



Group benefits fraud:

A leading edge perspective

Life's brighter under the sun



Foreword

In my conversations with group plan sponsors, advisors and others in the industry, I can tell you that concern around group benefits fraud is growing - and unfortunately this concern is not misplaced. Against the backdrop of rising health care costs, group benefits fraud is a serious and growing threat to group plan sustainability. Estimates have put losses due to fraud as high as 10 per cent of annual health care spending.¹

Applied to private health care insurance spending like employer sponsored group benefits plans, this potentially represents over 2.5 billion dollars in losses in 2015² – money plan sponsors need to help keep their plan members healthy, productive and engaged.

What's more, we're seeing the sophistication and scope of benefits fraud schemes escalate, driven by several factors, including the increasing involvement of organized crime, who view it as "easy money."

Fraud management is, without a doubt, a key component of plan sustainability. It's something we must be actively engaged in, with carriers taking a leading role. As the stakes rise, carriers can no longer afford to approach fraud management as a "one and done" solution. As the size and complexity of the threat increases, so must the response. What is required is a dynamic, intelligence-led approach based on leading technology and investigative techniques. The right technology, in combination with the right people, work together to produce a strategy that can keep pace with, and ultimately stay ahead of emerging threats.

There is good news. At Sun Life, we're working hard and making great strides – on the ground with skilled personnel and with evolving technology. Plan sponsors and plan members can also play a proactive role through plan design, education and awareness. Together, we can significantly reduce the risk of fraud to help ensure group benefits plans remain sustainable – now and in the future.



Gary Askin,
AVP, Fraud Risk Management
Sun Life Financial

Why Fraud Matters

When Sun Life recently met with some of its largest group benefits clients, the clients made it clear that benefits fraud is a major concern.³

As the pressure for plans to remain sustainable continues to increase, opportunities for cost containment – from any source – cannot be overlooked. Managing fraud is critical.

The threat to plan sustainability posed by benefits fraud continues to escalate due to a number of factors. These include:

- **Lack of understanding.** Low awareness and lack of understanding about their benefits plan may make plan members more susceptible to fraud as it's simply not on their radar.
- **Rising health care costs.** With the increased cost to provide health care benefits there's more opportunity for fraudsters to gain financially.
- **Organized crime.** Criminals are migrating to group benefits fraud as other sources, such as debit and credit card fraud, tighten up their controls, making them more difficult for criminals to target.
- **Other priorities for law enforcement.** Law enforcement agencies typically focus their limited resources on crimes against individuals – not companies. This means that carriers, and their clients, really need to step up if fraud is going to be addressed.

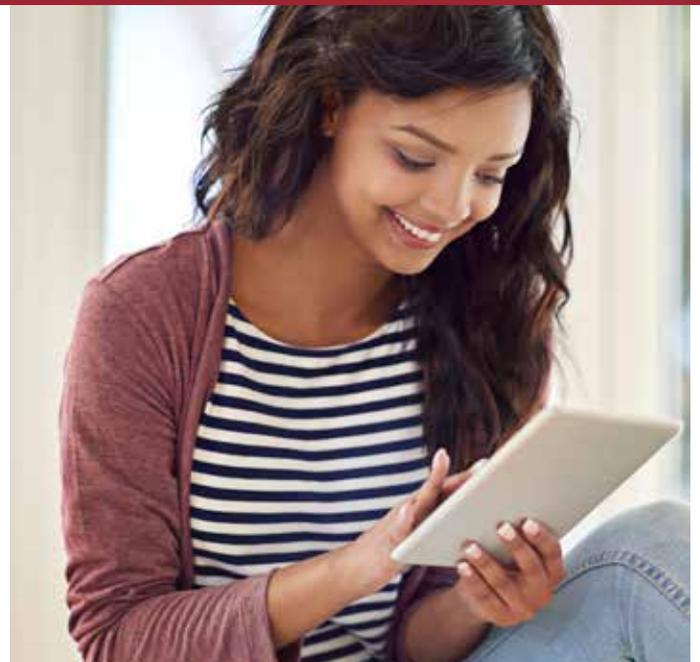
While most carriers have technology and processes in place to fight fraud, any one approach on its own simply isn't enough. It takes a combination of technology and skilled resources to put together a comprehensive strategy to address the escalating sophistication and scope of fraud schemes that are now occurring.

