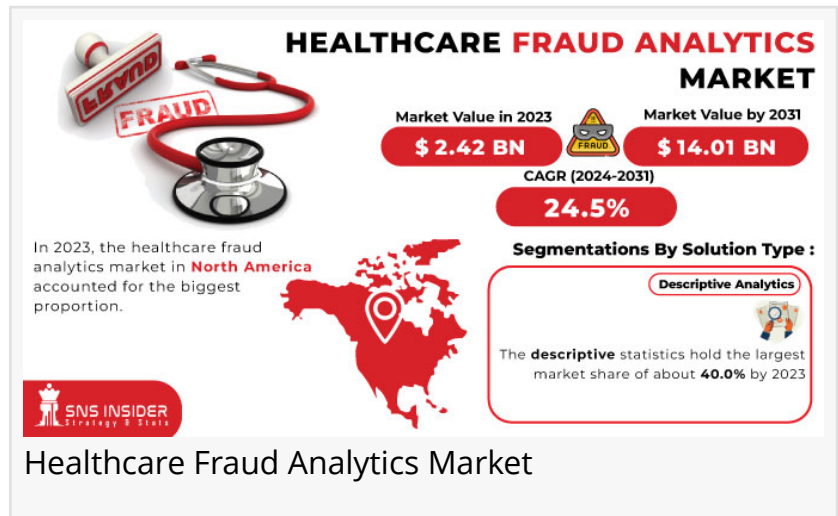# Healthcare Fraud Analytics Market to Surpass USD 14.01 Billion by 2031 Fueled by Rising Healthcare Costs

Healthcare Fraud Analytics Market Size and Share Analysis, Industry Overview, Report 2024-2031

AUSTIN, TEXAS, UNITED STATES, June 3, 2024 /EINPresswire.com/ -- The [Healthcare Fraud Analytics Market Size](#), valued at USD 2.42 Billion in 2023, is anticipated to reach a staggering USD 14.01 Billion by 2031. This translates to a remarkable compound annual growth rate (CAGR) of 24.5% projected throughout the forecast period from 2024 to 2031

Healthcare Fraud Analytics Market

The healthcare fraud analytics market is witnessing significant growth due to a multitude of factors, including the escalating costs of healthcare, the increasing number of patients opting for health insurance, and a growing emphasis on operational efficiency and reducing healthcare spending. Furthermore, the surge in fraudulent activities within the healthcare sector worldwide is propelling the demand for robust fraud detection solutions.

List of Healthcare Fraud Analytics Market Companies Profiled in Report:
- Conduent Inc
- Cotiviti Inc
- DXC Technology
- EXL Service Holdings Inc.
- HCL Technologies Limited
- IBM
- Optum Inc.
- OSP Labs
- SAS Institute Inc.
- Wipro Limited
- Others

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Several key factors are driving the expansion of the healthcare fraud analytics market. These
include:
-Rising Healthcare Expenditure: Globally, healthcare expenditure is on the rise, placing a
significant financial burden on governments and individuals. This necessitates stricter measures
to curb wasteful spending and identify fraudulent activities.

-Increasing Number of Patients with Health Insurance: With a growing population seeking health
insurance, the volume of healthcare claims is exponentially increasing. This creates a larger pool
of data that requires advanced analytics for fraud detection.

-Growing Pressure to Reduce Healthcare Spending: Governments and healthcare organizations
are constantly under pressure to optimize operational efficiency and reduce overall healthcare
spending. Healthcare fraud analytics solutions offer a cost-effective way to achieve this goal.

-Surging Fraudulent Activities: Unfortunately, the healthcare sector witnesses a significant
number of fraudulent activities, including unnecessary services being billed, fake claims, and
patient identity theft. This necessitates robust detection and prevention mechanisms.

The ever-growing financial burden of healthcare fraud necessitates efficient solutions
As per the National Healthcare Anti-Fraud Association, healthcare payers in the US alone lose
nearly USD 68 billion annually due to fraud. Traditional methods of fraud detection are often
time-consuming and ineffective. Conversely, data science, machine learning, and AI-powered
solutions offer a more proactive and precise approach to identifying and preventing fraud.

These advanced analytics solutions can analyze vast amounts of healthcare data to identify
patterns and anomalies indicative of fraudulent activity. This allows for early intervention and
prevents fraudulent claims from being processed. Additionally, these solutions can help
healthcare providers and insurers optimize resource allocation and improve overall healthcare
delivery quality.

A report published by Elsevier Inc. estimates that over USD 700 billion are lost annually due to
fraud, waste, and abuse within the US healthcare system. With Medicaid being a particularly
vulnerable target for such practices, healthcare fraud analytics solutions offer a crucial tool to
combat these financial losses. These solutions can effectively identify and prevent fraudulent
billing practices, ultimately boosting market growth.

The healthcare fraud analytics market is witnessing continuous advancements:
Biometric Verification Solutions: In March 2022, Veriff launched a suite of biometrics-powered
identity verification solutions specifically designed for the healthcare industry. This technology

utilizes facial recognition and artificial intelligence for user identification, potentially enhancing fraud prevention measures.

Industry Collaboration for Fraud Detection: The Canadian Life and Health Insurance Association (CLHIA) launched an initiative in February 2022 to combat fraud. This initiative involves pooling claims data and utilizing advanced AI tools to improve the detection and investigation of insurance benefits fraud.

Market Segment Analysis
By Solution Type
• Descriptive Analytics
• Prescriptive Analytics
• Predictive Analytics

Descriptive Analytics: Currently, descriptive analytics holds the dominant market share (around 40.0% as of 2023) due to its ease of use and effectiveness in identifying potential fraud through historical data analysis.

Predictive Analytics: Predictive analytics is expected to exhibit rapid growth during the forecast period. These solutions leverage historical data to identify potential fraud patterns and develop rules for flagging suspicious claims.

By Delivery Model
• On-Premise: On-premise solutions currently hold the largest revenue share due to the convenience of on-site data access, facilitating better record management and data monitoring.
• Cloud-Based: Cloud-based solutions are projected to witness the fastest growth rate due to their scalability and cost-effectiveness for managing large datasets. However, concerns regarding data security remain a challenge.

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

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North America is anticipated to maintain its dominance in the healthcare fraud analytics market throughout the forecast period

The United States has some of the highest healthcare expenditures globally, leading to a greater need for fraud detection solutions. North America boasts a high adoption rate of healthcare information technology, creating a robust infrastructure for utilizing healthcare fraud analytics solutions.

The prevalence of healthcare fraud cases in North America fuels the demand for advanced detection and prevention measures.

For instance, the National Health Care Anti-Fraud Association (NHCAA) estimates that the US healthcare industry loses over USD 10 billion annually due to fraud. This emphasizes the need for robust healthcare fraud analytics solutions in the region. Additionally, advancements by companies like Artivatic, with their AI-powered healthcare claims platform, further solidify North America's position in the market.

Key Takeaways from the Healthcare Fraud Analytics Market Study
• Gain a clear understanding of the projected market size, growth rate, and future trends in the healthcare fraud analytics market.
• Identify the most promising segments within the market, including solution types, delivery models, and end-users.
• Gain insights into the key players in the market, their product offerings, and competitive strategies.
• Understand the factors propelling market growth and the potential challenges that might hinder it.
• Explore the growth potential of the healthcare fraud analytics market in different regions across the globe.

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