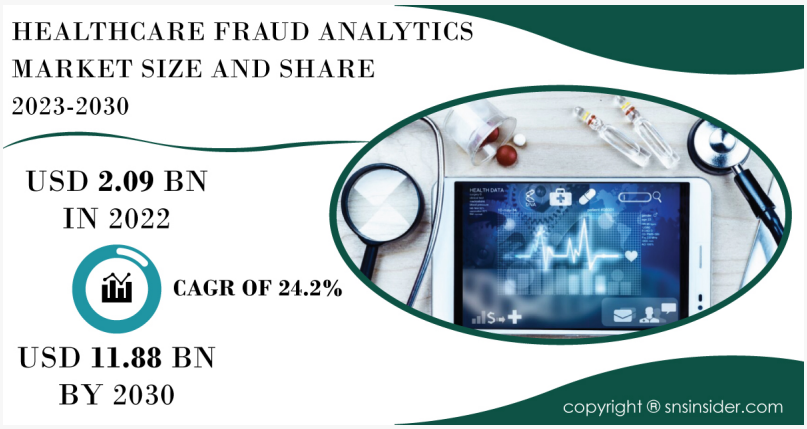
Healthcare Fraud Analytics Market Trends, Size, Share, Innovations, Future Strategies and Industry Growth Forecast 2030

Healthcare Fraud Analytics Market to Reach USD 11.88 Billion by 2030, Driven by Increasing Adoption of Advanced Analytics Solutions



Healthcare Fraud Analytics Market

AUSTIN, TEXAS, UNITED STATES, February 23, 2024 /EINPresswire.com/ -- The Report offers a comprehensive analysis of the Global Healthcare Fraud Analytics Market from 2023 to 2030. With a valuation of USD 2.09 billion in 2022, the healthcare fraud analytics market is projected to surge to USD 11.88 billion by 2030, indicating a remarkable compound annual growth rate (CAGR) of 24.2% during the forecast period. The scope of this study encompasses a thorough exploration of the market dynamics, including drivers, restraints, opportunities, and challenges influencing market growth. It aims to provide insights into key trends such as technological advancements, regulatory frameworks, and evolving fraud patterns in healthcare. Additionally, the report will present a detailed segmentation of the market based on component, deployment mode, application, end-user, and region, facilitating a comprehensive understanding of market dynamics across various segments. Through rigorous research and analysis, this report aims to serve as a valuable resource for stakeholders including healthcare providers, insurance companies, regulatory authorities, law enforcement agencies, investors, and solution providers, enabling them to make informed decisions and formulate effective strategies to combat healthcare fraud and capitalize on emerging opportunities in the global Healthcare Fraud Analytics Market.

Healthcare fraud poses significant financial, operational, and reputational risks to healthcare organizations, insurance companies, government healthcare programs, and patients, leading to billions of dollars in losses annually and undermining the integrity and sustainability of the healthcare ecosystem. Fraudulent activities, such as billing for medically unnecessary services, upcoding, unbundling, kickbacks, and identity theft, are perpetrated by individuals, organized crime syndicates, and unscrupulous providers seeking to exploit vulnerabilities in the healthcare

reimbursement system and evade detection.

Major Key Players in the Healthcare Fraud Analytics Market:

- Cotiviti, Inc.
- Conduent Inc.
- DXC Technology
- EXL Service Holdings Inc.
- HCL Technologies Limited
- IBM (especially through its Watson Health division)
- OSP Labs
- Optum Inc. (a subsidiary of UnitedHealth Group)
- SAS Institute Inc.
- Wipro Limited

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Healthcare Fraud Analytics Market Analysis

The healthcare fraud analytics market is experiencing significant growth due to several key factors. One of the primary drivers is the increasing complexity and volume of healthcare data, which has made traditional methods of fraud detection ineffective. Healthcare organizations are turning to advanced analytics solutions to detect fraudulent activities in real-time and prevent them before they result in financial losses. Additionally, regulatory requirements such as the Affordable Care Act have placed a greater emphasis on the need for accurate reporting and compliance with existing laws, further driving demand for fraud analytics tools. Moreover, the rising incidence of healthcare fraud globally, coupled with the growing adoption of digital technologies in the healthcare sector, is expected to fuel market growth in the coming years. Overall, increased awareness of the benefits of healthcare fraud analytics in improving operational efficiency and reducing financial losses is driving adoption among healthcare providers, payers, and government agencies alike.

Healthcare Fraud Analytics Market Segmentation

By Solution Type
- Descriptive Analytics
- Prescriptive Analytics
- Predictive Analytics

By Delivery Model
- On-premises
- Cloud-based

By Application
- Insurance Claim Review
- Postpayment Review
- Prepayment Review
- Pharmacy billing Issue
- Payment Integrity
- Others

By End User
- Public & Government Agencies
- Private Insurance Payers
- Third-party Service Providers
- Employers

Based on the type analysis, Descriptive Analytics held around 41.2% of the market in 2023. It can be attributed to its widespread adoption facilitated by user friendliness; descriptive analytics use both current and historical data to identify trends, relationships and detect potential fraud, and it is the cornerstone of successful implementation of prescriptive and predictive analytics, which will contribute significantly to its growth in 2023.

Based on the application, the increasing adoption of health insurance and fraud activity in claims, the Insurance Claims Review segment will account for more than 36.5% of market share by 2023. In order to take into account, the faster compound annual growth rate expected as a result of increasing healthcare provider demands, this segment can be divided into post payment review and prepayment review segments.

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Key Regional Development

North America held approximately 37.8% of the market and holding USD 0.945 Billion revenue in 2023. Factors such as high per capita income and healthcare spending levels, an ageing population with widespread health insurance coverage, significant incidences of healthcare fraud, favourable government initiatives against it, and pressure to reduce healthcare costs can be attributed to this. In addition, the proliferation of service providers and progress in fraud detection software contribute to market expansion within this region.

Rapid growth is expected in the Asia Pacific region as a result of rapid deployment of technological solutions. In the region, healthcare fraud is also rising as a result of technology improvements. In particular, the Insurance Fraud Survey of 2023 conducted by Deloitte showed that almost 60% of insurance companies in India are facing a serious rise in fraud on life and

health insurance. This is expected to boost market growth in the region.

Key Takeaway from Healthcare Fraud Analytics Market Study

- In order to combat the ever-increasing threat of fraud in health care services, healthcare fraud analysis is becoming more and more important.
- AI and machine learning (ML) technologies are driving continuous technological progress and innovation, improving accuracy and adaptability in fraud detection systems.
- North America held approximately 37.8% of the market and holding USD 0.945 Billion revenue in 2023.

Recent Development Related to Healthcare Fraud Analytics Market

- In May 2023, to address supply chain optimization, insurance claims and fraud in time payments, Teradata and FICO are set to introduce integrated analytical solutions. The efficient development of solutions to address a variety of use cases in sectors such as finance, healthcare, retail, manufacturing and travel is facilitated by integrating data, analytics and insight into an integrated environment.
- In June 2023, the Payrailz Fraud Monitor, an artificial intelligence powered and native cloud component of the Payrailz Digital Payments Platform, has been introduced by Jack Henry. This feature is designed to detect fraud in real time, from the start of a payment transaction.

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