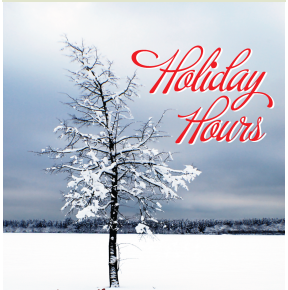
INSIGHTS

DECEMBER 2008
ISSUED QUARTERLY

IN THIS ISSUE...



The staff at RWAM Insurance Administrators Inc. would like to wish you a safe holiday season & the best of health and happiness in 2009.

Wed. Dec. 24 - Closed at 1:00 pm
Thurs. Dec. 25 - Closed all day
Fri. Dec. 26 - Closed all day
Wed. Dec. 31 - Closed at 1:00 pm
Thurs. Jan. 1 - Closed all day
Fri. Jan. 2 - Closed all day

The office is open regular hours on Dec. 22, 23, 29 & 30.

Fraud Squad

Increasing your awareness to an evergrowing issue

Each year, private plans lose large sums of money to benefits fraud, which also drives up plan costs. But there are steps that employers can take to protect themselves - and their plan members - from underhanded activities.

Plan sponsors are acutely aware of the rising costs of providing employee benefits - in particular, the cost of extended health and dental insurance. What many sponsors may not appreciate, however, is the extent to which fraudulent conduct on the part of patients and healthcare providers contributes to escalating premium levels.

While no firm figures are available, the Canadian Health Care Anti-fraud Association estimates that 2% to 10% of all healthcare dollars spent in North America are spent fraudulently. With healthcare spending in Canada estimated to have surpassed $160 billion in 2007, this suggests that the amount lost to healthcare-related fraud falls between $3.2 billion and $16 billion annually. Even if public healthcare spending is excluded, with private healthcare expenditures in 2007 estimated at close to $50 billion, between $1 billion and $5 billion is lost by insurers, plan sponsors and members each year. And, with healthcare inflation running in excess of 10% annually, these figures are increasing at an explosive rate.

Even if these losses are conservative, it's a staggering sum - one that is ultimately passed on to the employers and plan members in the form of higher benefits premiums. Moreover, incidences of fraud are not isolated. According to the 2004 Canadian Health Care Fraud Survey, 94.9% of plan sponsors have been victimized by at least one fraudulent claim.

Deception Points

Fraud comes in many forms, and the ingenuity of the perpetrator is often the only limit to the schemes employed. However, certain types of fraud are reported most often and inflict significant damage on insured plans.

The most common types of fraud engineered by plan members fall into the following categories: malingering (exaggerating illness or injury to collect additional disability benefits); doctor shopping (obtaining multiple drug prescriptions from various physicians); misrepresenting dependents (maintaining eligibility for individuals not qualified for benefits such as formerly dependent children who cease to qualify under the terms of the plan, or failing to coordinate benefits with an insured spouse); and submitting false claims.

Fraud committed by medical service providers generally takes the form of billing for services that are not medically necessary, not rendered or more expensive than those actually performed (upcoding), or billing for non-covered services disguised as medically necessary covered treatments for the purposes of obtaining reimbursement (in many cases, the patient would decline treatment but for the assurance that the treatment is covered by insurance). These fraudulent activities can occur with or without the assistance of the patient. In many instances, the patient is unaware of the service provider's misconduct. In other cases, the parties are joint participants, with the patient receiving kickbacks, or other benefits from the provider.

Discovery Channels

Attempts by plan sponsors, insurance carriers and law enforcement to reduce fraudulent benefits claims generally fall into one of four categories: prevention, detection, investigation and prosecution. The success of any fraud reduction initiative will depend, in large measure, on the relationship between the plan sponsor and its benefits administrator, regardless of whether the plan is insured or an administrative services only arrangement.

The insurance industry is devoting increasing resources to reducing benefits fraud and developing more sophisticated programs for identifying patterns of fraudulent behaviour to limit costs and increase the chances of recovery. As a result, when engaging in a search for a benefits administrator or evaluating the performance of an existing administrator, plan sponsors should obtain detailed information about the administrator's counter-fraud measures. Sponsors should also extract a commitment - either orally or, preferably, as part of a written contract - from the benefits administrator that its counter-fraud initiatives will stay current and will meet or exceed industry best practices with respect to the prevention and detection of fraudulent activity.

continued on reverse...

