IIHMR UNIVERSITY

DISSERTATION

HOTSPOT areas of fraudulent claims in individual Personal Accident policies of TATA AIG Health Insurance Company during April 2021-March 2023.

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CONTENTS

INTRODUCTION

History

the Insurance system has a long history in India, and it can be found in the texts of Manu Smriti, Dharma Shastra, and Arth Shastra.

The 1930s saw the advent of health insurance in the form that we know it today.

India has made significant progress during the past 50 years
the insurance industry was privatised in 1991, after the government of India's presentation of a new economic strategy and economic liberalisation.

Indians have been the most active and involved when it comes to obtaining health insurance for themselves and their families amidst increasing awareness.

INTRODUCTION

- **Health Claims**
- Compared to other general insurance plans, the health care coverage method is extremely complex
- Health insurance claims concede two types of cases. These are: 1) Cashless and Reimbursement claims

- **Fraudulent activities in health insurance claims:**
- Healthcare fraud as defined by the National Health Care Anti-Fraud Association (USA): "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." "Intentional deception or misrepresentation that the individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity, or to another party."

- **The triangle of fraud**
- Incentive/Motivation/Pressure
- Chance
- Rationalisation/ Attitude

Types of frauds

- Deliberate and Opportunity Fraud
- External and Internal Fraud
- Policyholder’s Fraud
- Eligibility Fraud
- Application Fraud
- Claim Fraud

BACKGROUND

Health insurance customers frequently commit fraud by:

1. Hiding pre-existing conditions (PEDs) or chronic illnesses,
2. Falsifying results of pre-policy health checks, and other offences.
3. Duplicate and inflated invoices, impersonation,
4. Participating in fraud rings, purchasing numerous policies,
5. Fake / created documents to meet insurance terms conditions,
6. Staged accidents and false disability claims,

The agents and brokers are typically involved in fraud that involves:

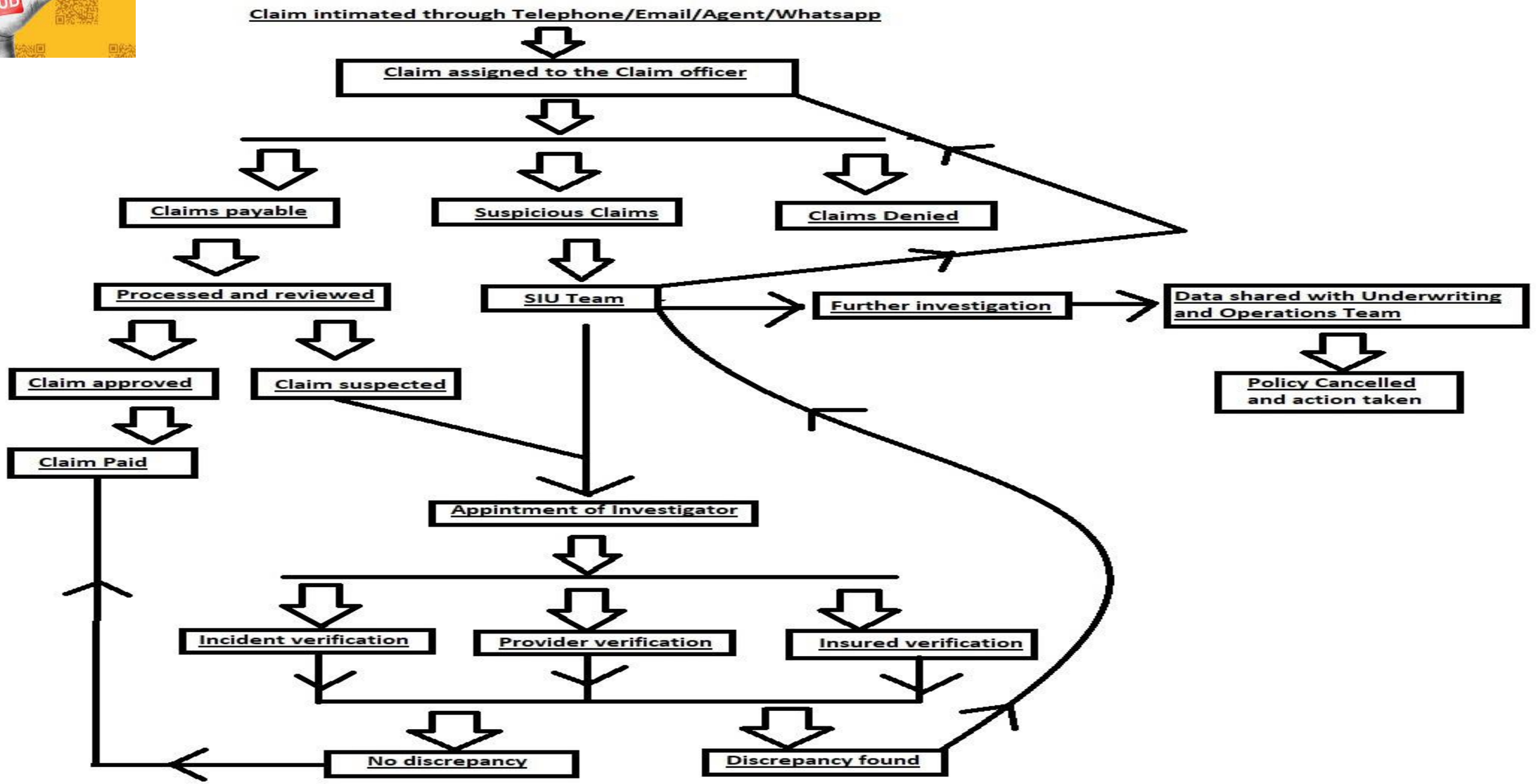
1. Giving customers fake policies and pocketing the premiums,
2. Falsifying pre-policy health check-up records,
3. Advising customers to conceal PEDs or other material facts in order to obtain coverage or file claims, participating in fraud rings and facilitating policies in fictitious names.
4. Channeling customers to dishonest providers

