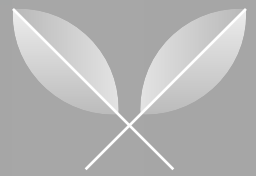
“A STUDY ON BLACKLISTING OF NETWORK & NON-NETWORK HOSPITALS”



Under the Supervision and Guidance of
Tripti Bisawa
Associate Professor at IIHMR University

IIHMR UNIVERSITY

BY DR. SAMIKSHA ARUN RUSHIYA
(MBA HM 26)
Roll No: 1388

CONTENTS

ABOUT THE ORGANIZATION

Aditya Birla Health insurance co. Limited (ABHICl), a part of Aditya Birla Capital Ltd. (ABCL), is a joint venture of Birla Group and MMI holdings of South Africa. ABHICL was incorporated in 2015 wherein Aditya Birla Capital momentum metropolitan strategic investments (pty) limited (formerly known as MMI strategic investment) 51% and 49% shares, respectively.

- **VISION:**

  To be a leader & to be a role model in broad-based player & integrated player for financial services business.

- **MISSION:**

  To deliver superior value to our customers, shareholders, employees and society at large.

- **VALUES :**

  -INTEGRITY

  -COMMITMENT

  -PASSION

  -SEAMLESSNESS

  -SPEED

ABOUT THE ORGANIZATION

It offers a wide assortment of health care coverage designs.

- Chronic Care Management Program
- Cancer Health Insurance Plan
- Active Health Management Programs
- Rewards & Health Returns
- Dedicates customer support
- Wide Range of Network Hospitals
- Tax Benefits

Till date Aditya Birla Health Insurance has proudly insured 2.5 crores+, have their presence in 4,800+ cities, connected with 10500+ cashless hospitals, settled 5 lacs+ claims with 94% of Claim settlement ratio.

MY LEARNINGS

One of the most important things I gained from this internship is newfound knowledge.

I got an idea of what my biggest strengths are, most importantly the areas of improvement I should work on.

I have learned about the work environment in corporate industry.

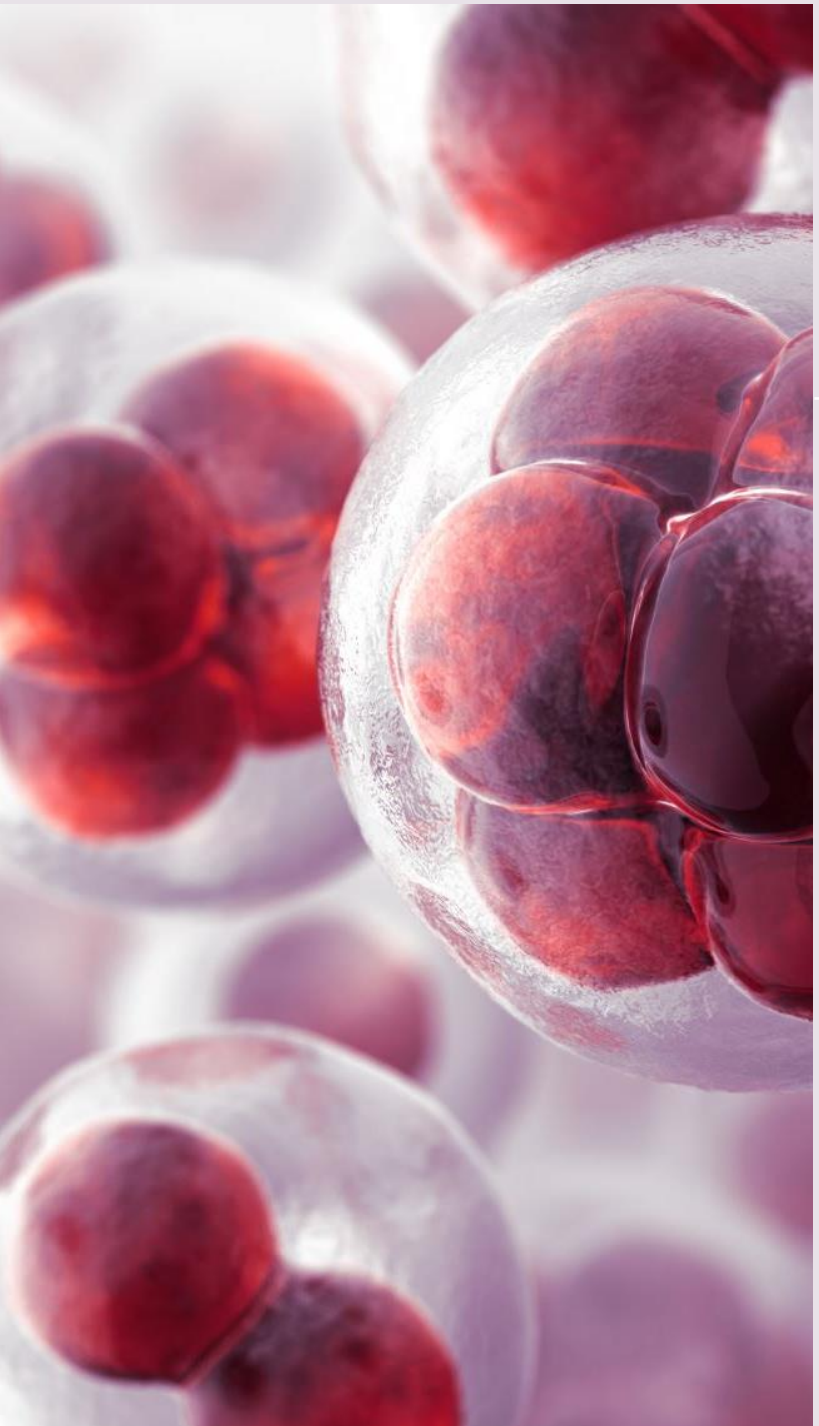
I got to know about functioning and role of different departments here.

