

Benefacts

A MEARIE Publication

AN EMPLOYEE BENEFITS NEWSLETTER FOR MEARIE MEMBERS

Preventing and Managing Fraudulent Claims

As insurance providers, plan sponsors and plan members take strides to control the costs of their health and dental coverage, the issue of fraud and its effect has captured increasing attention.

No matter what form it takes, fraud results in expense increases throughout the health care chain. Preventing and controlling abuse therefore is beneficial to providers, consumers and carriers.

Fraudulent claims contribute to increasing health and dental benefit costs for everyone, despite the fact that only a small percentage of providers and consumers deliberately engage in acts of fraud. Even a small percentage of fraudulent claims can dramatically affect private health care costs.

Fraudulent health or dental claims originate with someone intentionally seeking a benefit payment based on false or misleading information. Causing someone else to submit false or misleading information for this purpose also qualifies as claims fraud.

Fraud can take many forms, so it can be difficult to track and to prove. Claims fraud may be committed by service providers (provider fraud) or by plan members themselves (consumer fraud).

Provider fraud schemes may include:

- Waiving patient co-payments and over-billing the benefit plan for the full service
- Billing for services not actually performed
- Falsifying a diagnosis to justify unnecessary tests, treatments or devices
- Misrepresenting procedures performed to obtain payment for non-covered services
- "Up-coding" – billing for a more costly service than the one performed, and
- "Unbundling" – billing each stage of a procedure as if it were separate.

Consumer fraud schemes may include:

- Filing claims for services or medications not received
- Misrepresenting themselves to their carrier or to multiple doctors
- Forging or altering bills or receipts, or
- Using someone else's coverage or insurance card to obtain benefits.

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Benefit Trends:

The Increasing Cost of Drugs

How to tackle the rapidly increasing cost of providing drug coverage is a challenge being faced by plan sponsors. This serious issue is receiving a lot of attention, as evidenced by the following excerpts from some very respected sources.

Increasing Drug Utilization

(The Globe & Mail, May 4, 2000)

"According to the health information company, IMS Health, which tracks drug trends, prescription drug sales hit \$7.3 billion in 1999, up from \$3.5 billion a decade earlier. By 2004, the figure is expected to hit \$11.3 billion."

Rising Costs Per Claim

(Health and Productivity, June 1999)

The average cost per claim for all prescriptions during the period 1993 to 1997 rose at an annual compound rate of 7.5%.

As you might expect, the increasing utilization and cost of drugs is also reflected in the claims experience of employer-sponsored drug plans.

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Reform for Suggested
Fee Guide**

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This newsletter is for information purposes only, intended for the benefit of MEARIE members. Any information contained herein shall not represent confirmation of coverage for specific circumstances, incidents and claims. Individual cases of coverage interpretation are dealt with external to this publication and shall be solely determined by your policy wording. Members wishing assistance on specific matters are invited to consult directly with MEARIE staff.

STRENGTH through participation!

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Preventing and Managing Fraud

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Plan sponsors and plan members play an important role in preventing and detecting claims fraud. There are many steps both can take to help manage fraud costs.

1. Ensure benefit maximums are reasonable and control services that are prone to excess abuse.
2. Choose positive enrollment (having plan members enroll their dependents in advance of making claims) and report plan member changes to your carrier so records can be updated. Where direct enrollment (enrolling dependents when they make a claim) is preferred, report plan member changes to your carrier promptly.
3. Urge plan members to ask their health care provider about services they receive. Are the services necessary? What do they cost? Would the same treatment be used if the plan member did not have benefit coverage?
4. Urge plan members to request invoices from health care providers who bill the carrier directly for service. Plan members should compare the provider's invoices to their Explanation of Benefits forms from their carrier. Is the information correct?
5. Urge plan members to sign only one completed claim form at a time and to not pre-sign blank claim forms presented by a provider. Notify your carrier if a provider has a practice of obtaining pre-signed claim forms.
6. Urge plan members to be careful about disclosing insurance information to others unless required.
7. Contact your carrier if you know of a provider who regularly waives co-payments or deductibles.
8. Ask plan members to respond to audit confirmation letters. These are important assurances that billed services are correct.

Controlling fraud is a concern for everybody. ■

The Increasing Cost of Drugs, *continued from page 1*

Assure Health Inc. reported the following statistics, based on approximately 2.1 million cardholders:

	1st Quarter, 1999	1st Quarter, 2000
Utilization: Scripts per cardholder	0.85	1.00 (15% increase)
Cost: Average cost per cardholder	\$33.71	\$42.22 (25% increase)

What Are the Causes?