Special Investigation Unit

TATA-AIG has set up a fraud monitoring department which has been termed as a special investigation unit. This unit is responsible for monitoring, evaluation and detection of fraud as [er the IRDA guidelines.

It provides expert guidance and detection services and runs hand in hand with Department of claims, Underwriting, operations, and legal services.

They have their sub-units across the country, with regional managers and area managers who investigates and reports the fraudulent activities.



Process of claim and SIU team to detect fraudulent claims.

AIM OF THE STUDY

To identify state wise and area wise, the concentration of the fraudulent cases been detected during the financial year 2021 to 2023 in respect to the Accident guard, Accident Guard plus and Accident shield policies.

OBJECTIVES

To identify the suspected areas which has larger volume of policies sold.

To identify the area who has a greater number of claim intimation

To identify the area which are more prone to fraudulent activities

MATERIALS AND METHOD

STUDY SAMPLE:Taken into account the144627 policies sold and 2019 claims intimated during the financial year 2021 to 2023 in respect to the Accident guard, Accident Guard plus and Accident shield policies.

SAMPLING TECHNIQUES: All the claims intimated during the financial year 2021 to 2023 in respect to the Accident guard, Accident Guard plus and Accident shield policies.

STUDY LOCATION: Corporate office, Tata AIG Health insurance Company, Goregaon East, Mumbai.

Study Design: Cross-sectional study with data analysis using Excel.

Duration Of The Study: 3 Months- March 2023 to May 2023

METHODOLOGY

Data was obtained by raising tickets from the Data office of TATA-AIG General Insurance company towards the total number of policies of Accident guard, Accident Guard plus and Accident shield policies sold across the country for the financial year 2021-22 and 2022-23.

The data for total number of claims intimated across the country in the above policies was obtained from the Department of Health claims.

The data regarding the number of investigations done in the claims intimated across the country in the above policies was obtained from the Special investigation Unit, TATA-AIG.

The data was than analysed to know the number of claims intimated from the number of policies sold and distribution of the same across the county.

The hotspot areas were identified in relation with the highest number of fraudulent activities been found as per the SIU data for the financial year 2021-22 and 2022-23.

The study findings were compared with the trend of health insurance frauds in India.

