College of Insurance, Insurance Institute of India, Mumbai

Workshop on Fraud and Abuse control in health insurance – Feb 23rd-24th, 2012

Detailed Report on Sessions, speakers, Group work, Deliberations

Day 1

1000-1015 Welcome by Shri PK Rath, Director, College of Insurance

1015-1045 Keynote address by Shri R Chandrasekaran

Secretary General, General Insurance Council

Session I

1100-1145 Setting the Context & Agenda for the Workshop, introductory PPT,

Changing face of fraud and evolving techniques of detection/prevention

Speakers Dr George Thomas, Insurance Institute, Malti Jaswal,

Shri U Jawahar, IRDA, Dr Nayan Shah, Paramount TPA

Session II

1145-1300 International Experience – Discussion on underwriting practices, provider network & fraud management by TPAs, anti-fraud forums, etc.

Speakers Jennifer Nuelle Dimoulas, Nextcare TPA, Alam Singh, Milliman India,

Jagbir Sodhi, SwissRe

Moderator Sanjay Datta, ICICI Lombard

1300-1315 Formation of 4 groups from all participants (each with representation of stakeholders/relevant expertise, led by experts/faculty)

Group I – Universal definition of Fraud/Abuse/Leakage,

Key players in perpetrating fraud, roles & controls

Group II - Methods/best practices of fraud prevention & detection – IT,

Trend watch, Scoring, Analytics, Investigation, audit, training etc.

Group III – Action against fraud - role of each stakeholder,

Creation of additional social pressure – publish, expose etc.

Recovery of money, punitive and legal measures, establishment of anti-fraud forum, law & policy etc.

	Group IV - Fraud prevention in Mass Insurance schemes of the Govt
Session III	
1400-1530	Group work in Syndicate Rooms
Session IV	
1545-1700	Provider Perspective on healthcare fraud, discussion followed by
	Participants Q&A
Speakers	Dr Bhujang, Harkrishan Hospital, Dr Manoj Gupta, Consultant
	Dr Nayan Shah, Paramount TPA, Dr Gayatri, Director NABH
Moderator	Dr V Ranjan, Consultant
1700-1715	Wrap up Day 1 – Malti Jaswal
Day 2	
Session V	
1000-1030	Fraud control – Verification & Investigating agencies perspective
	Presentation and discussion followed by participants Q&A
Speakers	Dr Bangal, EMC Investigating Agency, Dr Ashish Dogra, Jupiter Hospital
	Nazeem Khan, ICICI Lombard,
Moderator	Dr B S Powdwal, Bajaj Allianz
Session VI	
1030-1115	Presentation by Group I, followed by full house participation
Moderators	Abhijeet Chattoraj, NIA, Sanjay Dwivedi, ICICI Lombard, Dr Anurag Srivastva, Future Generali
1130-1215	Presentation by Group II, followed by full house participation
Moderators	Dr Ravi Kumar, TTK TPA, Rohit Kumar, Max Bupa,
1230-1315	Presentation by Group III, followed by full house participation
Moderators	Rudraraju Rajagopalan, Apollo Munich, Amulaya Dash, Reliance General Insurance, Dr V Ranjan, Consultant
1400-1445	Presentation by Group IV, followed by full house participation
Moderator	Nishant Jain, GIZ, Nazeem Khan, ICICI Lombard, Bhaskar KU, Cholamandalam General Insurance, Dr Abhijit Jadhav, MD India, K Ganesh, United India

Session VII

1445-1530	Fraud Control – IT Interventions and Solutions
	Discussion followed by participants Q&A
Speakers	Gayathri Menon, Cognizant, Harbinder Singh, HCX, Mehul Kapadia, Mastek
Moderator	Alam Singh, Milliman India

Session VIII

1545-1645	Way Forward - Discussion and Open House
	Formation of anti-fraud forum, Publishing White Paper and Best Practices
	Guide, sharing information/data exchange platform
Speakers	K Murali, L&T Insurance, K Prabhakaran, United India Insurance,
	Dr Nayan Shah, Paramount TPA, Alam Singh, Milliman India,
	Dr Thomas George, Insurance Institute
Moderator	Malti Jaswal

1645-1700	Valedictory Address, Shri P K Rath, Director, College of Insurance, III

Annexure - Group Work – Discussion Topic and presentation contents

Group I Universal definition of Fraud/Abuse/Leakage, Key players in perpetrating fraud, roles controls. The key purpose is to define the exact problem and its root cause so that it can be effectively addressed

Suggested Minimum Output of the Group for Presentation

1) Define what constitutes

fraud, abuse, leakage as distinct from each other,

2) Specific contribution in detail to each type by

- sales/marketing team, agency force,

- Underwriting lapses, product features,

- Customer's lack of awareness/deliberate acts,

- Healthcare provider practices

3) Ways & means to control above behaviour of different parties

Group II Methods/best practices of fraud prevention & detection – IT, Trend watch, Scoring, Analytics, Investigation, audit, training etc.

