Johnstone's Benefits

THE JOURNAL

solid group plans made simple

BENEFITS FRAUD & ABUSE

Affecting plan costs for everyone

According to the Canadian Life and Health Insurance Association, supplementary health coverage is provided by Canadian insurers to 27 million Canadians, which costs over $30 billion annually. Insurance fraud and abuse accounts for between 2% and 10% of healthcare spending in North America. Benefits fraud and claims abuse is not a small issue – and it impacts both plan sponsors and employees, with increased premium costs.

What is benefits fraud?

Fraud and claims abuse is committed by both service providers and plan members, sometimes with the member's consent and often without.

Fraud by service providers often includes falsified claims, such as billing for services not rendered, misrepresenting claim details, charging for a service more expensive that the service provided, or providing services outside of their scope of practice. Plan members abuse the benefits plan with over-utilization, claiming for services that are not medically required, altering their claim document, returning goods after payment, providing false information about their illness or injury, and making claims after their eligibility has terminated.

Prevention steps by the insurers

The good news is group insurers are increasingly focused on ensuring the legitimacy of claims. They continue to strengthen their claiming requirements in an effort to protect themselves as well as consumers of their plans. The increase in online claims submission enables insurers to red flag claims by building in levels of filters to identify claims that may require additional investigation and possible action. Red flags can include:

- An invoice with a modified date
- Family members claiming similar services or medical products
- A plan member who consults many healthcare providers
- A plan member who purchases prescription drugs at several pharmacies
- History of frequent and/or expensive claims

THE JOHNSTONE'S ADVANTAGE

Our mission is simple: **Treat each client as if they were our only client**.

Our value is clear: **We are completely independent**. We work for you and offer total flexibility on insurers and plans.

We offer all your group insurance services including administration, brokerage, consulting, and communications.

We provide dedicated client support, customization and flexibility to meet all of your company's benefits needs. And we make **solid group plans simple**.

Now insurers can systematically track claim records by service provider and plan member in their databases, allowing for easier identification of claims patterns and trends.

Fraudulent claims for medical supplies and services are increasingly common. Insurers now ask for additional information from the physician for the need of a specific purchase.

In addition, many insurers encourage whistle blowers, urging service providers and consumers to contact them anonymously with any knowledge of suspected fraudulent behaviour.

The bad news is criminals who want to pursue fraudulent activities in the group insurance market continue to find ways to do so. For example, according to Benefits Canada, a recent trend is identity theft, where a service provider's identity is used to submit fake claims under the provider's name, address and provider registration number.

If your personal health records are corrupted, you may lose your eligibility for benefits, and your insurability may be at risk. When fraud occurs, insurers may terminate a service provider agreement, an employee's coverage, and may seek legal action.

How you can help stop claims abuse

We all need to support programs designed to minimize claims abuse and fraud.

A well-designed benefits plan helps to reduce benefits fraud. When employees share in the premium costs, they are more interested in controlling costs. Plans with fair and reasonable caps, including health spending accounts, limit abuse and plan liability. In addition, plan sponsors are encouraged to educate employees about benefit fraud and the implications to a sustainable benefits plan.

Plan members can also guard their benefits plans:

- Check your receipts and explanation of benefits statements to make sure they accurately reflect the services you received, and report any discrepancies to the insurer.
- Do not sign blank claim forms.
- Keep copies of all claim forms submitted for yourself or dependents,
- Protect all of your health cards, and don't let others use them.

Saskatchewan – New PST

Effective August 1, 2017, insurance premiums for residents and businesses located in Saskatchewan will be subject to the 6% provincial sales tax (PST).

Self-insured and administrative services only (ASO) arrangements are also subject to the new PST.

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JOHNSTONE'S JOURNAL is published monthly and designed to provide topical information of interest not only to plan administrators, but to all employees who enjoy coverage under the benefit plan. Feel free to make copies and share with your employees.