ROOT-CAUSE ANALYSIS

Time delay due to investigations

Depleting trust between stakeholders

Business Losses

High cost of Premium

Motivates the fraudsters

Overburdening of health system

Successful Frauds in Health insurance

Increased digitization in public domain

Illiteracy

Non digitization in hospitals

No time constraint to report a claim

Lack of medical coding

Unethical medical practices

Employee involvement

Poor quality of data

Trend of Health insurance fraud across India

- Business today, dated 06/01/2020, due to the unethical behaviour, the National Health Authority (NHA) has de-empanelled 171 hospitals from the PMJAY. 60 of them are from Maharashtra, and 46 are from Uttar Pradesh.
- As per the Times of India, dated 30/08/2019, a massive 45 lakh claims were intimated worth Rs 2600 crores under PMJAY which was scrutinised with the suspicion of fraud in the state of Rajasthan
- As per the Times of India dated 06/08/2022, 26% of the fraudulent cases of PMJAY hailed from Punjab and Haryana. Union health ministry and state agencies has detected 24152 fraud claims out of which 6161 belongs to Punjab and Haryana alone. Chhattisgarh, Madhya Pradesh, and Punjab are leading the list.
- As per NDTV dated 04/01/2020, about 20,000 fraudulent names were cancelled from the beneficiary list of PMJAY after it was detected that those fraudsters were not even eligible under the scheme in Gujrat
- Economic times, dated 07/10/2016, Gujarat may have gained a reputation as the finest place in the nation to conduct business, but when it comes to insurance policy holder behaviour, it is among the worst due to poor behaviour.
- Hindustan Times, 02/03/2017, the state of Gujrat, has become one of the fraud-prone regions with 30% of claims were filed within 30 days of the person becoming insured under this programme.

Why are insurance frauds increasing? —A survey by Deloitte India

- According to Deloitte's Insurance Fraud Survey 2023 dated 17/02/2023, About 60 per cent of the respondents believe that there has been a significant rise in fraud, while a further 10 per cent said they experienced a marginal increase in fraud.

- According to the survey, some major variables for fraud include increased digitization (34%) and remote working following the pandemic (22% each).

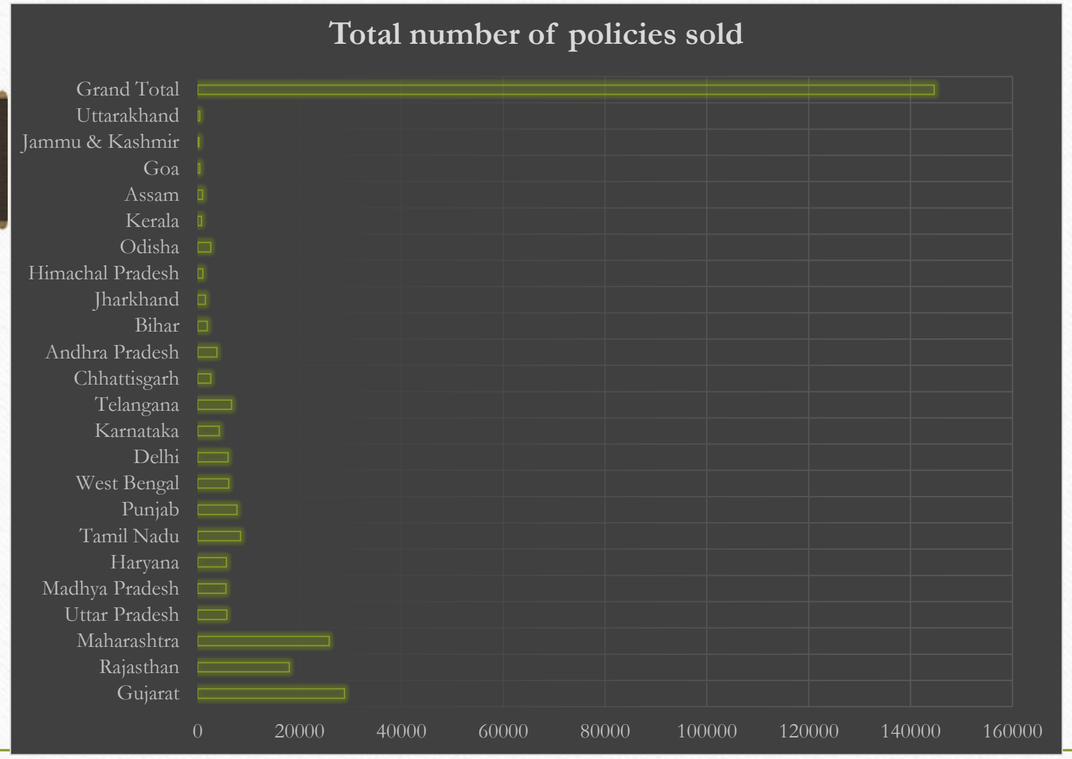
- The data shows that fraudsters are growing more tech savvy and are coming up with novel techniques to commit fraud. According to respondents in their poll, more digitisation and remote working are the main causes of an increase in fraud instances, followed by weaker controls

