Private Healthcare Benefits Fraud:

A Group Insurers' perspective

Research Project for Emerging Issues/Advanced Topics Course

Diploma in Investigative and Forensic Accounting Program

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INTRODUCTION

Many employers offer generous health and dental benefits as well as short-term and long-term disability coverage as part as their employment package. The employers, who sponsor the benefit plans, are acutely aware of the rising costs of providing employee benefits. What many sponsors may not appreciate however, is the extent to which fraudulent conduct on the part of the patients (their employees) and healthcare providers contributes to escalating premium levels.

The Canadian Health Care Anti-fraud Association estimates that 2% to 10% of all healthcare dollars are spent fraudulently (Maxwell, 2008). By stealing from the private benefit plans, the employees are in fact stealing from the very hand that feeds them, their employers, who usually pay a significant portion of the premiums, if not all of the premiums.

This research project will focus on healthcare fraud in the private sector; in other words, on areas of healthcare not covered by public plans.

The author is the Manager of Investigation Services at The Standard Life Assurance Company of Canada and accordingly has direct and daily exposure to the challenges, successes, but also to the frustrations and limitations involved in the prevention, detection and deterrence of fraud and abuse in private healthcare. As the issue of fraud on private insurers is considered an emerging issue that has only begun to attract more attention in

recent years, the author relied on his personal experience when he deemed necessary, in order to provide the private insurers' perspective of the problem as accurately and objectively as possible.

This research project will be divided in three sections:

- The first section will provide an overview of what the Extended Healthcare Benefits (also known as private healthcare benefits) and how they are affected by fraud and abuse;

- The second section will focus on the multi-faceted approach deployed by the insurers to effectively prevent fraud from happening, detect the existing fraud and deter the perpetrators; and

- The third and last section will focus on the legal limitations and dangers the insurers are faced with when investigating private healthcare fraud.

SECTION I: FRAUD AND ABUSE IN HEALTHCARE BENEFIT PLANS – AN OVERVIEW

This section will focus on describing the extended health and dental benefits as well as defining fraud and abuse by differentiating them. Details on the schemes put forward and their perpetrators will then be analysed to properly illustrate how they impact on the benefit plans.

1.1 Extended Health and Dental Group Benefits – General Description

Extended Health and Dental Group Benefits are offered by a plan sponsor. The plan sponsor is usually an employer. As part of the employment offering, employers usually offer their employees healthcare benefits packages, in addition to their wages. The insurer charges premiums to the employer based on the claims expected to be reimbursed. The plan sponsor in essence foots the bill, as the insurer will pass-on any increase in the claims experience in renewal rates. The irony for the private employer is that it typically has the least amount of information on direct costs. Because of various privacy legislations, the amount of information that can be shared with the employer on employee claims is very limited.

When an employer contracts with an insurance company, the employer is the customer and is responsible for paying all premiums to the insurer. The employees, whether they share a portion of the cost or not to support the plan, are only users of the plan, usually referred to as "plan members." In Canada, insurers seldom sell group insurance contracts

directly to plan sponsors. Another layer exists between the two parties, the independent insurance advisor who seeks quotes on behalf of the employer (its client) from different insurers based on coverage, services and type of plan that he recommended. The advisor, as its name suggests, proposes to the employer suggestions on the group insurance plan design, which essentially is the type and level of coverage the employer will propose to its employees. In unionized groups, the plan design is usually negotiated between the employer and the union and is an integral part of the working contractual agreement.

Typically, healthcare benefit plans include coverage for prescription drugs, dental care, paramedical treatments[1], hospital rooms, private duty nursing care, medical devices and out-of-country benefits. Essentially, the extended healthcare plan covers expenses not included in the provincial public healthcare system program.

When the allure of easy money comes around, criminals are never too far behind. Undoubtedly, the vast majority of plan members and healthcare practitioners are honest and ethical. But for a small group of individuals, benefit plans can be tempting targets as they seek out ways to exploit the benefits for their personal financial gain.

1.2 Fraud vs Abuse

Benefit plans can be affected by fraud or abuse. In order to understand how benefit plans suffer from misuse, it is important to differentiate fraud from abuse.

[1] In Group Insurance, the term paramedical services refers to professional services rendered by professional healthcare providers such as Chiropractor, Physiotherapist, Massage therapist, Naturopath, Osteopath, Psychologist and Speech Therapist and not covered under public plans.

1.2.1 Fraud

There are many definitions available for healthcare insurance fraud. Although using different terminologies, all the definitions have the same ideology.

The National Health Care Anti-Fraud Association in Washington defines healthcare fraud as:

> *"…an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or the entity or to some other party."* (Alleyne, 2006)

On its company website, The Standard Life Assurance Company of Canada (2008) defines fraud and insurance fraud as:

> *"…the intentional use of deception to obtain an unjust or illegal advantage for one party, or parties, to the detriment of another. Insurance fraud involves insurance claims being filed with the intent to defraud an insurance provider and by extension, its clients.*"

Falsified claims would fall in that category. For example, a plan member creates a receipt on a personal home computer for treatments never received. The plan member then files the fabricated receipt as a valid claim with the insurer to obtain reimbursement for an expense never incurred. The objective of the claimant is to obtain an illegal advantage (additional income) to the detriment of the insurer and the benefit plan's claims experience.

1.2.2 Abuse

Abuse occurs when a participant and/or a service provider exploit the plan provisions, which includes overbilling, providing treatment or services when not medically required and overusing services.

Fraud and abuse can both be equally devastating for benefits plans. Sometimes, only a fine line may separate one from the other. However, one significant element differentiates them. Abuse, although damaging for the benefit plans, can be unethical, however is not necessarily illegal. Fraud, on the other hand, is illegal and is a criminal offense. In practice, the insurers will consider all misuses to be abuse when it cannot demonstrate that there was fraud.

Plan members may not realize that their employer ultimately funds the insurance program that pays the claims. So, if an inappropriate claim gets paid, it can lead to increased costs for the plan sponsor, which could then place an undue burden on the benefit coverage available to plan members.

Most of this research project will be devoted to analyzing the impact of fraud, rather than abuse, on the benefit plans. As mentioned above, although abuse is as damaging as fraud is for the plans, it is not criminal; which causes the insurers to focus mainly on preventing it from happening in the first place.

1.3 The Fraud Perpetrators

Fraud and abuse of private healthcare benefits usually happens in one of three ways:

1- When an individual patient perpetuates a fraud scheme against his or her own health plan, also called *beneficiary fraud* (Busch, 2008);

2- When the treatment providers and medical equipment vendors act on their own by using to their advantage a benefits plan, also known as *provider fraud* (Busch, 2008); and

3- When there is collusion between the providers and patients, which essentially is a combination of *provider and beneficiary fraud*, but which opens the door to whole new sets of possible schemes to defraud the insurer.

Although there are perpetrators who carry out fraud in a systematic and planned manner, fraud also has its opportunistic offenders who take advantage of the faceless nature of insurance claims, so it is difficult to know who, in an organization, is more susceptible to commit fraud.

Although there is no typical profile, plan members involved in fraud and/or abuse patterns invariably fall in one of three categories:

- **The Innocent**: This occurs when there is no involvement at all from the plan member. An example is when a member is being overcharged by the practitioner, without his/her knowledge. The plan member does not benefit in any way from the fraud or the abuse, but the provider does.

- **The Half-Guilty**: The plan member is somewhat aware that the practice of the provider is suspect, but does not question it because he/she also benefits from the practice. For example, an insured member purchases a pair of custom-made foot orthotics and obtains a free pair of shoes.[2]

- **The Professional**: The plan member is the artisan (e.g., member fabricates false receipts or returns medical devices after obtaining a reimbursement from the insurer) or is an accomplice by colluding with a questionable practitioner or provider to abuse the plan (e.g. the practitioner issues an invoice for treatments never rendered, which the plan member submits to the insurer for reimbursement; the plan member and the practitioner share the amount reimbursed).

One of the greatest challenges for the insurer is to properly identify and prove whether or not the plan member is involved in the fraudulent or abusive scheme. All members usually plead that they were innocent victims.

1.4 Overview of the Schemes

Fraud comes in many forms and is only limited by the ingenuity of the perpetrators. The following highlights several examples of fraud and abuse classified by the type of perpetration.

[2] Foot Orthotics fraud will be defined and addressed in details in section 3.2

1.4.1 Beneficiary Fraud

The most common types of fraud engineered by plan members invariably fall into one of four categories (Maxwell, *Fraud Squad*, 2008):

- Malingering: exaggerating illness or injury to collect additional health benefits (more widely present in disability benefit fraud, which is outside the scope of this research project);
- Doctor shopping or pharmacy shopping, which involves:
    - Sharing drug cards with non-members;
    - Purchasing drugs on behalf of non-members;
    - Abusing narcotics by "shopping" different doctors/pharmacies to obtain prescriptions and purchase drugs, which also usually involves addiction or resale on the streets; and
    - Shopping for doctors until one will provide a prescription for the medical equipment or treatment that is not medically necessary.
- Misrepresenting dependents, such as:
    - Creating "non-existing" dependents, or adding as dependents non-related members while lying about their relationship with the member;

- Maintaining eligibility for individuals not qualified for benefits such as formerly dependent children who cease to qualify under the terms of the plan (i.e. by being dishonest about the student status of a dependent in order to maintain coverage); and

- Failing to coordinate benefits with the insurance carrier of a spouse by, for example, submitting the same "original" invoice to the member's insurer and the spouse's insurer without disclosing coordination of benefits ("double-dipping") which can result in a claim being reimbursed at more than 100%.

