

CHAPTER- 20

A STUDY ON BLACKLISTING OF NETWORK & NON-NETWORK HOSPITALS

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INTRODUCTION

The world is fraught with uncertainties and potential threats, encompassing various hazards that can disrupt lives, well-being, resources, and property. The Insurance Industry has evolved as a safeguard against such unpredictability, providing coverage for losses and uncertainties to protect individuals and their interests. Positioned as a societal tool to mitigate or eliminate risks to lives and property, insurance significantly contributes to a country's overall development by fostering secure interactions. In nations like India, where employment and savings hold immense importance, the Insurance industry plays a crucial role, employing millions of people [1].

Despite the numerous benefits it brings, the insurance sector faces a significant challenge in the form of insurance fraud.

In 2019, insurance fraud in India amounted to approximately 45,000 crores, with health insurance fraud alone accounting for 15% to 35% of fraudulent claims. This poses a considerable financial burden on insurance companies, costing them an average of 10% to 15% of their annual revenue. India stands as one of the world's major trading platforms for insurance providers. However, the health insurance sector in the country is fraught with risks due to the exceptionally high prevalence of fraud. Fraudsters continually devise new schemes to exploit insurance companies, with obtaining insurance for terminally ill individuals being a common method. While Indian cities have measures in place to prevent such fraud, rural areas lacking proper infrastructure become susceptible to such schemes [4].

The term "Insurance Fraud" lacks a specific definition under the Indian Insurance Act. According to the International Association of Insurance Supervisors (IAIS), fraud involves acts or omissions intended to gain dishonest or unlawful advantage for the committing party or related entities. The National Health Care Anti-Fraud Association (USA) defines healthcare fraud as intentionally submitting false claims to health insurance plans or public health insurance programs, causing concerns within the insurance industry. Healthcare fraud takes various forms, including life insurance fraud where faking death leads to financial gains. Hospitals may engage in healthcare insurance fraud by misrepresenting information related to healthcare benefits, such as submitting false medical bills or ordering unnecessary medical procedures [2][3]. Physicians are sometimes complicit in such fraud, performing unnecessary procedures for personal gain.

Insurance companies in India often face challenges due to fraudulent claims after tragic accidents, where claimants exploit

clauses for financial gains. The persisting issue of fraud has led to the establishment of techniques to combat fraud along the insurance value chain, including pre-medical exams, fast renewals, KYC compliance, and improved services. The Insurance Regulatory and Development Authority of India (IRDAI) recommends that all insurance companies in India implement a certified anti-fraud plan approved by their respective boards.

RESEARCH QUESTION

How was the process of identifying and the impact of blacklisting hospitals at the health insurance industry level conducted?

RESEARCH OBJECTIVES

1. To understand the average claim size for both Cashless and Reimbursements.
2. To examine instances of fraud and abuse in hospital claims across India.
3. To analyse unwarranted losses to facilitate overall cost reduction.

RESEARCH METHODOLOGY

The study was designed as a correlational quantitative study, with Aditya Birla Health Insurance serving as the primary setting. The study population comprised suspected fraud hospitals, determined by inclusion and exclusion criteria. Inclusion criteria involved suspected fraud hospitals, while non-suspected hospitals were excluded. The study utilized secondary data and spanned a duration of three months, from February 22, 2023, to May 21, 2023. The sample size consisted of 2,916

suspected hospitals identified from a master dataset of 55,000 hospitals, forming the basis for drawing conclusions. The sampling technique employed was purposive non-probability sampling.

The subsequent phase involved a multistage analysis of the collected data. Common responses were systematically coded and categorized into themes, facilitating entry into Microsoft Excel for further detailed analysis. The outcomes of this analysis were then presented through tables and graphs, offering a condensed summary of the data. Conclusions were drawn based on the emergent themes from the thorough data analysis process.

RESULTS AND DISCUSSION

The analysis of claims distribution over three fiscal years (2020-2023) revealed significant trends. In the financial year 2020-2021, suspected fraud hospitals incurred expenses of 8,27,44,672 INR, with 78% spent through Cashless transactions and 22% through Reimbursement. In 2021-2022, the expenses rose to 19,24,97,625 INR, with 79% through Cashless and 21% through Reimbursement. Notably, in 2022-2023, Cashless transactions surged to 89%, amounting to 19,24,97,625 INR, while Reimbursement constituted 11%, totalling 2,12,89,668 INR. Over the three years, cashless claims totaled 44,13,02,357 INR, while total reimbursement claims cost 9,59,57,250 INR. The findings underscored the potential savings of approximately 53,72,59,607 INR by blacklisting fraud hospitals, contributing to the overarching goal of preventing financial losses and optimizing inpatient care and medical services. To enhance fraud prevention, the study recommended increased investment in education and training for fraud detectives within insurance companies. The process of blacklisting fraud hospitals was identified as a

strategic approach to reducing the average claim size, preventing unwarranted losses, and facilitating overall cost reduction in the insurance industry.

The healthcare industry grapples with a surge in fraudulent activities, a concern addressed by privacy laws, as indicated in reviewed articles. The National Health Care Anti-Fraud Association (NHCAA) proposes effective measures, including predictive modeling and enhanced transparency between private insurance entities and government programs, to combat healthcare fraud. The study suggests a comprehensive multi-stage approach to fraud detection, involving five key steps. Initial stages focus on identifying fraud among providers, services, and claim numbers, with subsequent stages integrating information to determine an overall risk level. The decision-making process in the final stage involves computing a risk threshold value to ascertain whether a claim indicates fraud. The overarching objectives of this fraud detection technique are to prevent financial losses and ensure the quality of inpatient treatment and healthcare services. It's emphasized that these procedures are adaptable to specific circumstances or fraud-related challenges.

CONCLUSION

Healthcare fraud, an ever-evolving criminal activity, necessitates increased investment by insurance companies in the education and training of fraud detectives to effectively curb such practices. The rise in insurance fraud cases contributes to elevated costs and premiums, underscoring the need for robust risk management systems. Current legal frameworks, treating insurance fraud as a low-risk offense, warrant reconsideration to impose stringent penalties on offenders. Detection and

prevention of healthcare fraud remain challenging due to insufficient investigations. However, continuous advancements in understanding fraudulent schemes and employing adaptable methods offer avenues for progress. Factors influencing customers' insurance choices revolve around no-claim discounts, brand equity, trust, customer service, and premium considerations. Notably, intermediate frauds and claim frauds emerge as key vulnerabilities, prompting recommendations for preventive measures like preauthorization checks, call verifications, prompt response to fraud charges, and the blacklisting of fraudulent hospitals. Regular assessments are vital to mitigate fraud risks, benefiting both the industry and policyholders. Addressing regulatory scope issues, particularly the inclusion of healthcare service providers, calls for a coordinated approach by the Insurance Regulatory and Development Authority (IRDA), akin to the banking sector's regulatory model. Enhanced controls and shared fraud-related data could extend monitoring and control, fostering a more comprehensive regulatory framework.

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