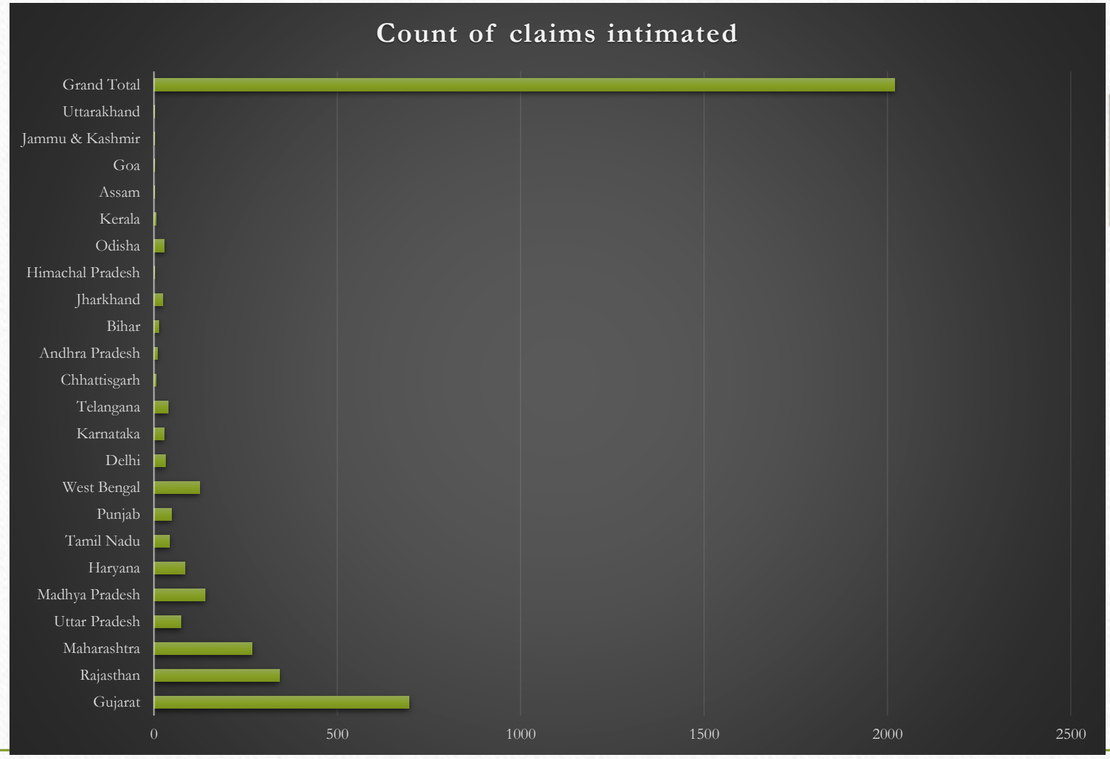
RESULTS

The states of Gujrat, Rajasthan and Maharashtra have the highest number of policies sold and hence the highest number of claims received.

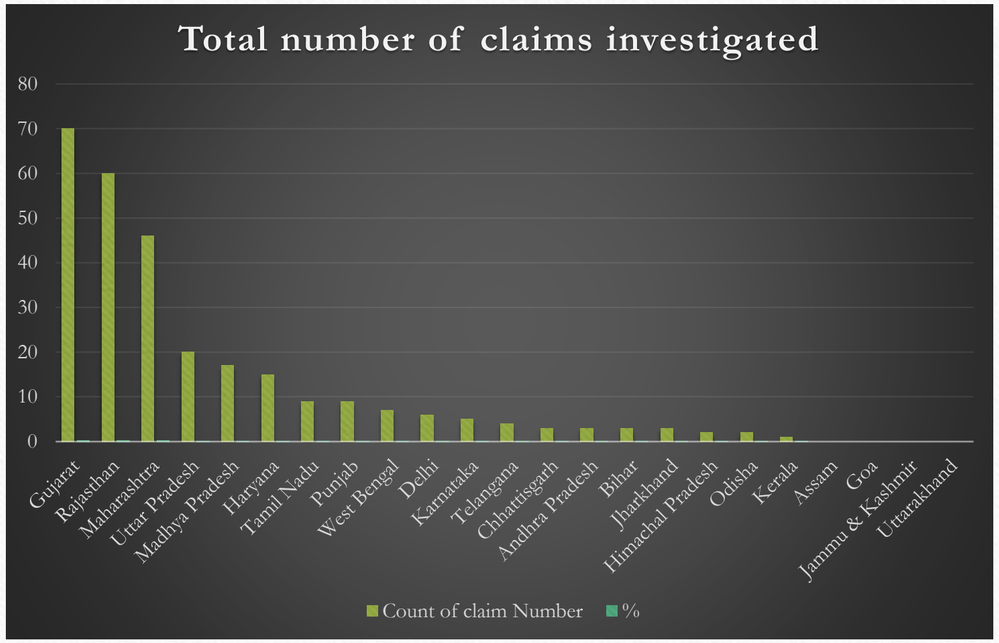
The state of Uttar Pradesh, Madhya Pradesh, Haryana, Tamil Nadu, Punjab, West Bengal, Delhi, Karnataka, Telangana has approximately same number of policies been sold during the for FY.21 to 23.

