SPEAKING NOTES ON HEALTH INSURANCE FRAUDS

In the emerging Insurance scenario in India, pricing and claim servicing will decide where an Insurance Company stands. In fact, in the days to come, claim cost will have a direct bearing on the pricing. Leakages and frauds on account of claim / underwriting will adversely affect the claim experience, which in turn will affect the pricing. Because of the misdeeds of a few and because of the lack of effective control by the Insurance Company, the genuine customers, who constitute the majority, will have to pay higher prices for Insurance Products than is actually warranted. In an open market with lot many option available, the consequence are very obvious. Not only because of higher prices it will deter new customer to come – even existing client base will start dwindling. It is, therefore, essential for their own survival that Insurance Companies formulate a claim management philosophy where concern on account of leakages and frauds are taken care of properly. A transparent claims management policy in fact can be a good market strategy also.

As long as there has been Insurance, there have been Insurance frauds. Let's accept the fact that the leakages and frauds cannot be eliminated altogether. But let's also accept the fact that they can be managed, controlled and kept within a limit.

In common parlance fraud is associated with dishonesty, breach of trust, criminal deception, misappropriation, etc. However, "fraud" is not defined in I.P.C. But we can say that "Whenever there is intention to deceive and by means of deceit to obtain an advantage there is fraud". If we extend this

concept to Insurance, then any act aimed at making profit from an Insurance contract constitute "Insurance fraud", e.g. Non-disclosure of material fact with the intention of:

- Getting reduced Insurance Premium – rate
- Getting claim settled, which otherwise could not have been possible.

Of late, there have been spurt in Insurance related frauds and this cannot be viewed in isolation, as this also reflects on the shortcomings in the society we live in and partly explains the spurt. Economic disparity, unemployment falling moral values, materialism, etc. in their own way give rise to white collar crime in society.

What is a fraudulent Insurance claim?

An Insurance claim prepared with the intention to deceive, conceal or distort relevant information that eventually accounts for Health care benefits for an individual or a particular group is defined as fraudulent Health Insurance claim.

Fraudulent and dishonest claims are a major morale and a moral hazard, not only for the Insurance Industry, but even for the entire nation's economy. Concrete proof as evidence including documentation, statements made by the Policyholder and his family members and even neighbours are taken into consideration.

Frauds committed by a Policyholder could consist of members that are not eligible, concealment of age, concealment of pre-existing diseases, failure to report any vital information, providing false information regarding self or any

other family member, failure in disclosing previously settled or rejected claims, frauds in physician's prescriptions, false documents, false bills, exaggerated claims, etc.

Essential Components of Health Insurance Fraud

The essential components of fraud include intention to deceive, derive benefits from Insurance Industry, preparation of exaggerated or inflated claims or medical bills and malafide intention to induce the firm to pay more than it otherwise would. Devising innovative methods and tactics including pressure tactics, favouritism, nepotisum, etc. form a part of fraud, which is a hazard growing by leaps and bounds since the last decade.

Frauds by Healthcare Provider or its employees include preparation of bogus claims by fake physicians, billing for products or services not rendered, exaggerated claims submission, billing prepared for higher level of services, modifications or alterations made in submission of claims, change in diagnosis of the patient, fake documentation, and fraud committed by the employees of a hospital or any other Healthcare product / service provider in order to make a quick buck.

Broad Statistics in India and USA

According to a recent survey, it is estimated that the number of false claims in the Industry is approximately 15% of total claims. The report suggests that the Healthcare Industry in India is losing approximately Rs.600-Rs.800 crores incurred on fraudulent claims annually. Health Insurance is bleeding sector with very high claims ratio. Hence, in order to make Health Insurance

a viable sector, it is essential to concentrate on elimination or minimization of fake claims.

