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The costly issue of benefits fraud

Just over a year ago, St. Michael's hospital in Toronto dismissed 70 employees for alleged benefits plan abuse after a routine audit discovered $200,000 in irregularities. A few months later, the Toronto Transit Commission announced 170 employees had been dismissed – or resigned or retired to avoid dismissal – while 10 former employees were facing criminal charges over their part in alleged benefits fraud.

The stories made headlines. But they also put a much-needed spotlight on the costly issue of benefits fraud.

Benefit fraud is on the rise, it's a crime, employees have lost their jobs, and they are being prosecuted.

So, what exactly is benefits fraud? Basically, it involves anybody who takes advantage of or abuses or uses deception to exploit a company benefit plan. According to estimates from the Canadian Life and Health Insurance Association, benefits fraud results in the loss of two to ten per cent of health-care dollars. It's stealing. It's a crime - plan members are charged and go to court.

There's the abuse where somebody's just exploiting benefits within the parameters of the plan and then there's the other cases where plan members are knowingly attending clinics that don't exist, yet submit receipts for claims as if they do. It can involve creating fake associations and fake providers, with fake schools and credentials (diplomas). Fraud can be committed by a service provider, one or more plan members, or a combination of both. Many of these cases are complex and require many resources to combat them – the group benefits provider, plan sponsors, law enforcement, regulatory bodies, etc. – all working together to assist in the investigation.

Why do employees get involved? It's happening because they have rationalized to themselves that it is not theft, that it's part of the plan. They may be told by the perpetrators of the fraud that it is budgeted for, so not to worry, or an employee may justify it by telling themselves, "I didn't get a raise so I deserve this." The idea of getting "some easy cash" or being compensated with a designer purse or expensive shoes for doing what they have done for years – using their plan – seems easy to do and after all "I'm not hurting anyone". But they are. Plan costs increase so everyone is paying more. If employees understood that skimming off extra benefits could mean a colleague of theirs, or a work-mate's child, isn't able to get the drug coverage they need due to the benefit being capped, or that coverage was cancelled altogether due to the rising cost of providing it, maybe they would think twice about doing it.

So, what can plan sponsors and advisors do? For starters, help plan members understand the value of their benefits and the cost of them. Remind them they are consumers, and that they have a role in managing the future cost of their plan. Asking them to review their claim(s) to ensure they are correct and that they have received the services they are submitting the claim for ensures they are part of the process. Acknowledging that fraud is on the rise and that it's a crime allows employers and advisors to let employees know the consequences of committing a fraud – loss of benefits, restitution of monies owed, termination of their employment, referral to police, criminal charges and/or prosecution – all possible outcomes. It's no

...continued on reverse

THE FRAUD TRIANGLE

Fraud typically occurs when three elements are present.

Opportunity - A perception that there is little chance of detection, penalty, or consequences.

Rationalization - A sense of benefits entitlement, or unawareness that it's the employer's money that pays for benefits claims.

Pressure - Desire or need for financial gain, encouragement from provider.

What Plan Sponsors can do...

Here are a few suggestions to help plan sponsors mitigate fraud in their organizations.

- **Engage Plan Members in a way that helps them understand** the importance and value of their plan and educate them on their role in managing their plan as informed consumers.
- **Ensure Plan Members acknowledge, through a printed or online statement, that the claims they're submitting are correct.** It is also best practice to have them acknowledge that they understand benefits fraud is a crime and the related consequences. These consequences can include loss of benefits, restitution of monies owed, termination of their employment, referral to police, criminal charges and/or prosecution.
- **Plan Sponsors should also update their Codes of Conduct and Employee Contracts** to address how employees will be dealt with if they are found to be engaging in fraudulent activity relating to their employer's group benefits plan.
- **Plan Sponsors can consult with their carrier about building fraud protection** into their group benefits contracts. This includes coverage maximums for certain types of benefits, caps on how much is paid out, etc.

Fraud... continued from reverse

different than any other workplace theft.

The misuse of benefits leads to increasing health-care costs for employers and employees alike. Informing staff as to how plans are costed allows them to protect it. Using the examples provided in the St. Michael's and TTC cases as a deterrent – people lost their jobs, their dignity, and the respect of their friends, family and other colleagues. Some went to jail. All of them lost their jobs. And because it's a crime, some have now found they can't travel abroad any longer.

Carriers are resilient in the fight to prevent fraud. They have approved provider networks. The provider is vetted, their credentials are verified, where they went to school and their governing body is checked. Carrier analytics are improving all of the time. Carriers are able to see where a service was purchased and match it against the employee's home address. Does the distance make sense? Systems have alerts, red flag, outlier capability and collusion analytics built into their algorithms. Working in concert with the Ontario Provincial Police, and other policing agencies has increased the awareness of fraud. How it's being perpetuated, and who is behind it has brought not only more attention to it, but a higher level of education and awareness as well.

At RWAM, claims adjudicators are the first line of defence for detecting abuse, misuse and fraud. Each experienced approver has been trained to look for red flags during processing. Any suspicious submissions are referred to the Special Investigations Unit (SIU) for further review and are often selected for targeted auditing.

Their provider maintenance team is the next line of defence. The team is dedicated to supporting the provider profiling database where every provider is vetted and assigned a status. As part of the claims adjudicator's protocol, the provider's status is verified using the database. Any submissions where a provider isn't in good standing are referred to the SIU.

The SIU also maintains a watch list of providers and suppliers who appear to be over-billing, billing inappropriately and/or colluding with clients or other service providers. Claims where the provider and/or supplier appear on the watch list are also referred to be reviewed in greater detail.

In the end, it's still about good employee/employer communication. Plan members should be encouraged to report suspected plan abuse or fraud when they encounter providers who try to persuade them to misuse their plans. Most carriers have a confidential email or phone tip line where plan members can report suspected abuse or fraud. Encourage employees to use it. Benefits fraud hurts everyone – do your part to be the first line of defence.

Until next time…

Sources: Benefits Canada, March 2018 - HRReporter, March 2018 - Sun Life of Canada, Gary Askin, April 2018 - Julie Diebolt, Special Investigations Analyst, RWAM