Being all new to Insurance sector I got the opportunity to make new connections here with senior employees, clients, fellow interns, etc.

Even though I was at the bottom of the career ladder, but I felt needed as my basic work was appreciated, that kept boosting my morale throughout the internship.

INTRODUCTION

- The unpredictability of unpleasant things happening to people's lives, well-being, resources, and property is just one example of the different types of risks that can exist. To protect the interests against catastrophe and vulnerability.
- Millions of people are employed by the Insurance industry, which is particularly important in nations like India where employment and savings are crucial.
- The Insurance Industry has evolved to cover the loss and uncertainty.
- However, it should be noted that operating in the health insurance sector in India carries several dangers due to an exceptionally high prevalence of fraud.
- Due to all the benefits, insurance fraud unfortunately has a high likelihood.
- This study aims to investigate the reasons behind the blacklisting of hospitals and the impact it has on patients, hospitals, and insurance providers.



TYPES OF HEALTHCARE FRAUDS

- Healthcare Frauds
  - Waiving Copayments
    - Hospitals routinely waiving patient's copayments & overbilling the healthcare insurance provider
  - Pinging the System
    - Referring a patient within the same healthcare organization for laboratory tests, medication & pharmacy
  - Commission Based
    - Doctors referring patients to specific hospitals, clinics, pharmacists, medicines or equipment to get a commission
    - Providing specific brands of medicines, to get a commission from pharmaceutical company
  - Billing Manipulation
    - Hospitals providing unwanted care to the patients, increasing service hours in the bills, claims, phantom billing, or replacing codes of diseases with ones with more price
    - Hospitals increasing prices of medical equipment for patients whose insurance covers equipment costs or claiming for expensive equipment while providing the ones with less expenses
    - Hospitals manipulating diagnosis in the claims without the knowledge of patients
    - Hospitals billing patients for provided by unlicensed care providers

- **RESEARCH QUESTION:**

  What is the process of identification and impact of blacklisting the hospitals at health insurance industry level?

- **RATIONALE:**

  Prevention in claims from blacklisted hospitals will result in lower Average Claim Size (ACS).

- **OBJECTIVES:**

1. To understand the Average Claim Size of both Cashless & Reimbursements
2. To study the Fraud-Abuse claim incidences in Hospitals Pan India
3. To analyze Unwarranted Losses further leading to overall Cost Reduction

- **METHODOLOGY:**

  DATA COLLECTION PROCEDURE: A group of insurers came together to tackle hospital fraud. Each insurer shared a list of excluded hospitals for this purpose. The data was collected using a system portal, and a comprehensive list of fraudulent hospitals was compiled. Next, the collected data undergo multistage analysis. The common responses were coded and categorized into themes, which then was entered into Microsoft Excel for further analysis. The resulting tables and graphs provided a summary of the data. Finally, conclusions were drawn based on the themes that emerged from the data analysis.