From data analysis, collaboration with law enforcement and skilled boots on the ground conducting investigations, Sun Life takes an intelligence-led approach to fraud management - and it's working.



FRAUD BUSINESS = BIG BUSINESS

Estimates put fraud representing as high as **10 per cent** of health care spending in Canada.⁴



THE POTENTIAL IMPACT OF FRAUD AT THE PLAN LEVEL

Consider a group plan with 100 employees, which typically costs a plan sponsor \$300,000 to \$400,000 per year. Based on conservative industry estimates, fraud could represent up to **\$40,000** of this plan's costs.⁵



FIRST THINGS FIRST

The first thing carriers need to do is to manage the data they collect so they can spot, and then address, fraudulent activities. By doing so, they can avoid the old tech adage, “garbage in equals garbage out”.

Something Sun Life does, for example, is to close the information gaps. Our fraud detection systems allow us to capture all relevant data when a claim is assessed. Better data helps us build more complex models to better identify potential fraud.

A CLOSER LOOK AT PATTERN ANALYSIS

Pattern analysis examines a vast group of inter-related entities (e.g. doctor to patient, patient to facility) and quickly extracts the most concentrated relationship(s).

Here’s how Sun Life has used pattern analysis to stop one suspected fraudster.

- After our proprietary data tool picked up an unusual claiming pattern, our data analytics team created a report to visually validate a pattern of suspicious claiming behaviours.
- Our analysis showed that a large number of plan members from one client organization claimed massage benefits from a single provider. This and other details obtained through analysis provided us with significant intelligence.
- Based on the information uncovered by the data analytics team, in-house investigators visited the provider’s office to see what was actually happening. The provider’s office turned out to be a front for a large and complex fraud scheme. Plan members submitted claims for services they didn’t receive while the provider received kickbacks.

SERVICE PROVIDER FRAUD

Service provider fraud and collusion schemes are estimated to represent **87%** of all fraudulent group benefits activity.⁶

Collusion occurs when two or more parties work together to plan abuse or fraud schemes. For example, a provider may work with a plan member to defraud the plan sponsor (and carrier); the provider then splits the money they receive with the plan member.

Multi-disciplinary clinics and facilities are an emerging risk. This is because there's an opportunity for fraudsters to take advantage of several practitioner and medical equipment benefits at the same time.

Another key part of the problem is identity theft: Providers who assume the identities of other providers or plan members and use them to submit false claims, or provide services under false pretenses. This deception can risk plan members' health. For example, members may receive treatments from unqualified individuals, or end up with a false medical record, where the file notes suggest a diagnosis and/or treatments that were never provided. False claims can also use up the plan members' benefits plan so that coverage isn't available when they need it the most.

It can take months or longer for carriers to build a case with strong enough evidence to hand off to law enforcement. In our experience, law enforcement then often struggles to find the time, or resources, to pursue their own investigation, which in turn may also take many months or years.

Fortunately, prosecution isn't always needed to deter fraudulent behaviour. There are many actions that carriers, plan sponsors and plan members themselves can take to help deter - or reduce - the impact of a fraud scheme. That's why it's important for everyone to play an active role in fraud management.

ALL CLAIMS ARE CREATED EQUAL - WHEN IT COMES TO DETECTING POTENTIAL FRAUD

While plan members tell us they want their claims paid quickly, plan sponsors tell us they need to keep their plans sustainable and minimize the risk of fraud. So how are these competing priorities balanced? The answer is technology.

Most claims submitted to Sun Life, even paper-based claims, in effect becomes an electronic claim. Our FastForward Claims Solutions, a combination of four technologies, work together to adjudicate claims while capturing and storing their data electronically. It's industry leading and no other Canadian carrier currently has this capability. Since e-claims are subject to rigorous analysis, we know we can pay claims quickly, while mitigating the risk of fraud to the plan sponsor.



