MAX Bupa HEALTH INSURANCE

STUDY TO IDENTIFY AND ANALYZE THE OVERRULING IN CLAIMS

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INTRODUCTION

- Health insurance can be defined as a contract where an individual or group purchases in advance health coverage by paying a fee called “premium”. Health insurance refers to a wide variety of policies. These range from policies that cover the cost of doctors and hospitals to those that meet a specific need, such as paying for long term care.
- Health insurance business is classified into Government Sponsored Health Insurance, Group Health Insurance (Other than Government Sponsored) and Individual Health Insurance.
- Health insurance in India typically pays for only inpatient hospitalization and for treatment at hospitals in India. Outpatient services were not payable under health policies in India.

STUDY BACKGROUND

- The claims team intimates or triggers a claim to the F&I for investigation and a report is submitted by the investigator to the F&I team which then does the QA and submits the report by adding their remarks in the claim recommendations section. The claims team then studies the report and comes to a conclusion of whether to approve the claim or not.
- In some instances, the opinions differ, which is termed as overruling.
- There are two types of overruling:
  - **Deny to pay (Positive overruling):** wherein the F&I recommend to deny the claim but the claims team decides to pay.
  - **Pay to deny (Negative overruling):** wherein the F&I recommend to pay but the claims team denies.
- As the philosophy of MBHI to pay every genuine claim and to deter every fraudulent claim, the philosophy needs to be developed, accepted and implemented across.

STUDY BACKGROUND (cont..)

- ❖ The study focuses on identification of reasons of overruling. Some of the reasons are as follows:
- Hospitalization only for evaluation purpose or Hospitalization not justified
- Absence of mandatory documents
- PED/ND
- Misrepresentation of facts
- Policy Exclusion
- Unrecognized provider
- Non-cooperation
- ❖ Majority of the deny to pay claims are because of some Pre-existing disease or Non-Disclosure of material facts (PED or ND) which is the main focus of the study.
- ➢ **Pre-existing disease** is a condition, ailment or injury that already exists at the time of buying a health insurance policy. Conditions such as DM, Epilepsy, CKD etc. are some of the pre-existing health conditions.
- ➢ **Non-Disclosure** refers to that situation where a customer fails to reveal a relevant fact when applying for or renewing an insurance contract.

OBJECTIVES

To strengthen the philosophy of MBHI for F&I and claims.

To identify potential financial leakages.

To establish an understanding of overruling decisions of claims and F&I

OUTLINE OF THE STUDY

- This study was performed using secondary data of past four months from 1st January, 2020 to 30th April, 2020. Firstly, categorization of the claims was done on the basis of fraud categories to find out the most common category under which claims were denied but were paid. All the Group Health Insurance (GHI) claims were excluded from this study. After the categorization it was identified that majority of the claims were denied under the PED/ND category (56%).

- All the PED and ND cases were then separated and were categorized into Related/Non-Related and Material/Non-Material respectively. The cases which were related to the diagnosis and were proven fraud under PED and were paid instead of getting denied were filtered in Excel and the sum amount of those claims was calculated. The same was done for all Related Material ND cases to fulfill the objective of prevention or reduction of financial leakages in the organization.

RESEARCH METHODOLGY

Study Design:
Observational

Study Duration:
February, 2020 to May, 2020 (3 months)

Sample Size:
194 cases of PED/ND out of 345 total cases

Sampling Technique:
Purposive sampling

Data Period:
4 months (January 1,2020 to April 30,2020)

Data type:
Secondary

Inclusion criteria:
Reimbursement and Deny to Pay claims

Exclusion criteria:
Pre-auth, Pay to Deny, Spot RM and GHI claims

Study Setting:
F&I Department of MBHI

RESULTS

DIFFERENT CATEGORIES OF INSURANCE FRAUD:

1. **Pre-existing Disease or PED** is defined as a condition, ailment or injury that already exists at the time of buying a health insurance policy. Conditions such as DM, Epilepsy, CKD etc. are some of the pre-existing health conditions.

2. **Non-Disclosure or ND** refers to that situation where a customer fails to reveal a material fact when applying for or renewing an insurance contract.

3. **Policy Exclusion** is a provision that eliminates coverage for some type of risk. The insurers make policy exclusions to narrow down what is covered and what is not covered in the policy. There are some waiting periods applicable in the policies such as 30 day waiting period, PED waiting period in which if the insured has a pre-existing condition then he has to wait for a specific time to claim for that condition after which it will get covered in the policy, a specific waiting period and a personal waiting period. There are some permanent exclusions also that are not paid under any circumstances.

RESULTS

4. Misrepresentation of facts, as its name suggests, is the discrepancy in the information provided to the insurer by either a customer or a provider.

5. When an insured is admitted in a Hospital just for the purpose of evaluation and investigations and does not undergo any form of treatment then it is said that the Hospitalization is not justified.

