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Insurance fraud and Abuse

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Insurance fraud and Abuse

Fraud refers to any deliberate act committed by an individual that brings illegal benefits to the person responsible for the action.

Fraud involves a deliberate commitment of a dishonest act to acquire unauthorized benefits.

Insurance fraud refers to deliberately taking authorized claims from the health insurance benefits.

In most cases, those people are not entitled to receive health insurance benefits at other clients' expense.

Abuse of health insurance policies and regulations is the key contributor to health insurance fraud.

Many irregularities are associated with the health insurance policies in Saudi Arabia. Insurance fraud and abuse are very common in the health care sector. Health insurance fraud involves an instance where one party deliberately claims another person's health insurance claims, where he or she is not legally entitled to at the expense of another party. The case of fraud in the health sector is majorly caused by the abuse of the health officials' office (Palutturi et al.,.2019). The health officials aid the patients in committing fraud. The collaboration of the health officials responsible for accounting for the health insurance claims facilitates insurance frauds. Any health officer in Saudi Arabia who is in any way engages in acts of fraud is liable for an offense. The commitment of insurance fraud or facilitating fraud is punishable through the law. Health insurance fraud and abuse of health insurance laws by the health officials contribute to the ineffectiveness of the health insurance policy in Saudi Arabia.

Fraudulent actions

The following are actions are considered fraud

Representation of the service offered wrongly

Improper presentation of persons providing services

Accounting for items not supplied.

Accounting for services not provided

Fraudulent actions are considered illegal, and anyone found guilty of committing fraud is liable before the law in Saudi Arabia. In case there is a misrepresentation of a particular service, then that action can be considered fraud. In some instances, the official's charge of controlling the health insurance funds may represent information concerning a specific service wrongly to benefit the party who is not entitled to receive such benefits. For example, the officials may misrepresent a victim's health insurance claims to benefit another person or gain from the benefits. Accounting for the services not provided is another action that shows fraudulent activities (Al Otaibi, 2017). The accountants may misrepresent the information intentionally to benefit other parties or themselves. Similarly, accounting for the services not provided is another example of fraudulent practice. In case there is the intentional misrepresentation of information concerning the services that were not provided to the client, then there are chances of fraud in the health centre.

Indicators of fraud

Several activities in the healthcare insurance sector show evidence of fraud,

Misrepresentation of claims

Not indicating the claims taken

Failure to keep up to date record of claims made

Not indicating the name of the person claiming compensation.

One can observe several methods to detect the presence of fraud in the health insurance system. For example, in the case of an absence record of the person claiming compensation, there is a high chance of fraud. Failure to keep a proper record of the person taking the insurance compensation is one of the most common indicators is fraud in health insurance. The organization should keep an accurate record of the person talking about insurance claims to avoid misrepresenting insurance claims (Palutturi et al.,.2019). Misrepresentation of insurance claims is another key indicator of insurance fraud in Saudi Arabia. In case there is improper allocation of claims in the health insurance, then the more the chances of fraud. Those offering claims should keep an accurate record of the claims given by the health insurance. The last indicator of fraud in health insurance is an improper indication of the compensation taken records. In most cases, those in charge of controlling the health insurance funds abuse their office by allocating claims to persons who do not exist. Alternatively, those

who do not have insurance policies. Fraud contributes to the ineffectiveness of health insurance policies in Saudi Arabia.

Impacts of fraud on the medical community

Fraud has contributed to several negative impacts on the health sector, such as

Overburdening the healthcare sector

Increase in medical harm to patients

Increase in financial constraints by medical institutions.

There are several negative impacts of fraud in health insurance. These fraudulent practices have led to ineffectiveness in service delivery in the health sector. The fraud in the health sector makes doctors and other health professionals organize unnecessary treatment. The doctors' unnecessary treatments to make the clients look for compensation from their insurance firms contribute to increase in unnecessary activities in the health care sector (Albejaidi, 2018). The increase in unnecessary activities in the health facilities overburdens the facilities. Secondly, increase in case of fraud contributes increases in case of medical harm to the patients. Fraudulent doctors may perform unnecessary operations to the patients in order to benefit from the compensation from the healthcare insurance. These operations may harm the patients' health. Performance of unnecessary treatment causes more health complications to the patients and, at times, even death of the clients.

Effects on health insurance companies in Saudi Arabia

Fraud has caused several negative effects on the health insurance companies,

The negative brand image of the company

Huge losses for the company

Increase in premium charges

Loss of demand for insurance policies

The decline in the economic growth of Saudi Arabia

The negative effect of the economy of the country

Health insurance fraud causes various negative effects on the insurance company. The major impact of fraud on insurance is an increase in losses. When there is an increase in misrepresentation cases, health insurance incurs huge losses because it cannot trace its expenditure. Furthermore, huge losses by the insurance company affect the company's performance. When the health insurance company reports continuous losses over some time, it may shut down. The company may shut down due to a lack of funds to run the insurance operation; in this case, the insurance company is declared insolvent hence liquidate with immediate effect(Nugraheni et al., .2020). Additionally, an increase in fraud cases may make the health insurance company increase the premium rates. An increase in the rate of premiums reduces the demand for the company's policies. An increase in cases of fraud from an insurance company may reduce the brand image of the company. When insurance is associated with more fraud cases, it reduces its popularity in public and the entire brand image.

How to report health insurance fraud

There are various methods that a person can use to report fraud,

The use of the recommended hotline

Reporting the suspects of fraud to the department of health and human resource department

Reporting the cases to the anticorruption agencies

When a client notices any signs of fraud in the health care facility, it is important to report the incident to the relevant authority. Furthermore, it is the responsibility of Saudi Arabia citizens to report any cases of fraud and promote equality in the kingdom. In case one notices any case of fraud, one can use the hotline services to report the case to the necessary authority. The hotline services are the most efficient way of reporting fraud if the clients want to remain anonymous (Alonazi, 2020). The identity of the person reporting fraud should be kept anonymous to guarantee the person's safety reporting fraud. The second way of reporting fraud is reporting the incident to the anticorruption body. When one detects any fraud incident in healthcare insurance, one should report the case to the nearest anticorruption body and provide the evidence collected to facilitate the investigation of fraud.

Penalties for Fraud

There are various measures put by the Saudi Arabia government to punish cases of fraud. They include,

Imprisonment

Fines

Probation

There are three main ways of punishing the cases of fraud in Saudi Arabia. Probation is the first method of dealing with fraudulent officers. If suspected to have committed an act of fraud, the court may decide to put the officer on probation where further investigations are being carried out (Albashrawi, 2016). In the stage of probation, the suspects are denied access to the insurance premises to avoid tampering with the evidence. Fine is another effective method used by law enforcers to deal with cases of fraud. Those who are found guilty of practicing fraudulent activities are fined according to the amount of money in question. The larger the amount of money involved in fraud, the larger the fines. Lastly, those who are found guilty of practicing fraud may be jailed for six months to one year, depending on the intensity of the fraudulent practices.

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