Bending the benefits cost curve

Fraud – how we identify it and reduce it

Life's brighter under the sun

Sun Life

The story
In a perfect world...

- prices would be transparent, and plan members would always know what they're paying for
- drug manufacturers and health-care providers would only offer the best value
- plan members and health-care providers would always behave honestly and ethically.

Unfortunately, this is not always the case. Product and service prices can vary wildly, and benefits fraud prevention is necessary. As a result, benefits plan costs are higher than they should be.

Our goal is to move plan sponsors as close as possible to that perfect world – through programs and innovations that drive costs down. We do this in several ways:

- By empowering plan members as health consumers
- By encouraging providers to offer discounts
- By leveraging scale to negotiate pharmaceutical discounts
- By reducing the risk of fraud with data analytics

The information that follows highlights our ongoing work in fraud prevention – and the benefits of this work for plan sponsors.

Leading the way in fraud reduction

Benefits fraud is big business – amounting to hundreds of millions of dollars in losses each year in Canada. Insurers are fighting back, and Sun Life is paving the way. We lead our industry in both the size and capabilities of our fraud risk management team – and in our fast action to delist service providers who exhibit suspicious claiming patterns.

There are four main parts to our fraud risk management strategy:

1. **Prevention:** Our advanced statistical modeling tool uses machine learning and predictive modeling to generate actionable leads. The tool identifies outliers and high-risk plan members for intervention and investigation. It also monitors all types of claim submissions: e-claims, pay-direct drug claims, electronic claims from dentists and paramedical providers and paper claims. The data model also learns from previously identified suspected fraud cases. This lowers false positives and increases our success rate in detecting fraudulent behavior.

2. **Preparedness - laying the groundwork:** We have a team of over 100 fraud risk management professionals, including data scientists, analysts, ex-law enforcement professionals, trained investigators, and specialists from each line of business. Our team spreads the word on how to recognize suspicious activity and fraud and the consequences involved. We offer comprehensive fraud awareness tools and resources that are available to share with organizations and their employees. We also support our claims professionals in vetting new providers to ensure they are legitimate, properly credentialed and not involved in any suspect activity.

3. **Response:** If we suspect fraud, we will make plan sponsors aware of the activity. Following this, we will have an investigator monitor all claims from the suspected plan members and providers. We review and analyze claims submissions and other documents to evaluate the relationships between plan members and service providers. Our investigations can include site visits and obtaining witness statements, while also supporting plan sponsors through any interviews of employees suspected of fraud or abuse. Depending on the scope of the suspect fraud, we may also work with law enforcement and benefits industry stakeholders, including other insurance carriers and relevant associations. When evidence of suspicious activity relates to providers, we take fast action to delist them and prevent future losses.

4. **Recovery:** Our goal is to bring the suspect fraud or abuse to an end, repair as much of the damage as possible and recover any funds. We help facilitate a postmortem on what happened – and where any additional improvements and controls can be put in place. If needed, we also provide plan sponsors with education and communication materials for their workforce, as well as additional staff training to help manage the situation and repair trust within their organization.

The benefit to plan sponsors – millions of dollars in savings

There is a high incidence of service provider suspicious activity and potential collusion schemes, which is why the delisting of providers is so important. We lead all insurers in this prevention step, having delisted over 1,800 entities as of April 2019.

The savings are significant. We have saved plan sponsors approximately $100 million through our profiling program since 2014, and much of this has been through the delisting of suspect providers. Delisting the provider or clinic prevents that entity from colluding with plan members to engage in suspicious activity.

Expanding our fraud detection capabilities

While the majority of fraud cases involve paramedical services, dental or drug claims, we continue to increase our fraud risk management capabilities across all of our benefit lines. One initiative is developing the best approach to managing fraud within the disability landscape.

Our initiative incorporates a number of elements:

- Further developing predictive modelling to identify suspicious leads within disability claims
- Using a clues hotline for people to report suspicious activity
- Cross-referencing plan members implicated in suspected health and dental fraud against disability claimants
- Cross-referencing known suspected providers of health and dental products and services with those supporting disability claimants.

Fraud of all kinds remains a growing concern. Our fraud risk management capabilities will continue to expand and play a key role in plan sustainability.

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