



HEALTH INSURANCE REFORM AT A GLANCE

PREVENTING WASTE, FRAUD, AND ABUSE

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments made by individuals, businesses, and government. The Senate-passed bill as improved by reconciliation strengthens Medicare and Medicaid's existing compliance and enforcement tools, reducing fraud and abuse and saving billions of taxpayer dollars.

NEW FUNDING TO FIGHT FRAUD AND ABUSE

- Provides \$700 million over the next decade in new funds to fight fraud.
- Increases funding for the Health Care Fraud and Abuse Control Fund and the Medicaid and Medicare Integrity Programs to provide new resources to fight fraud.
- The Congressional Budget Office estimates that every \$1 invested to fight fraud yields approximately \$1.75 in savings.

IMPROVE SCREENING TO CATCH AND PUNISH FRAUDULENT PROVIDERS AND SUPPLIERS

- Allows CMS to conduct background checks, site visits, and other enhanced oversight to weed out fraudulent providers before they start billing the program.
- Creates a national pre-enrollment screening program for all providers, and requires disclosure of prior association with delinquent providers or suppliers.
- Places new controls on high-risk programs, like home health services or durable medical equipment, to ensure that only Medicare and Medicaid providers in good standing can provide these services.

STRENGTHEN MEDICARE AND MEDICAID PROGRAM REQUIREMENTS FOR PROVIDERS, SUPPLIERS, AND CONTRACTORS

- Requires providers and suppliers to adopt compliance programs as a condition of participation in Medicare and Medicaid.

NEW PENALTIES TO DETER FRAUD AND ABUSE

- Creates new penalties for submitting false data on applications, false claims for payment, or for obstructing audits or investigations related to Medicare or Medicaid.
- Establishes new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.

AGGRESSIVELY MONITOR MEDICARE AND MEDICAID FOR EVIDENCE OF FRAUD, WASTE, AND ABUSE

- Creates a comprehensive Medicare and Medicaid Provider/Supplier Data Bank to conduct oversight of suspect utilization, prescribing patterns, and complex business arrangements that may conceal fraudulent activity.
- Narrows the window for submitting Medicare claims for payment and requires electronic payments in order to decrease the opportunities for "gaming" the system.
- Creates new data sharing arrangements to help CMS and other agencies identify fraudulent providers.