America's Health Insurance Plans

Coverage

AHIP STATEMENT ON NEW NATIONAL PUBLIC-PRIVATE PARTNERSHIP TO REDUCE HEALTH CARE FRAUD

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Washington, D.C. – America’s Health Insurance Plans (AHIP) President and CEO Karen Ignagni today released the following statement on a new national public-private partnership to fight health care fraud announced by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice (DOJ):

“The new partnership announced today is a major step forward in the fight against fraud and abuse in our health care system. Greater collaboration and information sharing between the public and private sectors will enable the nation to more effectively identify fraud early, root it out quickly, and protect patients from the harmful consequences of fraud.

“The cost of fraud can far exceed what is paid for falsified claims. It can cause real harm to patients who are intentionally exposed to radiation, invasive surgeries, and medications they do not need, or suffer the lasting consequences of receiving a fraudulent diagnosis.

“Health plans have prioritized reducing health care fraud and use cutting edge technology and sophisticated data analysis to prevent fraud from occurring in the first place rather than ‘paying and chasing’ after the fact. By sharing data, information, and best practices across all payers, this partnership will ensure the public and private sectors are even better equipped to fight fraud and will provide a powerful deterrent to would-be perpetrators looking to prey on patients and steal money from taxpayers.

“Health plans look forward to working with HHS and the DOJ to advance the fight against health care fraud.”

What Health Plans are Doing to Fight Fraud

Health plans operate special investigations units (SIUs) that are staffed with qualified personnel, including many with statistical, medical, and law enforcement experience. These SIUs perform sophisticated tasks that include investigating claims, coordinating with law enforcement personnel, training in-house personnel to identify and report possible fraud, developing and using sophisticated software to identify possible fraudulent claims, initiating civil actions seeking recovery of improper claims payments, and preparing "evidence packages" of suspected fraudulent providers for the benefit of law enforcement entities. Health plans also are vigilant about the credentialing of providers to be included in their networks, and continue to monitor the maintenance of those credentials to assure quality.

Health plans focus on preventing and detecting fraud rather than “paying and chasing” after the fact. The specific tools that health plans use to assure integrity and detect the delivery of inappropriate or
unnecessary care varies by company, but usually includes the following four categories of activities:

- **Identifying potential fraud:** The first step is for the anti-fraud units to develop and use procedures to identify and detect suspect claims. The goal is to have this occur up-front, and to identify patterns of performing, ordering, or delivering medically unnecessary procedures before the claim is paid. Identification of such claims can come from the health plan’s own systems, where software detects aberrant billing patterns, using data analysis and other analytics techniques. Information on suspected cases of fraud also is obtained from law enforcement agencies, as well as from the National Health Care Anti-Fraud Association (NHCAA). Members of the public also play an important role, as our members’ fraud “hotlines” encourage patients as well as providers to report information that helps identify fraud in real-time, before payments are made.

- **“Tagging” suspected cases of fraud:** The second step is for such suspicious claims to be “tagged” for further review before payment. Health plans have been steadily expanding their use of technology to increase their capabilities for detecting fraud, such as through the implementation of electronic “smart flags” or “tags” that quickly identify potentially false or misleading diagnoses, as well as “mining” of claims databases to find suspected cases. A particularly important strategy is the widespread use of predictive modeling to identify suspected cases of fraud by particular providers, often for a more intensive review before claims are paid.

- **Investigating and auditing suspected fraudulent claims:** The next step includes extensive investigation and auditing of suspected claims, comprising medical record review, clinical investigations, and coordination with clinical services departments (including in-house doctors and nurses) to develop appropriate medical opinion of the legitimacy of the claim. Companies are hiring and training personnel to become more knowledgeable about health care fraud and prevention, and involving their auditors in working across multiple disciplines. Those consulted in this review might include not only clinical and pharmacy personnel, but also state and federal law enforcement officials.

- **Taking action on suspected fraud:** While claims found to be appropriate and accurate would then be paid, claims that are suspected to be fraudulent would be handled on a case-by-case basis. In certain cases, facts that may constitute violations of law would be escalated by referral to a federal or state law enforcement agency (including the FBI and State Attorneys General) through development of what our special investigations units call an “evidence package” detailing the possible fraud. Health plans’ data, including extensive computer runs, are valuable evidence for prosecutors in subsequent trials.

An AHIP Research Brief entitled “Insurers’ Efforts to Prevent Health Care Fraud” highlights health plans’ innovative fraud prevention and detection programs and the cost-savings that have been achieved as a result of these initiatives. According to the survey, large companies estimated net savings from anti-fraud operations (savings less costs) of over $3 per enrollee, resulting in total net savings of nearly $300 million in 2008. Medium-sized companies estimated net savings of about $1 per enrollee, or $10 million net savings in 2008, and smaller companies estimated net savings of about $2.70 per enrollee, with approximately $5 million in total savings.