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DISSERTATION SYNOPSIS

TITLE: A Study on Health Insurance Fraudulent Cases

INTRODUCTION:

In the health insurance industry, a significant portion of claims received are fraudulent, adding unnecessary costs and legal complications.

The Insurance Regulatory and Development Authority of India (IRDAI) used and quoted the definition of insurance fraud as said by the International Association of Insurance Supervisors (IAIS), which is "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties." [1]
According to an review article, health insurance fraud is defined as “an act based on deception or intentional misrepresentation to obtain illegal benefits concerning the coverage provided by health insurance”. [3]

At Aditya Birla Health Insurance Company Limited, approximately 15% of the total claims received are identified as fraudulent. The company faces legal cases from both consumers and ombudsman forums, and the number of such cases has seen a 13% increase in Q3 Nov 23 to May 24 compared to the previous quarter, with 673 cases received.[2] Healthcare fraud presents significant financial and human costs, yet there remains a lack of agreement on its precise definition, as well as an absence of comprehensive documentation detailing its various forms and contributing factors. The aim is to discern the definition, manifestations, and influences of health insurance fraud (HIF).[3]

Insurance companies in the USA face annual losses exceeding 30 billion USD due to healthcare insurance fraud, a staggering figure mirrored in developing countries like India. According to the report, the healthcare sector in India suffers an estimated loss of Rs 600 to Rs 800 crores each year due to fraudulent claims. [4]

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. Effective risk management practices and the protection of policyholder interests are crucial for maintaining the company's reputation and ensuring long-term sustainability.

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.
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Different types of Health insurance frauds:

Insurance Regulatory and Development Authority (IRDA) who regulated the insurance industry classifies fraud into these three categories [5].

1. Policy Holder Fraud and Claims Fraud: Fraud against the insurer in the purchase or execution of the insurance product including at the time of making a claim.

2. Intermediate Fraud: Fraud by the insurance agent / intermediary against the insurer and policy holders.

3. Internal Fraud: Fraud against the insurer by its staff member.

RESEARCH QUESTION:

- What are the pattern, trends and outcomes of fraudulent health insurance cases over the period of Nov 23 to May 24?
- What are the types of frauds in health insurance implementation?
- How to manage the risk of the frauds?

OBJECTIVES:

To review the pattern, trends and outcomes of fraudulent health insurance cases over the period of Nov 23 to May 24.

To analyze types of frauds during last Nov 23 to May 24 by its possible reasons

To suggest alternative ways to reduce frauds.

MATERIAL AND METHODS:

The steps will be followed like

Step 1:
In a health insurance company data will be collected to review the pattern, trends and outcomes of fraudulent health insurance cases over the period of Nov 23 to May 24

Step 2:
All the lost legal cases of ombudsman and consumer forum for Nov 23 to May 24 will be selected for in-depth study

Step 3:
The documents like court judgement, claims documents, case brief related to the selected cases will be reviewed

Step 4:
Qualitative analysis, categorization of fraud, and cross case analysis will be done for each of the case selected

Step 5:

Trend analysis of the fraud cases by months for the Nov 23 to May 24 will be conducted
Root cause analysis to identify the underlying reasons for lost litigation cases will be conducted.

ETHICAL CONSIDERATION:

- Insure both the confidentiality and the privacy of policyholders' information as well as other confidential data.
- Ensure transparency and accuracy in reporting research findings.

IMPLICATION OF RESEARCH:

Cost savings:

1. Reducing litigation costs by improving case outcomes
2. Avoiding penalties and fines from regulatory bodies

Improved operational efficiency:

1. Streamlining claims processes to minimize errors leading to litigation
2. Optimizing resource allocation for handling legal cases

Enhanced repudiation and trust:

1. Building trust with policyholders by protecting their interests
2. Improving company's reputation by fair and transparent claims practices

Better risk management:

1. Identifying and mitigating risks that lead to litigation
2. Implementing preventive measures to reduce legal exposure