Session 103 PD, Fraud and Abuse Risk

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SOA Antitrust Disclaimer
SOA Presentation Disclaimer
A bit about me

• In the industry since 1995. Prior to that IT background.
  • Lead Sun Life Financial (Canada) group benefits health claims operations.
  • Leadership in material outsourcing, e-claims, cross industry initiatives, fraud, business transformation (offshoring and imaging/workflow/paperless).

• Consulting clients since 2012
  • Insurers, tech companies, claims network co’s, provider groups.

• Executive Director, Canadian Drug Insurance Pooling Corporation since 2015
How about you?

<table>
<thead>
<tr>
<th>Country</th>
<th>Question</th>
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<tbody>
<tr>
<td>Canada</td>
<td>How big is the health insurance fraud problem as % paid claims?</td>
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<tr>
<td>United States</td>
<td>Do you feel your organization is adequately addressing the risk?</td>
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Agenda

• Extended health care risk composition
• Perspective from 3 different client views
  • Health care providers
  • Prevention & detection: Technology / software companies
  • Insurers
• Opportunities & challenges
• Crystal ball
• Panel Q & A
Claims risk composition by benefit type

Dental 22%

EHC - Drug 50%

EHC - Other 28%

But what % is abuse?

Sources: Cdn. Institute of Actuaries report (2007-2009) and ATIP - 2014 PSHCP claims experience (proxy for “std heath care plan”)
Perspective: Health Care Providers
### Benefits view

<table>
<thead>
<tr>
<th>Paramedical</th>
<th>Other</th>
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<tbody>
<tr>
<td>Acupuncturists</td>
<td>Ambulance</td>
</tr>
<tr>
<td>Chiropodists</td>
<td>Custom Shoes (Chiropodists, Pedorthists)</td>
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<tr>
<td>Chiropractors</td>
<td>Eye wear / contact lenses</td>
</tr>
<tr>
<td>Massage therapists</td>
<td>Hospital rooms</td>
</tr>
<tr>
<td>Naturopaths</td>
<td>Medical supplies &amp; equipment</td>
</tr>
<tr>
<td>Optometrist</td>
<td>Orthotics (Chiropodists, Pedorthists)</td>
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<tr>
<td>Osteopaths</td>
<td></td>
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<tr>
<td>Other practitioners</td>
<td></td>
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<tr>
<td>Physician services</td>
<td></td>
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<tr>
<td>Physiotherapists</td>
<td></td>
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<tr>
<td>Podiatrists</td>
<td></td>
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<tr>
<td>Psychologists</td>
<td></td>
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<tr>
<td>Speech therapists</td>
<td></td>
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<tr>
<td>Benefits view</td>
<td></td>
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Their realities....

• Generally very competitive environments

• Reputation is highly coveted. Patient relationship is critical.

• Small business mindset often sole proprietor
  • Mixed degree of technical business proficiency – ex: practice management.
  • Positive cash flow is very important.

• Generally view regulator (college(s)) as important but somewhat ineffective

• Serious concerns of others moving into their health care space
  • Physiotherapists: Chiropractors, naturopaths, massage therapy, others
  • Dentists: Independent hygienists
  • Optometrists: Chains, mail order glasses/lenses
  • Podiatrists: Chiropodists, pedorthists, physiotherapists, chiropractors!
Insurance fit to business / practice model

- Estimated insurance revenue make-up as % gross revenue

<table>
<thead>
<tr>
<th></th>
<th>Health Insurance</th>
<th>Casualty Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatrists</td>
<td>40-60%</td>
<td>5-10%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>30-50%</td>
<td>30-60%</td>
</tr>
<tr>
<td>Optometrists</td>
<td>25-40%</td>
<td>5-10%</td>
</tr>
<tr>
<td>Dentists</td>
<td>60-75%</td>
<td>5-10%</td>
</tr>
</tbody>
</table>

- They generally don’t understand the nature or business of group insurance.
  - Plan designs, role of employer, deductibles and co-insurance, etc.

- Often perceive themselves in an adversarial relationship.
Insurance fit to business / practice model

• Associations
  • Believe insurers share information widely – both formally and informally.
  • Almost never advocate for fraudulent billing practices.
    • They have no problems supporting disciplinary action of any practitioner that does.
  • Open to working with insurers or insurer association groups.
  • But don’t understand insurers can make coverage rules that may disadvantage their patients and impact their cash flow.
  • Often have evidence of perceived unwarranted demand letters from insurers which have been paid off to avoid reputational consequence.
## When fraud occurs