- False claims:

  - For services never rendered, using the credentials of legitimate practitioners or creating fake ones. The receipts often look very legitimate showing the name and credentials of a legitimate practitioner. Some fraudster will provide false contact information on the receipts in order to fake a real clinic and/or impersonate a practitioner legitimate practitioner when contacted;

  - Falsifying the diagnostics on a prescription to reflect a condition covered under the plan; and

  - Tampering with receipts to claim a higher amount.

1.4.2. Provider Fraud

Fraud committed by medical service providers usually takes one of the following forms (Alleyne, 2006):

- Billing for services not rendered or products/devices not dispensed; examples include:
    - Pharmacist who bills for drugs that were not dispensed;
    - The insured member who reached the benefit maximum, but requests and obtains a receipt under the spouse or children benefits in order to maximize coverage illegally (a certain degree of collusion with the patient is usually necessary for this scheme to operate – the insured member is not out-of-pocket and the provider can invoice for additional services and keep his customer satisfied);
    - Dentists that bill insurers for treatments they never performed. They send the insurer forged bills for fake treatment, medicine and supplies they never used. These schemes are possible since the insurers often allow dentists to invoice them directly rather than requesting that the members pay for the services up front and submit their claims thereafter for reimbursement by the insurer. This process is called "Assignment of Benefits", which is a value-added service for the plan members and a service usually required as part of the benefit package since the approach is common among all insurers, but it also opens the door to provider fraud; and

- Dishonest dentists do minor procedures such as routine tooth cleanings, but bill the insurance plan for costlier treatments such as phantom root canals or cavity fillings.

- Practitioners treating outside their scope of practice:
  - Practitioners, although not qualified to do so, dispense supposedly custom-made foot orthotics and bill the insurers for them; and
  - Paramedical treatment providers treating conditions, such as cancer, for which there is no evidence that the technique used has any benefit. In extreme cases, patients suffered severe complications that led to their death.

- Unlicensed practitioners treating:
  - Paramedical service providers often not recognized by the regulatory body, such as massage therapists using illegally the protected designation of RMT (*Registered Massage Therapist*) without being registered with its provincial College;
  - Untrained assistants who do the work, but the billing reflects that services were rendered by a registered specialist; and
  - Dentists who illegally treat patients despite losing their licenses for previous infractions. Some dentists also have hygienists, assistants or other staff performing treatments — even though they are not licensed or

qualified. The dentists then bill insurers as if the dentists had performed the treatment themselves. Meanwhile the patients receive treatments of questionable quality.

- Kickbacks or referral payments, such as:
    - Healthcare professional providing a free pair of shoes for any orthotic referral; and
    - Unscrupulous clinic owners overbilling for treatments provided by legitimate practitioners.
- Providing treatments that are not medically necessary:
    - Dentist who performs work that is not required;
    - Physiotherapist or Chiropractor maximizing visits even if not necessary;
    - Practitioner registered under dual professions (such as massage therapist and naturopath) interchanging the reported type of work to maximize benefits;
    - Dentist performing cosmetic work but billing as treatments covered under the terms of the policy; and
    - Dishonest dentist performing useless surgery on a perfectly healthy patient to hike his/her own insurance billing. The dentist removes healthy teeth, does root canals that aren't needed, and drills for cavities that don't exist.

1.4.3. Collusion

Many of the schemes above can be slightly "modified" to allow collusion and benefit both the plan member (patient) and practitioner (service provider). For example:

- Licensed practitioners preparing false receipts for a fee. If questioned, the practitioners promise to confirm having treated the customer; and
- Providers and members mutually agree to modify the nature of the treatment to appear on the invoice in order to maximize reimbursement.

Fraud schemes involving collusion are on the rise and have the added "benefit" for the fraudsters involved to be very difficult for the insurer to detect. It is very difficult (even sometimes impossible), time consuming and costly for an insurer to attempt proving that treatments were not provided when both the practitioner and plan member say otherwise.

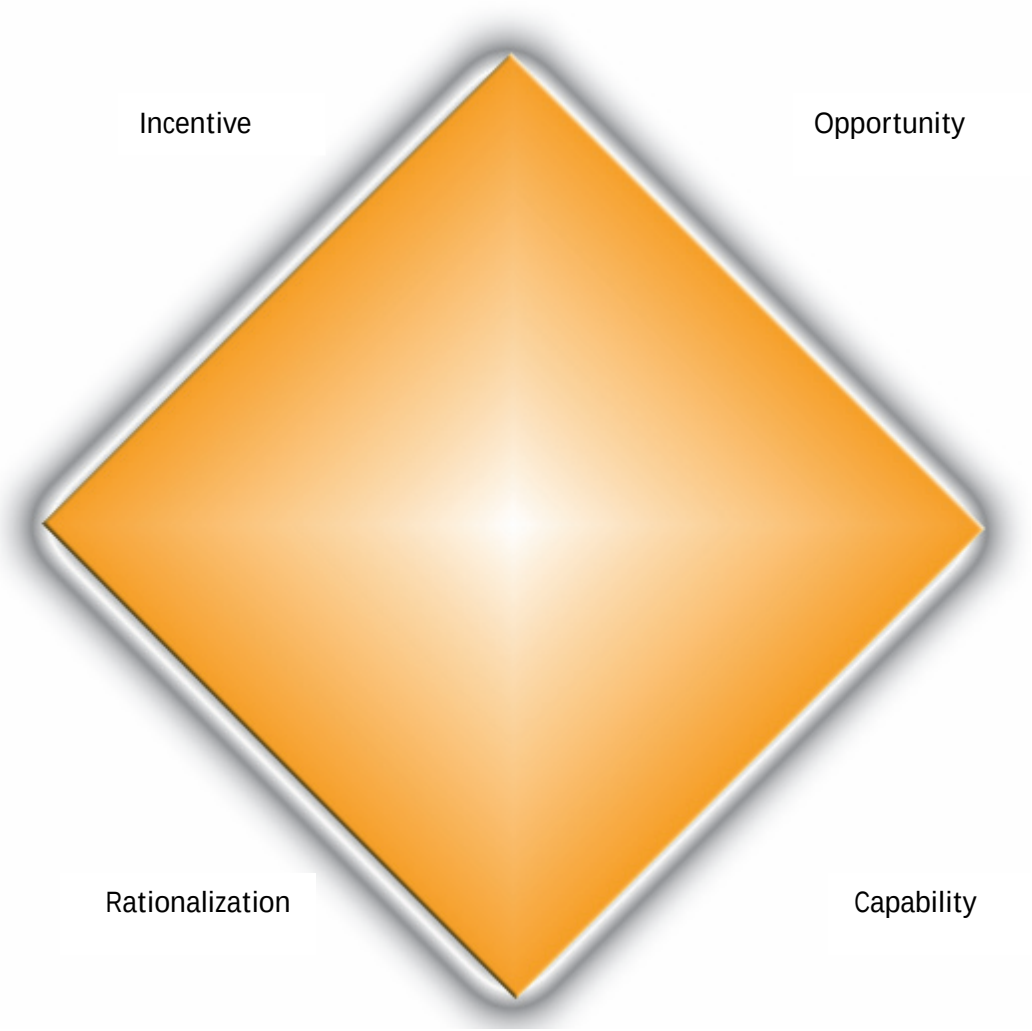
1.5 The Mindset of the Fraudsters

As there are no typical members defrauding healthcare plans, we have to consider the mindset of the fraudsters. The well-known fraud triangle (SAS No.99, 2002) provides information on the factors pushing individuals to commit fraud. However, authors David T. Wolfe and Dana R. Hermanson (2004) believed the triangle could be enhanced. In addition to considering incentive, opportunity, and rationalization, their four-sided "fraud diamond" also considers an individual's *capability*, which is defined as:

> *"Personal traits and abilities that play a major role in whether fraud may actually occur even with the presence of the other three elements"* (Wolfe, 2004).

Exhibit 1 shown below presents the diamond as created by David T. Wolfe and Dana R. Hermanson.

Exhibit 1: The Fraud Diamond[3]



[3] The Fraud Diamond: Considering the Four Elements of Fraud, The CPA Journal, December 2004

Using the four-element fraud diamond (see Exhibit 1), a health insurance fraudster's thought process might proceed as follows:

- *Incentive: "I want to, or have a need to, commit frau.*" (Wolfe & Hermanson, 2004). In other words, I need the money.
- *Opportunity: "There is a weakness in the system that the right person could exploit. Fraud is possible*" (Wolfe & Hermanson, 2004). The health insurance industry presents tremendous opportunities for fraudsters. Although there are perpetrators who carry out fraud in a systematic and planned manner, fraud also has its opportunistic offenders who take advantage of the faceless nature of insurance claims.
- *Rationalization: "I have convinced myself that this fraudulent behavior is worth the risks*" (Wolfe & Hermanson, 2004).