(Benefits Canada, April 2000)

“Here are some of the factors influencing drug costs faced by employers: aging workforce; merging pharmaceutical manufacturers; shorter hospital stays; prescribing guidelines; new discoveries; direct to consumer advertising; waste; increased stress.”

Of these factors, one of the main drivers is the trend toward the introduction of new and more expensive drugs.

According to *Health and Productivity* (June 1999), in 1993 the average cost per claim of new patented drugs was \$36.03, while in 1997 it was \$76.88. This represents an annual compound increase of 20.9 per cent, or 113 per cent overall.

We can see that this trend is not diminishing when we consider the new drug therapies announced over the past year, which include:

Drug	Application	Expected Cost
Herceptin	First genetic therapy to fight breast cancer	\$3,000 per month
Betaseron	Used in the treatment of Multiple Sclerosis	\$1,700 per month
Lupron Depot	Used in the treatment of prostate cancer	\$1,200 per month
Serostim	Used in the treatment of AIDS	\$25,000 for 12 weeks

What Does This Mean for Plan Sponsors?

Simply put, it means the cost of providing drug coverage for employees will be increasing. Insurers will be responding by adjusting trend and utilization factors to reflect actual and anticipated increases in overall costs. After all, approximately 75 per cent of health claim expenditures are attributable to the drug benefit.

Employers can temper rising costs associated with their drug plans by implementing one or more of the following measures:

- Managed drug formularies;
- Preventive/educational programs in the workplace which encourage healthy lifestyles and develop informed consumers;
- Tiered drug plans (i.e. drug plans which include varying coinsurance levels);
- Health Spending Accounts;
- Mandatory generic substitution;
- Increasing coinsurance and/or deductible levels.

For more information, please contact the Customer Service & Marketing Co-ordinator, Andrea Greto, at the MEARIE office. ■

Wellness Report

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is one of the most common forms of arthritis. A chronic illness, it affects 300,000 Canadians.

RA is generally diagnosed in patients aged 20 to 50 years, and is the leading cause of workplace disability in this country. Within 10 years of diagnosis, more than half of those diagnosed with RA are unable to work.

RA is an autoimmune disease causing the body's immune system to attack itself. It is a chronic, painful disease characterized by damaging inflammation of the joints.

Initial symptoms may include fatigue, joint pain and anemia. RA

usually begins in the hands, wrists, feet, knees and elbows, but it may also involve the shoulders, neck, hips and ankles. Persistent inflammation may destroy cartilage, bones, tendons and ligaments, leading to permanent disability.

Who does it affect?

Approximately one in 100 Canadians suffer from RA. Three times as many women as men are affected. Although RA is most common in those aged 20 to 50, nearly one in 1,000 children under age 16 develops the disease.

A gene associated with this disease has been tracked in families where the condition is prevalent, but its presence is no guarantee that the carrier will develop the disease. Similarly, some people with RA do not carry this gene.

Early symptoms of RA mimic the flu. Classic signs of joint involvement follow, including pain during rest and sleep, tenderness, warmth, swelling and stiffness after periods

of inactivity.

In most people, symptoms develop gradually, but in some people may progress rapidly. Some people experience constant pain, while others go into remission.

To diagnose RA, doctors will investigate pain location (which joints, both sides of the body), and morning stiffness. Rheumatoid nodules (bumps under the skin), blood tests and x-ray results may help a doctor diagnose RA. Early diagnosis is often key in preventing joint deformity and long-term disability.

Treatments

Different types of medications are used in the treatment of arthritis. Non-prescription analgesics are used to provide pain relief. Anti-inflammatories may help to reduce swelling and discomfort. Non-steroidal anti-inflammatories (NSAIDs) and some steroids, like cortisone, may prove helpful bat-

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Ontario Dental Association Recommends Suggested Fee Guide Reform

The Ontario Dental Association (ODA) has indicated that it will change the methodology used to calculate the suggested fees for its ODA Fee Guide.

The first of these adjustments will come into effect with the 2002 Fee Guide (published late in 2001), and will be phased in over a period of three to five years.

The ODA has not yet indicated the full extent and nature of these changes. However, several dental carriers are participating in a working group formed under the leadership of the Canadian Life and Health Insurance Association (CLHIA) to ensure that the needs and concerns of plan sponsors are addressed.

The proposed changes include:

- The elimination of the recall package codes starting with the

Fee Guide for 2002;

- A shift from a methodology based on the costs of supplying dental care to one which places more emphasis on factors that affect the demand for various types of dental care, and
- Annual revisions to the fee guide will no longer be based on a single adjustment to all suggested fees, but rather, an adjustment to the individual fees for individual services.