- **RESEARCH METHODOLOGY:**

  STUDY DESIGN: Correlational Quantitative Study
  SETTING: Aditya Birla health insurance

- **STUDY POPULATION:**

  INCLUSION CRITERIA: Suspected fraud hospitals
  EXCLUSION CRITERIA: Non- suspected hospitals
  STUDY TOOL: Secondary data
  DURATION OF STUDY: 3 Months (22nd Feb 2023 – 21st May 2023)

- **SAMPLE SIZE:**

  Master data consists of 55,000 hospitals, out of which 2,916 hospitals were identified as suspected hospitals. Conclusions are made on basis of suspected hospitals.

- **SAMPLING TECHNIQUE:**

  Purposive Non- Probability Sampling

PROCESS FLOW

• At first, Insurance companies which are listed in the healthcare industry identified the hospitals on their level, that these hospitals are suspected to do fraud or maybe there are on the verge of doing fraud. The companies then segregated the hospitals on the basis of their claim trends, past experiences, reports by FWA (Fraud Waste and Abuse) team.

• The industry then fixed the number of 2,916 for suspected lists of fraud hospitals & published it in the healthcare industry.

• Multi-stage process was done such as Internal review and cross checking with hospitals in order to see how many of them are on every Company's network.

• The team of Aditya Birla started working on this list of 2,916 Hospitals, the trend with these hospitals were reviewed again on internal level as per their claimed amount to ABHI & reimbursements made to them by ABHI, out of this, 539 hospitals were on network with ABHI. These Network hospitals were then de-empaneled by sending a temporary suspension letter. Along with it the parallel process of tagging was on going in system.

PROCESS FLOW

Aditya Birla Health Insurance Co. Ltd.
(A part of Aditya Birla Capital Ltd.)

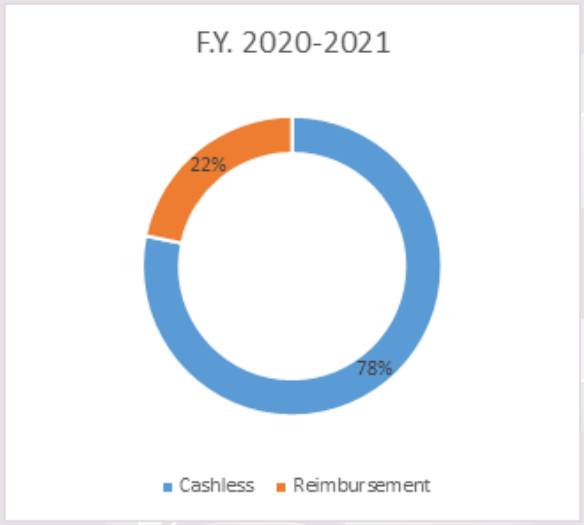
ADITYA BIRLA CAPITAL

Excluded/Delisted Hospitals

Please Note: Expenses incurred towards treatment in any hospital or by any medical practitioner or any other provider specifically excluded by the Insurer and disclosed on its website/notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

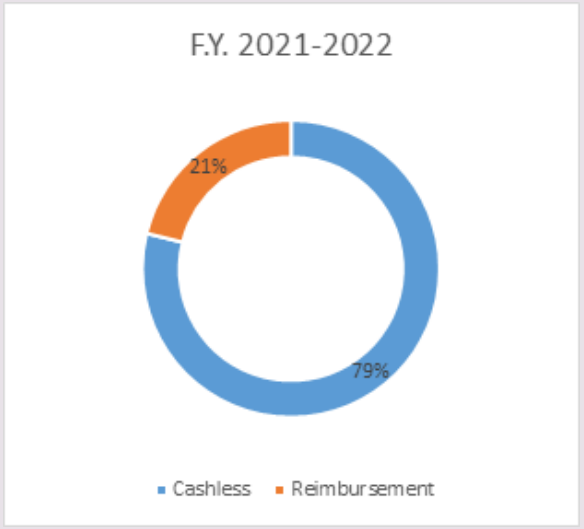
- The remaining 2,377 Non network hospitals were tagged as blacklisted & the future claims made by these will be verified first as they straight away goes to verification bucket for genuineness.
- For the information to customers, ABHI has also been showcasing such hospitals names with their addresses, so that the customers should not fall prey to such fraudulent activities. Also, it has been mentioned on the official website that Claims coming from these hospitals will not be entertained unless it is an incident of emergency (casualty) or sudden fatality.