SERVICE PROVIDER PROFILING

Once there's strong evidence of suspected abusive or fraudulent practices, it's important that the provider is brought to the attention of plan sponsors and plan members. A program Sun Life put into place serves this purpose.

Sun Life instituted a **Service Provider Delisting program** that has helped to significantly reduce the risk of plan abuse or fraud until further action, if any, is required by law enforcement.

- After significant investigation, the fraud team provides the details about suspect providers to an internal committee. This committee then decides whether the risk of fraud is substantial enough to place them on the delisted providers list.
- We maintain this list of all providers and clinics/locations from which we no longer process or reimburse claims.
- The list is regularly updated and shared only with plan sponsors and plan members through the password protected plan member services website, mysunlife.ca. We emphasize that we won't pay for claims from providers who are on the list.
- Finally, we inform the service providers themselves that claims will no longer be processed for services or supplies that they provide to our plan members. This also acts as a deterrent to future fraudulent activity.

Once we intervene (e.g., through a phone call, site visit, request for additional information), there's typically a drastic drop in claims even before we take the step to delist them. This can immediately reduce losses to plans compared to no action being taken. Since plan members are not reimbursed for claims from any Sun Life delisted entities, these activities, and the subsequent delisting, are powerful plan abuse and fraud deterrents and help maintain the integrity of the benefits plans.

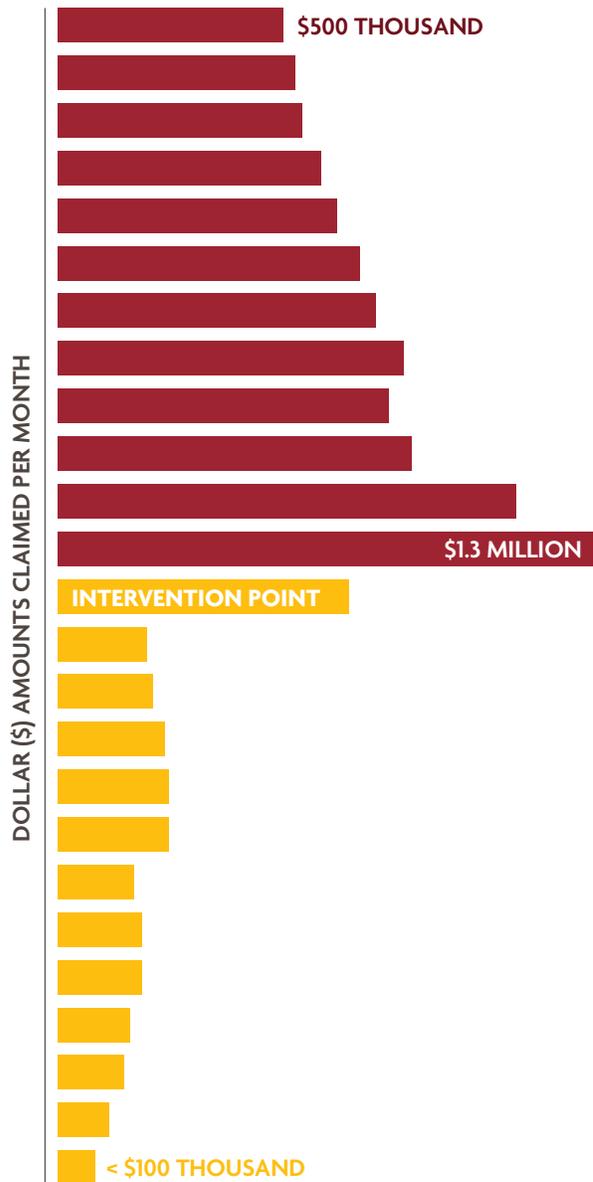
In this graphic, the 12 months leading up to the provider being profiled indicates an increasingly higher volume of paid claims. At the point of intervention there's a significant drop in claims. The months following the point of intervention demonstrate reasonable claiming levels across the profiled providers and facilities.