Being always vigilant is the only Insurance to plug the leakages and frauds. Some studies made in USA a couple of years back reveal that in USA, insurer lose $120 billion annually as fraudulent claims and about 90% of this relates to Health Insurance. This obviously does not include cases not detected. The study further revealed that if Insurance fraud was a business it would rank 56th among the top Companies in USA. A very disturbing trend that was noticed was that most of the young respondents covered by the study did not see any wrong if the claims are exaggerated to cover Insurance premium / Policies, excess, etc. The position is not that alarming in India. However, MACT and Health segment claims are posing serious threats. In fact, in India no study has been made to assess the extent of frauds / leakages and what percentage it constitutes of the total claims paid. Any such study in reference to MACT and Health will bring out startling revelation.

How do you detect fraud (Fraud Indicators)

- Claims made shortly after the Policy inception;
- Serious underwriting lapses observed while processing a claim;
- Insured overtly aggressive in pursuit of a quick settlement;
- Willing to accept small settlement rather than documentation all losses;
- Documents of doubtful nature;
- Insured behind in loan repayment;
- Accident un-witnessed and not promptly reported;

- Invisible injury;
- High value leakage claim without any known casualty.

One of the main reasons that medical fraud is such a prevalent practice is that nearly all of the parties involved find it favourable in some way. Many physicians see it as necessary to provide quality care for their patients. Many patients, although disapproving of the idea of fraud, are sometimes more willing to accept it when it affects their own medical care. Programme Administrators are often lenient on the issue of Insurance fraud, as they want to maximize the services of their providers.

The most common perpetrators of Healthcare Insurance fraud are health care providers. One reason for this is that the historically prevailing attitude in the medical profession is one of **"fidelity to patients".** This incentive can lead to fraudulent practices such as:

Billing insurers for treatments not covered by the patient's Insurance Policy. To do this, physicians often bill for a different service, which is covered by the policy, than that which was rendered.

Another motivation for Insurance fraud in the Healthcare Industry, just as in all other types of Insurance fraud, is a desire **for financial gain**.

"Upgrading", which involve billing for more expensive treatments than those actually provided;

Providing and subsequently billing for treatments that are not medically necessary;

Scheduling extra visits for patients;

Referring patients to another physician when no further treatment is actually necessary;

"Phantom billing", or billing for services not rendered; and

"Ganging", or billing for services to family members or other individuals who are accompanying the patient, but who did not personally receive any services.

Fraud is committed by the Health Insurance Companies themselves.

Insurance Companies intentionally not paying claims and deleting them from their systems,

Denying and cancelling coverage,

Blatant underpayment to hospitals and physicians beneath what are normal fees for care they provide.

Although difficult to obtain the information, this fraud by Insurance Companies can be estimated by comparing revenues from premium payments and expenditures on Health claims.

The detection of Insurance fraud generally occurs in two steps. The first step is to identify suspicious claims that have a higher possibility of being fraudulent.

Fraudulent claims can be one of two types. They can be otherwise legitimate claims that are exaggerated or "built up", or they can be false claims in which the damages claimed never actually occurred.

For internal frauds:

- Strict adherence to system and procedure relating to underwriting and claims.

- Internal check and balances to be strengthened and strictly enforced.
- Severe punishment to guilty persons and speedy disposal of CDA cases.
- Apart from their traditional role and functions, IAD and Vigilance should prepare system of prevention rather than having whole heap of records.
- Developing culture of work place ethics / integrity in the organization.
- People in Insurance Company should be educated that their indifference towards the leakages and malpractices in their offices has serious implications for them also, apart from the organization.

For external frauds:

- Pursuits of civil litigation against these involved in fraud.
- Close cooperation with law enforcing agency.
- Seek the help of public spirited people / NGOs.

Let's develop a culture where it becomes difficult to commit fraud / leakages and get away with it. This is in the best interest of insuring public at large, the Insurance Companies as also the society. Claims settlement being a key service parameter, and therefore, while every effort should be made for speedy settlement of claims, a balance has to be maintained to ensure claims of doubtful nature are properly examined and looked into before they are passed.

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