

Healthcare Fraud Detection Market Forecasts to 2034 – Global Analysis By Component (Software and Services), Solution Type, Technology, Fraud Type, Application, End User and By Geography

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Abstracts

According to Statistics MRC, the Global Healthcare Fraud Detection Market is accounted for \$5.4 billion in 2026 and is expected to reach \$14.7 billion by 2034, growing at a CAGR of 13.3% during the forecast period. Healthcare Fraud Detection encompasses a broad set of software solutions, analytical platforms, and services that identify, prevent, and investigate fraudulent, wasteful, and abusive activities within healthcare payment and claims ecosystems. Utilizing advanced technologies including artificial intelligence, machine learning, predictive analytics, and natural language processing, these systems analyze vast volumes of claims, billing, prescription, and eligibility data to detect anomalous patterns indicative of fraud.

Market Dynamics:

Driver:

Escalating healthcare fraud losses and growing regulatory mandates for fraud prevention

Healthcare fraud imposes an estimated hundreds of billions of dollars in annual losses on public and private payers globally, with schemes ranging from phantom billing and upcoding to prescription drug diversion and identity theft. Governments and regulatory bodies in the United States, Europe, and beyond have responded with stringent mandates requiring payers to implement proactive fraud detection capabilities as a condition of program participation. CMS requirements for Medicaid and Medicare fraud

prevention, combined with commercial insurer obligations under state insurance regulations, are compelling organizations to invest in sophisticated AI-driven detection platforms that can identify complex multi-party fraud schemes beyond the capability of traditional rule-based systems.

Restraint:

High false positive rates disrupting legitimate claims processing

A persistent challenge confronting healthcare fraud detection systems is the generation of excessive false positive alerts, which incorrectly flag legitimate claims for investigation and create administrative burden for payer organizations and healthcare providers alike. High false positive rates erode clinician and administrator trust in detection systems, potentially leading to reduced adoption of automated alerts and continued reliance on manual review processes. Calibrating fraud detection algorithms to achieve adequate sensitivity without generating unmanageable investigation queues requires extensive model tuning and domain expertise. This technical challenge, combined with the dynamic evolution of fraud schemes that continuously adapt to detection methodologies, demands ongoing model refinement investment from solution providers.

Opportunity:

AI and predictive analytics for real-time pre-payment fraud prevention

The evolution of fraud detection from post-payment audit and recovery to real-time pre-payment prevention represents the most significant growth opportunity in the market. AI-powered predictive analytics platforms can evaluate claims against complex behavioral models derived from historical fraud patterns in milliseconds, enabling payers to reject or flag suspicious claims before payment is disbursed, eliminating the costly and time-consuming process of recovery. The integration of network analytics capabilities, which model relationships between providers, billing entities, and patients to identify organized fraud rings, is further enhancing prevention efficacy. Real-time detection capabilities are becoming a competitive differentiator for payers seeking to minimize fraud-related financial losses.

Threat:

Sophisticated and continuously evolving healthcare fraud schemes

Healthcare fraudsters continuously adapt their schemes in response to advances in detection capabilities, developing new methodologies that exploit regulatory gaps, digital identity vulnerabilities, and emerging telehealth billing frameworks. The rise of telehealth fraud, involving fictitious remote consultations and improper billing for services never rendered, has created new detection challenges requiring rapid model updating. Additionally, increasingly sophisticated organized crime networks employing healthcare professionals with clinical knowledge to construct plausible fraudulent claims create challenges that rule-based and even basic machine learning systems struggle to address. The adversarial nature of the fraud detection domain necessitates continuous investment in adaptive AI systems and human expert oversight.

Covid-19 Impact:

The COVID-19 pandemic precipitated a surge in healthcare fraud activity, as emergency authorization of new telehealth services, expanded billing codes, and relief program funding created fertile ground for exploitation. Fraudulent billing for COVID-19 testing, treatment, and vaccination services generated significant losses across government and commercial payer programs. The crisis simultaneously accelerated investment in AI-driven fraud detection capabilities as payers recognized the inadequacy of legacy rule-based systems in detecting novel scheme variations at scale. Post-pandemic, the expanded telehealth billing ecosystem and residual fraud patterns have maintained heightened demand for advanced fraud analytics platforms with adaptive detection capabilities.