IMPACT OF PROVIDER PROFILING PROGRAM

Based on a total of **137 providers**

Source: Sun Life data

- 12 month period leading up to intervention
- 12 month period following intervention



THE HUMAN ELEMENT

While technology solutions are powerful weapons in the fight against fraud, they're only one part of the fraud management solution. The other part is people with the right skills and expertise to leverage the solutions, analyze the data, and conduct investigations.

Sun Life's in-house **75 member fraud** team's skills include:

- **Data analytics** – this pulls all of the claim details and information together into a number of reports that are used to identify patterns of suspicious behaviour. Through the use of data analytics, we have the ability, in-house, to create and monitor evolving schemes. Ad hoc reports are generated to identify these schemes.
- **Intelligence analysis** – takes the data analytics even further to identify other potential leads and players in a complex network scheme.
- **Investigative skills** – once potential leads are identified, an investigative plan is put in motion. For example, when we identified suspicious claiming behaviour coming from a particular facility, we placed the facility under surveillance and scheduled interviews with plan members who had recently made claims there.



ALWAYS ON THE RADAR

Along with a team focused specifically on fraud, many resources across a carrier organization also need to do their part.

For example, more than 1,000 people at Sun Life have some degree of fraud detection training to help prevent and mitigate fraud. These include hundreds of Customer Care Centre representatives, who receive fraud awareness training and can quickly alert the fraud team to suspicious claims or phone calls.

The results of these efforts are millions of dollars in recoveries each year, and an ever-tightening net of preventative measures to help prevent fraud from happening in the first place.

CHECKS AND BALANCES

A carrier should also conduct checks and balances on claims. These include the following:

- **Web prepayment audits** – based on random, threshold and profile.
- **Prepayment audits** – these reduce the risk of reimbursement for fraudulent claims.
- **Hospital audits** – claims are audited through a prepayment hospital audit program to ensure hospitals are billing correctly and accurately.
- **A “Clues” email and toll free tip line** – can generate dozens of referrals a month for investigation – depending on the size of the carrier.
- **Medical and dental providers** – provider claims are audited for unusual billing patterns and anomalies, volumes, or combinations of services are flagged for further investigation by specially trained analysts.
- **An “Alerts” technology** – where most analyze claims, no matter the format of submission (paper or electronic), are screened through this scenario-based diagnostic tool. Alerts are generated for drug seeking behaviours, dental procedures with unreasonable treatment frequencies, plan members or service providers who may be testing coverage or limits, etc.



Sun Life's fraud team and consultants bring a wide variety of skills and disciplines to the table. We have personnel with experience in policing, intelligence, organized crime, human trafficking, complex investigations, customs and immigration as well as medical and dental practitioners.



A carrier's fraud team can immediately suspend and disable access if the situation warrants, which acts as a deterrent to future abusive or fraudulent behaviour.

For example, we can suspend or permanently revoke e-claims submission access for suspected fraudulent plan members and providers. We can also add a "flag" at the plan level so all claims are reviewed by the fraud team, or only allow claims of interest to be stopped for review, while others are processed as usual.

RELATIONSHIPS THAT WORK

Many carriers find it challenging to admit that fraudsters impact their clients' organizations and that some plan members may actively work with providers to perpetrate fraud. As challenging as it is, when carriers work collaboratively with police, plan sponsors, associations and other carriers to share appropriate information, everyone can benefit.



Fraudsters may try to use plan member information (i.e. usernames, passwords and other personal information) to target products and services the plan member may have across the insurance carrier's organization.

To reduce this risk, Sun Life is actively involved in sharing information about fraudulent behaviour amongst its different business areas, where appropriate.



Everyone has a part to play

More and more, plan sponsors turn to their carriers for help with fraud prevention. This isn't surprising as a top of mind concern for plan sponsors, given how costs of benefits plans continue to rise.

It can also pay to play more of a proactive role in the fight against fraud through an intelligence-led strategy. The carrier's role is to aim to provide the best possible protection through a variety of tried and true investigative techniques and methods – along with current technologies and highly skilled resources.

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 related to their employer's group benefits plan. Sun Life supports and encourages this type of rigorous expectation setting.
- 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.

