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Dhofar University
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Vulnerability of Indian Health Insurance Industry to Frauds

Kavita Chavali
Assistant Professor
College of Commerce and Business Administration
Dhofar University, Salalah, Sultanate of Oman
E-mail: kavita.chavali@gmail.com

V V Ajith Kumar
Assistant Professor, Skyline University College
University City of Sharjah, United Arab Emirates
E-mail: ajithkumarvv@gmail.com

M Sudha
Visiting Faculty, GITAM University
Visakhapatnam, India
E-mail: sudha.mavuri@gmail.com

Abstract

The study is to understand the perception of respondents who have an exposure to health insurance by having a policy with respect to frauds and the measures to curtail frauds in health insurance in India. Literature review says ineffective internal controls, insufficient information and tolerance to fraud are major reasons for frauds in the sector. Questionnaire survey in the study reveals that Intermediate fraud and policy holders' fraud are the predominant ones. Results from the survey reveals that checks on pre authorization requests, proposal call verification, responding to fraud allegations like black listing hospitals and doctors and conducting periodic reviews are the predominant factors which can curtail the possibility of frauds. Another major dimension of the problem is the scope of regulation to control frauds. Insurance companies, agents and brokers come under the preview of the regulator Insurance Regulatory Development Authority but hospitals, doctors and providers of health services are not covered under its net. It is recommended that the regulatory system of the insurance industry needs a more integrated approach like the banking industry.

Keywords: Health insurance, Medical Insurance fraud, Regulation, Insurance Regulatory Development Authority.
JEL Code: G22

1. Introduction

With increasing ailments and medical expenses the dependency on health insurance has increased in the recent years. According to Health Ministry in India over 63 million people are facing poverty every year due to health care costs alone. According to the draft of National Health Policy in 2011-12 the share of "out-of-pocket" expenditure on health care as a proportion of total monthly household per

capita income, expenditure was 6.9 percent in rural areas and 5.5 percent in urban areas (*Medical Expenses made 63 million poor*, 2015). With these changes in the environment, the route for success and growth has changed its direction and now industry is moving from regulated to a liberal and a customer friendly path. Along with the growing size of the market demand, health insurance industry has started growing and paved way for the entry of new insurance companies to supplement the existing companies' capacity.

With this growth in the health insurance industry, insufficient or faulty documentation cropped up as an emerging problem (Albrech.,1996). The reason for such a problem to arise is the fear of decline of the coverage among insurers due to rules and conditions applied in the process of verification and fixing insurance coverage and claim settlement. These further results into frauds and malpractices in the practices and claim settlement process in health insurance industry.

Health care Fraud as defined by National Health care Anti Fraud Association (USA) "The deliberate submittal of false claims to private health insurance plans and or tax-funded public health insurance programs". "Intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or entity or to another party".

The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3 percent of health care spending is lost in health care fraud. www.nhcaa.org . There is a concern among the insurance industry about the increasing incidence of fraud in health insurance. Fraud in the insurance sector affects both the insurer and the customer. It results in distrust and reduces the confidence of the consumers and results in paying high premium for insurance products and the individual insurer with financial and reputational risk.

Insurance Fraud is not defined under Indian Insurance Act. International Association of Insurance Supervisors (IAIS) defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties". This is achieved by means of:

- Misappropriating assets
- Deliberate misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to financial decision, transaction or perception of the insurers status
- Abusing responsibility a position or trust of fiduciary relationship.

2. Previous Research

Existing literature on this issue is very limited.

Beirstaker *et al.,* (2005) proposed fraud protection and detection techniques which include fraud policies, telephone hotlines, employee reference checks, fraud vulnerability reviews, vendor contract reviews and sanctions, password protection, firewalls, and other forms of software technology.

Phua *et al., (2005)* examines both supervised and unsupervised methods of fraud detection and points out lack of publicly available data and lack of quality in the available data as the two major problems for fraud detection.

Derring (2002) describes the range of frauds in insurance arising from asymmetric information especially in claiming behavior in insurance. They devised steps to enhance detection and deterrence of fraud.

