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Private Health Insurers to Gain From New US Fraud Rules

By: Sean P. Carr, AmBest

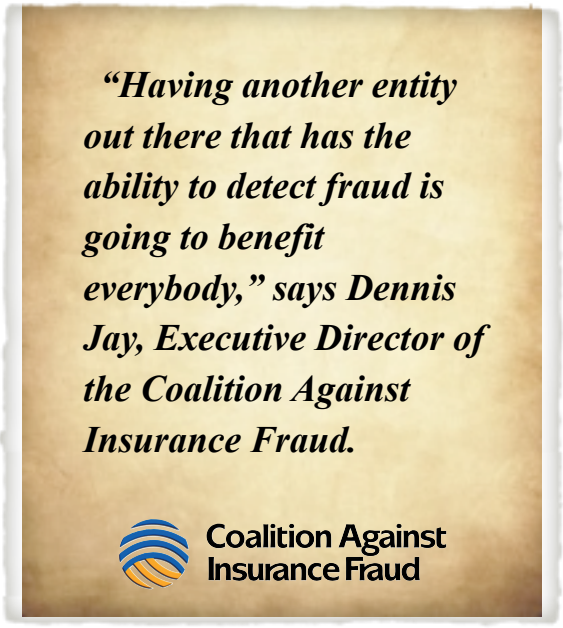
New federal anti-fraud rules will not only cut down on Medicare and Medicaid fraud but provide significant benefits to private health insurance providers, said Dennis Jay, executive director of the **Coalition Against Insurance Fraud**.

New rules authorized by the Affordable Care Act include the debut of a screening process for providers and suppliers participating in Medicare, Medicaid and the Children's Health Insurance Program to weed out those with a history of fraud, the U.S. Department of Health and Human Services announced Jan. 24. For the first time, federal and state officials will be able to provide a more thorough process for types of providers and suppliers that have been identified as posing a higher risk of fraud, including durable medical equipment and home health care providers. Other rules cover the ability to temporarily stop enrollment of providers and suppliers in the midst of a trend of fraud in a geographic area and/or specialty and the authority to temporarily stop payments in cases of suspected fraud.

Several of these tools are not new, but are new to the government, Jay said; previously, federal legislation had hamstrung the power of regulators to act when they suspected fraud, he said. Medicare and Medicaid have traditionally been "gateway" opportunities for fraudsters, he said.

"Having another entity out there that has the ability to detect fraud is going to benefit everybody," Jay said. "The same people who are ripping off the government are ripping off private insurers."

The new rules will allow regulators to preemptively keep fraud opportunists out of government health programs, Donald Berwick, administrator of the Centers for Medicare and Medicaid Services said in a statement.



Still under development is a joint public-private strategy for the sharing of fraud-fighting data, Jay said. Firm plans should be in place by the end of 2011, he said.

The Affordable Care Act mandated the centralization of certain claims data now independently administered by various federal programs in order to prevent and investigate fraud. Portions of the federal government to be involved include Medicare, Medicaid, CHIP, the Veterans Administration, the Department of Defense, Social Security Disability Insurance, and the Indian Health Service.

U.S. Department of Health and Human Services Secretary Kathleen Sebelius also announced a new report saying the administration recovered a record more than $4 billion in public funds in Fiscal Year 2010 as the result of health care fraud prevention and enforcement efforts. The report credited the Health Care Fraud Prevention and Enforcement Action Team, a joint HHS and U.S. Department of Justice operation.

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