  Rationalization can take many forms and an individual can say to himself: "Others do worse", "The insurance company makes so much money anyway", "I'm entitled to it" or "I'm not hurting anybody."

  A survey on insurance fraud performed by Accenture (2003) revealed that:

  - Nearly one in four of American adults say it is acceptable to defraud insurance companies and more than one in ten say they approve of submitting claims for treatments that were not provided.
  - Two-thirds of respondents linked insurance fraud to the offenders' need for money, while nearly one-fourth (24 percent) said they believe that the

people who commit insurance fraud do so because they believe they pay too much for insurance.

- About half the respondents (49 percent) said that people commit insurance fraud because they can get away with it.

- *Capability: "I have the necessary traits and abilities to be the right person to pull it off. I have recognized this particular fraud opportunity and can turn it into reality*" (Wolfe & Hermanson, 2004). Insurance fraud knows no distinctions. A health care practitioner is just as likely to commit fraud as a plan member. Then again, it could also be a combination of both through collusion. Health care fraud through collusion is easy to perform as the parties involved have everything to gain from the partnership. The insurer and ultimately the employers and employees will pay the price.

Given that the right combination to defraud health benefits is rather easy to achieve, it is not a surprise to realize that there is no typical profile of fraudster. There is room for everyone, from small opportunistic thefts (by exaggerating by a few hundred dollars a massage therapy receipt) to the extravagant tour-de-force (creation of a false claim ring, where the "creator" of the ring obtains a "commission" every time he provides a plan member with false receipts).

1.5.1 The Hidden Element: Entitlement

A critical element that fuels both the capability and rationalization sides of the diamond is the sentiment of entitlement to healthcare benefits that some plan members demonstrate. Possibly the most interesting aspect of healthcare benefit fraud is the apparent non-

realization by the employees defrauding the plan, sponsored by their employer, that they are in fact stealing directly from the hand that feeds them. The employees are stealing from their employer and their fellow co-workers who all have to share the burden of increasing insurance premiums. When confronted with their actions, many individuals respond: “I am entitled to those benefits”.

There is an impression – and a strong belief – by a small proportion of plan members that benefits are there to be used, regardless of medical necessity. For those individuals, the benefits are perceived as a supplementary source of income. The legitimacy of the method used to “unlock” that value is of little importance.

In some cases, for a single year, and depending upon the policy provisions, fraud and abuse may represent tens of thousands of dollars per insured (especially for those members with family coverage). A few members with this profile can significantly increase the costs of the plan. Then, as the employee’s portion of premiums increases (and in Québec, as the taxable benefit increases), the pressure to maximize the amounts “claimed” leads others to abusing their plan. If not properly addressed and acted upon, the beginning of this vicious circle of fraud and abuse may lead to catastrophic losses for the plan sponsors and the insurers.

1.6 The Consequences

The consequences of fraud and abuse of health benefit plans are insidious. As the claims experience deteriorates over the years, and if the same coverage is maintained, the cost of the plan will increase significantly and premiums will increase in order to make up for the cost of illegitimate or abusive claims, making coverage less affordable for both the

plan sponsor (employer) and the plan members (employees) who often share the cost of the plan with their employer.

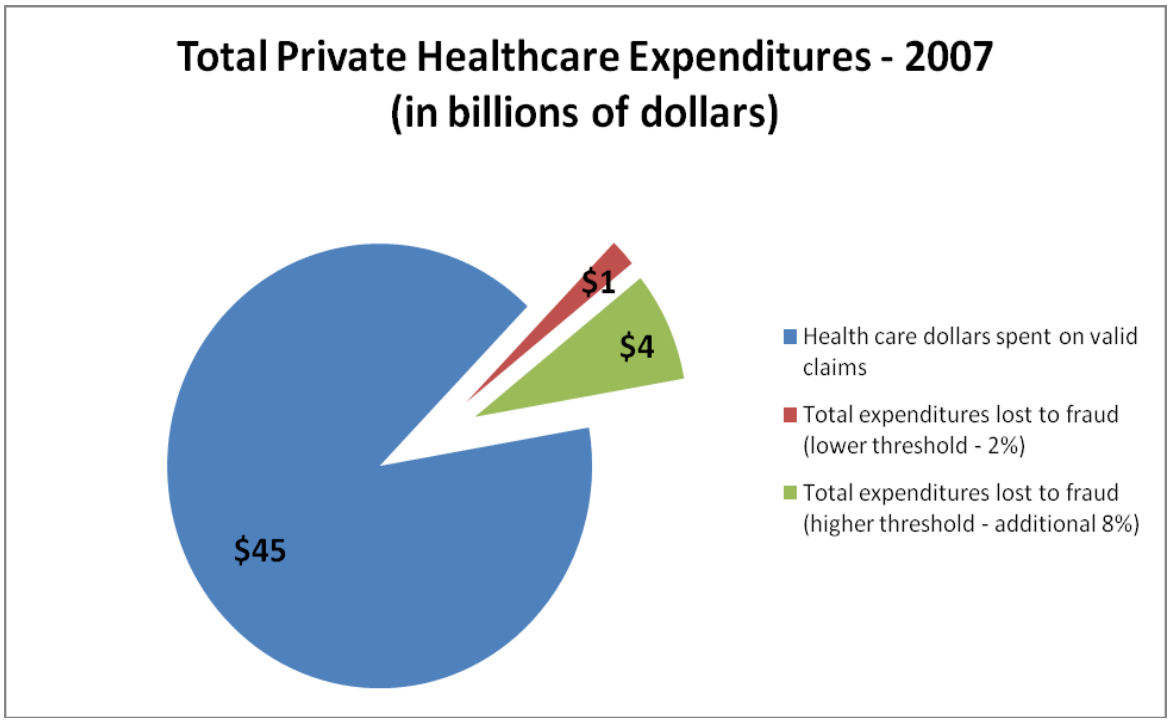
As the years progress, the cost increases may become unjustifiable for the employer and the plan sponsor may be forced to significantly reduce the level of coverage in order to maintain affordable premiums. In extreme cases, the employer would no longer be able to afford to offer health and dental benefits to its workforce, which of course does not benefit anybody, including the fraudsters.

1.7 The Situation

While no firm figures are available, the Canadian Health Care Anti-fraud Association estimates that between 2% and 10% of all healthcare dollars are spent fraudulently. Considering only the private healthcare expenditures estimated at close to $50 billion, between $1 billion and $5 billion is lost by insurers every year (Maxwell, 2008). The insurers have no choice but to pass the loss onto the plan sponsors and plan members. Considering that healthcare inflation is running in excess of 10% annually, these figures keep growing unstoppably (Maxwell, 2008).

The graphic shown as Exhibit 2 on the next page highlights the thresholds of estimated amounts lost to fraud by insurers and plan sponsors, based on 2007 estimated expenditures.

Exhibit 2: Private Healthcare expenditures lost to fraud in 2007 (estimated figures[4])



Perhaps even more of a worry is the fact that the incidents are not isolated. According to the 2004 Canadian Health Care Fraud Survey (CHCAA, The Fraud Box), 94.9% of plan sponsors have been victimized by at least one fraudulent claim.

[4] Based on figures extracted from the article Fraud Squad, written by Sean Maxwell, published by Benefits Canada in October 2008

1.8 Media Coverage

The phenomenon is also catching media attention:

- In March 2009, local and national media reported that the City of Toronto announced that it had fired nine workers in relation to alleged submission of fraudulent claims. The plan administrator, Manulife Financial, had uncovered the scam. (Hanes, 2009)

- A chain of optical stores located across the Greater Toronto Area has been making headlines in the region for several years for prescribing and dispensing eyeglasses illegally, causing the insurers to reimburse invalid claims. The Court established that eyeglasses and contact lenses must be dispensed by a registered optician based on a prescription supplied either by an optometrist or a physician. Under the business model selected by the chain, the only optician listed for the entire chain was its founder, who has been suspended as an optician since late 2006. The outlets have been repeatedly ordered to abide by Ontario's health regulations and to stop dispensing eyeglasses based on eye tests conducted on a computerized machine without a proper prescription.

  In October 2008, The College of Opticians and College of Optometrists of Ontario were successful before the Court of Appeal in a case ordering the largest known fine for contempt in Canada. The College of Opticians is now seeking a Court action that would shutdown the franchises that may be operating in violation of provincial health regulations. (College of Opticians, 2009)

- The news of a woman jailed for two years for fraud committed in dental offices was reported in media across the country, including the National Post, in March 2009.

