360° HEALTH INSURANCE

GROUP INSURANCE

# Understanding the effects of fraud and abuse on your group benefits plan

## Let's work together to prevent them

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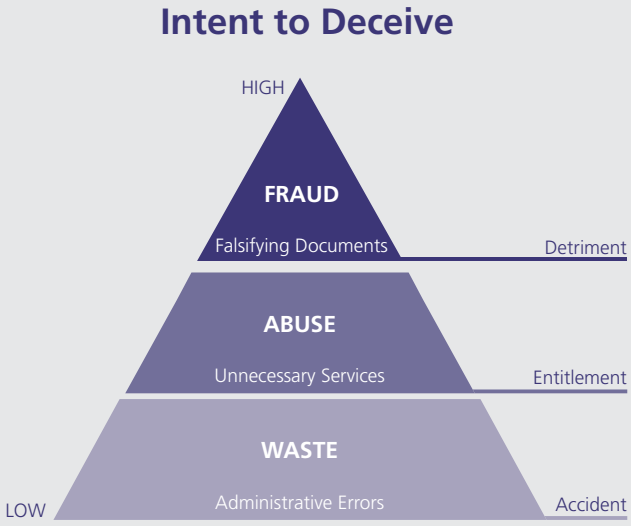
# Fraud and abuse have a big impact on your group benefits plan

The cost of healthcare in Canada rose to about $215 billion in 2014.[1] An estimated 2% to 10% of that amount was lost to fraud and abuse—that adds up to as much as $2 billion in 2014 alone.[2] That's a lot of money to lose. Especially when plan sponsors are faced with the escalating costs of prescription drugs and chronic illness.

[1] Canadian Institute for Health Information.
[2] Canadian Health Care Anti-fraud Association.

## Fraud vs. abuse vs. waste

Healthcare fraud is deliberate deception for financial gain at the expense of a group benefits plan. Abuse is more of a grey area and often stems from a sense of entitlement rather than criminal intent. Waste is normally unintentional—often the result of an administrative error or missing documentation.




Fraud is illegal. Abuse is not usually illegal, but it's highly unethical. Waste isn't illegal or unethical, but it's time consuming and it makes the claims process much longer.

### EXAMPLE OF WASTE

A plan member submits a claim for compression stockings, but the medical recommendation provided is dated after the stockings were purchased.

### EXAMPLE OF ABUSE

Plan members and/or their dependants use all the annual maximums in your policy every year, even if the products and services provided are not medically necessary.

### EXAMPLE OF FRAUD

A plan member or healthcare provider knowingly falsifies a claim or lies about products or services provided.

# True crime – real cases of fraud

Healthcare fraud can be committed in one of three ways: by the healthcare provider, by the plan member, or by the healthcare provider and plan members working together. We've uncovered cases of all three types of fraud. Here are just a few examples.

## Healthcare provider

An audit check revealed that a plan member had submitted a number of claims for drugs that had been prescribed by several different doctors. We contacted each doctor, and all confirmed that they had not prescribed the drugs for the plan member. The plan member, who was a practicing pharmacist, had been submitting false electronic claims using the doctors' identification numbers. We recovered all the amounts claimed and reported the plan member to his professional association. The Order of Pharmacists subsequently revoked his license to practice.

## Plan member

As part of a random online claims audit, we asked a plan member to send us the receipt for a medical procedure she had claimed. Instead of sending us the receipt, she sent us a cheque for the amount she had been reimbursed. Upon further investigation, we found that she had submitted a similar online claim for her son. We contacted the healthcare provider, who confirmed that he had not performed the procedure on either the mother or the son. We recovered the amounts claimed and the plan sponsor fired the plan member.

