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# **The Impact of Health Care Fraud on the United States Healthcare System**

**An Undergraduate Honors Thesis by**  
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## **ABSTRACT**

Health care fraud is an important and visible factor associated with increasing health care costs in the United States. Medicare and Medicaid contribute to a vast majority of those costs and therefore must be heavily scrutinized. This thesis will investigate the types of fraud, who commits them, and why the health care system is more susceptible to fraud. More specifically, the problems and complications of current fraud investigation for Medicare and Medicaid are examined. This thesis will then evaluate how successful these initiatives were in reducing health care fraud and explore new suggestions for preventing health care fraud in the future.

## **INTRODUCTION**

As elections approach Americans are hearing more and more about health care reform, and what needs to be done to fix the ailing health care system. The main problem candidates are trying to address is the dramatic increase in health care costs that are causing the number of underinsured and uninsured patients to increase across the country. Many different factors are related to the increase in health care costs. This paper will focus on health care fraud and abuse, and more specifically health care fraud and abuse within the Medicare and Medicaid programs.

Health care fraud is an important and visible factor associated with increasing health care costs, because there is no positive side to it. Some of the other factors that increase costs, such as better technology, have positive implications, but health care fraud is only viewed as a drain on health care resources. Health care fraud and abuse costs the United States an estimated 110 billion dollars a year (Caldwell 1997). Because health care fraud has played such a vital role in increasing the cost of health care it has gained a lot of attention from the government and the United States people. In the 1990's the Clinton administration began a health care reform campaign and focused a lot of resources on stopping and, furthermore, preventing health care fraud within the Medicare and Medicaid programs. This paper will investigate those reforms, and evaluate how successful they were in reducing health care fraud. This paper will also address some of the many different types of fraud, who commits them, why the health care system is vulnerable to fraud, the problems and complications of current fraud investigation, and explore new suggestions for preventing health care fraud in the future.

## **THE IMPACT OF FRAUD ON RISING HEALTHCARE COSTS**

Since the 1960's health care costs have risen from 28 billion dollars per year to an estimated 1.9 trillion dollars per year in 2004 (Snapshot, 2006). That rise in cost accounts for an average of 6,300 dollars per person per year spent on health care, compared to 3,600 dollars per person per year in 1994 (Snapshot, 2006). This substantial increase in cost causes a problem for most Americans because average income has not increased as steadily as health care costs, leaving many Americans unable to afford or access health care (Effect, 2007; Snapshot, 2006). The "health care cost inflation invariably exceeds growth in the economy as a whole" (Sage, 1999). Many factors have contributed to the dramatic increase in health care costs such as a cultural preference to focus on expensive treatment instead of preventative measures, technological advances, the ability to live longer thus using more resources, medical malpractice, and healthcare fraud.

### **Factors Increasing Health Care Costs**

The first cause of rising healthcare costs is related cultural values and patient preferences. When it comes to health care, it seems like Americans are always looking for a quick fix. As obesity rates increase, Americans turn to easy ways to lose weight immediately, like liposuction or gastro bypass surgery, instead of focusing on changing their diet and increasing their activity. Americans celebrate beating cancer, and call those who do heroes, but very rarely stop to consider the lifestyle choices that may have contributed to the disease. People do not choose to get cancer, but in many cases, like most diseases, lifestyle choices play a big factor. Americans do not consider the possibility that expensive chemotherapy, radiation treatments, and possibly the whole disease itself may have been prevented if in some cases a person wore sunscreen, smoked less, drank less alcohol, ate healthier or stayed physically active. Instead of changing

unhealthy lifestyles and focusing on preventing disease, Americans continue to come up with innovative and often expensive ways to fix things. Because American culture continues to value expensive retrospective medicine instead of preventative medicine, health care costs will continue to increase.

The need to compete and have more innovative technology is also a contributing factor to the dramatic rise in health care costs. In the United States healthcare is treated like any other billion dollar business, and each facility strives to provide the best care. In order to provide the best care each facility spends a large amount of money each year purchasing new top-of-the-line equipment. They do this even though the equipment they are replacing is still useful and efficient and in some instances are still being paid off. Providers spend millions of dollars purchasing and advertising their new-top-of-the-line equipment in order to win consumers. The problem is that as each provider spends millions on every new piece of technology available they have to charge the consumers more to pay for their new technology. If healthcare facilities would collaborate more, costs would be less. Instead of each facility in the area competing for market domination in their cardiovascular department by spending millions of dollars on new innovative equipment, one could focus on oncology, while the other focuses on cardiovascular. Collaboration would decrease the need for each facility to have every single piece of new innovative equipment, put the focus back on the patient, instead of the competition, and decrease costs for all involved.

New technology does not only increase costs, it also makes it possible for people to live longer. The result is that the longer a person lives the more health care they need to maintain a normal quality of life. As a person ages their health care needs encompass more types of procedures, more types of physicians, their healthcare becomes more expensive, and their procedures and physician visits become more frequent. As a person ages they need more health

care, and even with government assistance they are often unable to pay for it. They are unable to afford healthcare, because most are unable to work, and often live their last 20 years or so in retirement, only earning small amounts of money from retirement funds and possibly the government. This is a huge problem, because the population who needs the most health care are the least able to afford it. We are beginning to see this trend as the baby boomers reach retirement. According to the American Academy of Family Physicians in 2000 there were 354,000 uninsured people 65 years and older in the United States, and that number is expected to grow (Surprising, 2004).As the growing number of elderly struggle and are unable to find ways to pay for the health care that they need the number of people who are uninsured or underinsured increases.