The Software segment is expected to be the largest during the forecast period

The Software segment is expected to account for the largest market share during the forecast period. Advanced analytics software, AI-driven claims review platforms, and real-time detection engines represent the highest-value components of fraud detection solutions, generating substantial licensing and subscription revenues from health insurers, government payers, and healthcare providers. The transition toward SaaS delivery models is broadening software accessibility and enabling smaller regional payers to deploy sophisticated fraud prevention capabilities previously available only to large national insurers. Continuous algorithmic enhancements and expanding integration with claims management systems sustain strong software segment demand.

The Artificial Intelligence (AI) segment is expected to have the highest CAGR during the forecast period

Over the forecast period, the Software segment is predicted to witness the highest growth rate. AI-powered platforms demonstrate superior fraud detection accuracy compared to conventional rule-based approaches by identifying subtle and complex patterns across large, multidimensional datasets that are imperceptible to human analysts. The application of unsupervised learning for anomaly detection, graph neural networks for fraud network mapping, and natural language processing for unstructured claims data analysis is expanding AI's detection capabilities across an increasingly diverse range of fraud scheme types. Growing vendor investment in explainable AI is also addressing regulatory requirements for audit-ready fraud detection decision transparency.

Region with largest share:

During the forecast period, the North America region is expected to hold the largest market share. The United States generates the greatest absolute demand for fraud detection solutions, driven by the scale of its public healthcare programs, a large private insurance market, and stringent federal anti-fraud enforcement frameworks administered by the Department of Justice and Office of Inspector General. Significant financial penalties associated with False Claims Act violations, combined with CMS pay-and-chase reform initiatives emphasizing predictive prevention, are compelling healthcare organizations to invest in sophisticated fraud analytics platforms. Canada's evolving provincial healthcare fraud prevention programs contribute to regional market volume.

Region with highest CAGR:

Over the forecast period, the Asia Pacific region is anticipated to exhibit the highest CAGR. Rapidly expanding national health insurance programs across China, India, South Korea, and Southeast Asia are generating growing exposure to fraudulent claims activity, prompting governments and insurance regulators to mandate fraud prevention investments. The region's large and growing digital health ecosystem, combined with increasing adoption of AI across financial services and government operations, is creating a technology-receptive environment for advanced healthcare fraud analytics platforms. Growing awareness of healthcare fraud risks among private insurers in emerging Asian markets is further fueling regional demand.

Key players in the market

Some of the key players in Global Healthcare Fraud Detection Market include SAS Institute Inc., IBM Corporation, Optum Inc., Cotiviti, LexisNexis Risk Solutions, Conduent Inc., EXL Service, Wipro Limited, HCL Technologies, Fair Isaac Corporation, PegaSystems Inc., Oracle Corporation, McKesson Corporation, Gainwell Technologies, and NTT DATA.

Key Developments:

In January 2026, Cotiviti announced the launch of its enhanced Eliza Payment Integrity platform, incorporating new generative AI capabilities for automated explanation of benefits review and anomaly investigation narrative generation. The upgraded platform enables payer organizations to significantly accelerate their claims review workflows by automating the identification and documentation of overpayment opportunities across complex multi-code billing scenarios, reducing manual analyst workload.

In March 2026, IBM Corporation announced a strategic partnership with a major U.S. government health program administrator to deploy its Watson Health fraud analytics platform across a portfolio of Medicaid managed care plans. The engagement focuses on implementing real-time pre-payment fraud screening using advanced network analytics to identify provider fraud rings and coordinated billing anomalies, targeting a measurable reduction in improper payment rates within the first year of deployment.

Components Covered:

Software

Services

Solution Types Covered:

Payment Integrity Solutions

Claims Review Solutions

Identity & Access Management Solutions

Revenue Cycle Monitoring Solutions

Audit & Recovery Solutions

Case Management Solutions

Network Analytics Solutions

Technologies Covered:

Artificial Intelligence (AI)

Machine Learning (ML)

Predictive Analytics

Big Data Analytics

Blockchain

Robotic Process Automation (RPA)

Natural Language Processing (NLP)

Fraud Types Covered:

Claims Fraud

Billing Fraud

Prescription Fraud

Identity Theft & Eligibility Fraud

Provider Fraud

Waste & Abuse Detection

Applications Covered:

Insurance Claims Analysis

Payment Accuracy & Integrity

Provider Monitoring

Member & Patient Analytics

Pharmacy Claims Monitoring

Compliance & Risk Management

Real-Time Fraud Detection

End Users Covered:

Public & Government Healthcare Agencies

Private Health Insurance Providers

Healthcare Payers

Healthcare Providers

Third-Party Administrators (TPAs)

Pharmacy Benefit Managers (PBMs)

Regions Covered:

North America

United States

Canada

Mexico

Europe

United Kingdom

Germany

France

Italy

Spain

Netherlands

Belgium

Sweden

Switzerland

Poland

Rest of Europe

Asia Pacific

China

Japan

India

South Korea

Australia

Indonesia

Thailand

Malaysia

Singapore

Vietnam

Rest of Asia Pacific

South America

Brazil

Argentina

Colombia

Chile

Peru

Rest of South America

Rest of the World (RoW)

Middle East

Saudi Arabia

United Arab Emirates

Qatar

Israel

Rest of Middle East

Africa

South Africa

Egypt

Morocco

Rest of Africa

What our report offers:

- Market share assessments for the regional and country-level segments
- Strategic recommendations for the new entrants
- Covers Market data for the years 2023, 2024, 2025, 2026, 2027, 2028, 2030, 2032 and 2034
- Market Trends (Drivers, Constraints, Opportunities, Threats, Challenges, Investment Opportunities, and recommendations)
- Strategic recommendations in key business segments based on the market estimations
- Competitive landscaping mapping the key common trends
- Company profiling with detailed strategies, financials, and recent developments
- Supply chain trends mapping the latest technological advancements

Free Customization Offerings:

All the customers of this report will be entitled to receive one of the following free customization options:

Company Profiling

Comprehensive profiling of additional market players (up to 3)

SWOT Analysis of key players (up to 3)

Regional Segmentation

Market estimations, Forecasts and CAGR of any prominent country as

per the client's interest (Note: Depends on feasibility check)

Competitive Benchmarking

Benchmarking of key players based on product portfolio, geographical presence, and strategic alliances

Contents

1 EXECUTIVE SUMMARY

- 1.1 Market Snapshot and Key Highlights
- 1.2 Growth Drivers, Challenges, and Opportunities
- 1.3 Competitive Landscape Overview
- 1.4 Strategic Insights and Recommendations

2 RESEARCH FRAMEWORK

- 2.1 Study Objectives and Scope
- 2.2 Stakeholder Analysis
- 2.3 Research Assumptions and Limitations
- 2.4 Research Methodology
 - 2.4.1 Data Collection (Primary and Secondary)
 - 2.4.2 Data Modeling and Estimation Techniques
 - 2.4.3 Data Validation and Triangulation
 - 2.4.4 Analytical and Forecasting Approach

3 MARKET DYNAMICS AND TREND ANALYSIS

- 3.1 Market Definition and Structure
- 3.2 Key Market Drivers
- 3.3 Market Restraints and Challenges
- 3.4 Growth Opportunities and Investment Hotspots
- 3.5 Industry Threats and Risk Assessment
- 3.6 Technology and Innovation Landscape
- 3.7 Emerging and High-Growth Markets
- 3.8 Regulatory and Policy Environment
- 3.9 Impact of COVID-19 and Recovery Outlook

4 COMPETITIVE AND STRATEGIC ASSESSMENT

- 4.1 Porter's Five Forces Analysis
 - 4.1.1 Supplier Bargaining Power
 - 4.1.2 Buyer Bargaining Power
 - 4.1.3 Threat of Substitutes
 - 4.1.4 Threat of New Entrants

- 4.1.5 Competitive Rivalry
- 4.2 Market Share Analysis of Key Players
- 4.3 Product Benchmarking and Performance Comparison

5 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY COMPONENT

- 5.1 Software
- 5.2 Services

6 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY SOLUTION TYPE

- 6.1 Payment Integrity Solutions
- 6.2 Claims Review Solutions
- 6.3 Identity & Access Management Solutions
- 6.4 Revenue Cycle Monitoring Solutions
- 6.5 Audit & Recovery Solutions
- 6.6 Case Management Solutions
- 6.7 Network Analytics Solutions

7 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY TECHNOLOGY

- 7.1 Artificial Intelligence (AI)
- 7.2 Machine Learning (ML)
- 7.3 Predictive Analytics
- 7.4 Big Data Analytics
- 7.5 Blockchain
- 7.6 Robotic Process Automation (RPA)
- 7.7 Natural Language Processing (NLP)

8 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY FRAUD TYPE

- 8.1 Claims Fraud
- 8.2 Billing Fraud
- 8.3 Prescription Fraud
- 8.4 Identity Theft & Eligibility Fraud
- 8.5 Provider Fraud
- 8.6 Waste & Abuse Detection