  A dental assistant who defrauded dentists, insurance companies and banks was jailed two years in March 2009 for a series of scams. In total, she defrauded $193,336 from various banks and insurers, including TD Canada Trust, CIBC, Manulife Financial and Great-West Life, in what Justice John Moore called a "well planned, sophisticated piece of work."(Bowden, 2009)

  The dental assistant, aged 40, worked for six dental offices in and around Toronto between late 2005 and 2007. She forged orders for expensive dental procedures under patients' names and then intercepted their insurance cheques, pocketing the cash. (Bowden, 2009)

SECTION II: THE MULTI-FACETED DEFENSE APPROACH AGAINST FRAUD AND ABUSE IN PRIVATE HEALTHCARE BENEFITS

Each party to the plan (plan sponsors, plan members, insurer, healthcare practitioners and professional regulatory bodies) has a partial responsibility to ensure that fraud and abuse do not go unnoticed. However, given that it is the insurer's plan that is being defrauded, the insurer is quite naturally at the forefront of the parade, attempting to provide solutions to the problem. As the insurer Standard Life indicates in its educational session on fraud and abuse:

> *"Combining initiatives is the key: When preventing, detecting and deterring fraud and abuse, the "one-size-fits-all" approach is rarely effective. A multi-faceted approach is the only way to effectively tackle fraud and abuse in health and dental claims (Standard Life – Investigation Services, 2008)."*

This research will now focus on detailing the three approaches used by the insurers to tackle fraud and abuse.

2.1 Preventive Measures

2.1.1. The Role of the Forensic Accountant in Prevention

The forensic accountant can use his knowledge, experience and credibility in educating and providing supporting evidence to the effect that modifications to plan designs can in fact save the plan sponsor losses. The forensic accountant also has the knowledge and the expertise to interpret the impact of potential modifications for the plan sponsors, by reviewing the claims experience and calculating pro-forma analyses reflecting the impact on the premiums of the recommended changes to plan designs. In order to justify his recommendations, the forensic accountant is in a most favourable position to present a clear picture of the financial impacts (i.e. savings), which is the single most important element in order to convince an employer to modify its current practices. We will now address in detail the education and plan design approaches to prevention.

2.2.2 Education

The direct link between fraudsters and abusers stealing from the benefit plans and the related increase in premiums is the most important aspect affecting the plan sponsors. The insurer must ensure that independent advisors, plan sponsors, their administrators and employees understand the problem of fraud and abuse and their impact on the plans, as well as the necessity for claims audits (i.e. requests for additional information such as proof of medical necessity) and the need to support these practices.

Employee communication materials should include clear references to the impact of fraudulent claims on the cost of employee benefits. Materials prepared by the insurer

should emphasize the plan member's obligation to make honest use of the benefit plan and state that making a fraudulent claim can void coverage and/or constitute a criminal offence. Most insurers also have in place a whistle-blowing telephone line and email address to report fraud anonymously, another way of preventing fraud and abuse.

The Challenge in educating: It is extremely difficult to reach all parties involved in every group insurance contract, as group insurers insure hundreds of thousands of employees. However, by preparing relevant publications and providing large employee groups with live education sessions, the insurers may successfully achieve the education portion of their mandate. The insurers should also always keep as a priority the education of the independent advisors who provide their clients, the employers, with suggestions on plan designs.

2.2.3 Plan Design and Fraud Prevention

Benefit plan design is the single most important element influencing the vulnerability of a plan to possible fraud and abuse. The use of co-pays and deductibles, although not always popular with employees, provide incentives to plan members to agree to only medically necessary procedures. More effectively, while many plan sponsors have implemented annual and sometimes lifetime caps on certain benefit items, as a means for controlling costs, these limits also had the side effect of reducing opportunities for fraud, when applied to items that have proven most vulnerable to abuse.

By modifying certain requirements of the plan, it is possible to protect the integrity of the benefit plan. The following are a few of many examples of benefits particularly vulnerable to questionable practices:

- Paramedical services covered at 100% with high or no maximums. The result is that all members of a same family suddenly require multifaceted treatments for an extended period of time. In order to reduce the exposure, the plan should limit the amount reimbursable per paramedical service to a reasonable maximum or combine several paramedical services in one maximum. The plan should also require that a physician's referral be obtained for certain paramedical services; this will support the insurer in requesting additional information, justifying the medical necessity of treatments directly from the prescribing physician.

- Eyewear where coverage for prescription lenses are unlimited; receipts may suddenly show inexpensive, low-quality frames with expensive, top of the line Hi-Index lenses, when in fact, designer sunglasses, without prescription lenses, were dispensed. The plans should include combined maximums for frames and lenses.

- Multiple pairs of support hose and surgical stockings to treat varicose veins with no maximum per pair. Stockings are sold at abusive profit levels, if dispensed at all. One pair of stockings should be allowed with a prescription from a family doctor. Additional pairs should be allowed only with a prescription from a vascular specialist. Maximums per pair should be set.

- As a general rule, plans should include co-insurance factors in order to keep the plan member involved in sharing a portion of the cost. This is useful for overuse of services, however it can be easily bypassed for fraudulent claims or when collusion with the practitioner is involved (i.e. if the maximum covered is $500 and 80% of it is covered, then the amount of the fake claim simply has to show a total of $625 instead of $500 — either way the fraudster reaches its maximum reimbursable under the plan without being out of pocket).

The challenges of plan design modifications: As the advisors are responsible to recommend the best coverage tailored to their clients' needs, the insurers must carefully convince the advisors of the positive impact the modifications can have on claims experience. However, the principal limitation often comes from a party on which the insurers have no influence. As group insurance benefits are often part of a union-negotiated agreement, modifications to plan design must then be negotiated with the employer. Consequently, proposed changes may be very difficult to implement.

2.2 Detection Measures

In order to achieve the objective, the responsibility of establishing a proper detection program lies with the insurer (Standard Life – Investigation Services, 2008).

Fraud and abuse in private healthcare benefits happens in a variety of ways and the schemes are constantly evolving. This makes a prevention strategy based on effective mechanisms and procedures for intercepting fraudulent claims mandatory for the insurers in order to avoid massive losses.

2.2.1 The Role of the Forensic Accountant in Detection

The investigation of health claims may appear, at first glance, to be outside of a forensic accountant's scope of practice. After all, forensic accountants are not medical experts. However, transactions involving healthcare practitioners and patients are normal accounting transactions that should leave traces. Secondly, healthcare benefits are managed by contractual agreements. Thirdly, the management of an investigation department for an insurer requires public relations skills. Convincing plan sponsors of the necessity of claims investigations to obtain their support is as important as performing a thorough investigation. The credibility brought by the presence of a forensic accountant is valuable in convincing the numerous parties involved of the legitimacy of the insurers' quest in fighting fraud and abuse. Finally, the investigation of healthcare fraud, especially cases where collusion is involved, requires a great deal of creativity in the methods used to prove the scheme in order to, at least, avoid payment of illegitimate claims.

Benefits are managed by contractual agreements and legislation, including privacy legislation. The role of the forensic accountant is to be sure to establish a detection plan based on an adequate risk analysis. This is where the forensic accountant can really use his potential. By correctly identifying areas at risk, the forensic accountant can focus the very limited investigative resources to the proper sector.

As group benefit contracts use wording that can both be helpful and harmful to the investigations performed, the forensic accountant is in a good position to suggest modifications that could facilitate the work.

Detection measures are divided in two main categories: Pre- and post-payment of the claims, which will now be explained in detail.

2.2.2 Pre-Payment Investigations

Pre-payment investigations are obviously preferable as they eliminate the need for the insurer to try to recuperate incorrectly reimbursed amounts. But identifying abusive or fraudulent claims prior to their payment is more easily said than done. For one, the insurer usually sees thousands of claims coming through the mail every day and the turnaround time to process claims is established via service level agreements, usually between 5 and 7 business days (Standard Life – Investigation Services, 2008). The content of the claim is usually unknown until the claims examiner adjudicates the claim. Once the claim has been processed, there is not much time left for the investigator to intercept payment, usually between 24 and 72 hours. Attempting to intercept claims without a proper system in place becomes the equivalent of playing chess in the dark.

A proper pre-payment investigation system involves the establishment of criteria in order for claims to be flagged and brought to the attention of the investigators. In that regard, claims adjudicators are at the front line of detection. These criteria, in order to be effective, have to be easy-to-use and have to cover two separate aspects: the patient and the provider.

> ***Focus on the patient:*** The investigator may elect to verify all claims from a specific participant if he has serious reasons to believe that all claims could either be fabricated or contain elements of abuse.
>
> ***Focus on the provider:*** The second detection tool is by "monitoring" specific healthcare providers by requesting a review of all claims submitted by plan members who obtained treatment or purchased medical equipment from that specific provider.

The combination of both initiatives is essential, as one method feeds the other and vice versa. By watching individuals with excessive claim patterns, the investigator is able to identify practitioners involved in abusive practices and start monitoring their activities, which in turn allows the investigator to identify new plan members involved.

This way of intercepting claims has the highest chance of success as the claimant and/or the provider can be questioned prior to any payment being issued.

2.2.3 Post-Payment Investigations

In post-payment investigations, extensive analysis of claims information using "data mining" tools to identify abnormal or unusual patterns will assist in targeting efforts in the right direction. By reviewing claims showing patterns of fraud or abuse, the investigator can identify new claimants and providers that are not already being watched.

There are many challenges to claims investigation. Firstly, valid claims and invalid claims often look alike. The fraudster wants the insurer to perceive the claim submitted as a valid claim. The investigator has to be very careful when questioning claims so that the claimant who presented a valid claim does not feel threatened. Furthermore, investigating claims requires additional time when compared to the mainstream adjudication process. The main risk for the insurer is the possibility of alienating his customers by questioning claims that should not be questioned or by taking excessive time to obtain evidence in order to determine the validity of the claim. Many plan sponsors do not appreciate having their employees complaining about the insurer appearing to "restrict" claim payment, which often leads to complaints about the quality of their health benefits. This risk highlights the necessity of providing education sessions to employers in order to ensure support when needed.