Albrecht (1996) describes the symptoms of poor internal controls increase the possibility of frauds. Internal control symptoms include a poor control environment, lack of segregation of duties, lack of physical safeguards, lack of independent checks, lack of proper authorizations, lack of proper documents and records, the overriding of existing controls, and an inadequate accounting system.

Bologna (1994) cites the environmental factors that enhance the probability of embezzlement which are inadequate rewards, inadequate internal controls, no separation of duties or audit trails, ambiguity in job roles, duties, responsibilities, and areas of accountability, failure to counsel and take administrative action when performance levels or personal behavior fall below acceptable levels,

inadequate operational review; lack of timely or periodic review, inspections, and follow-up to assure compliance with company goals, priorities, policies, procedures, and governmental regulations and failure to monitor and enforce policies on honesty and loyalty.

Calderon and Green (1994) made an analysis of 114 actual cases of corporate fraud. They found that limited separation of duties, false documentation, and inadequate or nonexistent control account for 60 percent of the fraud cases. Based on the findings, they propose that the internal auditors should ensure that strong prevention systems based on the fundamental principles of good internal control be established and used. To detect and investigate fraud, organizations must ensure the existence of strong internal audit departments with sufficient resources to pursue the increased responsibilities faced by internal auditors.

Jeffords *et al.,* (1992) examined 910 cases during the nine-year period from 1981-1989 to assess the specific risk factors. Approximately 63 percent of the 910 cases are classified under the internal control risks that include: lack of regular independent checks in performance, inadequate organizational control methods, inadequate methods of communicating or enforcing the assignment of authority and responsibility; and unauthorized access and physical control of assets, records, computer programs, or data.

Hoyt (1990) has examined the significance of fraud insurance industry and presented an economic model to control insurance fraud. The author has developed a framework and proposed of allocation of more resources for creating awareness among public on the serious nature of fraud and enforcement of tougher civil and criminal penalties by law enforcement agencies.

3. Classification of Fraud

Insurance Regulatory and Development Authority (IRDA) who regulated the insurance industry classifies fraud into these three categories

a. Policy Holder Fraud and Claims Fraud: Fraud against the insurer in the purchase or execution of the insurance product including at the time of making a claim.
b. Intermediate Fraud: Fraud by the insurance agent / intermediary against the insurer and policy holders.
c. Internal Fraud: Fraud against the insurer by its staff member.

3.1. Guidelines

Insurance Regulatory and Development Authority (IRDA) laid down guidelines requiring insurance companies to have in place Fraud Monitoring Framework. The guidelines mandate insurance companies to have fraud detection and mitigation measures and submit periodic reports to IRDA

The frame work shall at the minimum protect the insurer from the threats posed by the following broad categories: Policy Holder Fraud and Claims Fraud, Intermediate Fraud and Internal Fraud

According to IRDA Insurance fraud monitoring framework all insurance companies are required to have in place as Anti-Fraud Policy duly approved by their boards. The anti-fraud policy should broadly cover the following:

- Procedures for Fraud monitoring
- Identify potential areas for fraud.
- Coordination with law enforcing agencies
- Lay down procedures for exchange of necessary information on frauds among insurers.
- Lay down procedures to carry out due diligence on the personnel –staff, agents, intermediaries, TPA before appointment.
- Generate fraud mitigation communication at periodic intervals.
- The statistics of various fraudulent cases which included outstanding cases and closed fraud cases within 30 days of the close of financial year shall be filed with IRDA .

- The insurer should inform both the potential clients and existing clients about their anti-fraud policies.