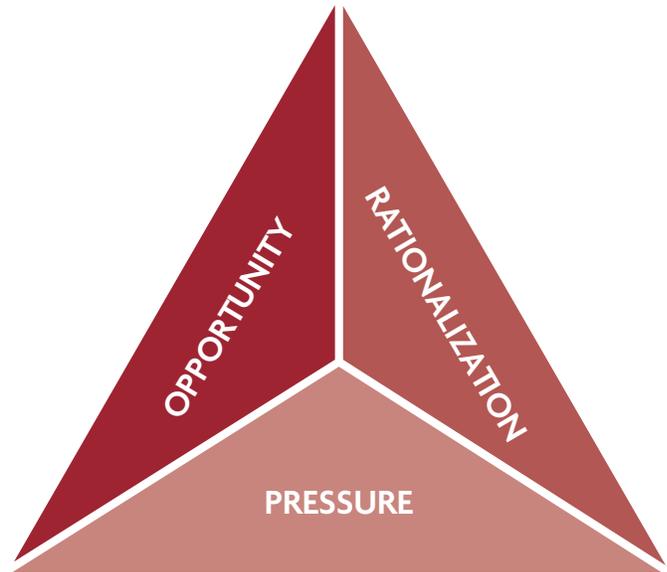
PLAN MEMBERS, THE FIRST LINE OF DEFENCE

While fraud may often be initiated by providers, there are also situations in which a provider depends on the participation (knowingly or not) of plan members. A provider may help a plan member rationalize his benefits choices so that he or she will fall victim to fraud schemes. An example is where a provider encourages a plan member to “max out” his benefits plan even when treatments are not medically necessary.

A carrier can provide clients with anti-fraud tips to share with their plan members. This might include asking plan members to cooperate with their group benefits provider when receipts from a provider are requested as part of the claims verification process. This messaging is often enough to deter future attempts at fraud. Plan members should also be reminded that they need to retain receipts for a year in case of verification requests.

It's important for plan members to learn about their plans (i.e., what's covered, what's not) to understand appropriate usage. They'll know how to use their plans wisely and avoid fraudulent schemes. Plan sponsors are encouraged to work with their carriers to help develop plan member educational collateral.

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.



THE FRAUD TRIANGLE

Fraud typically occurs when three elements are present:

Opportunity – A perception that there's 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.



TAKE ACTION

While the benefits fraud issue may be large and complex, this Bright Paper illustrates that even though fraud schemes continue to evolve, there's much we can do to mitigate the risk.

Talk to your insurance carrier to learn more about how they work to reduce group benefits fraud and how they can support you and your organization to take action to help protect your plan.

Real Life Case Studies

CASE 1



INVESTIGATION REVEALS FALSE CLAIMS

In this case, out of country benefits claims were submitted for young children where the fees for service appeared to be unusual. Prior to the claims being paid, we contacted the medical facility where the children were treated. While the facility confirmed that it had a record of the invoice on file, the mother's name was on the claim rather than the children's names.

The plan member was then asked to supply proof of payment, which he did. The bank confirmed that while a draft existed, the date and dollar amount had been altered.