<table>
<thead>
<tr>
<th>Fraudulent activity</th>
<th>Provider involved</th>
<th>Provider association</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity theft of credentials by other health care provider entity or person(s).</td>
<td>Provider who’s credentials stolen: Often unaware unless advised by insurer. Restrictions place on patients claiming seen as professional affront.</td>
<td>Anxious to understand circumstances &amp; help but challenged in balancing privacy and reputation of effected provider.</td>
</tr>
</tbody>
</table>
| Billing for services that did not occur. Often collusion with plan member.         | • Often unaware of this issue – billing done by subordinate or office worker.  
• If aware, will often settle once caught red handed. | In most instances not supportive of this billing approach. Exceptions are “package plans / subscriptions” – chiropractors, some massage, naturopaths. |
| Actual practice of service is not covered by insurance but billing for covered service(s). | • Says he/she lack of awareness of circumstance.  
• Sometimes in cahoots with third party – ex: union local. | Generally unsupportive of this approach but some see it as important part of “package services”. |
| Multidisciplinary game: Another professional (ex: massage) provides service but billing says chiropractor. | • Claims lack of awareness.  
• Often takes kickback of fees.  
• Sees this as legit because “under supervision”. | Generally not encouraging practice but some see “under supervision” as bonified approach. |
Perspective: Prevention & detection – Technology / software
## Prevention & detection in highly transactional environment

<table>
<thead>
<tr>
<th>Approach</th>
<th>In-stream or post claim processing</th>
<th>Dependence on manual review</th>
<th>Complexity</th>
<th>Cost</th>
<th>Risk / reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims audits</td>
<td>In-stream</td>
<td>Medium</td>
<td>Low – medium</td>
<td>$</td>
<td>++</td>
</tr>
<tr>
<td>Trend and/or outlier based data analysis</td>
<td>Post &amp; in-stream</td>
<td>Low</td>
<td>Low - medium</td>
<td>$$</td>
<td>++</td>
</tr>
<tr>
<td>Multidimensional relationship analysis</td>
<td>Usually post</td>
<td>Low</td>
<td>High</td>
<td>$$$</td>
<td>+++</td>
</tr>
<tr>
<td>Social relationship analysis</td>
<td>Usually post</td>
<td>Low</td>
<td>Very high</td>
<td>$$$</td>
<td>++ Evolving</td>
</tr>
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</table>

**Caveats:**
- Prior or dual investment in provider registry is paramount.
- Paper based claims vs “e” and/or imaged paper.
- Degree to which claim system is “legacy” and prior investment in data warehouse / extraction.
Players

- Many but they fall into several categories

- Suites of services layered into broad technology solutions (ex: IBM / Oracle)

- Cloud based services where data is given to tech company and results accessed by subscriber (ex: Daisy Intelligence)

- Niche analytics standalone and/or integration platform addons using rules based approach (ex: SAS, TIBCO products)

- Leveraged analytic solutions repurposed for health care fraud detection (ex: AML & anti-terrorist software)
Challenges

• Realistic business case showing reasonable 3-5 year ROI can be difficult.
  • Especially so for small and mid-size insurers
    • Inter-company shared approaches create opportunities for cost leverage but confidentiality, competitive, and reputational risk hurdles must be dealt with.
    • Industry opportunity?
  • Technology vendors understanding of challenging business value proposition for EHC insurers is at best evolving.
    • They generally won’t put skin in the game (ex: gain sharing approaches).

• Often requires process changes in Claims and Call Centre areas to be effective.
  • Consistent internal AND external communication is critical.

• Technology is evolving driven by casualty and US insurers but use is often seen as competitive differentiator.
Perspective: insurers
Key challenges

• Dental & EHC margins = tight
  • But brand exposure is high value – especially in emerging voluntary benefit markets.

• Health care fraud is sensational and in the news
  • Corporate PR&C concerns // Brand worries

• With market consolidation, consultant auditing is “new” sponsor value add for ASO (and to degree Refund)
  • Sponsor on hook for claims risk BUT... not if perceived systemic control fail
    • 5 & 6 digit $ refund cheques not unheard of
    • Budgeted amounts for fraud refunds continues to grow

• Law enforcement generally doesn’t have the resources to assist.
Quantifying risk & recovery/stop loss

• What benefits will you target % how?
• What is the abuse % vs fraud % by benefit?
• What is “true” anticipated recovery / stop loss?
Reality check / plan for:

• Not being a “fraud” program, it must be a “fraud and abuse program”
  • Find, quantify, and leverage synergies.

• Business case
  • Very challenging
  • Costs can be reasonably determined
  • Benefits in terms of stop loss and recovery – risky / go conservative.

• Expect organizational friction
  • Claims, call center, underwriting, sales, finance, actuarial, PR&C.
  • Top down commitment is critical.

• Conscious risk sharing: What is an allowable fraud rate that is reasonable to share with sponsors?
  • Fully insured – in premiums
  • Refund and ASO – in fees
Sanity check

• Beyond lowest hanging fruit, fraud management doesn’t come cheap (upfront + ongoing costs)
• Need to ensure value is realized. Beware of negative returns!
• **Finding all fraud will bankrupt you.**
Opportunities and challenges
Insurer based long term strategies needed for both fraud and abuse.
Criminals don’t stand still (it’s a bad strategy).