Claimants involved in fraudulent or abusive schemes may also "use" their employer to legitimatize the claim, by complaining that the insurer treats him unfairly in order to influence the reimbursement decision. Claimants involved in such schemes also regularly use the mandatory complaint processes that insurers are required to maintain, in order to put pressure on the investigator. For instance, the claimant may escalate

complaints to the Ombudsman of the insurer, senior executives and regulatory bodies, in order to prevent an investigation to continue, forcing the investigator to justify his requests.

2.2.4 The Canadian Health Care Anti-Fraud Association

Most major Canadian Private Healthcare Insurers, along with The Workplace Safety & Insurance Board of Ontario (WSIB), the Ministry of Health of Ontario and the Ontario Provincial Police (O.P.P.) are members of the Canadian Health Care Anti-Fraud Association:

> *The Canadian Health Care Anti-fraud Association (CHCAA) was founded in 2000 to give a voice to the public and private sector health care organizations interested in preventing fraud in the Canadian health care environment. Membership is open to organizations and individuals responsible for the detection, prevention, investigation and prosecution of health care fraud (CHCAA, 2008)*

The CHCAA offers opportunities to its members to share information assisting them in focusing their investigative efforts where other members have discovered wrong-doing or were made aware of potential wrong-doing.

2.2.5 Case Studies

The insurers have access to many tools to achieve their quest in finding the truth. The following are two fictional examples illustrating how the insurers can use their creativity along with contract wording and legislation to effectively detect fraud:

The False Student

A plan member has a dependant over the age of 21. The plan member indicates that the dependant is a full-time student (which is the condition for eligibility under standard contracts), when in fact he is not, in order to claim for expenses that would not be eligible under the plan.

Under the terms of the contract, the insurer may request proof of school attendance. The insurer is also allowed to confirm with the educational institution that the student is registered as a full-time student.

Plan members frequently lie about the status of their dependents and, in some instances, plan members have invented children that did not even exist in order to claim for additional expenses.

The Narcotics Addict

A plan member uses his healthcare benefits to finance his addiction to a narcotic, which is a regulated drug under the *Controlled Drugs and Substances Act*. The plan member also sells a portion of the narcotics on the streets. The private insurer reimburses the total purchases, which are recurring and are often substantial.[5]

[5] The funding of narcotics addiction by benefits plan has increasingly caught media attention in the recent years.

Under the *Narcotic Control Regulations*, C.R.C., c.1041, S.3 (3):

> *A person in whose favour a prescription or a narcotic has been issued shall not seek or receive another prescription or a narcotic from a different practitioner without disclosing to that practitioner particulars of every prescription or narcotic that he has obtained within the previous 30 days.*

Controls will help flag a plan member showing higher than normal consumption of a medication. The insurer can then verify with the prescribing physicians and pharmacists (if more than one) that the plan member was not "doctor-shopping" illegally or not plainly falsifying prescriptions. In either case, the insurer could refer the case to local law authorities to seek criminal prosecution.

If we assume that a plan member successfully convinces a physician that the narcotic is a medical necessity because of severe pain symptoms and, if we also assume that the narcotics are sold on the streets, then the insurer does not have many options:

- *Independent Medical Examination:* If the contractual agreement with the plan sponsor authorizes the insurer to request an independent medical examination, it may be beneficial to request that such an examination take place. However, the examination could prove nothing at all if the pain is related to a subjective condition, such as chronic pain, which is difficult to identify. In order to verify that the medication is taken, the insurer could be tempted to request blood tests, however a physician could be accused of forcing a patient to provide a blood

sample. The insurer should be very prudent not to expose itself or the physician to reputational risks and lawsuits.

- *Surveillance:* In order to prove trafficking, the insurer could also recourse to surveillance by undercover investigators. Although potentially effective, the process can be costly and it could also be deemed an invasion of privacy, especially if the scheme cannot be proven.

The insurers are literally caught in the middle. By not acting upon a potential fraud, the insurer could incur massive financial losses that would ultimately be passed on to plan sponsors. Additionally, although there has not been any precedent in that regard, the insurer could be accused of negligence for funding an addiction if it reimbursed claims for an individual when it was aware or ought to be aware that the individual was addicted to the narcotic.

An insured member may also appear suspicious and attract the attention of the insurer's investigators by his/her behaviour. The following highlights claimant behaviours that are considered to be red flags by insurers.

2.2.6 Behavioural Red Flags

- Aggressive claimant, or claimant inquiring on the status of a claim very shortly after submission, escalating issues directly to the plan administrator (plan sponsor) or advisor, usually without contacting the call centre first (pressure tactic);
- Reluctance by the claimant and/or practitioner to provide any requested supporting information, arguing the plan does not require this information;
- Lack of response to questioned claims. The claimant prefers submitting new claims hoping the insurer will not notice the stratagem;
- Claimant waits several months after being asked for additional information, then files a complaint and pretends he forwarded the information requested months ago, or that he never received the correspondence issued by the insurer; and
- Frequent claim submissions in nominal amounts (under the radar) on a weekly basis.

2.3 Deterrents

2.3.1 The Role of the Forensic Accountant in Deterrence

Insurers and plan sponsors are both becoming more and more aware of the importance of taking action against fraud and abuse to protect themselves and their clients. The forensic accountant is in a great position with his knowledge and skills to prepare the evidence required by legal counsel, regulatory bodies and law enforcement authorities. This forensic accountant, with assistance of legal counsel, has the required abilities to select the appropriate deterrent response to fraudulent or abusive behaviour. In that regard, the forensic accountant is in a privileged position to tailor deterrents that are in accordance with the objectives set by the insurer, which is to only reimburse legitimate claims.

2.3.2 Types of Deterrents

In order to be effective, plan sponsors and insurers have to set examples by effectively pursuing recovery of funds when fraud was perpetrated. Demonstrating through action that fraud will not be tolerated is essential; not taking action means tolerance, which other insured members can perceive as sponsoring this type of behaviour.

Setting a clear objective is essential, as the investigators must know what result is expected of them. For instance, the objective established by Standard Life (as quoted in section 2.2) implies that the main priority is to avoid financial losses by protecting the plan against reimbursement of illegitimate claims.

The level of evidence necessary to prosecute individuals criminally (beyond reasonable doubt) is by far superior to what is required in order to avoid payment of an illegitimate claim that could be challenged in a Civil Court (balance of probabilities). Nevertheless, when the evidence is sufficient to warrant it, the insurers should consider referring the case to law enforcement authorities, as benefit fraud can be prosecuted under the Criminal Code of Canada, specifically section 380 (1):

> *Every one who, by deceit, falsehood or other fraudulent means, whether or not it is a false pretence within the meaning of this Act, defrauds the public or any person, whether ascertained or not, of any property, money or valuable security or any service,*
>
> *(*a*) is guilty of an indictable offence and liable to a term of imprisonment not exceeding fourteen years, where the subject-matter of the offence is a testamentary instrument or the value of the subject-matter of the offence exceeds five thousand dollars; or*
>
> *(*b*) is guilty*
>
> *(i) of an indictable offence and is liable to imprisonment for a term not exceeding two years, or*
>
> *(ii) of an offence punishable on summary conviction,*
>
> *where the value of the subject-matter of the offence does not exceed five thousand dollars.*

When there is no evidence of fraud but clear evidence of abuse, or in cases where the fraud cannot be proven (often occurs on cases where there is collusion between the practitioner and the patient) the strategy of the insurer is usually to fall back on the

medical necessity clauses.[6] Most often, abusive claims come in a package of a variety of treatments. It becomes more difficult for the claimant to justify the medical necessity and reasonability of a multi-faceted treatment regimen if there is medical evidence supporting it.

Evidence of wrongdoing by the practitioners:

Most health professions are regulated. When wrongdoing by a professional is suspected, such as providing unnecessary treatments, dispensing unnecessary medical devices for personal gain, or to engage in questionable billing practices, the insurers have the possibility to report the conduct (through a formal complaint or through a "letter of concern") to the regulatory body in charge of overseeing the practice of that professional. The regulatory bodies, considered an investigative body under the *Personal Information Protection and Electronic Documents Act* (PIPEDA), can request all information deemed necessary from the professionals involved in order to investigate the complaint.

Evidence of wrong doing by the plan members:

As the plan member is a user of the benefits plan contracted between the employer and the insurer, there are recourses available against plan members abusing or defrauding the health benefits sponsored by their employers. When the evidence gathered confirms wrongdoing by the plan member, the benefits administrator (the insurer) may notify the plan sponsor (employer) of the activities. The plan sponsor can then make a decision in

[6] Medical necessity clauses are also used in Criminal investigations but would not be the main piece of evidence.

relation to the employee's status in the organization based on the information shared by the insurer.