Suggested Minimum Output of the Group for presentation

1) List the Prevention/Detection Methods, Control measures

2) Relevance of specific method for particular function e.g. u/w, claim,

provider practices,

3) Common triggers, Red Alert for specific function/controlling specific type

of fraud/abuse/leakage

4) Best practices for key methods – investigation, audit, analytics, scoring etc.

5) Tools required/deployed – IT, trained manpower etc.

Group III Action against fraud - role of each stakeholder, Creation of additional social pressure – publish, expose etc. Recovery of money, punitive and legal measures, establishment of anti-fraud forum, law & policy etc.

Suggested Minimum Output of the Group for the presentation

1) what is the current action post detection of fraud?

2) Is that adequate and effective in further abatement

3) What other methods should be adopted by industry for deterrence of fraud, in influencing the perpetrator behaviour

4) What kind of sharing mechanism can be developed at industry? Level, what could be shared – best practices, case studies, Self- audit guide, and investigation technology, triggers, Red Alerts developed, rogue hospital/customer/intermediary list

5) Punitive and legal action framework, current and ideal, influencing/ lobbying with policy makers for effective laws – industry White Paper, publishing data etc?

6) Anti-fraud forum – constitution, role, responsibility, powers to pursue – publish, punish, punitive action

Group IV Fraud prevention in Mass Insurance schemes of the Government

Suggested Minimum Output of the Group for the presentation

1) How fraud in mass scheme different & easier than private health insurance – welfare schemes promoting utilisation, wide publicity and awareness campaigns by government, political & social issues, easy process, difficult to measure fraud as beneficiary not involved in claim/cashless process

2) How to measure fraud in social schemes, what parameters to use as all benefits covered, no exclusion, no waiting, no co-pay

3) Ways to detect/prevent fraud in RSBY, SAS, Arogyasri, TN Scheme

4) Triggers, Red Alerts & process to control fraud in above schemes

5) Special role of government agencies/nodal agency in supporting insurance company initiative

Annexure - Notes and Deliberations

1. Shri R Chandrasekaran, Secretary General, GI Council

    - GI Council keen to support work on controlling fraud and abuse
    - Industry needs to view fraud from perspective of customer, bring out products with clear benefits and terms
    - Impact of fraud on product pricing, penetration
    - Estimation of loss due to fraud, leakage
    - Measures and remedies to deal – internal, external
    - Stringent laws dealing with issue elsewhere in the world
    - Monthly newsletter for sharing of information among industry players
    - Collation/publication of case studies, modus operandi of fraud

2. Shri PK Rath, Director, College of Insurance, III

    I. III willing to be nodal agency to carry forward work except for publishing fraudsters names

    II. Will help in developing matrix of deviations, case studies, types of frauds being committed etc.

    III. Willing to undertake research, impact studies to help industry

    IV. Industry should establish framework like that existing for Banks, Housing companies under RBI, NHB

3. Shri U Jawahar, IRDA

    I. Role of industry, all stakeholders in controlling fraud

    II. Perception of insurance industry, its services, especially on claims side with customers, legal forums, consumer bodies, need for industry to introspect

    III. Database like CIBEL, declined lives should be helpful in containing fraud and protecting genuine customers

    IV. All efforts to contain fraud, jointly by Regulator (IRDA already in the process of setting up database), industry bodies like GI & LI Councils, industry players

4. Participants, Panel Speakers, Moderators

I. Welcome initiative by III to bring together industry for common cause, first ever workshop with high level of participation by all, should be made an annual event, invite international forensic experts, participation by legal department of insurers, two days insufficient to discuss issues in-depth, to carry out detailed discussions.

II. III should continue to play nodal agency role in the sphere, especially publishing data, best practices, knowledge and information dissemination, in providing common neutral platform for all.

III. Industry players willing to work jointly for contributing to sharing platform, may be health underwriters group can be expanded to health claim managers (LI Council has several sub groups – risk managers, claim managers, compliance etc.).

IV. It is important to adopt smart and effective underwriting techniques to control fraud at proposal stage.

V. Internationally healthcare insurance fraud rampant, difficult to control medical providers and practioners. TPAs and insurers facing similar issues.