6. Non-cooperation can be from a customer in the form of not providing information or not answering the investigator's questions or it can be from the provider in the form of not providing the investigator the complete set of ICP and investigation reports required for investigation.

7. Unrecognized providers are those providers that do not fulfill the criteria set by the organization.

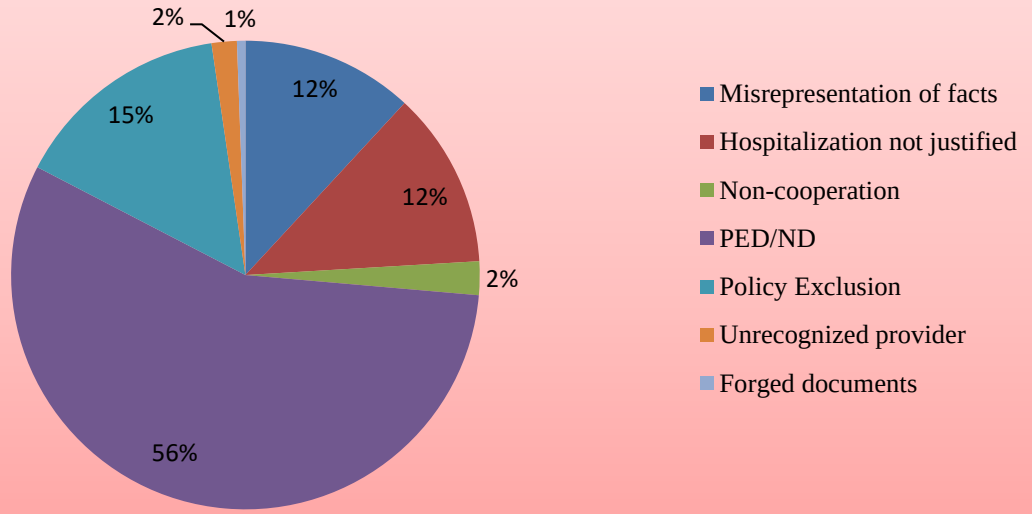
RESULTS

Categories	Number of cases	Percentage
Misrepresentation of facts	**41**	**11.88**
Hospitalization not justified	**42**	**12.17**
Non-cooperation	**8**	**2.32**
PED/ND	**194**	**56.23**
Policy Exclusion	**52**	**15.07**
Unrecognized provider	**6**	**1.74**
Forged documents	**2**	**0.58**
Total	**345**	

The table shows the number of cases from different categories of Fraud under which claims are denied. It is clearly shown that the highest numbers of cases, that is, **194 cases out of 345 are denied under the PED/ND** category where PED stands for Pre-existing diseases and ND stands for Non-Disclosure.

RESULTS

Percentage of cases denied under different Fraud categories



RESULTS

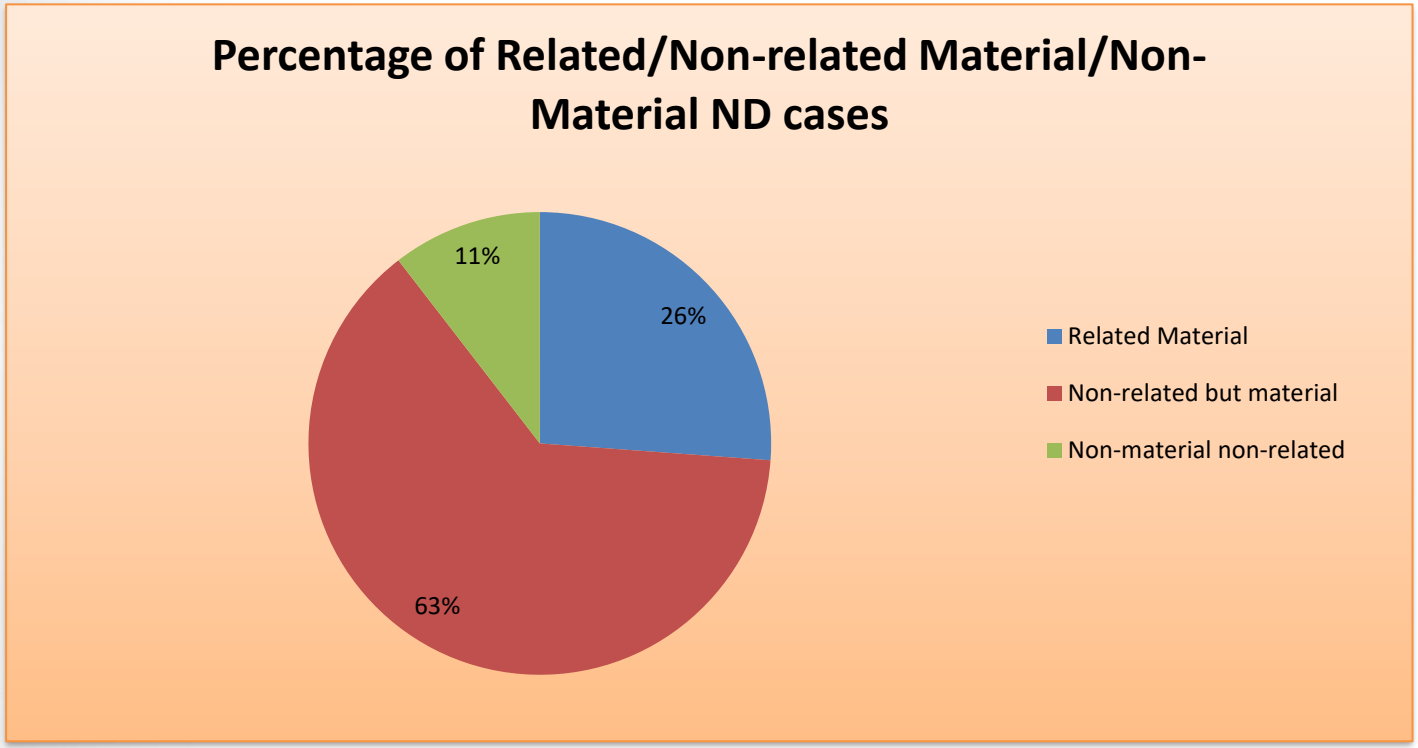
PED	No. of cases	Percentage
Related	20	90.91
Non-related	2	9.09
	22	