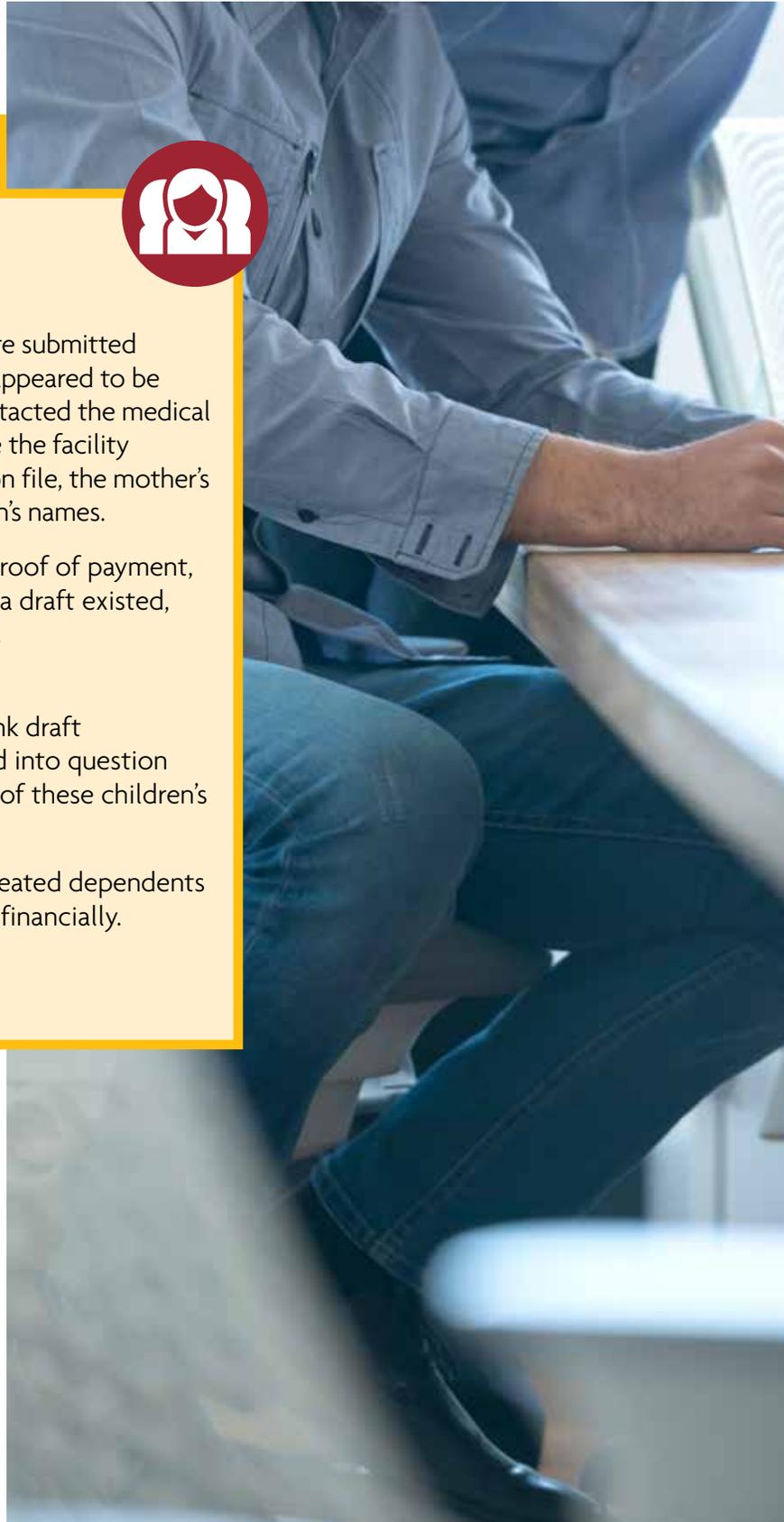
FAKE FAMILY

Both the facility confirmation and altered bank draft established false claim submissions and called into question the legitimacy of the dependents. No record of these children's birth was found.

In this case, the plan member intentionally created dependents that did not actually exist in order to benefit financially.

RESULT

The evidence was turned over to the police.



CASE 2

ORGANIZED CRIME: BAWDY HOUSES AND INSURANCE BENEFITS



On November 29, 2013, Montreal police announced arrests related to three massage parlours in Montreal that were operating as bawdy houses. Organized crime was responsible for bringing women from Romania to be used as sex slaves and forced them to work as prostitutes.

HOW DOES THIS AFFECT YOUR INSURANCE BENEFITS?

These massage parlours issued receipts to their clients, under the names of accredited Quebec massage therapists. The “johns” who frequented these places claimed these expenses as medical treatments under their group insurance plans for reimbursement.

By the time these fraudsters were arrested, Sun Life had publicly addressed the issue of Quebec bawdy houses as related to insurance benefits and had already identified and stopped accepting claims for more than a year before the arrests. One facility was identified by Sun Life as an ineligible provider by their advertising, which was sexually suggestive. The advertising showed pictures of nude or almost nude women offering services 24/7 and pictures of rooms with mattresses on the floor rather than massage tables. A second massage parlour was identified by Sun Life’s process of flagging behaviour patterns of plan members who frequented known bawdy houses. These plan members would have their claims declined from one place only to boldly attempt to submit receipts from another bawdy house - and sometimes submit claims under a dependent’s or spouse’s name to try to trick Sun Life into believing the claims were valid.