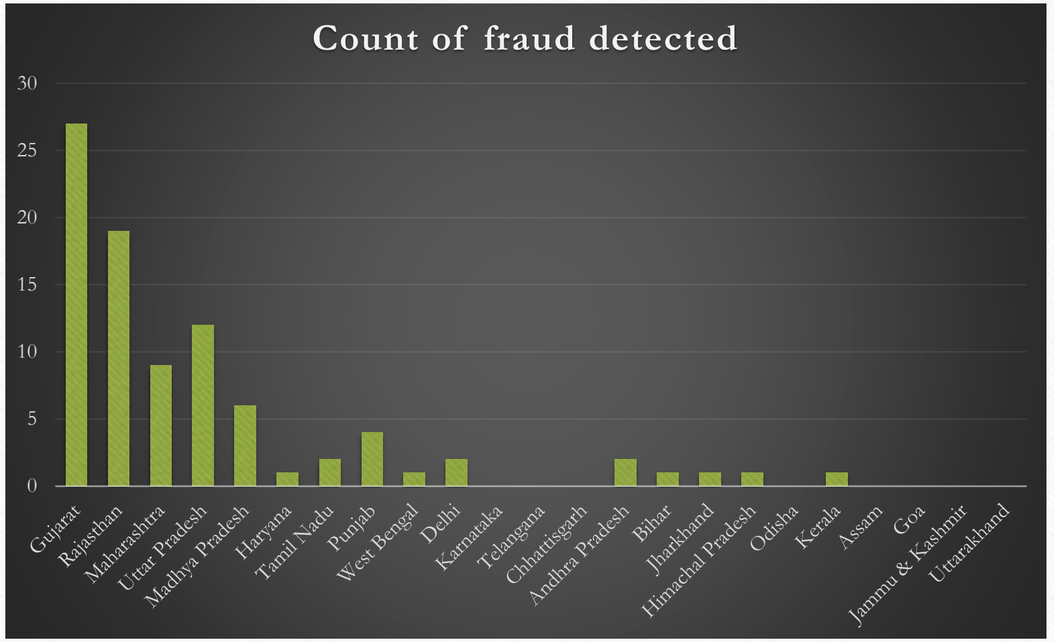
But it is noteworthy to state that the claim intimation is higher from the states of Madhya Pradesh, Haryana and West Bengal.