Advising the employer comes with its share of challenges and great caution is required. By revealing the identity and potential fraudulent scheme performed by an employee recklessly, the insurer could be violating PIPEDA and/or provincial privacy legislations, such as the *Act Respecting the Protection of Personal Information in the Private Sector (R.S.Q. Chapter P-39.1)* in Québec. It could also violate the *Canadian Human Rights Act* (R.S., 1985, c. H-6).

The employer also has to be extremely cautious when deciding to terminate an employee on grounds of health benefit misuse or abuse and should consult with its legal counsel prior to termination. These are delicate situations as an erroneous judgment call when divulging the insurer's information could jeopardize the entire business relationship with the employer, if the employer is later charged with wrongful dismissal. The plan sponsors also have to ensure that they are not indirectly implicated in the fraud, as an insurer may allege that the employer, through its conduct, enabled the fraud to take place, if for example, the employer does not take any action against an employee found to have misused the benefits. Inaction by the plan sponsor could also lead to the loss of trust and the destruction of the business relationship with the insurer.

The insurer also has the possibility to initiate civil action against the plan member for recovery of funds incorrectly paid to a plan member. However, as mentioned earlier, the insurer could also consider informing law enforcement, particularly if there is suggestion that the employee is colluding with a practitioner or if there is evidence of forgery.

Reminiscent of the different recourses mentioned above, Manulife Financial, one of Canada's largest group insurers, posted its official position in relation to fraud and abuse on its corporate website:

> *"When Manulife Financial has reason to suspect a case of fraud or abuse, we will conduct further investigation in an attempt to recover any money that has been obtained improperly. In cases where fraud is identified, Manulife Financial will contact the employer to provide details of the findings. And when the likelihood for a successful prosecution exists, a criminal complaint is submitted to the appropriate law enforcement agency* (Manulife, 2008)."

SECTION III: THE LEGAL LIMITATIONS AND DANGERS OF INVESTIGATING PRIVATE HEALTHCARE BENEFITS FRAUD AND A COMPARATIVE ANALYSIS OF THE IMPACT OF REGULATION ON FRAUD

Now that we have addressed the actions an insurer may take against fraud and abuse, this section will now focus on the contractual and legal limitations when investigating and deterring fraud and abuse.

3.1 Healthcare Professionals and Regulation

Group health benefit contracts typically require that the healthcare practitioners providing services or dispensing medical devices be legally authorized in their province to practice their profession, in accordance with legislation.

Healthcare professionals are regulated under provincial legislation, such as the *Regulated Health Professions Act* in Ontario and the *Professional Code*[7] in Québec. Regulation provides the insurers with greater support when performing investigations. An insurer may request for regulatory bodies to investigate the conduct of regulated professionals if the insurer has evidence on hand that indicates potential misuse of the benefits involving them. The practitioners can be held accountable by their regulatory bodies, which can, amongst other remedies, restrict or suspend their right to practice after investigating the complaint.

[7] The Professional Code oversees 45 professions, not all related to healthcare. Refer to Appendix II for a complete list.

However, not all health practitioners are regulated. For reference purposes, the regulated professions in Ontario and Québec are presented in Appendices 1 and 2 respectively.

In addition, regulations between provinces are different and standards of practice differ. In addition, certain professions are regulated in one province but not in another. For example, in Québec, the absence of legislation pertaining to massage therapy and naturopathy exacerbates the problem of fraud and abuse, making it often effortless for plan members to collude with a practitioner. Ontario is infamous for its lack of regulation surrounding orthopaedic products (mainly foot orthotics) and medical supplies, such as compression stockings used for the treatment of varicose veins and this greatly reduces the insurance carrier's means to limit the proliferation of fraud in those benefits.

Therefore, although a profession may be regulated, the act performed is not necessarily regulated and can be performed by other unqualified professionals.

3.2 The case of Orthotics and other Orthopaedic devices: Ontario vs Québec

Orthotics and orthopaedic shoes are medical devices that are used to alter or modify foot function and are designed to treat, adjust, and support various biomechanical foot disorders (Podiatry Channel, 2009). However, orthotics also became a tool to defraud the insurers, especially in the province of Ontario.

There is no legislation in Canada regulating who can provide you with custom orthotics and orthopaedic shoes, except in the province of Québec. However, in all other provinces, many insurers restrict the list of practitioners that can prescribe and dispense

orthotics, clearly differentiating the two actions. Even so, the restriction, at best, limits the roles to a short-list of professionals that operate under different rules and standard of practice. In Ontario, the list of dispensing practitioners includes, at a minimum, podiatrists, chiropodists and pedorthists and orthotists, all specialized in the treatment of foot disorders.[8] Certain contractual agreements may also allow chiropractors and physiotherapists as recognized dispensing providers, while the contracts proposed by many insurance carriers do not provide any restrictions on the dispensing providers. There are no standards across the industry.

On the prescribing side, the situation is simpler to manager, as only podiatrists, chiropodists and physicians may prescribe orthotics. As a prescribing practitioner can also be dispensing the products at a profit (except for physicians), a conflict of interest ensues that may lead unscrupulous providers to take advantage by considering their personal financial gain rather than considering the medical necessity of dispensing the devices. CBC Marketplace (2008) revealed in its report that aired in February 2008 that some medical professionals were caught on camera prescribing and selling custom orthotics when they weren't medically necessary.

In addition, the insurers commonly witness the price of the same orthotics, fabricated with similar materials by the same practitioners, being invoiced at different prices tailored to the level of insurance coverage available (often varying between $300 and $600 per pair).

[8] Although there are differences in the scope of practice of each professional, it is outside the scope of this research to define them.

Finally, to complicate things, it is very difficult for patients to identify well-made custom-made orthotics from the others. As demonstrated by Mrs. Leslie Trotter, Pedorthist, interviewed in a CBC Marketplace report (2008), there is little difference between the off-the-shelf $20 shoe insert purchased at your local drugstore and the $500 custom-made inserts. Despite the supposed “custom-made” product being "covered" by private insurance, every unnecessary prescription for these expensive inserts will increase premiums for everyone. This leaves the door open to many fraud artists. Some operators in Toronto were recently caught selling fashion shoes and televisions while invoicing them as custom orthotics for the insurance claim. Some operators in mall kiosks will lead unsuspecting patients to believe they are fitting you for a custom orthotic by taking an impression and then supplying you with an inexpensive arch support. Some operators in trade shows will tell patients that their orthotic is custom made just for them, since they glued some material under a standard arch support.

Behind the dispensing providers are the laboratories, which are also unregulated, fabricating the orthotics and heavily marketing their products to the dispensing providers.

The lack of regulation and the fraud and abuse that follows it is costing insurers and plan sponsors millions of dollars every year in orthotic benefits that are not medically necessary, are inadequate to treat a valid condition, and are overpriced. The situation keeps deteriorating as there is a constant (for at least the past 5 years) and pronounced (greater than 10%) increase in claim levels every year (Standard Life – Investigation Services, 2008).

In order to address this issue and to protect patients, the province of Québec regulated the acts of prescribing, manufacturing and dispensing orthotics and other orthopaedic products. These acts are regulated under the *Act respecting medical laboratories, organ, tissue, gamete and embryo conservation, and the disposal of human bodies (R.S.Q., c. L-0.2, s. 69).* The Act ensures, through section 135, that all custom-made orthotics and other orthopaedic products are prescribed by a physician or a podiatrist:

> ***135.*** *Any manufacturing of ortheses or prostheses and any change carried out in an ortheses or prostheses laboratory must be done in response to a prescription signed by a professional empowered to sign such prescription under the Act governing the professional corporation to which he belongs.*

The Act also regulates through issuance of a permit by the Minister of Health and Social Services the acts of operating laboratories manufacturing and dispensing orthopaedic products through sections 91 and 92.

> ***91.*** *A permit to operate a laboratory may be issued in one or the other of the following fields of activities or more than one at a time:*
>
> *(a) For the manufacture and repair of prosthetic devices or ortheses*

> ***92.*** *The laboratory permits contemplated in paragraph a) of section 91 shall be issued for one or several of the following sectors of operation:*
>
> *(a) Orthopaedic ortheses;*
>
> *(b) Orthopaedic prostheses;*
>
> *(c) Foot ortheses*

Finally, section 128 of the Act details the qualifications required by the practitioner exploiting the laboratory:

> ***128.*** *A foot ortheses laboratory must be directed by a person who:*
>
> *(a) directed a foot ortheses laboratory in Québec on January 1, 1978 and possessed on that date, at least 10 years experience in the sector of manufacturing and adjusting orthopaedic shoes; or*
> *(b) holds a diploma of collegiate studies in prosthetic and ortheses techniques and has at least 5 years' experience in designing, measuring, manufacturing, adjusting, installing and repairing orthopaedic prostheses or ortheses, at least 3 years of which are in the field of foot ortheses including orthopaedic shoes.*

3.2.1 Study: The Impact of Regulation on Orthotics Claims Experience (Tourangeau, 2009)

The Analysis

In order to attempt quantification of fraud and abuse of orthotics in Ontario, the author relied on the conclusions of a study he performed in 2009. The analysis consisted in selecting the claims reimbursed by Standard Life for orthotics and orthopaedic shoes submitted by all plan members located in Québec and comparing them to the same type of claims submitted by plan members located in Ontario, for the year ending December 31st, 2008.

