THE F FILES

Group benefits fraud – what you need to know to fight fraud

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Sun Life

A look into the world of provider fraud

Benefits fraud and abuse is big business. It amounts to hundreds of millions of dollars of losses each year in Canada. And it costs us all – from plan sponsors and insurers to providers and plan members. Higher premiums, delisting of providers, employee dismissals and even criminal consequences are outcomes that affect everyone.

So what is benefits fraud? Benefits fraud happens when a plan member or a provider purposely misrepresents or falsifies information on a benefits claim for financial gain.

Provider fraud and collusion schemes are common cases of group benefits fraud. Because of this, delisting suspicious providers is important. Delisting means that we stop paying for products and services from providers. We delist for many reasons. These include poor administrative or billing practices or suspected fraud. We lead all insurers with delisting. We've delisted over 2,400 entities as of January 2020.

Sometimes providers may start a fraud scheme. But there are cases where the provider depends on the participation (knowingly or not) of plan members. Providers can convince your plan members to buy services or products not covered by your plan. Then they claim them as covered services and products. There have also been cases where providers will help plan members falsify medical conditions to gain coverage for unneeded treatments or services.

Collusion happens when multiple participants, such as a group of employees and a provider, band together to send false claims. This group will then split the proceeds once paid. Providers can persuade employees to take part by promising to give a receipt and answering all the insurer's questions. The provider may convince employees that this scheme isn't actually fraud. They justify their actions by saying that employees are entitled to these benefits anyway.

Plan members play an important role in managing the risk of fraud. Plan members need to be aware of what products and services their plans cover. With this knowledge, they can use their plans wisely and avoid suspicious provider schemes.

Most people don't knowingly take part in elaborate provider schemes. But we see that many don't think twice about sending a false claim. Many people believe that falsifying claims is a "victimless crime" or that their insurer will never catch them. "Often employees believe that it's the insurance company's money funding their plan. They don't realize that it's their employer's money or their own," says Shelley Frohlich, Director of Fraud Risk Management at Sun Life.

The next two case studies show recent examples of provider investigations. They go over how we discovered the scheme, how we addressed it, and the lessons we learned.

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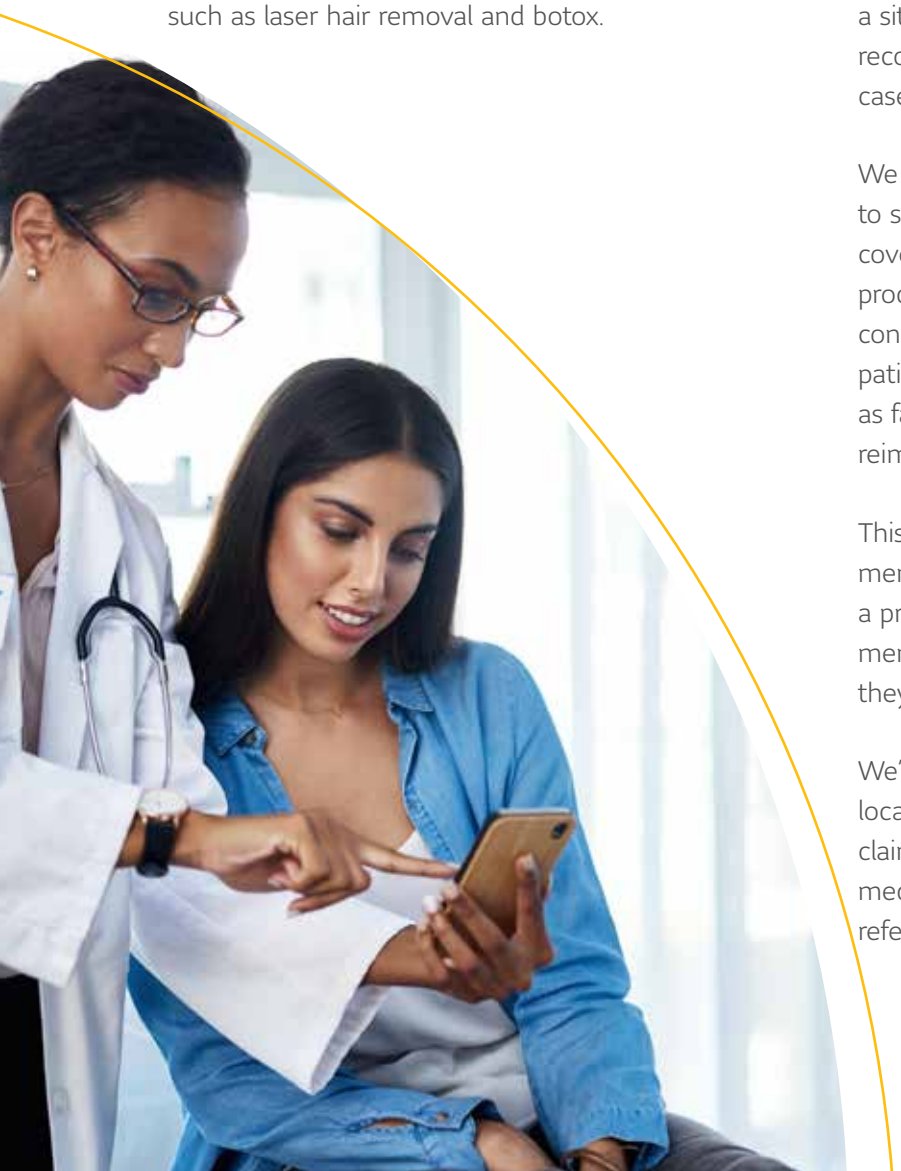
CASE STUDY:

Claiming cosmetic treatments as benefits

One type of benefits scheme involves receiving ineligible services and products but claiming them as a covered benefit. For example, Sun Life's extended health care plans don't cover cosmetic treatments. However, we uncovered a scheme where a provider encouraged this to happen.

Sun Life identified irregular claiming that linked back to a medical spa with multiple locations. This medical spa provided cosmetic procedures, such as laser hair removal and botox.



The suspicious claims were all connected to a drug product allegedly administered at the medical spa. Usually a doctor prescribes this product. This product has a drug identification number (DIN).

During interviews with Fraud Risk Management (FRM), plan members said they had never seen the prescribing doctor nor received the drug. However, when FRM contacted the prescribing doctor, he confirmed otherwise. When FRM conducted a site audit, they looked at the spa's records. These records either didn't contain the details or in some cases didn't exist.

We found that the spa would coach patients to send forms to their insurance company for coverage of the drug. This form included the product name, DIN and required medical conditions that the claimants never had. The patients would then get cosmetic services, such as facial laser treatments and botox, but receive reimbursement for the drug.

This example reveals why it's important for plan members to always review any documents from a provider. Documents need to reflect a plan member's medical conditions and any services they get.

We've since delisted all of these medical spa locations. This means that Sun Life will not accept claims for services or products provided at these medical spas. We're also seeking payment and referring the case to law enforcement.

CASE STUDY:

Claiming fashion sunglasses as prescription eyewear

We received an industry tip about an optical store that sold non-prescription, high-end fashion sunglasses. But it would give receipts for prescription glasses. Non-prescription sunglasses are not covered by our plans.

To investigate this tip, Sun Life sent secret shoppers to the location mentioned in the tip. As we predicted, our secret shoppers were able to buy fashion sunglasses and get receipts showing they paid for prescription eyewear.

This optical store had locations across the country. Through our secret shoppers, we learned that the scheme was happening at other locations as well.

Our next step was to contact the dispensing stores. The stores claimed the receipts for prescription glasses were accurate. That's despite our secret shoppers finding otherwise. We also learned some of our plan members received products from unlicensed staff.

Once we completed our investigation, we delisted all of the store's locations. We're currently seeking payment for the claims and have informed the relevant regulatory bodies.

Conclusion

Both of these case studies show the different ways provider fraud can happen and how we find it. By stopping these schemes, we are able to save our Clients hundreds of thousands in benefits dollars.

These case studies also illustrate the importance of plan member awareness and their role in fraud detection and prevention. Plan members need to understand their benefits coverage and use their benefits plan appropriately. Plan members are also responsible for confirming that the documents they get from providers are accurate. If they aren't, they should question the provider and alert their insurer to any inconsistencies.

Employees highly value their benefits plans. And employers rely on benefit plans to keep their workforce healthy, productive and engaged. To help ensure plan sustainability, we all have to work together to fight potential fraud.

The Fraud=Fraud program is sponsored by the Canadian Life and Health Insurance Association with the support of its member companies.

4 Plan Member Tips

TIP 1

If you suspect fraud or have any tips, please call our confidential hotline: 1-888-882-2221.

TIP 2

Double check all the documents you get from your provider before you send them to your benefits plan.

TIP 3

Remember that cosmetic services and non-prescription sunglasses are not usually covered benefits.

TIP 4

Review what's covered by your plan before submitting any claims.

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