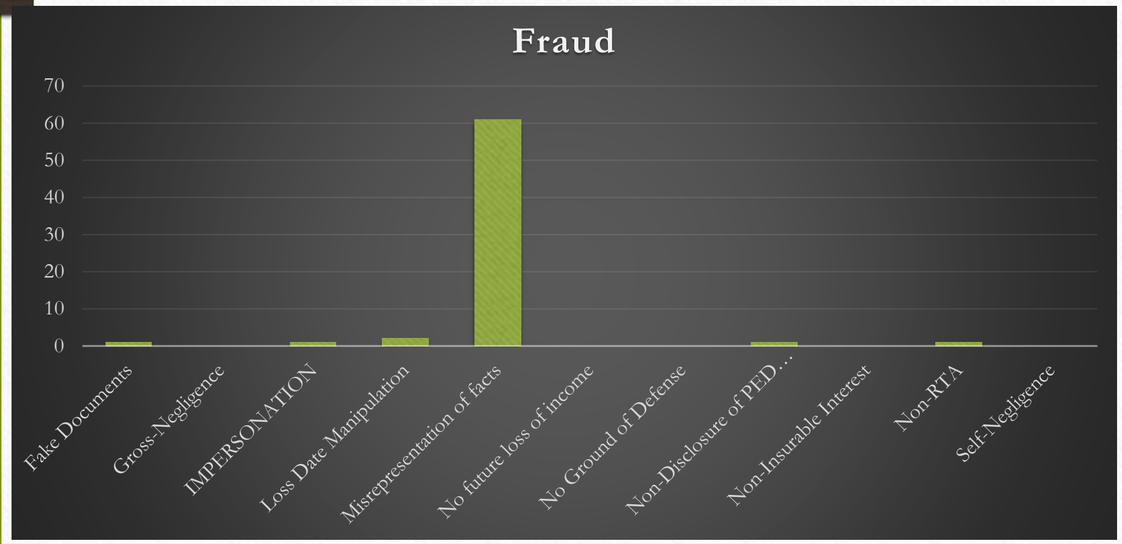
- The highest number of alleged suspected claims were found in the state of Gujrat, Rajasthan, Maharashtra, Uttar Pradesh, Madhya Pradesh and Haryana which were further investigated by the SIU team.
- It further co-relates with the fact that this above-mentioned state has high number of policies being sold in the region.
- The state of Gujrat, Maharashtra, Uttar Pradesh, Rajasthan, Madhya Pradesh and Punjab has high tendency of fraudulent activities and high percentage of frauds being detected.
- The fraudulent activities detected are seen concentrated in the urban areas like that of Ahmedabad, Surat, Jaipur, Indore, Ludhiana etc.





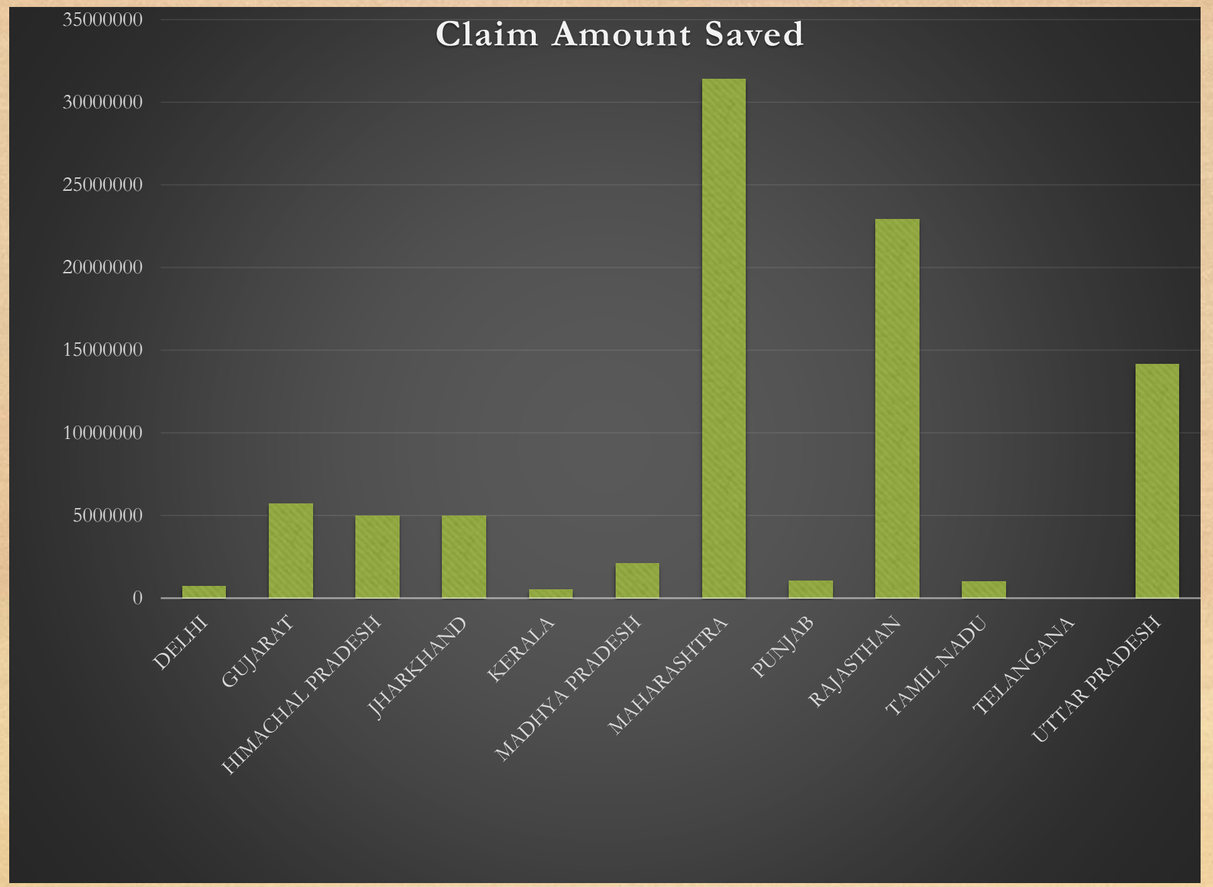
- Approximately >90% of the claims were proved to be of fraudulent nature due to the misrepresentation of the facts.