3.2. Overview of Frauds in Health Insurance – Factors Responsible

A survey conducted by FICCI on Health Insurance Fraud the following were identified as fraud prone areas in health insurance

Policy holders are usually involved in frauds relating to:

- Concealing preexisting diseases / chronic ailments, manipulating pre policy health check ups
- Fake / fabricated documents to meet policy term conditions
- Duplicate and Inflated bills
- Staged accidents and fake disability claims

The agents and brokers are usually involved in frauds relating to:

- Providing fake policy to customer
- Manipulating pre-policy health checkup records
- Guiding customers to hide preexisting diseases
- Facilitating policies in fictitious names
- Fudging data

Provider related fraud usually pertain to:

- Overcharging, Inflated billing, Billing for services not provided.
- Unwarranted procedures, Excessive investigations and expensive medicines.
- Over utilization and extended length of stay
- Fudging records and patient history

The study has been initiated keeping in mind the growth in the health insurance industry and the need to minimize the losses arising from frauds so as benefit the industry as well as policy holders. In order to understand the customer's perspective on the awareness, scope and reasons of fraud and opinions on possible measures to curtail frauds in health insurance a detailed study was conducted in Bangalore Karnataka by administering a questionnaire and hypothesis were developed.

4. Developing the Hypotheses

The following hypotheses are formulated based on the review of literature. The factors considered were expectation of respondents, awareness level of respondents, perception related to areas of fraud, need for audits, checks and verifications done by insurance companies, ethical standards of employees and role played by IRDA as a regulator.

Hypothesis 1: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to their expectations from Health Insurance Company

Hypothesis 2: H0-The exposure to health insurance by having a policy will not make a significant difference on the awareness level of respondents

Hypothesis 3: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to major areas of fraud.

Hypothesis 4: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to the need for rigorous and continuous audits

Hypothesis 5: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents regarding checks and verifications done by the insurance company

Hypothesis 6: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents on ethical standards of employees / agents of the insurance company

Hypothesis 7: H0-The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to role played by IRDA as a regulator.

5. Research Method

A survey was conducted in Bangalore with the help of a structured questionnaire which was administered to 105 respondents who had exposure to health insurance in the form of having a policy with an insurance company. The objective of the research is to understand the respondent's opinion on frauds in health insurance.

Friedman Rank Test was conducted to understand the factors which influenced respondents to take a health insurance policy and respondents ranking on the areas vulnerable for fraud

Factor Analysis was conducted to understand the probable factors which prompted respondents to take a medical insurance. The factors considered were based on past research and the respondents' opinion was taken on a 5 point Likert Scale and are as below:

- Past family health track record
- Provided by the company
- Advised by agent
- Advised by family and friends
- Taken by self

The respondents opinion was taken on a 5 point Likert Scale on the factors that detect the possibility of detecting frauds in medical insurance. The factors considered are:

- Proper verification
- Checks on preauthorization requests
- Periodic audits
- Medical protocols and treatment guidelines
- Responding to fraud allegations
- Whistle blowing mechanism and rewards
- Periodic meetings to check incidence of frauds
- Creating Awareness
- Autonomous body to receive complaints

6. Data Analysis and Findings

This section details the findings of the survey and shows the perceptions of respondents with respect to health insurance in India.

Table 1: Hypothesis Testing using ANOVA

S No.	Hypothesis Testing	P value	Accept / Reject
1	The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to their expectations from health insurance	0.001	Reject Hypothesis 1
2	The exposure to health insurance by having a policy will not make a significant difference on the awareness level of respondents	0.004	Reject Hypothesis 2
3	The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to major areas of frauds.	0.01	Reject Hypothesis 3
4	The exposure to health insurance by having a policy will not make a	0.04	Reject Hypothesis 4

S No.	Hypothesis Testing	P value	Accept / Reject
	significant difference in the perception of the respondents relating to the need for rigorous and continuous audits		
5	The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents regarding checks and verifications done by the insurance company	0.042	Reject Hypothesis 5
6	The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents on ethical standards of employees / agents of the insurance company	0.07	Accept Hypothesis 6
7	The exposure to health insurance by having a policy will not make a significant difference in the perception of the respondents relating to role played by IRDA as a regulator.	0.5	Accept Hypothesis 7

*α =0.05

Table 1 represents hypotheses testing using ANOVA to test statistical significance. As per the results null hypothesis 6 & 7 have been accepted and others rejected. It is observed that the respondents exposure to health insurance by having a policy have an impact on the perception in terms of a closer watch on the ethical standards of those employees/ agents and role of IRDA as a regulator in regulating the insurance industry.