The Objective

Establish the total amount spent on average, per member insured by the private plans and determine if regulations act as a viable deterrent for fraud and abuse.

Methodology

- Members insured (average): All members from all groups insured by Standard Life in the province of Québec and in the province of Ontario were part of the selection. In order to calculate the number of members insured, the author calculated the number of active members at the end of each month of the calendar year 2008 from which an average was derived.
- Claims: We compared the amount of claims submitted for reimbursement and the claims reimbursed amounts following adjudication, using information submitted by Standard Life. Although the exact figures will not be revealed[9] in order to protect strategic information of the insurance carrier, the total population selected was significant, i.e. over 150,000 insured members.

Assumptions made to perform the analysis

- On average, each insured member had the same number of dependents (spouse and children) in Ontario and in Québec;

[9] The exact total number of insured members and the distribution of the population per province as well as the total value of claims for orthotics and orthopaedic shoes will not be revealed as requested by The Standard Life Assurance Company of Canada.

- Residents of both provinces had access to the same level of care, had the same awareness to foot care and we considered that the same number of individuals would suffer from foot disorders, in equal proportions, in both provinces;
- The population ensured by Standard Life under its group insurance plans is representative of the entire population of the provinces selected; and
- The group insurance contracts between the two provinces are similar and representative of other group insurance contracts administered by other insurance carriers located in both provinces.

Expectation

In theory, in absence of fraud and abuse in both provinces, the amounts spent per member insured on orthotics and orthopaedic shoes should be similar, if all other variables are equal.

The Results

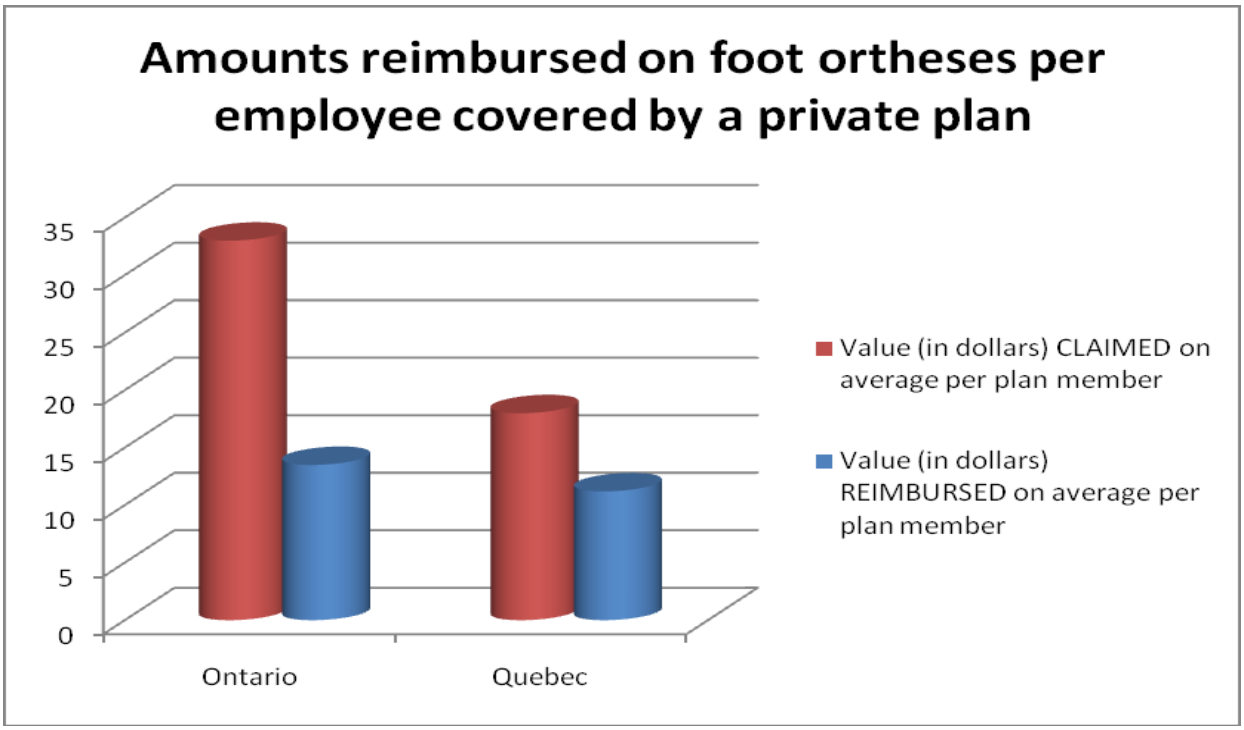
The difference in the results was by far greater than what was expected. As highlighted on the graphic below, the total amount of claims for orthotics submitted was on average, per plan member, and regardless of whether individual or family coverage was selected by the insured member, is nearly twice as high in Ontario when compared to Québec.

The difference in the total amounts reimbursed for such claims was, on average, 20% higher in Ontario when compared to Québec. Exhibit 3 (see next page) presents a visual presentation of those results.

The data suggests a far greater number of claims are being declined in Ontario than in Québec, following claims adjudication. That suggestion would be accurate as the insurer spent most of its investigative efforts concentrating on claims in Ontario to counter fraud and abuse, which explains that a higher number of claims submitted were never reimbursed to the claimants.

Exhibit 3: Comparison of orthotics (or ortheses) claims levels between Ontario and Québec based on average value of claims submitted per insured member

(Tourangeau, 2009)



Conclusion

The methodology used and assumptions made could have created, in my opinion, minor discrepancies. However, the analysis shows a clear gap between claims reimbursed in Ontario when compared to the amounts reimbursed for claims incurred in Québec.

Considering the imperfections in the methodology, which could impact the conclusion, it appears that a fair portion of the amounts paid by insurers, for orthotics and other orthopaedic products in Ontario, is spent on fraud and abuse. This analysis shows that $4 is lost on each person insured through a private healthcare plan in Ontario. Considering that millions of individuals are insured through a private healthcare plan, this number represents millions of dollars in losses, every year.

The analysis is also imperfect as it may underestimate the losses in Ontario. By looking primarily at the difference between claims submitted by insured members in Ontario vs Québec, the analysis implicitly assumes that no fraud or abuse is taking place in Québec because of the regulations. That cannot be true. Although regulations might help reduce fraud and abuse, they can never totally stop it. In that regard, the analysis was conservative and the extent of fraud and abuse in Ontario may have been underestimated.

This is the first analysis, as far as the author is aware, attempting to quantify the amount of money lost to fraud and abuse in the orthotics industry. Although imperfect in its methodology and assumptions, which could impact the conclusion, it supports the theory that a significant portion of the amounts spent by insurers and employers on orthotics and other orthopaedic products in Ontario is lost to fraud and abuse.

3.3 The impact of Privacy legislation on Investigations

Plan sponsors' reliance on the insurers to detect fraudulent activity has increased significantly in recent years. The enactment of federal and provincial privacy legislation has significantly limited plan sponsors' access to employee claims information. Consequently, they are less able to detect or investigate fraudulent activity and must depend, to a large degree, on the counter-fraud initiatives of their group benefits insurance carrier.

Privacy legislations also limit the possibilities for the insurer to reveal information to the plan sponsor, if a claim submitted by one of its members appears to be questionable.

Privacy of the participants is regulated through PIPEDA. In addition, several provinces have enacted their own privacy legislation, which usually goes a step further in protecting the privacy of individuals. The insurers have to consider the impact of the privacy legislation when conducting their investigations and when divulging information to the plan sponsors or any other third parties.

The following are selected excerpts from PIPEDA that are relevant to the insurers when conducting their investigations:

Collection without knowledge or consent

> ***7.*** *(1) … an organization may collect personal information without the knowledge or consent of the individual only if :*
>
> *(b) it is reasonable to expect that the collection with the knowledge or consent of the individual would compromise the availability or the accuracy of the information and the collection is reasonable for purposes related to*

investigating a breach of an agreement or a contravention of the laws of Canada or a province.

Use without knowledge or consent

7. *(2) … an organization may, without the knowledge or consent of the individual, use personal information only if*

(a) in the course of its activities, the organization becomes aware of information that it has reasonable grounds to believe could be useful in the investigation of a contravention of the laws of Canada, a province or a foreign jurisdiction that has been, is being or is about to be committed, and the information is used for the purpose of investigating that contravention;

(d) it was collected under paragraph (1)(a), (b) or (e).

Disclosure without knowledge or consent

7. *(3) … an organization may disclose personal information without the knowledge or consent of the individual only if the disclosure is:*

(c) required to comply with a subpoena or warrant issued or an order made by a court, person or body with jurisdiction to compel the production of information, or to comply with rules of court relating to the production of records;

(d) made on the initiative of the organization to an investigative body…

(i) has reasonable grounds to believe that the information relates to a breach of an agreement or a contravention of the laws of Canada, a province or a foreign jurisdiction that has been, is being or is about to be committed, or

(i) required by law.

Subsection 7. (3) (d) refers to the disclosure of confidential information to investigative bodies. Regulatory bodies (Colleges) applying the legislation of the regulated health professions oversee the professional practice of their members. As they are responsible for performing investigations as part of their mandate, they have the investigative body

status. This allows the insurers to file complaints to the regulatory bodies when professional misconduct is suspected without fear of violating the privacy legislation by doing so.