9 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY APPLICATION

- 9.1 Insurance Claims Analysis
- 9.2 Payment Accuracy & Integrity
- 9.3 Provider Monitoring
- 9.4 Member & Patient Analytics
- 9.5 Pharmacy Claims Monitoring
- 9.6 Compliance & Risk Management
- 9.7 Real-Time Fraud Detection

10 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY END USER

- 10.1 Public & Government Healthcare Agencies
- 10.2 Private Health Insurance Providers
- 10.3 Healthcare Payers
- 10.4 Healthcare Providers
- 10.5 Third-Party Administrators (TPAs)
- 10.6 Pharmacy Benefit Managers (PBMs)

11 GLOBAL HEALTHCARE FRAUD DETECTION MARKET, BY GEOGRAPHY

- 11.1 North America
 - 11.1.1 United States
 - 11.1.2 Canada
 - 11.1.3 Mexico
- 11.2 Europe
 - 11.2.1 United Kingdom
 - 11.2.2 Germany
 - 11.2.3 France
 - 11.2.4 Italy
 - 11.2.5 Spain
 - 11.2.6 Netherlands
 - 11.2.7 Belgium
 - 11.2.8 Sweden
 - 11.2.9 Switzerland
 - 11.2.10 Poland
 - 11.2.11 Rest of Europe
- 11.3 Asia Pacific
 - 11.3.1 China
 - 11.3.2 Japan

- 11.3.3 India
- 11.3.4 South Korea
- 11.3.5 Australia
- 11.3.6 Indonesia
- 11.3.7 Thailand
- 11.3.8 Malaysia
- 11.3.9 Singapore
- 11.3.10 Vietnam
- 11.3.11 Rest of Asia Pacific
- 11.4 South America
 - 11.4.1 Brazil
 - 11.4.2 Argentina
 - 11.4.3 Colombia
 - 11.4.4 Chile
 - 11.4.5 Peru
 - 11.4.6 Rest of South America
- 11.5 Rest of the World (RoW)
 - 11.5.1 Middle East
 - 11.5.1.1 Saudi Arabia
 - 11.5.1.2 United Arab Emirates
 - 11.5.1.3 Qatar
 - 11.5.1.4 Israel
 - 11.5.1.5 Rest of Middle East
 - 11.5.2 Africa
 - 11.5.2.1 South Africa
 - 11.5.2.2 Egypt
 - 11.5.2.3 Morocco
 - 11.5.2.4 Rest of Africa

12 STRATEGIC MARKET INTELLIGENCE

- 12.1 Industry Value Network and Supply Chain Assessment
- 12.2 White-Space and Opportunity Mapping
- 12.3 Product Evolution and Market Life Cycle Analysis
- 12.4 Channel, Distributor, and Go-to-Market Assessment

13 INDUSTRY DEVELOPMENTS AND STRATEGIC INITIATIVES

- 13.1 Mergers and Acquisitions

- 13.2 Partnerships, Alliances, and Joint Ventures
- 13.3 New Product Launches and Certifications
- 13.4 Capacity Expansion and Investments
- 13.5 Other Strategic Initiatives

14 COMPANY PROFILES

- 14.1 SAS Institute Inc.
- 14.2 IBM Corporation
- 14.3 Optum Inc.
- 14.4 Cotiviti
- 14.5 LexisNexis Risk Solutions
- 14.6 Conduent Inc.
- 14.7 EXL Service
- 14.8 Wipro Limited
- 14.9 HCL Technologies
- 14.10 Fair Isaac Corporation
- 14.11 PegaSystems Inc.
- 14.12 Oracle Corporation
- 14.13 McKesson Corporation
- 14.14 Gainwell Technologies
- 14.15 NTT DATA

List Of Tables

LIST OF TABLES

Table 1 Global Healthcare Fraud Detection Market Outlook, By Region (2023-2034) (\$MN)

Table 2 Global Healthcare Fraud Detection Market Outlook, By Component (2023-2034) (\$MN)

Table 3 Global Healthcare Fraud Detection Market Outlook, By Software (2023-2034) (\$MN)

Table 4 Global Healthcare Fraud Detection Market Outlook, By Services (2023-2034) (\$MN)

Table 5 Global Healthcare Fraud Detection Market Outlook, By Solution Type (2023-2034) (\$MN)

Table 6 Global Healthcare Fraud Detection Market Outlook, By Payment Integrity Solutions (2023-2034) (\$MN)

Table 7 Global Healthcare Fraud Detection Market Outlook, By Claims Review Solutions (2023-2034) (\$MN)

Table 8 Global Healthcare Fraud Detection Market Outlook, By Identity & Access Management Solutions (2023-2034) (\$MN)