The above table shows the number of Related/Non-related PED cases.

Out of the 20 cases in which the pre-existing condition was related to the current diagnosis, 10 cases were such that were either covered in the policy or were cases of acute conditions and 10 cases were such which should have been denied instead of being approved.

The amount of money that could have been saved if those 10 claims had not been paid was calculated in Excel and it came out to be **Rs. 9,75,294/-**

RESULTS


Percentage of Related/Non-related Material/Non-Material ND cases
11%
26%
63%
Related Material
Non-related but material
Non-material non-related

RESULTS

- Material facts are those conditions that can have a long term effect or an increased morbidity in the health status of an individual. Some of the conditions that are material non-disclosures are HTN, DM, Hypothyroidism, COPD/Asthma, IHD etc.

- The above pie diagram shows that **26%** of the total Non-Disclosure cases were Material non-disclosures and also were related to the current diagnosis of the insured.

- Here also, the amount that could have been saved was calculated and recorded in Excel and it came out to be **Rs. 9,752,778/-**

- The total financial leakage which could have been saved under the PED/ Non-Disclosure category alone was **Rs. 10,728,072/-**

CONCLUSION

- The denial of claims in Health Insurance in no way means the denial of treatment. Approval of claims is a multi-step process and requires time, money and manpower. Claims are triggered for investigation in order to verify the admission and insured details. The F&I department has a responsibility to do a complete review of a claim after the investigator shares his/her report and provide recommendations or remarks in the report before sending it for a final review to the claims team. The recommendation may be to reject a claim if fraud is proven during investigation or to raise a query if certain documents are not provided by the provider or to approve a claim if no discrepancy found and the claim seems genuine.

- However there often arise some instances where there are differences in opinions of the claims and F&I team which is usually called Overruling. Both the departments have a different point of view and different philosophies regarding claims processing.

CONCLUSION

- In the study, secondary data of all the overruled cases from the month of January, 2020 to April, 2020 was collected and analyzed. The total size of the data without any exclusions was 445 and after excluding all the negative overruling and GHI claims the total data size became 345.

- Out of those 345 claims categorization was done based on denial of claims under different fraud categories, the result of which was that almost 56% of the claims (194 out of 345) were denied under the PED/ND category, 15% of the cases are denied under Policy Exclusion, 12% cases each are denied under Misrepresentation of facts and Hospitalization not justified, 2% cases each are denied under Non-Cooperation and Unrecognized Provider, Only 1% of the total cases are denied under the Forged Documents category. Hence the focus of the study became all the PED/ND cases that were denied by F&I but were paid by claims.

- The next step in the study was that all PED/ND cases were separated, which means, PED cases were analyzed separately and ND cases were analyzed separately. After the division of claims out of 194 cases, 22 were that of PED and 172 were that of ND. Further PED cases were divided into Related (20 cases) and Non-Related (2 cases) and ND cases were divided into Related Material (45 cases), Non-Related but material (109 cases) and Non-Related Non-Material (18 cases).

CONCLUSION

- All the 20 Related PED cases as well as the 45 Related Material cases were studied carefully and it was found that among the 20 Related PED cases 11 claims were such in which the decision taken by the claims team to pay the claim was correct (PED covered, acute conditions etc.) but 9 claims were such where the claims should not have been paid.

- The potential financial leakage was identified and calculated by summing up the amount of those 9 Related PED claims and it came out to be Rs. 9,75,294/-

- The same was done for all the Related Material Non-Disclosure cases and the amount calculated was Rs. 9,694,937/-

- The total financial leakage that could have been saved came out to be Rs. 10,728,072/-


Thank You