- **Definition of misrepresentation of the facts:**
  Getting into a contract with a person or a company on false grounds by making statements that are not in accordance with the facts is known as misrepresentation. In an insurance policy, misrepresentation on the behalf of the insured gives the insurance company a right to terminate the policy.



IMPACT OF THE FRAUD DETECTION

In total Rs 89589698 were saved only in the IPA policies of ACGP, ACG, AS policies during the two financial years, highest being from, Maharashtra, Uttar Pradesh, Rajasthan and Gujrat.



CONCLUSION

The study was conducted to identify the following factors:

To identify the suspected areas which have larger volume of policies sold.

- The Individual personal accident policies of Accident guard plus, Accident Guard and Accident shield were sold across the country with highest number of policies been sold in the State of Gujrat, Rajasthan, Maharashtra, Uttar Pradesh, Madhya Pradesh, Haryana, Tamil Nadu, Punjab, West Bengal, Delhi, Karnataka, Telangana.

To identify the area who has a greater number of claims intimation.

- The highest claims were intimated from the states of Gujrat, Rajasthan, Maharashtra, Uttar Pradesh, Madhya Pradesh, Haryana, and West Bengal.
- This finding further indicates that the higher number of claims were intimated from the regions where higher number of policies were sold.
- Out of the total number of the policies sold, a total of 2019 claims were intimated, which is 1.40% of the total policies sold.

Suggestion

- The analysis shall be done to understand the cause of the policies being sold only in a particular area in a large quantity to understand if there is any fraudulent intention of loop hole are identified by the fraudsters.
- Further the same shall be corrected and efforts should be taken to have a uniform distribution of the policies across the country.
- The trend of the claim intimation should be studied and to understand the pattern of the claim intimation from the areas of the country.
- The regional offices of the company shall be given advisories from time to time based on the trend analysis.
- The identified areas should be put under strict scrutiny of each n every claim to be either investigated or verified.
- Underwriting changes should be accordingly in the areas from where a greater number of claims are been intimated

CONCLUSION

To identify the areas which are more prone to fraudulent activities.

- Out of the total claims received, 285 claims were investigated with alleged suspicion of frauds.
- The highest number of alleged suspected claims were found in the state of Gujrat, Rajasthan, Maharashtra, Uttar Pradesh, Madhya Pradesh and Haryana which were further investigated by the SIU team.
- The result of the investigation carried out by the SIU unit of TATA-AIG General insurance company found that the state of Gujrat, Maharashtra, Uttar Pradesh, Rajasthan, Madhya Pradesh and Punjab has high tendency of fraudulent activities and high percentage of frauds being detected.
- Further it was noticed that the concentration of the claims was into the urban areas.
- The study is congruent to the trend of the fraud in health insurance across the country and effective preventive measures are needed to be taken to halt the financial loss.

Suggestion

- A dedicated cell of SIU should be established in each state and regional office of the identified areas and a strict legal action should be taken to set an example.
- The motivation to commit a fraud should be discouraged and a proper information should be spread amongst the policy buyers during the sale phase about the impact of frauds.

CONCLUSION

- The AB-PMJAY implemented across the country has found to have large number of fraudulent activities.
- The states of Maharashtra, Rajasthan, Gujrat, Haryana, Uttar Pradesh are found to have been mostly affected.
- The trend of the fraudulent activities matches with that of the frauds in the private health insurance.

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