BENEFITS INSIGHTS

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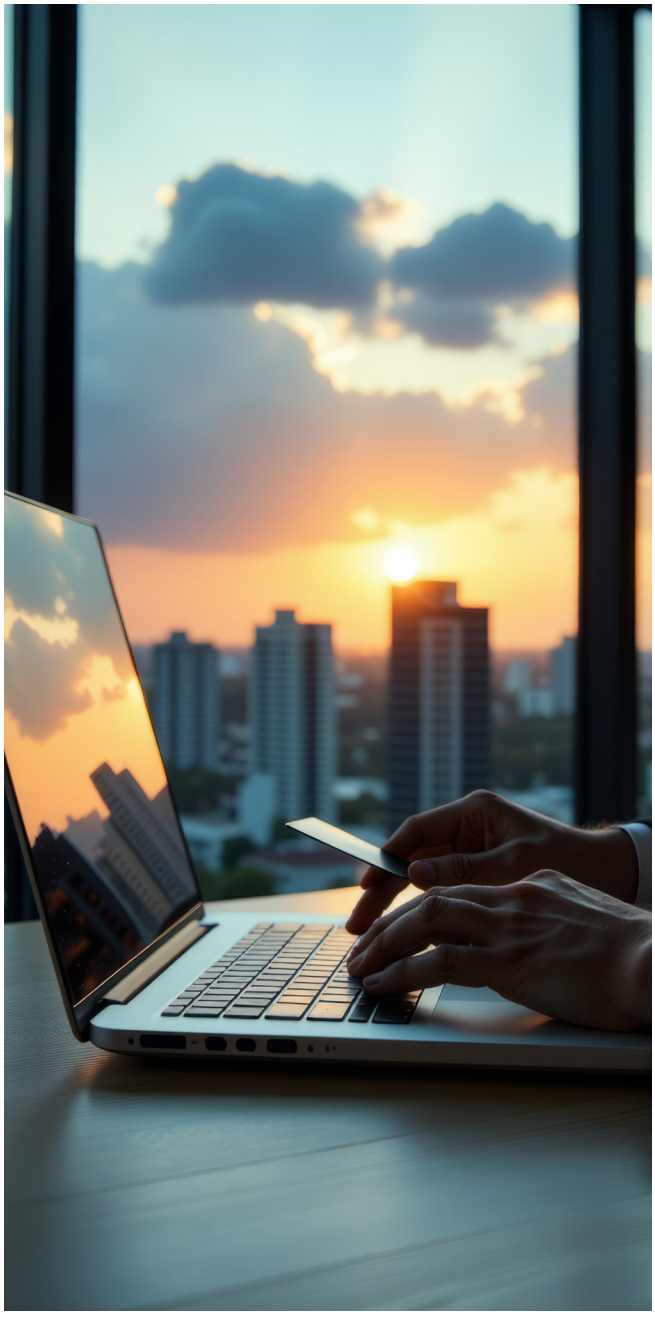
Most Common Employee Benefits Frauds in Canada

Benefits fraud is a serious issue in Canada, costing the health insurance industry billions of dollars annually. In Canada, it's estimated that benefits fraud costs between $1.2 billion and $6 billion each year.



COMMON SCHEMES

Several schemes are commonly used to commit benefits fraud:

1. **False Claims:** Submitting claims for services or products that were never received.
2. **Misrepresentation:** Claiming non-covered services as covered ones, such as spa treatments claimed as therapeutic massages.
3. **Identity Theft:** Using another person's identity to claim benefits.
4. **Collusion Rings:** Groups of employees collaborating with service providers to submit false claims and split the proceeds.
5. **Provider Fraud:** Healthcare providers submitting false claims or upcoding services.

IMPACTED BENEFITS

Typically, the following benefits coverages are most impacted:

1. **Health Benefits:** Including prescription drugs and medical services.
2. **Dental Benefits:** Cosmetic procedures claimed as necessary dental work.
3. **Vision Care:** Non-prescription sunglasses claimed as prescription eyewear.
4. **Paramedical Services:** Such as massage therapy and physiotherapy.

WHY PEOPLE COMMIT BENEFITS FRAUD

The motivation behind benefits fraud can be understood through the "fraud triangle":

1. **Pressure:** Financial problems or perceived needs that can't be met through legitimate means.
2. **Opportunity:** The ability to commit fraud with a low perceived risk of being caught.
3. **Rationalization:** Justifying the fraudulent act to themselves, often viewing it as a victimless crime.
4. **Unintentional Actions:** Some employees may commit fraud unknowingly due to misunderstanding their coverage, confusion over plan terms, or lack of education about proper benefits use.

Many Canadians underestimate the consequences of benefits fraud, with 75% believing that increased premiums are the only result.

HOW BENEFITS FRAUD IS COMMITTED

1. **Forging Receipts:** Creating false documentation for non-existent services.
2. **Sharing Benefits:** Allowing others to use one's benefits coverage.
3. **Provider Upcoding:** Healthcare providers claiming for more expensive services than those provided.
4. **Unbundling:** Providers claiming separately for procedures that are part of a single treatment.
5. **Kickback Schemes:** Providers offering incentives to plan members for participating in fraudulent activities.

CONCLUSION

Benefits fraud not only leads to increased premiums but can also result in reduced benefits, job loss, and even criminal charges. Insurance companies and employers are implementing sophisticated detection methods, including audit software and fraud investigation teams, to combat this growing problem.

To prevent benefits fraud, individuals should familiarize themselves with their plans, keep their benefits information confidential, and report any suspicious activity. By understanding the serious nature of benefits fraud and its consequences, Canadians can help protect the integrity of their benefits systems and ensure fair access to healthcare services for all.

If you have questions specific to your business, or would like additional information, please reach out to your Arbutus Financial Advisor.