• Fraud is continually evolving
• More and more evidence
  • Collusion
    • Providers and plan members
    • Unions acting as “bridges”
    • Plan members showing other plan members
    • Sponsors knowing and turning blind eye
  • Organized crime / syndication
    • Identity / credential theft
    • Means for money laundering
    • Even multinational approaches
Financial

• What is a reasonable risk to “price in” / share?
• Does reputation trump financial motivation?
• You can’t control what you don’t measure.

While far from perfect, there are learnings to be had from the casualty insurance business.
Crystal ball
Continued growth in EHC claim $ =

• Demand will continue to grow for fraud protection.
• Insurers that do not invest in at least a public antifraud persona will become or are already vulnerable.
• Fraud will continue to grow
  • In sophistication
    And
  • In simple schemes .... “e” is particularly vulnerable.
Q&A – panel discussion
CLHIA Update on Health Benefits Fraud and Abuse

SOA Health Meeting
June 13, 2017
Agenda

- CLHIA/Industry overview
- Group Benefits
- CLHIA role in healthcare anti-fraud
- The cost of benefits fraud
- Trends
- The “journey”
- Tips for preventing benefits fraud
Overview of CLHIA

- The CLHIA is a voluntary association representing 99 percent of Canada's life and health insurance business.

- Approx 24 m Canadians covered through Extended Health Care (EHC) private plans.
Health insurance

Benefits by coverage type

$32.2B
2015 health benefits

$10.7B
Drugs

$7.8B
Dental

$3.0B
Paramedical & vision

$1.8B
Hospital

$0.8B
Travel

Ext. health

Ext. health 75%
Disability 21%
Other 4%

87% of premiums paid out as benefits (5-year average)

*refers to services and professions, such as physiotherapy, that supplement and support medical treatment

It is anticipated that more than 40% of the cost of prescription drugs will be from specialty drugs by 2020*

27% 2014
30% 2015
42% (estimated) 2020

*Source: Drug Trend Report 2015, Express Scripts Canada
Why do employers offer benefits?

- Tax effective form of total compensation
- Support employee health to reduce absence/injury and improve productivity
- Attraction and retention of employees
- Driver of employee satisfaction
- For some employers there are requirements in collective agreements
- Driver of employee satisfaction
Group Benefit Plan considerations

- Offering benefits is voluntary for employers
- Private plans are supplemental to public plans
- Rising employee benefit costs are creating concerns regarding the sustainability of plans
- Employers seeking more aggressive cost management
- Technology is driving change
- Fraud and abuse contributes to cost concerns
- Medically necessary services or supplies
CLHIA Role in Healthcare Anti-Fraud

- Overall accountability for industry initiatives to assist in mitigating benefits fraud and abuse
- Strategic Partnerships:
  - Global
  - Law enforcement, public plans, etc
  - Health/Dental Colleges and Associations
  - Cross-industry collaboration
The cost of benefits fraud

• Estimated that 2-10% of healthcare $ are lost to fraud
• Potential impacts:
  – higher costs for everyone
  – may impact sustainability of benefit plans
  – may create a need for plan design changes
Fraud and Abuse: what's the difference??

Fraud = intentional submission of false or misleading information for the purpose of financial gain

- Example: Claiming for services or products not provided or received

Abuse = Exploiting the plan

- Example: Healthcare provider performs unnecessary treatment on a Plan Member to maximize billings
Trends

- Sophistication in schemes - highly organized
- Occurs at all levels, ie plan member, plan sponsor, provider, supplier, etc
- Cross-industry schemes
- Identity theft
- Billing for services not rendered
- Collusion between plan member and provider
- Fake facilities
The “Journey”

- Information sharing
- Relationships with stakeholders
- Unregulated professions
- Industry initiatives
- CLHIA Claims and Anti-Fraud Conference
Fraud Prevention Month (FPM)
FPM: CLHIA Participation

- Member of Fraud Prevention Forum (FPF)
- Second year for CLHIA participation in FPM events
- CLHIA planned activities
Healthcare fraud costs everyone!

All Canadians pay for healthcare fraud. Canada's life and health insurers work hard to reduce healthcare fraud but we need your help!

Recognize it
Reject it
Report it

For more information and tips on how you can protect yourself, visit clhia.ca/antifraud
Prevention is key to mitigating benefits fraud

- Team effort required
- Collaboration with various health profession association and colleges, law enforcement, other industries, etc
- Continued education and communication on how all stakeholders can protect themselves
Tips for Consumers

- Protect your personal information which includes your benefits plan access information
- Check your EOB provided by your insurer to ensure it reflects only those services or products obtained by you or your eligible dependents
- Don’t sign blank forms

For more information visit Tips for Consumers
Final thoughts...

• Prevention: Key to mitigating fraud- reject it before it happens
• Education: Help plan members recognize how to protect themselves and the benefit plan
• Team Effort: We all need to work together to assist in mitigating fraud. If you suspect fraud-report it.

Fraud:
- Recognize it
- Reject it
- Report it

Suspect Healthcare Fraud?
Click here to report it.