When the insurer has enough evidence that suggests that fraud occurred, the employer could be informed of the situation when deemed appropriate using the exception as described in PIPEDA under subsection 7.3 (i) as it could be considered a breach in the contractual agreement.

All insurers, however, do not share this position. Some carriers take the position that revealing such information would be a violation of privacy legislation. The author is not aware of any Canadian precedents that would provide the position of the Court on this matter.

In addition to federal privacy legislation, three provinces (Québec, British Columbia and Alberta) also have privacy legislation that are equivalent to PIPEDA in how they affect claim investigations.

3.4 The Dangers of Surveillance

Surveillance is more commonly used in investigations related to disability claims. Although disability claims are outside of the scope of this research project (the analysis of disability fraud and abuse could have been a project on its own), the schemes and investigation methods are similar between healthcare fraud and disability fraud.

Surveillance is one, if not often the most powerful tool that can be utilized by the insurer to prove the capacity or incapacity to work, but also to identify potential fraud. However, it should only be used when all other avenues are exhausted, as it can be deemed an invasion of privacy, as it has been highlighted in recent Court decisions (we will discuss two cases later in this section).

The Office of the Privacy Commissioner of Canada has also posted its *Guidance on Covert Video Surveillance in the Private Sector*. According to the *Guidance*, organizations should have a policy on covert video surveillance and document specific instances of video surveillance.

The *Guidance* also sets out the following considerations "that factor into determining whether an organization is justified in undertaking covert video surveillance":

- Demonstrable, evidentiary need;
- Information collected by surveillance achieves the purpose;
- Loss of privacy proportionate to the benefit gained; and
- Less privacy-invasive measures taken first.

Because surveillance is mostly used in disability cases, it is no surprise that Court precedents relating to invasion of privacy due to surveillance occurred on disability

related cases. However, as surveillance can also be used in healthcare and dental benefits, these precedents should be considered before authorizing the use of such services.

On February 8, 2008, the Court of Appeal of Quebec awarded $125,000 the award of exemplary damages against the *Penncorp Life Insurance Company* for filmed surveillance deemed inappropriate and abusive. There seems to be a trend emerging in the courts, prompting the awarding of higher damages for invasion of privacy, as confirmed by the recent Superior Court decision, *Tremblay v. Compagnie d'assurance Standard Life*, rendered June 3, 2008 (Aylwin, 2008). Standard Life is now appealing that decision.

Essentially, in *Tremblay v. Compagnie d'assurance Standard Life,* the Court concluded that Standard Life had committed an error by ordering surveillance without substantive reasons, resulting in a violation of Mr. Tremblay's right to privacy. In this particular case, there was an error of identity during the surveillance that lead to Mr. Tremblay being attributed actions that were not his own, actions that exceeded the functional capacities described by his treating physician. The Tribunal concluded that this error caused Mr. Tremblay to lose all credibility with Standard Life. The Court also considered that, through its actions, Standard Life interfered with the dignity of the claimant, and dignity is understood by the Court to refer to the respect and consideration to which every person is entitled (Aylwin, 2008).

CONCLUSION

The structure of the plans, which involves passing on "invisible" losses to plan sponsors through premium increases, is the main reason explaining the rapid and constant escalation of damages caused by fraud and abuse and for the non-attention of the general public.

Policyholders have come to expect that the insurer's responsibilities include conducting fraud and abuse activities to protect the integrity of the plan, and to ultimately only accept to pay legitimate claims. With the rising numbers of such cases on different fronts, the insurer's costs for managing fraud and abuse are on the rise; however policyholders are not necessarily willing to pay for such services. While the insurance industry is looking at options to minimize expenses relating to this topic, there is a valid concern that economic times may tempt certain organizations to cutback on some of these activities, allowing for an appearance of cost-saving in the short-run, but allowing fraud and abuse to prevail.

Private healthcare benefits are in constant evolution and are designed to meet the needs of the plan sponsors, the employers. The rapidity with which the costs for the plan sponsors are escalating is unlikely to be sustainable, partly due to fraud and abuse. It might only be a matter of time before the employers seek ways to reduce costs related to those benefits. The result would be a reduction in the quality of coverage for everyone.

Appendix I

REGULATED HEALTH PROFESSIONS ACT, 1991

S.O. 1991, CHAPTER 18

SELF-GOVERNING HEALTH PROFESSIONS IN ONTARIO

Health Profession Acts	*Health Profession*
Audiology and Speech-Language Pathology Act, 1991	Audiology and Speech-Language Pathology
Chiropody Act, 1991	Chiropody
Chiropractic Act, 1991	Chiropractic
Dental Hygiene Act, 1991	Dental Hygiene
Dental Technology Act, 1991	Dental Technology
Dentistry Act, 1991	Dentistry
Denturism Act, 1991	Denturism
Dietetics Act, 1991	Dietetics
Homeopathy Act, 2007	Homeopathy
Kinesiology Act, 2007	Kinesiology
Massage Therapy Act, 1991	Massage Therapy
Medical Laboratory Technology Act, 1991	Medical Laboratory Technology
Medical Radiation Technology Act, 1991	Medical Radiation Technology
Medicine Act, 1991	Medicine
Midwifery Act, 1991	Midwifery
Naturopathy Act, 2007	Naturopathy
Nursing Act, 1991	Nursing
Occupational Therapy Act, 1991	Occupational Therapy
Opticianry Act, 1991	Opticianry
Optometry Act, 1991	Optometry
Pharmacy Act, 1991	Pharmacy
Physiotherapy Act, 1991	Physiotherapy
Psychology Act, 1991	Psychology
Psychotherapy Act, 2007	Psychotherapy
Respiratory Therapy Act, 1991	Respiratory Therapy
Traditional Chinese Medicine Act, 2006 (not in force as of June 4th, 2009)	Traditional Chinese Medicine (Acupuncture)

Appendix II

PROFESSIONAL CODE, R.S.Q., Chapter C-26

THE 45 SELF-GOVERNING PROFESSIONS IN QUÉBEC

1. The Ordre professionnel des avocats du Québec;
2. The Ordre professionnel des notaires du Québec;
3. The Ordre professionnel des médecins du Québec;
4. The Ordre professionnel des dentistes du Québec;
5. The Ordre professionnel des pharmaciens du Québec;
6. The Ordre professionnel des optométristes du Québec;
7. The Ordre professionnel des médecins vétérinaires du Québec;
8. The Ordre professionnel des agronomes du Québec;
9. The Ordre professionnel des architectes du Québec;
10. The Ordre professionnel des ingénieurs du Québec;
11. The Ordre professionnel des arpenteurs-géomètres du Québec;
12. The Ordre professionnel des ingénieurs forestiers du Québec;
13. The Ordre professionnel des chimistes du Québec;
14. The Ordre professionnel des comptables agréés du Québec;
15. The Ordre professionnel des technologues en radiologie du Québec;
16. The Ordre professionnel des denturologistes du Québec;
17. The Ordre professionnel des opticiens d'ordonnance du Québec;
18. The Ordre professionnel des chiropraticiens du Québec;
19. The Ordre professionnel des audioprothésistes du Québec;
20. The Ordre professionnel des podiatres du Québec;
21. The Ordre professionnel des infirmières et infirmiers du Québec;

21.1 The Ordre professionnel des acupuncteurs du Québec;

21.2 The Ordre professionnel des huissiers de justice du Québec;

21.3 The Ordre professionnel des sages-femmes du Québec;

21.4 The Ordre professionnel des géologues du Québec;

22. The Ordre professionnel des comptables en management accrédités du Québec;
23. The Ordre professionnel des comptables généraux licenciés du Québec;
24. The Ordre professionnel des diététistes du Québec;
25. The Ordre professionnel des travailleurs sociaux du Québec;
26. The Ordre professionnel des psychologues du Québec;
27. The Ordre professionnel des conseillers en ressources humaines et en relations industrielles agréés du Québec;
28. The Ordre professionnel des conseillers et conseillères d'orientation du Québec;
29. The Ordre professionnel des urbanistes du Québec;
30. The Ordre professionnel des administrateurs agréés du Québec;
31. The Ordre professionnel des évaluateurs agréés du Québec;
32. The Ordre professionnel des hygiénistes dentaires du Québec;
33. The Ordre professionnel des techniciens et techniciennes dentaires du Québec;

34. The Ordre professionnel des orthophonistes et audiologistes du Québec;
35. The Ordre professionnel de la physiothérapie du Québec;
36. The Ordre professionnel des ergothérapeutes du Québec;
37. The Ordre professionnel des infirmières et infirmiers auxiliaires du Québec;
38. The Ordre professionnel des technologistes médicaux du Québec;
39. The Ordre professionnel des technologues professionnels du Québec;
40. The Ordre professionnel des inhalothérapeutes du Québec;
41. The Ordre professionnel des traducteurs, terminologues et interprètes agréés du Québec.

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* Standard Life accepted that short excerpts of these documents be quoted and paraphrased for the benefit of this research. However, the documents are the property of Standard Life and cannot be released with the document.