Table 9 Global Healthcare Fraud Detection Market Outlook, By Revenue Cycle Monitoring Solutions (2023-2034) (\$MN)

Table 10 Global Healthcare Fraud Detection Market Outlook, By Audit & Recovery Solutions (2023-2034) (\$MN)

Table 11 Global Healthcare Fraud Detection Market Outlook, By Case Management Solutions (2023-2034) (\$MN)

Table 12 Global Healthcare Fraud Detection Market Outlook, By Network Analytics Solutions (2023-2034) (\$MN)

Table 13 Global Healthcare Fraud Detection Market Outlook, By Technology (2023-2034) (\$MN)

Table 14 Global Healthcare Fraud Detection Market Outlook, By Artificial Intelligence (AI) (2023-2034) (\$MN)

Table 15 Global Healthcare Fraud Detection Market Outlook, By Machine Learning (ML) (2023-2034) (\$MN)

Table 16 Global Healthcare Fraud Detection Market Outlook, By Predictive Analytics (2023-2034) (\$MN)

Table 17 Global Healthcare Fraud Detection Market Outlook, By Big Data Analytics (2023-2034) (\$MN)

Table 18 Global Healthcare Fraud Detection Market Outlook, By Blockchain

(2023-2034) (\$MN)

Table 19 Global Healthcare Fraud Detection Market Outlook, By Robotic Process Automation (RPA) (2023-2034) (\$MN)

Table 20 Global Healthcare Fraud Detection Market Outlook, By Natural Language Processing (NLP) (2023-2034) (\$MN)

Table 21 Global Healthcare Fraud Detection Market Outlook, By Fraud Type (2023-2034) (\$MN)

Table 22 Global Healthcare Fraud Detection Market Outlook, By Claims Fraud (2023-2034) (\$MN)

Table 23 Global Healthcare Fraud Detection Market Outlook, By Billing Fraud (2023-2034) (\$MN)

Table 24 Global Healthcare Fraud Detection Market Outlook, By Prescription Fraud (2023-2034) (\$MN)

Table 25 Global Healthcare Fraud Detection Market Outlook, By Identity Theft & Eligibility Fraud (2023-2034) (\$MN)

Table 26 Global Healthcare Fraud Detection Market Outlook, By Provider Fraud (2023-2034) (\$MN)

Table 27 Global Healthcare Fraud Detection Market Outlook, By Waste & Abuse Detection (2023-2034) (\$MN)

Table 28 Global Healthcare Fraud Detection Market Outlook, By Application (2023-2034) (\$MN)

Table 29 Global Healthcare Fraud Detection Market Outlook, By Insurance Claims Analysis (2023-2034) (\$MN)

Table 30 Global Healthcare Fraud Detection Market Outlook, By Payment Accuracy & Integrity (2023-2034) (\$MN)

Table 31 Global Healthcare Fraud Detection Market Outlook, By Provider Monitoring (2023-2034) (\$MN)

Table 32 Global Healthcare Fraud Detection Market Outlook, By Member & Patient Analytics (2023-2034) (\$MN)

Table 33 Global Healthcare Fraud Detection Market Outlook, By Pharmacy Claims Monitoring (2023-2034) (\$MN)

Table 34 Global Healthcare Fraud Detection Market Outlook, By Compliance & Risk Management (2023-2034) (\$MN)

Table 35 Global Healthcare Fraud Detection Market Outlook, By Real-Time Fraud Detection (2023-2034) (\$MN)

Table 36 Global Healthcare Fraud Detection Market Outlook, By End User (2023-2034) (\$MN)

Table 37 Global Healthcare Fraud Detection Market Outlook, By Public & Government Healthcare Agencies (2023-2034) (\$MN)

Table 38 Global Healthcare Fraud Detection Market Outlook, By Private Health Insurance Providers (2023-2034) (\$MN)

Table 39 Global Healthcare Fraud Detection Market Outlook, By Healthcare Payers (2023-2034) (\$MN)

Table 40 Global Healthcare Fraud Detection Market Outlook, By Healthcare Providers (2023-2034) (\$MN)

Table 41 Global Healthcare Fraud Detection Market Outlook, By Third-Party Administrators (TPAs) (2023-2034) (\$MN)

Table 42 Global Healthcare Fraud Detection Market Outlook, By Pharmacy Benefit Managers (PBMs) (2023-2034) (\$MN)

Note: Tables for North America, Europe, APAC, South America, and Rest of the World (RoW) are also represented in the same manner as above.

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