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Client Alert

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Private Insurers Become Partners in the Fight Against Health Care Fraud

On July 26, 2012, Department of Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder joined with health insurance executives to announce a "ground-breaking" partnership among government stakeholders, health care anti-fraud groups, and private insurers to combat health care fraud. The newly-created "National Fraud Prevention Partnership" is notable for its formal inclusion of private insurers in the anti-fraud initiatives mandated by the Patient Protection and Affordable Care Act (PPACA). Among the private entities expected to become partners in "the voluntary, collaborative arrangement uniting public and private organizations" are Amerigroup, Humana, UnitedHealth, and WellPoint, as well as such insurance lobbyists as America's Health Insurance Plans and the Blue Cross and Blue Shield Association.

Recognizing that health care fraud schemes affect both public and private payers, the new partnership expands on previous anti-fraud partnerships, including the Health Care Fraud Prevention and Enforcement Action Teams (HEAT), as well as on the increased focus on data mining and information sharing to uncover health care fraud schemes. The National Fraud Prevention Partnership aims to reduce fraud further by sharing billing information among a wider group of payers, and analyzing claims from across the industry to detect suspicious billing patterns and other fraud indicators. "Lots of the fraudsters have used our fragmented healthcare system to their advantage," HHS Secretary Sebelius explained. "By sharing information across payers we can bring this potentially fraudulent activity to light."

Under the new partnership, the federal government and insurers are expected to share information about trends in health care fraud, the tools to search millions of claims for suspicious billing patterns, and the authorities provided by the PPACA to combat fraud. The federal government will hire a "trusted third party" to mine the claims data from Medicare, Medicaid, and dozens of private health insurance plans. If suspicious activity is detected and an investigation of possible fraud opened, the investigators will be able to share the names of health care providers and suppliers suspected of fraud with insurers, who may be able to suspend payments before they go "out the door." Reversing the previous "pay-and-chase" model of paying claims first and tracking the fraudulent ones afterward, the new approach, said Secretary Sebelius, involves "taking

away the crooks' head start." A potential long-range goal of the partnership is to use the sophisticated technology and analyses on the industry-wide data to predict and detect health care fraud schemes even before they can be completed.

While the details of the collaboration have yet to be worked out, several public-private working groups are meeting to finalize the operational structure of the partnership and to develop a draft initial work plan. The Executive Board, the Data Analysis and Review Committee, and the Information Sharing Committee will hold their first meeting in September.