Insurance Fraud - A Global Malaise

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Across the globe, health insurance is a tool that gives millions of people access to quality healthcare without burning a hole in their pockets. Patients, from those seeking medical aid because of an accident, to ones that are fighting a long battle against cancer, consider health insurance to be their primary financial support.

The Indian healthcare industry is pegged to reach USD 280 billion by 2020, recording a 16.5 CAGR. Following on the heels of this growth, the Indian health industry is also expected to grow 4 times in the next 10 years to USD 240 billion. This growth is encouraging as it translates to more people under the cover of insurance, but it also has a dark underbelly.

The vast amount of money involved and the lack of verification procedure while buying premium and settling claims has made the insurance industry a magnet for abuse, fraud and wastage. It is estimated that anywhere between 5 to 20% of all claims settled by insurance providers worldwide are fraudulent or wasteful.

One would think that countries with clearer laws would have fewer incidences of insurance fraud. Unfortunately, this is not the case, as malicious dealings in insurance claims have become endemic to most nations. The problem is worsened by the fact that it is possible for any of the three parties - the user, the provider and the payer to be in collusion while committing insurance fraud.

Let's look at a few figures related to insurance fraud over the past few years. The UAE's Mandatory Health Insurance law has gotten almost the entire population under the ambit of insurance. On the other hand, it has also caused a proliferation of malpractices. Experts believe that 20 to 30% of insurance premiums are spent in fulfilling bad or wasteful claims. This figure translates to more than USD 1 billion lost in dishonest settlements.

Similarly, Malaysia is also looking to crackdown on insurance fraudsters, which form upto 10% of all claims settled. The country launched a Fraud Intelligence System in 2017, which will become fully operational in the third quarter of 2018. This system is designed to use data to reduce the number of frauds and create a system of verification of claims. The reason for this is that the country's insurance service providers can no longer afford the flux of money to malicious claims. In 2016, it is estimated that insurance companies paid out over RM 580 million to just fraudulent motor insurance claims.

So how exactly does insurance fraud happen, especially in health insurance? Looking closely at fraud cases in India, Malaysia and the UAE, it is apparent that the modus operandi of fraudsters in various countries is shockingly similar. The following are the most commonly found types of insurance fraud by users and healthcare providers:

Users:

1. Falsifying reports and hiding pre-existing conditions while purchasing insurance
2. Claiming insurance for uninsured person(s)

3. Furnishing false treatment records for claim settlement
4. Inflating bills
5. Using other people's details for claims
6. Making false claims about accidents

Providers:

1. Unnecessary tests and treatments given to patients
2. Over treating in case of minor illnesses
3. Falsifying treatment papers and medical records
4. Providing false dates
5. Providing false details about the condition/accident
6. Falsifying certifications and specializations of medical providers
7. Performing unnecessary surgeries
8. Unbundling surgeries or tests to bill for a larger amount separately
9. Treating non-insured person on insured person's card
10. Inflating cost or amount of medicines used in treatment

In 2017, a doctor couple was arrested in Aurangabad for falsely claiming that they were labourers to get an accident claim worth Rs. 3 lakh. Even more shockingly, the police also busted a racket in which members of the police, lawyers and insurance company officials colluded to register false accident cases to claim insurance.

2017 also saw a Malaysian insurance company business manager being arrested for claiming and getting life insurance to the tune of RM402,500 for unrelated deaths not once, but twice.

In April 2017, 25 insurance law violators were fined from Dh 10,000 to Dh 80,000 for falsified claims. These included health service providers as well as insurance companies. Their activities were getting claims paid by altering the diagnosis, billing for services not performed, ordering unnecessary tests, misuse of health insurance card, etc.

These examples just go to show how brazenly people take advantage of a system designed to help patients in dire need of financial help. Insurance fraud has long reaching ill-effects on the insurance industry. On one hand, insurance companies are forced to increase the premium of honest users to offset the cost of fraudulent claim payments. On the other hand, it leads to compromised quality of healthcare. It also leads to wastage of precious man hours of insurance companies to verify or fight bad claims, and of genuine users trying to prove their veracity.

So, what is the solution to this increasing problem of insurance fraud? With growing technological advancements, data will prove to be the biggest weapon against fraudulent transactions. It is possible to detect insurance fraud and challenge a false claim, if you can analyse data about users, service providers and medical practices, and separate outlier or suspicious figures from the general trend. For example, if you have data about the standard rates for a procedure across a geographical location, and they are much lower than the one found in a disputed claim, you have the numbers on your side to prove a claim as a bad one. Similarly, you can also find out if the treatment given to a patient is in line with his or her medical history. Creating an algorithm with set rules that can learn and adapt according to

new inputs is an effective risk management system that can cull the settling of false claims before the money can land in wrong hands.

The silver lining to the cloud of universal insurance fraud is that it allows for a universal solution for the issue. While each country may differ slightly in its laws related to insurance, the foundation remains the same. The top 10 reinsurance companies handle nearly 70% of the reinsurance business. The standards and rules for insurance, parameters for health and sickness, and the methods for fraud are common across most countries. Hence a solution for fraud in one country can be successfully replicated across the world. This makes the algorithm mentioned above a viable answer for insurance fraud worldwide.

INCHES X-CLAIM is India's only enterprise to have such an algorithm in place for solutions related to underwriting, claims, legal, medical audit, risk and compliance functions. More than 40 years of experience in the medical field, along with customized knowledge-based inputs for the insurance industry combine to create an exclusive enterprise with an unprecedented success rate when it comes to providing solutions for the insurance industry.

The problem of insurance fraud may be universal, but it's not insurmountable. Stricter and clearer laws, along with data and knowledge-backed audits can help insurance companies plug the wound of fraud, saving millions of dollars every year.

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