The questionnaire took into account the factors considered by respondents while taking a health insurance and the areas vulnerable to fraud. Rakings were given by respondents and Friedman Rank Test was used to check the preferences and perceptions of respondents.

Table 2: Table representing the preference of respondents when they choose a policy from an insurance company

S No.	Factors	Friedman Rank Test
1	Premium paid	4.83
2	No Claim discount offered by company	5.67
3	Brand Equity	5.26
4	Network of hospitals covered	3.10
5	Customer service in terms of 24/7 answering queries	4.86
6	Product features	4.32
7	Ease of settling claims	4.03
8	Ease of Processing Cashless service	3.93

The respondents have ranked these factors on a scale of 1-8. As per table 2 the Friedman Rank test signifies that no claim discount offered by companies is the most enticing factor which respondents give preference to when they select a policy in an insurance company of their choice. It is followed by brand equity of the company which says that trust plays an important role, customer service, premium paid, product features, ease of settling claims, ease of processing cashless service and finally network hospitals covered. If the insurance companies can take cue from this and design the way they market medical insurance it would help them to reach a larger section of people.

Table 3: Table representing the respondents' perception on the areas vulnerable for fraud

S No.	Factors	Friedman Rank Test
1	Concealing preexisting diseases when policy is taken with the fear of policy getting rejected	**2.79**
2	Concealing preexisting diseases when policy is taken with the fear of paying high premium	**4.55**
3	Unwarranted excessive investigations and medications by hospitals / doctors	**4.50**
4	Providing wrong information by the agent about the product	**4.48**
5	Inflated bills or claims	**4.70**
6	Over utilization and extended length of stay in hospitals	**4.80**
7	False promises by the agent which the company never stated	**4.62**
8	Tampering patient records by hospitals	**4.54**

The Friedman Rank test signifies that maximum frauds are perpetuated with over utilization and extended length of stay in hospitals and inflated bills or claims submitted by hospitals or policy holder himself. If IRDA is more vigilant and makes use of Medical Council of India (MCI) for code of conduct and ethics for medical practitioners, it would reduce frauds to a considerable extent. As per Ernst and Young Fraud Survey 2010-11, 27 percent of the frauds are in the area of claims. It is estimated that India's medical insurance sector is losing around INR 10 billion on frauds relating to false claims every year. The second factor is false promises made by agents which the company never stated. Khalil (1997) suggested in his study that over compensation of agents is the only possibility to reduce frauds perpetuated by agents.

In the three categories of fraud given by IRDA Intermediate Fraud and Policy holder Claims Fraud are the predominant ones. The interesting fact according to literature review is there are varied levels of tolerance among people about frauds perpetuated in insurance. In repeated survey of consumer attitudes about the prevalence and acceptability of insurance fraud, the insurance research council has found a high level of acceptance (Insurance Research Council 2000). In 1989 this organization found that between 25 percent and 31 percent of consumer's surveyed stated claims exaggeration to be acceptable and in year 2000 these percentages remained nearly the same between 24 percent and 35 percent. There is a great deal of variation across groups of consumers in attitudes towards fraud. According to Tennyson (1991) women and highly educated does not accept or tolerate fraud. Consumer beliefs ranged between two extremes. Complete rejection of fraud and the view that it should be punished, to tolerance and acceptance of fraud and the view that it should be only lightly punished. Recent research on insurance education has shown that education and awareness improves knowledge of the insurance and also results in positive attitudes towards insurance institutions (Barrese *et al.,* 1998).

