Effective Fraud prevention for your benefits plan

As a health solutions partner, we want to help keep benefits plans affordable. In today's group benefits landscape, protecting your plan from fraud is more critical than ever. Benefits fraud costs Canadian plans hundreds of millions annually.[1] It can lead to significant financial losses for employers, increased premiums, and reduced coverage for plan members.

We know that providing effective health solutions while managing increasing plan costs is challenging. That's why we aim to help you get the best value for your health plans.

How do we do it? Fraud prevention

Fraud prevention is a key component of the way we manage group benefits plan costs. Our robust Fraud Risk Management team takes a proactive approach using advanced technologies, programs and innovations to detect and prevent fraud.

The key components of our fraud risk management strategy are *prevention, preparedness, response, and recovery*.

Pioneering fraud prevention: setting new industry standards

Prevention

Our focus on prevention is a key priority. Our innovative fraud detection techniques:

- Identify high-risk plan members and unusual claim patterns
- Analyse claims across all submission types including electronic and paper submissions
- Learn from past fraud cases to improve accuracy in detecting fraudulent behavior

This approach enhances our ability to identify and prevent fraudulent activity to protect your benefits plans.

What is a high-risk plan member?

A high-risk plan member is an individual whose claiming patterns, frequency of claim requests, or other factors raise suspicion of potential fraud based on our risk assessment model. Our Fraud Risk Management team is continuously implementing effective and innovative fraud detection and prevention strategies. By using advanced analytics, we're able to assess and score each plan member's claiming risk. This new technology works across all benefit types and claim formats, providing thorough analysis. It helps us to prioritize high-risk cases to detect fraud even faster and act quicker.

Preparedness

Our team involves over 100 experts from fields like data science, law enforcement, and industry specialists. We focus on raising awareness about fraud detection and its consequences. We do this by providing tools and resources for organizations to share with their employees. We also support our claims team in verifying new providers to make sure they aren't involved in any suspicious activity. Being well prepared with the knowledge and necessary tools helps our Clients to protect themselves.

Response

Fighting against fraud requires information gathering and collaboration to mitigate risk. Thanks to our proactive investigation strategy, we can quickly let you know about suspicious activity detected within your plan. We monitor claims from suspected plan members and providers to further assess and address the situation. Our analysis of claims submissions, related documentation and other advanced investigative techniques provides a complete picture of relationships between suspected plan members, service providers and facilities.

What kind of interventions do we provide?

We conduct site visits, gather witness statements, and assist plan sponsors with employee interviews suspected of fraud or abuse. We collaborate with law enforcement and benefits industry stakeholders as needed. If we suspect a service provider of committing fraud, we immediately remove them from the providers list to prevent further losses.

What's our goal?

To keep your plan safe, affordable, and minimize financial impact through quick fraud detection and decisive action.

Recovery

Our mission is to put an end to the suspected fraud or abuse and recover missing funds. We conduct a thorough analysis to understand the incident, how we can improve, and what we can put in place to prevent similar incidents in the future. We offer comprehensive support to plan sponsors, including tailored educational resources and communication materials for employees. Additionally, we provide training for management teams, that addresses concerns, rebuilds trust, and fosters a positive organizational culture.

The benefit to plan sponsors – millions of dollars in savings.

Sun Life is leading the industry in delisted provider and facilities. Our providers delisting program offers plan sponsors the highest level of protection for their benefits plan. As of December 2024, we've delisted over 5,000 suspicious entities since 2014. Our strategic approach to fraud has saved plan sponsors approximately $300 million during this same period. Our effective profiling and delisting strategies continue to protect against inappropriate billing practices activities, ensuring significant cost savings and excellence in service delivery.

To learn more about protecting your organization or recognizing fraud and abuse, access our **Fraud Risk Management webpage** for expert insights and actionable solutions.

1 Canadian Life and Health Insurance Association website: www.clhia.ca

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