VI. Use of technology, IT solutions, better claims management, analytics, investigations, anti-fraud forums with legal powers, punitive action, niche agencies (charging small fee per policy) to pay for effective fraud control, use of forensic experts, certified fraud controllers etc. by insurance industry to curb health insurance fraud all over the world

VII. Definition of fraud, abuse and leakage should be defined in the policy in the absence of legal definition so that there is consistent application of the same, easier to defend the same with courts, consumer forums. GI Council to be approached for the definitions agreeable to the industry and road map to be developed for adoption.

VIII. A White Paper should be brought about if possible to put perspective on issue from various aspects and suggested framework to deal with the same.

IX. Study on estimation of fraud – the extent, the quantum, the volume, the impact and the various methodologies used by fraudsters should be studied by a professional research/academic team to help raise awareness on the issue and joint action by the industry, to press for change in policy and law as need be

X. Most organisations – insurers and TPAs do not have a written, documented policy framework to manage/control fraud, leading to adhoc-ineffective measures which fail to establish robust mechanism companywide which is consistent and action oriented. Sometimes managers oscillate between leniency and tight controls (doubt every customer), petty fraud caught while big fish, systemic fraud undetected, potential to scare genuine customers.

XI. Investigating agencies – issues faced by investigating agencies - no authority to get information, non-cooperation from hospitals (use MCI format for information covered under Ethics code), dearth of good trained investigators, industry should develop standard investigation format, use of mobile technology for concurrent investigation and permission to use certain gadgets e.g. spy camera, recorders etc., legal provisions/permissions for investigation of claims, call for documents, question the hospital/treating doctor, payment of adequate fee for investigations, paper investigation vs. effective/actual investigation, there should be mandatory training/certification of investigators by IRDA as necessary for surveyors, agents etc., MCI guidelines section 1.3.2 (code of ethics) makes it mandatory for a health provider/ medical practioner to provide requested information to patient or authorised representative within 72 hours of request failing which it is construed as misconduct under section 1.7.

XII. Providers perspective – genuine providers clubbed with dubious ones, insurance industry unaware about hospital pricing issues, MCI and NABH could offer help in sharing quality parameters (and information provided by accredited hospitals on monthly basis – length of stay, infection rate etc., need to be explored), transparency and trust required in contracts and dealing between hospital and insurers/TPAs, some of the malpractices on the part of providers can be traced to contracting, NABH involvement in grading of hospitals for pricing purpose, policy to pay for same cost to non-network hospitals also to remove dichotomy between network hospital and non-network hospital, whether possible to backward integrate IIB data – provider cost for different line of treatment, joint audit/inspection of hospitals by insurers/TPAs

XIII. Whistle blower facilitation – there needs to be mechanism for whistle blower facilitation – toll free/helpline to enable genuine people to report malpractice, fraud and abuse cases on confidential basis without fear of repercussion by perpetrator. IRDA Health Forum/GI Council should look into the same. Entire guidelines – process from receiving intimation to sifting of cases, investigation and action should be documented and approved by industry body for uniform implementation

XIV. Triggers & Scoring methodology, case studies and best practices – should be collated and shared through a common platform, III should facilitate the same. Though dynamic and updated on regular basis, If the triggers can be standardised by the industry, the effectiveness of practices, data etc. can be analysed. It would also be possible for IT companies to offer solutions around the same, they should also develop proof of concept for functionality and effectiveness of triggers. The database of case studies, black listed hospitals etc. should be in searchable format, not copy-paste of long word documents/PDF files

XV. Mass policies need different mechanism, government agency/nodal agency support critical, software slippages should be identified to plug fraud – multiple blocking in same day after completing transaction each time

XVI. Anti-fraud forum – cooperation of all insurers required, should be developed under aegis of GI Council, report cases, take action, legal recourse, pursue recovery, to lobby for stronger laws. Beginning can be made by forming a core group with sharing of email ids and a coordinating agency. A small group on Google already sharing information on published cases.

XVII. Single view of customer required – across products, across insurers, thus sharing of information inter and intra company essential.

XVIII. Complicated products leading to misselling and consumer education issues, simple products with comparable covers and clauses like Marine A, B, C can be developed, add on benefits need not temper with basic product

XIX. Strict and punitive action, pursuing recovery, publishing the names, dismissal from job (e.g. dismissal of an employee who avails of fraudulent claim under group health), ring fencing the offenders etc. would send strong message to all, to refrain from similar activity as it entails strong legal, economic and social repercussions.

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