Table 4: Table representing the factors which can detect and curtail the possibility of frauds

Rotated Component Matrix

S No	Factors which can detect and curtail the possibility of frauds	Component		
		1	2	3
1	Checks on preauthorization requests	**.849**	**-.076**	**.075**
2	Proposal verification call	**.835**	**.165**	**.182**
3	Responding to fraud allegations by black listing doctors / hospitals involved	**.674**	**.588**	**-.056**
4	Conducting periodical review at branch/ departmental level to minimize the incidence of fraud	**.550**	**.293**	**.208**
5	Strict medical protocols and treatment guidelines	**-.022**	**.770**	**.293**
6	Whistle blowing mechanism and rewards	**.134**	**.766**	**.092**
7	Medical protocols and treatment guidelines	**.265**	**.500**	**.022**
8	Periodic audits	**.135**	**-.147**	**.825**
9	Creating awareness in people	**.344**	**.316**	**.751**
10	Autonomous body to receive complaints	**-.043**	**.471**	**.702**

Of the nine factors identified to detect and curtail the possibility of frauds in health insurance only four variables have significantly loaded. As per the perception of the respondents the factors are checks on preauthorization requests, proposal call verification, responding to fraud allegations and taking stringent action like black listing doctors or hospitals involved and conducting periodic reviews which are predominant factors which can curtail the possibility of frauds. Some triggers should be identified at every stage and managed automatically by a centralized system in each insurance company and manually detected by inspection of files. FICCI in their study has identified 37 triggers relating to various areas like Policy and Claim History, Provider location and profile, Diagnosis and claims, billing and tariff and customer based triggers. If these are followed meticulously, frauds can be identified at an early stage and curtailed. Proposal verification call should be made mandatory to ensure the understanding of the customer and avoid frauds. There should also be confirmation that the insurer does not have any preexisting diseases. Pre authorization and cash less service is an important

component. It should be checked meticulously to eliminate any type of false claims by the customer. One way to curtail this is to bring in standardization in the formats and procedures to avoid deviations.

IRDA's jurisdiction as a regulator is restricted to insurance companies, agents and brokers. The hospitals, doctors or providers' of health services where major frauds happens does not come under the preview of IRDA. The Ministry of Health should take an active role to take action against hospitals and doctors who indulge in fraud. IRDA should also work in collaboration with the Ministry of health to conduct regular audits, prescribe standard medical protocols and treatment guidelines. Publicly disclosing names involved in health insurance fraud and blacklisting of entities who indulge in fraud should be initiated by the regulator. The penalties and actions taken are to be spelled out clearly in the contract and the awareness also needs to be created. The insurance sector needs to develop and share a centralized data base related to defaulters and black listed entities like the banking industry. There should be a continuous training for fraud investigators to establish alerts for early detection to control fraud.

7. Summary and Concluding Remarks

Health insurance as a service started gaining prominence as the government liberalized the sector the size of the market expanded. Alongside of existing market segment, marketer attention diverted to low and middle income people where awareness was relatively low. It is this ignorance in the market and the growing need for medical expenses paved way for frauds in health insurance sector. A close look into the survey analysis showed quite interesting outcomes.

Literature in this area is limited; within these limited studies it is evident that asymmetric information, lack of publicly available data, poor internal controls and inadequate audit trails, poor incentives structures, poor monitoring and regulating systems are few reasons for frauds in health insurance sector.

Having understood the reasons for the problem, current study elicited the perceptions of customers about the perpetuated frauds in health insurance sector. Customers exposure to health insurance by having a policy have an impact on the perception in terms of a closer watch on the ethical standards of those employees/ agents and role of IRDA as a regulator in regulating the insurance industry.

Factors which predominantly influence a customer to take a policy of a company is no claim discount offered and brand equity of the company which says that trust plays an important role, followed by customer service and premium paid. These results of the study will provide signals to companies for framing a suitable strategy and develop the product that reaches larger market.

The respondents also expressed their opinions regarding areas vulnerable to frauds in health insurance, intermediate frauds and claim frauds are most important ones. To curtail these frauds, customers opined that checks on preauthorization requests, proposal call verification, responding to fraud allegations and taking stringent action like black listing doctors or hospitals involved and conducting periodic reviews are some predominant factors which can curtail the possibility of frauds. This would minimize the losses arising from frauds and benefit the industry as well as policy holders.

Another major dimension of the problem is the scope of regulation. Companies, agents and brokers only come under the purview of IRDA but hospitals, doctors and providers of health services are not covered under the net. So the insurance regulatory system needs a more integrated approach like the banking industry by sharing fraud related data among various parties and have a tighter control on frauds and increasing the gambit of monitoring and control.

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