## Healthcare provider and plan members

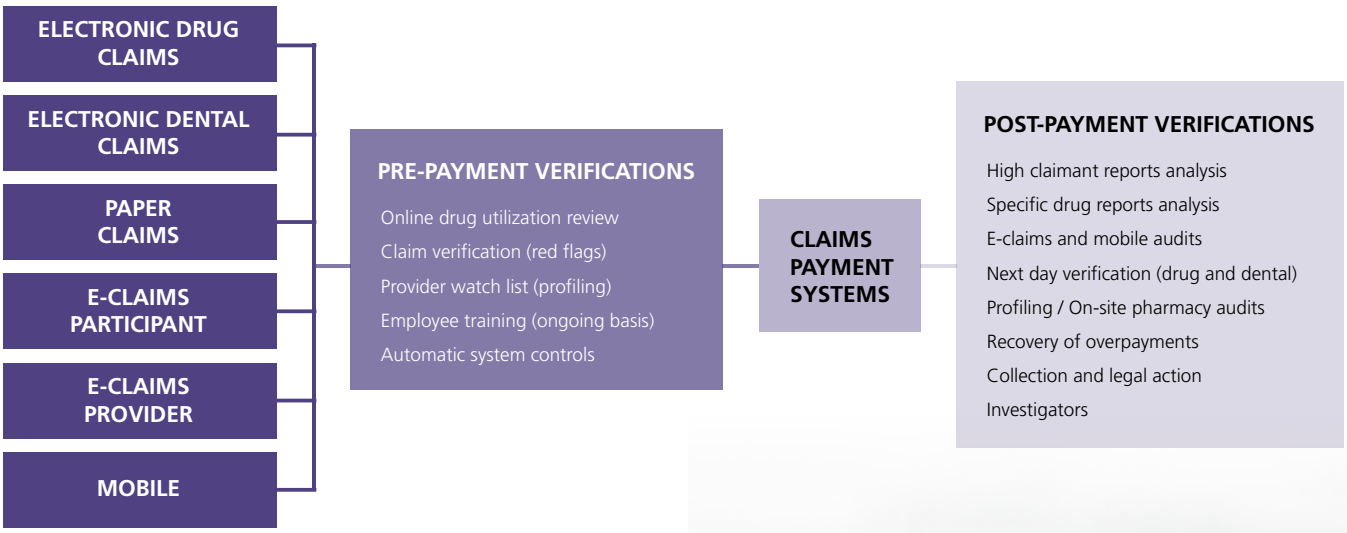
Our fraud and abuse team received an anonymous tip that a clinic was working with several plan members to defraud their group insurance plan. The healthcare provider encouraged plan members to choose items from a selection of new clothes, shoes and designer bags. The clinic then issued receipts for products covered by the plan members' plan but never provided. When the plan members got their reimbursements, they went back to the clinic and used the money to pay for the items the clinic had set aside for them. We began monitoring all claims from the clinic and sent inspectors out to investigate its activities onsite. The inspectors confirmed that the plan members and healthcare provider were working in collusion. Our investigation cut the problem off at its source.

# What we do to protect your plan

Fortunately, we can help you combat fraud and abuse. We step in before payments are made with pre-payment verifications and then follow up with post-payment profiling reports to detect suspicious trends and behaviours. Our goal is to ensure that:

- your plan only pays for services that were actually provided
- the healthcare provider who provided them is authorized to do so
- the plan member is eligible for the coverage
- the price paid was reasonable
- the services or medications provided were medically necessary

## Our fraud and abuse prevention and detection process at a glance




Our fraud and abuse team monitors claims based on specific red flags and further protects your plan with random checks. Here are some of the **red flags** we watch for:

- an invoice with a modified date
- an entire family claiming similar supplies or services
- a history of frequent or high-value claims
- many plan members in one group using the same healthcare provider or trends
- a plan member consulting many healthcare providers or buying drugs at numerous pharmacies
- vague or evasive answers from plan members and/or healthcare providers when we ask questions

# What you can do to help us protect your plan

You play a crucial role in helping us prevent fraud and abuse. There are a number of things you can do that will make a real difference.

## Adapt your plan to reduce the likelihood of fraud and abuse

Plan design is the single most important element that makes a group insurance plan vulnerable to possible fraud[3] and abuse. Here are some features you can introduce—at no extra cost—to limit fraudulent claims and abuse.

[3] *Benefits Advisor* – Business Insights.

| FRAUD AND ABUSE RESISTANT PLAN FEATURES | | | |
|---|---|---|---|
| **HEALTH SPENDING ACCOUNT** | **DEDUCTIBLES AND COPAYMENTS** | **REASONABLE COVERAGE LIMITS** | **ACTIVE PHARMACY** |
| Plan members can use the set amount given to them as they see fit. Flexibility for them; cost containment for you. | Plan members share in the costs, giving them a vested interest in controlling their spending. | Puts a cap on plan members' coverage within fair and reasonable limits. | Changes plan members' behaviour by reviewing prescriptions rather than just reacting to claims. |

## Educate plan members and encourage them to do their part

Fraud is clearly wrong, but certain types of abuse may not seem wrong to all plan members. Some may think they are entitled to claim all the benefits allotted to them and their dependants every year, even if the products and services claimed are not medically necessary. And others may not be aware that healthcare providers commit fraud, or how they do it. The more your plan members know about the negative impact of fraud and abuse, the better equipped—and more likely—they'll be to help prevent them. We've posted an anti-fraud and abuse pamphlet on their secure site to help encourage them to do their part.

**Build an anti-fraud/abuse culture in your workplace and let plan members know *what they can do* to help protect your group benefits plan.**

# How to report fraud

**There are many ways to report fraud**

- Call the Customer Contact Centre
- Send an email to our anti-fraud address **anti-fraud@dfs.ca**
- Call our toll-free number 1-866-692-7227
- Contact the Canadian Health Care Anti-fraud Association at **www.chcaa.org**

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## ABOUT DESJARDINS INSURANCE

Desjardins Insurance has been offering a wide range of life and health insurance and retirement savings products to individuals, groups and businesses for more than a century. As one of Canada's five largest life insurers, it oversees the financial security of over five million Canadians from offices across the country. Desjardins Insurance is part of Desjardins Group, the country's leading cooperative financial group.

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