BENEFITS

Fraud Really Does Matter

By: Kimberley Keeler & Susan Brown

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Fraud is an intentional deception deliberately practiced in order to secure unfair or unlawful gain. As a legal construct, fraud is both a civil wrong and a criminal wrong. Defrauding people or organizations of money is the usual purpose of fraud.

Fraud really does matter. Canadian businesses lose billions of dollars annually to healthcare fraud and abuse. Fraud and abuse results in not only higher insurance premiums and reduced benefits, but can ultimately impact the health of plan members and their dependents. Most medical and dental providers are honest and work hard to improve their patients' health. However, a few are only looking for financial gains and any opportunity to increase revenue.

Billing Fraud

There is extensive 'user' fraud associated with:

- Forging receipts which can sometimes be accessed from a provider office or created electronically. With today's technology it is fairly simple to produce a 'fraudulent document.'
- Changing the dollar value on existing receipts is another danger.
- Submitting duplicate claims that often get reprocessed through the system can also be carried out.
- Allowing ineligible individuals (family/friends) to use their drug card as the user is not policed at the pharmacy level is another method.

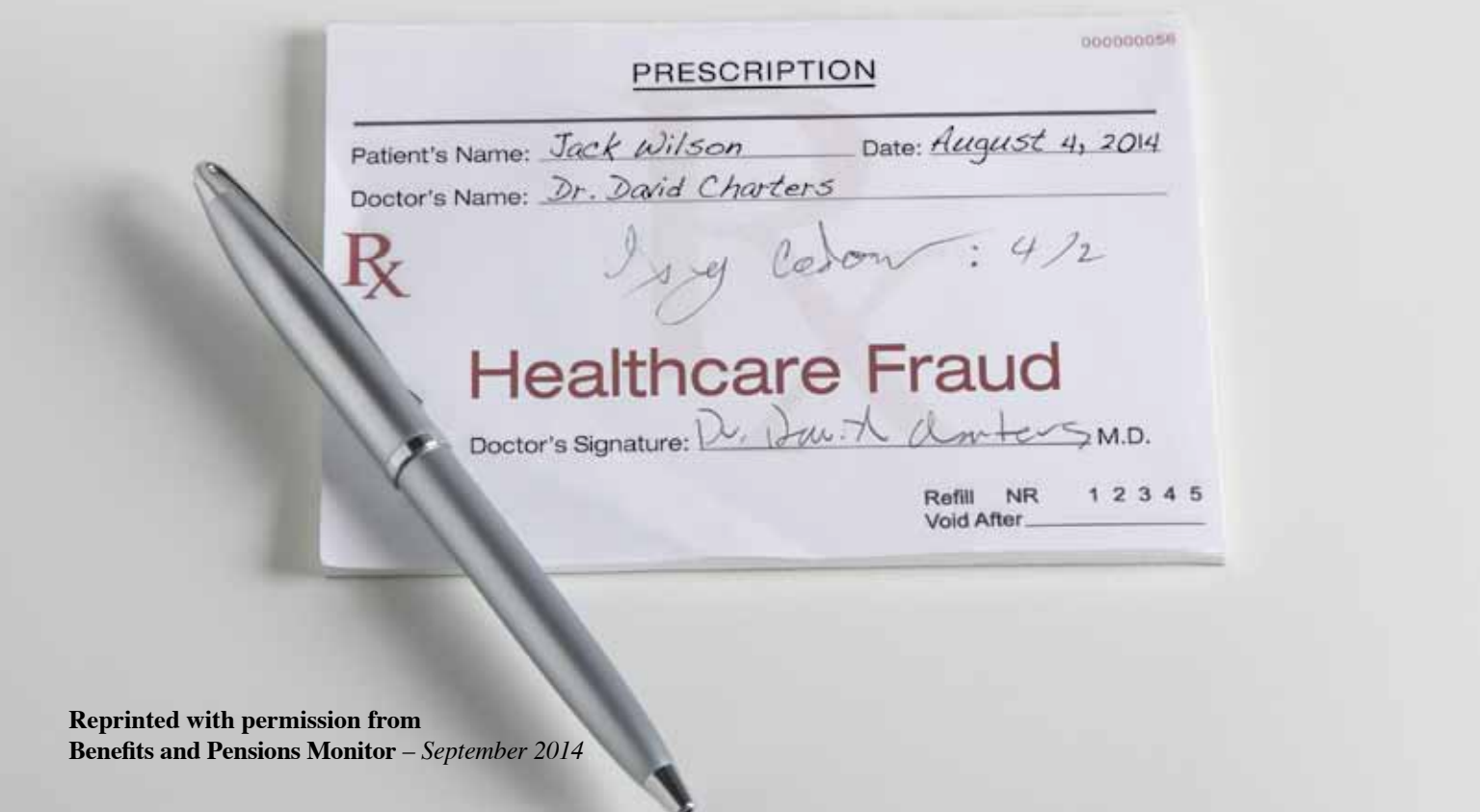
Plan sponsors need to preserve their benefit plans from 'providers' who:

- Provide and bill for services that are not medically necessary
- Receive 'kickbacks' from the manufacturer
- Consistently invoice 'inappropriately' for the services provided to patients
- Submit codes for more enhanced services than those actually provided to the patient

Suspicious Trends

Insurers incur the costs of professional training for staff, updating their system to identify suspicious trends, and subscribing to associations that keep them abreast of industry tracking on fraud. Additional expenses are often incurred related to maintaining claim turnaround times while assessing the claims for potential fraudulent activity. Time requirements are also increased by the need to check provider watch lists and review claims for potential 'altering' of the receipts as well as identifying claimants' changing claims patterns; an increase in a particular area of claims or in claims originating from a specific provider or clinic. This requires additional time commitments and investigation by the adjudicator. All these processes need to be factored in to the cost of doing business.

Employers/benefit providers must take on the role of educator when it comes to employees and their benefits.



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Plan design can help an employer and their employees to better manage their benefits. The employee has more control over the types of treatment they can access and the providers they can use. By utilizing some of the following measures, they often realize plan savings and increased plan viability:

- Combined maximums for such things as paramedical providers
- Setting per person or per family limits
- Implementating health spending accounts

These place the responsibility for benefit spending in the hands of the employee who will be informed of their remaining balance after each claim is paid. This also allows more flexibility in the ways an employee wishes to use their benefit dollars.

False Referrals

In today's environment, most people trust their practitioner to give them good advice and most do. There are, however, some who, in collusion with other providers of medical equipment, services, or devices, are prescribing unnecessary equipment/supplies.

In many cases, employees are oblivious to the impact of these costs to their employer's bottom line. It is important that clients clearly explain to their employees how increased benefit costs impact the company's costs and profitability. This, in turn, can result in reduced benefits and/or increased payroll deductions. The employee needs to feel some ownership for their benefit package and the costs that are incurred.

Pre-Signed Claim Forms

Your employees/members should never pre-sign claim forms for a provider to hold for future appointments. When a claim form is signed, it should be completely filled out with the date of service, a description of the services provided, and the cost for each service. The insured should feel comfortable asking for clarification of any information it contains. After the appointment, if they are still unclear and have questions that the medical/dental provider cannot answer, your insurance provider might also be a resource for this information.

Your member/employees should review their healthcare insurance claims history from time to time. Most providers offer an online service where members can view their individual and dependent's claim activity as well as monitor direct deposits and payments to service providers. Members should be reminded to keep personal information confidential and never share drug card, IDs, or certificate numbers.

Valuable Or Free Rewards

Getting something for free is a great motivator for where you do your shopping. A free pair of shoes with your orthotics or some free massage therapy sessions would be attractive to many individuals.

Your members should be aware of these get rich quick schemes and valuable or free reward offers. If there is pressure to make a big purchase decision immediately, it is likely too good to be true. The service being provided must be medically necessary and not purchased solely for the free item or reward associated with it. Because the claimant is somewhat removed from the employer/plan sponsor on these transactions, they do not take on the responsibility for any wrongdoing.

To be clear when a plan is abused, the ultimate costs to the employer go up and, in turn, the member will see increased monthly premiums and payroll deductions and/or a reduction in actual benefit coverage. It is in the employer's best interest to clearly explain this to employees.

Non-insured Services

Be aware that beauty treatments, running shoes, and non-prescription sunglasses are not covered by health insurance plans and substitution of these products or services for receipts for services that are covered by your plan is fraudulent activity. The beauty industry is very competitive. Service providers will offer to 'massage' receipts in order to cover pricey treatments otherwise not insurable. In these situations it is almost impossible for insurers to detect fraudulent activity. For all intents and purposes, the receipts appear legitimate. In these situations, the insurers rely on the tips received through associations such the Canadian Health Care Anti-fraud Assosciation or the Insurance Bureau of Canada. For consumers, the responsibility is to be aware that what is being billed to the insurance provider has been received.

Part of the solution is to foster employee engagement and understanding of their plan. Providing education and information relative to the coverage and the implications of claim misuse can lead to a feeling of ownership versus entitlement for the benefits and how they are used. The penalties associated with fraudulent claim activity should be clearly defined and supported by the plan sponsor/employer. Don't ignore tips provided by employees/members and don't hesitate to make an example of the employee whose fraudulent claims are detected and confirmed.

Cutbacks Or Reductions

It's challenging to engage employees in these tough economic times. However, the reality is most employees would prefer to pay higher premiums to maintain their benefits versus facing cutbacks or reductions. Involve your employees in the management of the health plan dollars. One example would be the implementation of healthcare spending accounts. These provide the employees with a specified amount which they can use for medical expenses as allowed under the CRA. It can be a plan that supplements an existing defined benefit plan or a standalone healthcare spending account in a specified amount.

Your insurance provider should be able to supply you with some educational material to share with your employees. You may want to encourage the option of an 'employee committee' to participate in a project to review the design and costs associated with their plan. Such a committee helps to create overall awareness and buy in regarding the importance of maintaining a viable benefits plan. BPM

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