RESULTS

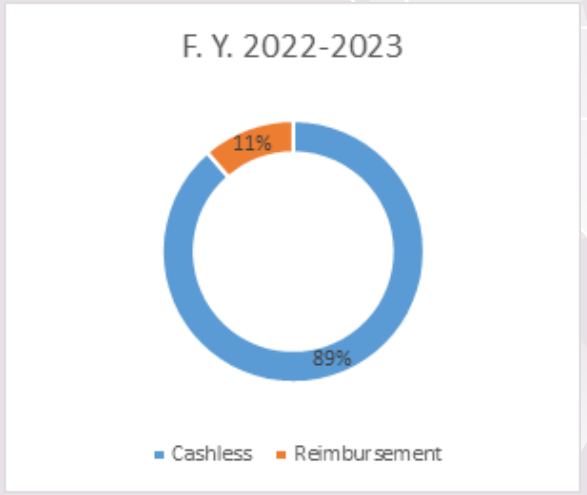


Cashless: 8,27,44,672 INR
Reimbursement: 2,29,95,856 INR

Cashless: 19,24,97,625 INR
Reimbursement: 5,16,71,725 INR



Cashless: 19,24,97,625 INR
Reimbursement: 2,12,89,668 INR



Cashless: 44,13,02,357 INR
Reimbursements: 9,59,57,250 INR

FINDINGS

- Increased insurance fraud cases result in higher costs for insurance companies and lead to higher premiums.
- A lump sum amount of approximately Rs. 53,72,59,607 INR that has been granted can be saved in the future by not engaging with these fraud hospitals.
- This blacklisting process will help prevent unwarranted losses in the insurance industry and further assist in cost reduction planning within the organization.

DISCUSSIONS

- The National Health Care Anti-Fraud Association (NHCAA) has recommended key measures to tackle healthcare fraud, such as the use of predictive modelling and promoting transparency between private insurance companies and government programs.
- Healthcare fraud is a crime that is constantly changing, with new schemes appearing on a regular basis
- The ultimate goal of the fraud detection approach is to prevent the loss of financial resources as well as inpatient care and medical services.
- Analyzing the results of previous studies through a synthesis table reveals that most research has relied on secondary data to identify and analyze instances of fraud.
- So, in future researchers can thus focus on identifying the weaknesses of fraud detection methods by collecting primary data, examining the various types and rules that pertain to fraud perpetrators in different countries, and making comparisons.
- This information can then be used to inform the development of legal sanctions for fraud, irrespective of the job or profession of the individuals involved.

RECOMMENDATIONS

- Sun Tzu once wrote, "***Know your enemy and know yourself, find naught in fear for 100 battles. Know yourself but not your enemy, find the level of loss and victory. Know thy enemy but not yourself, wallow in defeat every time.***"
- To stop insurance fraud in all its manifestations, both nationally and internationally, India urgently requires legislation against it
- To limit instances of fraud, insurance companies need to invest more in the education and training of fraud detectives.
- To reduce the prevalence of fraud, insurance companies must have an effective risk management system. Insurance fraud is considered a low-risk task, which is why it is frequently carried out by white-collar criminals. Therefore, laws need to be changed to punish offenders rigorously.
- As the primary regulator of the insurance industry, the Insurance Regulatory and Development Authority (IRDA) now has authority over businesses, agents, and brokers. Hospitals, physicians, and other healthcare service providers are not, however, covered by the rules. The insurance regulatory system needs to take a more coordinated strategy to address this issue, much like the banking sector does. With the help of tighter controls on fraud and the release of fraud-related data among multiple parties, this strategy would increase the scope of monitoring and control.

REFERENCES

- Chandra Das, V. (2022, November 14). *Health care frauds in India - Causes and Preventive measures.* Paytm https://paytminsurance.co.in/health-insurance/articles/health-care-fraud-in-india-causes-and-preventive-measures/

- Sinha, S. (2017, July 06). *How insurance firms are with fraud claims.* The Economic Times

https://economictimes.indiatimes.com/news/economy/finance/how-insurance-firms-are-dealing-with-fraud-claims/articleshow/59448276.cms

- Patil, K., & Abhyankar, M. (2019, March) *A study of fraud investigation in fraudulent insurance claim.* ResearchGate

https://www.researchgate.net/publication/339739901_A_STUDY_OF_FRAUD_INVESTIGATION_IN_FRAUDULENT_INSURANCE_CLAIM

- National Health Care Anti-Fraud Association

https://www.nhcaa.org

THANK YOU !