The elimination of the recall package codes will affect virtually all dental plans that cover plan members residing in Ontario. At present, in Ontario, regular services provided at the time of a routine "check-up" (e.g., the recall examination and cleaning) are grouped together with a single suggested fee applied to the whole package.

This "package fee" is significantly lower than the cost of the individual services if billed separately. For this reason, the elimination of the "package concept" is a concern. The ODA has indicated that cost increases to plan sponsors should be gradual, and that a major increase in any one year should be avoided.

Although the elimination of the package codes will occur in the 2002 fee guide, the ODA has indicated that the change in methodology for calculating suggested fees will be phased in over a period of three to five years. The ODA estimates a cost increase of 16.2 per cent over a five-year period.

The result of these changes will vary with plan design and utilization levels, and will have the most immediate impact on plans that base benefits on the fee guide in effect when services are rendered.

We will continue to provide you with information as it becomes available. ■

A Snapshot of the Cost of Arthritis

Arthritis can prove severely debilitating for those it afflicts, but building an understanding of the cost to society and the health care system can be challenging. The statistics that follow help to detail the wider-reaching effects of the disease.

■ Arthritis is the most common cause of long-term disability in Canada. In 1993, lost productivity due to long-term disability was estimated at \$38.8 billion.

■ Arthritis currently accounts for \$1.8 and \$4.4 billion in short- and long-term disability in Canada.

■ In Canada, the number of people with arthritis is expected to grow by one million per decade, until the year 2031.

■ One-third of RA patients are unable to work due to the severity of their disease.

■ Arthritis is the third most frequent cause of prescription drug use in Canada, and the second most frequent cause of non-prescription drug use in Canada.

■ The private sector pays for most drugs in Canada. In 1996, employers, insurance companies, unions and individuals paying out-of-pocket spent \$7 billion (64.4 per cent of drug expenditures).

■ In general, five to 12 per cent of RA patients account for 80 per cent of the acute care costs of orthopaedic surgery alone.

■ The cost of all illnesses in Canada totalled \$72 million in direct costs and \$85 billion in indirect costs in 1993. Of these totals, indirect costs were highest for arthritis and other musculoskeletal diseases, followed by cardiovascular diseases, injuries and cancer, respectively.

Source: Adapted from the Arthritis Society's Arthroscope

Please note: Wellness Report is for information purposes only, and is not intended to provide medical advice.

Rheumatoid Arthritis

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ting inflammation. Slower-acting, disease-modifying anti-rheumatic medicines (DMARDs) may be used to slow the progress of the disease. Combinations of different drugs may be used. Side effects must be taken into account over the long term.

In advanced cases, surgery may be required to restore movement to damaged joints.

Promising Advances

In recent years, new drugs and therapies developed specifically to treat RA have begun to offer hope. According to Dr. Eric Rich, Assistant Professor, Division of Rheumatology, Department of Medicine at the University of Montreal, there is a definite need for more effective and tolerable therapies. Traditional medicines have not controlled progression of the disease effectively.

Biological response modifiers (anti-TNFs) appear to be one of the most promising treatments for RA – particularly for severe cases where the disease progresses rapidly as well as cases where the patient has not responded to other forms of treatment. The *New England Journal of Medicine* states, "These agents are the fruits of biotechnology and bring improvements in efficacy and safety."

The Anti-TNFs bind to TNF-alpha – a highly active body chemical that initiates a chain reaction leading to the inflammation associated with RA. Acting as a chemical clamp, this compound decreases symptoms, joint deterioration and the progress of the disease.

In some patients, these treatments are more effective than existing treatments because they selectively target one of the key chemicals associated with joint inflammation rather than suppressing the whole immune system, as do existing disease-modifying therapies.

New treatments come at a cost, but the expense associated with new therapies has to be weighed against the cost of disability claims

that may result if people with RA can't find effective treatments for the symptoms resulting from the progress of the disease.

No single treatment proves ideal for every patient, so having a range of medicines and therapies to consider gives doctors more flexibility when considering treatments. Continuing research interest and success in the treatment of RA gives people affected by the disease – as well as their families – reason to hope that the disease can be successfully managed and treated.

For more information, and to find out about available programs and services for people with arthritis, please contact the Arthritis Society (1-800-321-1433) or visit the organization's web site at www.arthritis.ca. ■



MEARIE Chair: Brian Hollywood

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The Municipal Electric Association Reciprocal Insurance Exchange (MEARIE) manages and administers the Employee Benefit Programs for members.

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