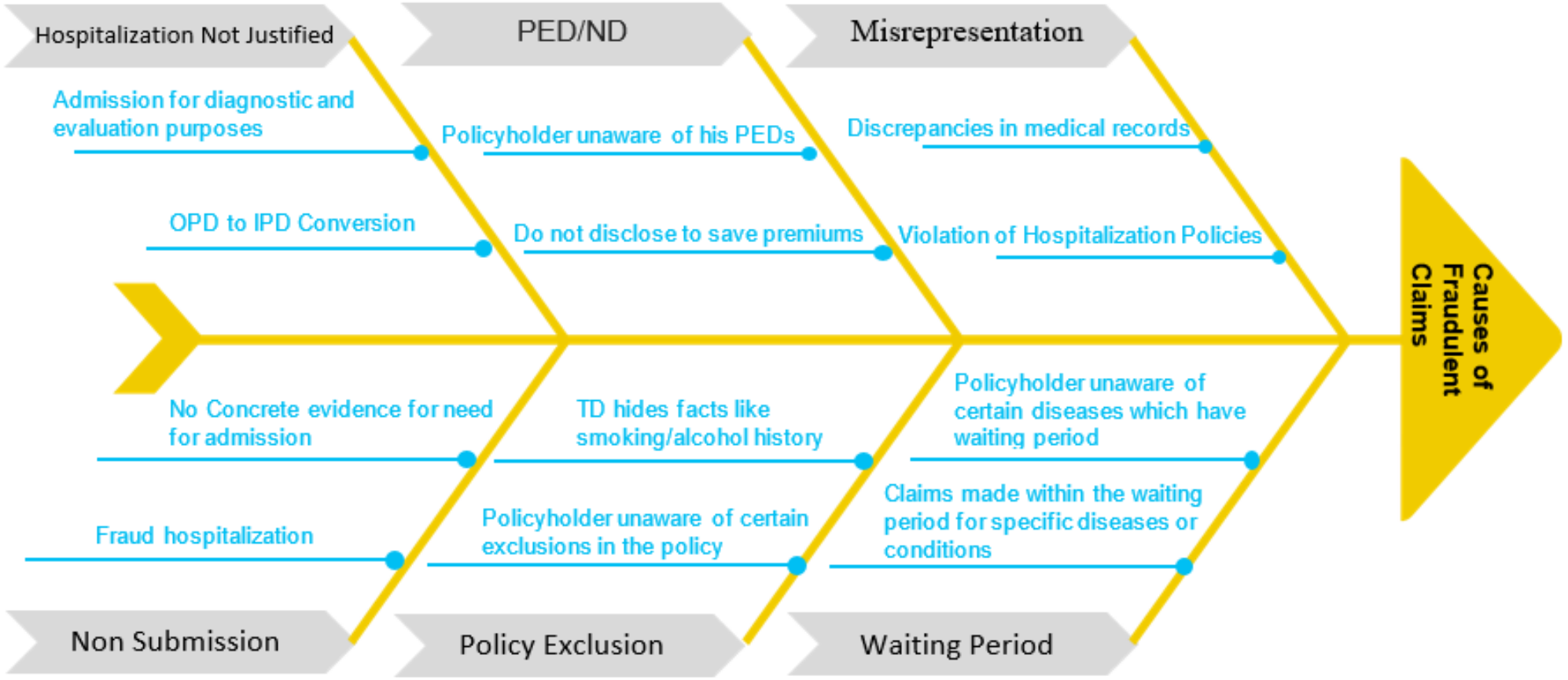
Ombudsman Forum



Misrepresentation Sub-Category



Fishbone Diagram- Causes of Fraudulent claims



Conclusion

- A breakdown of the cases by forums shows that Consumer Forum with 42% followed by the Ombudsman Forum at 48% have the most complaints indicating where they should be paying more attention to.
- It can be noted that XYZ Company has achieved good results in the protection against fraudulent claims, with the level of success in the considered forum- 74% in the Consumer Forum, 87% in the Legal Forum, 82.34 % in Ombudsman Forum proves the high efficiency of the current fraud detection and case management for the company.
- Non-disclosure of pre-existing diseases as a reason for claim rejection, is an issue that has remained persistent in all the forums, confirming that information failure is a key problem in health insurance.
- Misrepresentation – a concern that came out clearly was dishonesty in the candidate's documents, especially in medical reports.
- To address the potentially fraudulent cases, it is essential to promote integration between claims processing, fraud detection initiatives, and legal divisions.
- The usage of big data analytics and machine learning might increase the chances of exposing fraud patterns, specifically when it comes to suspicious abnormalities in healthcare records and frequent hospitalizations without a clear medical need.

References

- 1.https://www.kotak.com/en/stories-in-focus/insurance/guide-on-fraudulent-health-insurance-claims-in-india.html
- 2.Personal communication with Aditya Birla Health Insurance Company staff
- 3.Villegas-Ortega, J., Bellido-Boza, L. & Mauricio, D. Fourteen years of manifestations and factors of health insurance fraud, 2006–2020: a scoping review. Health Justice 9, 26 (2021). https://doi.org/10.1186/s40352-021-00149-3
- 4.Dr.Biswendu Bardhan. “Frauds in Health Insurance”,http://healthcare.financialexpress.com/200711/market13.shtml.
- 5. Chavali, Kavita, VV Ajith Kumar, and M. Sudha. "Vulnerability of Indian Health Insurance Industry to Frauds." European Journal of Economics, Finance and Administrative Sciences 73 (2015).
- 6. Villegas-Ortega J, Bellido-Boza L, Mauricio D. Fourteen years of manifestations and factors of health insurance fraud, 2006–2020: a scoping review. Health & justice. 2021 Dec;9:1-23.
- 7. Amponsah AA, Adekoya AF, Weyori BA. A novel fraud detection and prevention method for healthcare claim processing using machine learning and blockchain technology. Decision Analytics Journal. 2022 Sep 1;4:100122.
- 8. Liu J, Wang Y, Yu J. A study on the path of governance in health insurance fraud considering moral hazard. Frontiers in Public Health. 2023 Sep 14;11:1199912.
- 9. Mackey TK, Miyachi K, Fung D, Qian S, Short J. Combating health care fraud and abuse: Conceptualization and prototyping study of a blockchain antifraud framework. Journal of medical Internet research. 2020 Sep 10;22(9):e18623.
- 10.Deloitte’s Insurance Fraud Survey 2023, https://www2.deloitte.com/in/en/pages/forms/Insurance-fraud-survey-2023.html
- 11. Copeland KB. Health Care Fraud and the Erosion of Trust. Nw. UL Rev.. 2023;118:89.
- 12. MacFarlane D, Hurlstone MJ, Ecker UK. Protecting consumers from fraudulent health claims: A taxonomy of psychological drivers, interventions, barriers, and treatments. Social Science & Medicine. 2020 Aug 1;259:112790.
- 13. Xu J, Zhang T, Zhang H, Deng F, Shi Q, Liu J, Chen F, He J, Wu Q, Kang Z, Tian G. What influences the public’s willingness to report health insurance fraud in familiar or unfamiliar healthcare settings? a cross-sectional study of the young and middle-aged people in China. BMC Public Health. 2024 Jan 2;24(1):24.