WHY SUN LIFE WAS SUCCESSFUL

Validations and verifications are done on all claims submissions where we can link someone known to frequent or work at a bawdy house to a new facility. In this case, we quickly identified the second massage parlour and refused to accept claims from them or from any providers associated with them.

RESULT

We’ve identified more than 300 providers and facilities in Canada that operate bawdy houses and for which we will not accept claims.



DATA ANALYTICS FIND IDENTITY THEFT AND COLLUSION

Through sophisticated data analytics, a service provider was flagged based on unusual billing patterns. Investigators concluded that the provider's name and credentials were being used by a facility where they had never actually worked. As it turned out, the facility was issuing false receipts and, in addition, someone at the facility was impersonating the provider.

Using investigative techniques, we were able to distinguish the real service provider from the impersonator. They then worked with the service provider to obtain a victim impact statement and report the stolen identity to police.

NOBODY HOME

When a site visit to the imposter's address confirmed that a facility had closed, we contacted plan members who had made claims. A number were caught in discrepancies that they couldn't explain. For example, when one particular plan member called to demand payment of an outstanding claim, we asked to meet with her. She then quickly abandoned her claim and wouldn't return our calls.

Additional analysis was conducted and identified other providers and facilities where claims for services had been made by plan members who mainly worked for the same plan sponsor. There were also a small number of medical doctors as the main prescribers for these plan members. Through surveillance, site audits and social network analysis, connections and links were made to these individuals along with other potential suspects that tied a number of suspected fraudulent cases together.

RESULT

Through plan member confessions, a case was brought to the police and a number of the plan members who colluded with these providers were terminated from their jobs.

CASE 3



CASE 4

AN INTELLIGENCE-LED APPROACH FINDS IDENTITY THEFT

Irregular claiming patterns (high claiming patterns compared to peers) for a service provider were identified through provider profiling technology. When the provider was contacted, he confirmed that he did not provide any of the services claimed. He provided a victim impact statement, which attested to the fact that his name and credentials had been used on receipts for services that he did not provide.

TIP OF THE ICEBERG

Once other providers were identified using the same technology, a larger scheme began to emerge. As it turned out, service providers who had responded to employment ads on various classified sites were having their names and credentials stolen in personal interviews. This information was then used for fraudulent purposes.

In total, the credentials of 20 different service providers and 13 different medical facilities were linked to one suspect.

RESULT

A summary of the large network scheme was referred to the police for further investigation/action.

ANOTHER **BRIGHT PAPER**[™] BROUGHT TO YOU BY SUN LIFE

- 1 Canadian Life and Health Insurance Association (CLHIA), 2016 (<https://www.clhia.ca/antifraud>)
- 2 Based on fraud estimates reported by the Canadian Life and Health Insurance Association (CLHIA), 2016 (<https://www.clhia.ca/antifraud>) and the Canadian Institute for Health Information (CIHI) forecasted 2015 spending of private health insurers in Canada (https://www.cihi.ca/sites/default/files/document/nhex_trends_narrative_report_2015_en.pdf)
- 3 Sun Life Client Partnership Council (CPC), May 2015
- 4 Canadian Life and Health Insurance Association (CLHIA), 2016 (<https://www.clhia.ca/antifraud>)

- 5 Based on fraud estimates reported by the Canadian Life and Health Insurance Association (CLHIA), 2016 (<https://www.clhia.ca/antifraud>)
- 6 Canadian Health Care Anti-Fraud Association and The Fraud Box, Canadian Health Care Fraud Survey, 2004
- 7 November 29, 2013. Police arrest 3 accused madams with links to human trafficking. Retrieved November 12, 2015. <http://montreal.ctvnews.ca/police-arrest-3-accused-madams-with-links-to-human-trafficking-1.3566448>

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