

Health Insurance Claims Management

Forensic Data Analytics

Although the health insurance market in India lags behind other developed countries in terms of penetration, the segment is, however, improving. It continues to be one of the most rapidly growing sectors in the Indian insurance industry having witnessed an increase in the gross written health insurance premiums by 16 per cent, i.e. from INR 13,212 crore in 2011-12 to INR 15,341 crore in 2012-13¹.

While health insurance as a vertical has seen encouraging growth rates in recent years compared to others in the insurance space, its sheer size, retail nature of its customers, lack of reliable data and documentation challenges provide opportunities and bigger incentives to commit fraud.

False claim schemes are one of the most common types of health insurance fraud. The end goal in such schemes is to obtain undeserved payment for a claim or a series of claims. Frauds can be committed by anybody – either by a policy holder, a healthcare provider or

even employees of the health insurance provider and/or by collusion between any of them.

However the lack of a robust identification mechanism for Indian citizens like a social security number and manual processes coupled with the poor quality of data across Indian insurance companies make identification of a false claim a challenging proposition.

Leveraging analytics to identify fraud in the claim processing stage

With the insurance industry being highly data intensive, using the data logically and appropriately can therefore be an advantage. Using forensic data analytics at appropriate stages to sort through the vast data collected can play a key role in screening the claims received. Deloitte Forensic offers a solution that can also assist you in the effective screening of proposals at the underwriting stage, in addition to the detection of fraud at the time of a claim.

Some common health insurance frauds:

- Billing for services, procedures, and/or supplies that were not provided
- Preparation of bogus claims by fake physicians
- Misrepresentation of what was provided; when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider/recipient
- Charging for a service that was not performed
- Fake documentation
- Failure in disclosing previously settled or rejected claims
- Unbundling of claims
- Double billing
- Upcoding: Charging for a more complex service than was performed
- Miscoding: Using a code number that does not apply to the procedure
- Kickbacks: E.g. Receiving payment or other benefit for making a referral

¹ Source: Article in DNA, Link: <http://www.dnaindia.com/health/report-health-insurance-in-india-still-remains-untapped-market-1891509>

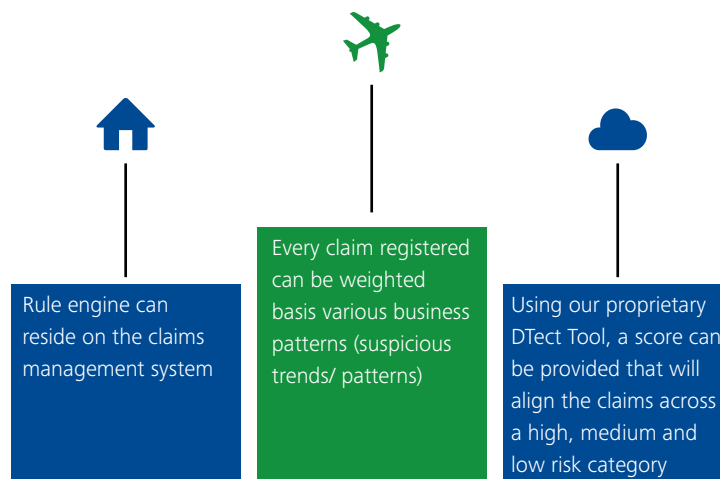


Some key questions that we can help you answer

- Do we have a robust system to track fraudulent claims?
- Do we capture appropriate data elements that will help us analyze better?
- Which geographic areas need attention from a claim scrutiny perspective?
- Do we have a list of suspicious hospitals?
- Do we have a range for the potential cost for each type of treatment(s) and the capabilities to compare it across the relevant data, to find outliers?
- Do we know the specific types of diseases which are at a higher risk of being mis-used for fraud?
- Which claims should be investigated thoroughly?
- Can we get a product-wise, area-wise and state-wise report for dubious claims?
- Can we get a score card for all the claims registered?
- How can we minimize claim administration costs?

Our solution

Our main objective would be to help provide an insight of the possible intention behind the claims registered with your company. Using a 'rules based' analogy and a dynamic scoring mechanism, we can help you segregate the claims into high, medium and low risk categories. Carrying out an investigation into the relevant claims can then help you eventually accept or reject them.



- Score cards can be provided for claims, agents, hospitals, surveyors, contracts, regions etc.
- Rules can be applied to identify regular anomalies in the data
- Anomaly detection can be fine-tuned on a regular basis through feedbacks

Deloitte Forensic Package


We can also help you with the following:

- Regular check on changes recommended by Insurance Regulatory and Development Authority (IRDA) as well as compliance with their recommended fraud risk management framework
- Provide regular support on the extraction of data
- Help standardize data and store it in the requisite format, as eventually required for the analysis

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