

FRAUD – GROUP INSURANCE IS BUT ONE CONCERN!

March is Fraud Prevention Month. It's a good time to remind clients of common scams and potentially fraudulent activities. It affects our everyday lives and group insurance too!

Common Scams are Frauds!

According to the [Canadian Anti-Fraud Centre](#), the types and number of scammers with opportunities to take advantage of Canadians greatly increased during COVID-19. They list some types of scams that have become very popular and are increasing even after the pandemic:

- Buying and selling scams (receipts for items or services that you didn't buy or sell)
- Financial scams
- Identity fraud
- Email and text messaging scams (phishing, extortion, etc.) – all with the same intention: to trick you into opening malicious attachments or to trick you into revealing sensitive personal and financial details.
- Online scams (romance, immigration, deceptive government services, etc.)

Group Insurance Fraud

Fraudulent group benefits claims, where false or misleading information about a treatment or service, can be submitted to the insurer by a service provider, clinic, facility, and/or plan member. 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.

Sustainability of group plans is important. It is estimated that employers and insurers lose millions of dollars each year to benefits fraud. Benefits fraud is a crime that affects insurers, employers and employees and puts the sustainability of workplace benefit plans at risk. If your organization's benefits plan costs \$100,000 annually, and fraudulent claims reach 10% of claims, that would cost the plan an additional \$10,000 for no benefit to employees.

Anti-Fraud Initiatives

Canadian life and health insurers take anti-fraud management seriously. Insurers cannot overlook the threat of fraud and have focused on solutions to manage fraud through technology and improvements to their processes. In March 2023, the Canadian Life and Health Insurance Association (CLHIA) reported that with significant investments into technology, skilled staff and education programs to mitigate fraud,

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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.**



insurers are now working together to conduct joint investigations into health service providers that are suspected of fraudulent activities.

The March 2023 announcement built on the CLHIA-supported industry program launched in 2022 that uses advanced artificial intelligence to identify fraudulent activity across a vast industry pool of anonymized claims data. Both initiatives are part of an industry strategy to leverage the knowledge, expertise, and resources of life and health insurers to reduce the time it takes to act on those who are exploiting workplace health benefit plans.

Common Benefit Frauds

According to many insurers, the most common benefit frauds include:

- Billing for services not rendered: creating false claims using genuine patient information or padding claims with extra charges for services that never took place
- Up-coding services or items: billing for more expensive services or products than what was actually provided
- Submitting false claims: altering an existing claim receipt, such as the date or dollar amount, in order to claim twice for the same service, or have the date fall within a time frame that is eligible
- Unbundling: submitting separate bills for services that would normally be bundled together
- Charging for excessive or unnecessary service Kickbacks: rewards given to entice clinics, facilities, and providers into using specific services or products
- Falsifying patient records: creating a false diagnosis to justify tests, products or treatments, or other procedures that aren't medically necessary
- Co-pay activities: billing more than the co-pay amount when services were paid in full by the benefit plan, or waiving the co-pay and overbilling the insurer

Prevention can be the Cure!

We encourage plan sponsors to educate employees about benefit fraud and what steps they can take to mitigate plan risks, which include:

- Protect personal information to mitigate identity theft
- Don't give your benefits information to others to obtain services or products
- Ensure your receipts reflect the service or treatment you received
- Check your Explanation of Benefits provided by the insurer to ensure it's correct
- Don't sign your name to blank claim forms
- Understand your coverage and plan limits
- Ask questions if the treatment or service given to you, or invoiced, doesn't make sense to you, and alert the insurer if not satisfied with the information.

Good administrative processes are key!

If Johnstone's Benefits is your benefits plan third-party administrator, we count on the information that our clients provide us. It's important that employers do not misrepresent the information about an employee, such as hire date or benefits effective date. Not only might it make a claim void if the insurer becomes aware of incorrect information, but such a practice might also increase the potential for a fraudulent claim by an employee.

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