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2009 Premium Summary

Ontario Residents

1two3

RENEWAL RATES - Designed specifically for the Self-Employed & Small Group Employer

MANDATORY BENEFITS

Life Insurance, Dependent Life, AD&D, Extended Health Care & Out-of-Canada

All Eligible Employees

Single Coverage	$ 69.90 /month
Family Coverage	$ 151.00 /month
Exempt Coverage	$ 14.50 /month

OPTIONAL BENEFITS

Dental

All Eligible Employees

Single Coverage	$ 43.40 /month
Family Coverage	$ 107.00 /month

Long Term Disability

Some occupations are not eligible for Disability coverage due to the nature of the risk.

All Eligible Employees $2.85/$100 of benefit

Plan Changes for the Year Ahead

Commencing January 1st, 2009, the following changes will be made to the overall plan design for all new and existing 1two3 groups:

- Increase to Annual Prescription drug Maximum
  The annual prescription drug maximum will increase from $1,500 to $2,000 per insured.
- Benefit Maximum Reduction for Prosthetics
  The lifetime benefit maximum for prosthetics will reduce from $25,000 to $10,000 per insured.
- Increase to Out-of-Province/Canada Benefit
  Your annual maximum for your Out of Province/Canada benefit will increase from $1,000,000 to $2,000,000 per insured person.

Fraud, ...continued from reverse

Internal Initiatives - There are also opportunities for plan sponsors to make their plans more fraud-resistant through increasing employee awareness of the magnitude and cost of benefits fraud, encouraging honest use of benefits plan and implementing plan design features to frustrate would-be defrauders.

Employee communications materials should include clear references to the impact of fraudulent claims on the cost of employee benefits. Materials prepared by the benefits administrator should be reviewed by the plan sponsor to ensure that they emphasize the member's obligation to make honest use of the benefits plan and state that making a fraudulent claim can void coverage and/or constitute a criminal offence. Education sessions on employee benefits plans should draw explicit attention to this obligation, and information about how to report suspicious activity should be posted prominently in the workplace and/or on the company intranet.

Most employers have implemented fraud prevention measures aimed at protecting company assets from rogue employees and service providers. Plan sponsors should ensure that conflict-of-interest and whistle-blower policies (ensuring protection for employees wishing to report their suspicions of fraud or other improprieties), as well as written codes of conduct, are broadly drafted to ensure that each makes reference to employee benefits plan usage. Employees who are reluctant to report suspicious activity on the part of co-workers to company personnel should be encouraged to use anonymous tip lines established by the benefits administrator. In addition, employees should receive regular reminders to review the Explanation of Benefits statement circulated by the insurer, along with any receipts provided by the medical services provider, to ensure that these documents accurately reflect the services provided. Any inaccuracies should be reported immediately.

Plan design can also effectively deter fraud. The use of co-pays and deductibles - while not always popular with employees - provides incentives to plan members to agree to only medically necessary procedures, obtain second opinions (particularly with respect to dental work) and carefully examine claims information. Similarly, while many plan sponsors have implemented annual and/or lifetime hard-dollar caps on certain benefits items as a means of controlling costs, these limits also reduce opportunities for fraud when applied to items that have proven most vulnerable to abuse, such as orthotics, medical stockings and other medical supplies, as well as paramedical treatments such as massage therapy.

Dealing with Defrauders

If fraudulent activity is uncovered, plan sponsors should be careful not to hastily publicize the discovery. Any investigation of fraud may be compromised if the perpetrator is given notice that his or her activities have drawn suspicion. Instead, plan sponsors should immediately contact the insurer, as the insurer is the direct victim of the fraud and is best positioned to lead an investigation. They may also consider informing law enforcement - particularly if there is any suggestion that the employee is not working alone or is engaged in a wide-scale fraud - as benefits fraud is frequently prosecuted under the Criminal Code of Canada.

Finally, plan sponsors should consider contacting legal counsel if they have been defrauded directly (e.g., if the plan is self-insured), as well as to ensure that they are not otherwise implicated in the fraud - for example, an insurer may allege that the employer, through its conduct, enabled the fraud to take place. Plan sponsors should also immediately establish and mark a "litigation file" for use in any subsequent litigation to ensure privilege over any documents produced in the course of an investigation or in dealings with the insurer.

By Sean Maxwell, Bennett Jones LLP, Toronto

Editors Note:

RWAM Insurance Administrators Inc. Special Investigations Unit and claims staff are active members in the Canadian Health Care Anti-Fraud Association.

RWAM is committed to diligently monitor claims activity to ensure we are only paying for claims that your contract instructs us to pay.

Until next time…

Premium Summary for Life & Dependent Life Benefits

A summary has been sent to each group outlining the monthly volume of employee life insurance and the associated premiums. The monthly premium includes dependent life premium (if applicable to your group).

The employee's individual total premium includes any applicable taxes.

According to the Income Tax Act, any portion of this total that is employer paid is considered a taxable benefit and should be reflected as such on each employee's T-4.

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