As the number of uninsured or underinsured Americans increase the cost of health care for all Americans increases. Even though uninsured and underinsured Americans can not afford health care, they still seek treatment in the emergency room, where federal law requires treatment under the Emergency Medical Treatment and Active Labor Act (EMTALA). The cost of their treatment is often expensive; because being treated in the emergency room usually is more expensive in general, and their condition may be more serious because they were unable to afford to see the doctor earlier in order to prevent their condition from worsening. Because the uninsured and underinsured can not pay for treatment in the emergency room and the law requires they are treated, the cost of their treatment is shifted to those who do have insurance or already pay for care out of pocket, which further increases the costs of health care for everyone else.

Another reason that health care costs are increasing is that medical malpractice insurance for physicians is on the rise. In order for physicians to practice they must have medical

malpractice insurance. Medical malpractice insurance is then used to pay for negligence or other claims against the doctor. As more and more people collect medical malpractice money, the rates rise, and as the rates rise for the physicians prices for the patients rise as well. Some states, such as Indiana, have enacted laws limiting medical malpractice claims to reduce the burden of litigation on medical practice. These laws have helped, but some physicians fear being sued for malpractice. To protect themselves from possible lawsuits, they make very conservative recommendations and utilize additional health care procedures. Over-utilization of unnecessary procedures further leads to an increase in health care costs.

Like the other factors discussed above, health care fraud also contributes to the increase in health care costs. Health care fraud can be committed many different ways by any person involved with the health care system. Since most Americans are involved with the health care system, whether they are providing health care, or consuming health care, most Americans have the opportunity to take advantage of the system and commit fraud. In 2003, Blue Cross Blue Shield released a survey stating that out of \$1.7 trillion spent on health care, \$85 billion of that was lost to health care fraud (Blue, 2004). That \$85 billion dollars was essentially stolen. Health care fraud is the most obvious and often the most upsetting factor that has increased health care costs.

### **Health Care Fraud Defined**

Out of all of the factors mentioned above, Americans believe health care fraud is the most significant reason for the rise in health care costs (What, 1997). It is clear to see why Americans consider this the biggest cause, when health care fraud was estimated to cost approximately \$100 billion to \$250 billion per year in 1998, or 10 percent to 25 percent of total health care spending

in 1998 (Lieberman and Rolle, 1998). It is estimated that 25 cents of every dollar being spent on health care are supporting fraudulent practices, and that a family of four pays as much as 1,400 dollars per year on health care fraud related costs (Lieberman and Rolle, 1998). Health care fraud has been one of the fastest growing U.S. criminal activities of the last decade. Many criminals are abandoning credit card fraud, drug trafficking and other dangerous activities in favor of the safe, lucrative arena of health care fraud (Allmon, 2005; Coccia, 1997; FBI, 1995). Given the surge in health care expenditures, it is not surprising to find an increase in the number and complexity of schemes devised to steal from the health care system (Morris, 1993). With so much money at stake it is essential for the American people and the government to explore the reasons why the health care industry is at risk for fraud, how they can minimize the occurrences of fraud, and take positive steps to prevent fraud related costs in the future.

Health care fraud has become a main stream issue (Kalb, 1999). Because of this, the government has spent the last ten years focusing on investigating health care fraud with the goal of decreasing its occurrence, and they continue to initiate new policies, and investigative bodies to deal specifically with health care fraud. Health care fraud is a critical issue for the government for many reasons. First off, the government is the principal payer of health care, and health care fraud is a waste of taxpayer money. “Elimination waste, fraud, and abuse is one of the few steps about which “disparate political ideologies can agree” (Sage, 1999). Secondly, they are in charge of regulating the health care system. Finally, they are entrusted with protecting the American people from criminals. Because of these reasons the government has dedicated many resources towards researching and investigating fraud, and how it occurs with the hopes of identifying new ways to fix the problem.

The National Health Care Anti-Fraud Association (NHCAA) has defined health care fraud as: “an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or the entity or to some other party (Offen, 1999). This definition encompasses a broad range of activities. Through studying health care fraud cases from the past investigators have been able to define the specific types of fraud that are committed most often, and have attempted ways to stop them from happening. Research has also suggested that the health care industry is more vulnerable to fraud than most other industries, because the medical field is complicated and the lay person does not understand it, and the regulations that govern the health care industry are constantly changing and ambiguous.

### **Why the Health Care Industry is Vulnerable to Fraud**

#### *The Complexity of Medicine*

As medicine becomes more technological, payment methods more ambiguous, and health policy becomes more complex, the average American often find themselves left in the dark. Because of this confusion, the health care industry is highly susceptible to fraud. Most Americans know very little about medicine, which procedures match which diagnosis or how insurance works. Until recently, the patient-doctor relationship was completely unbalanced. The doctor told the patient what to do, and the patient trusted the doctor completely without questioning the doctor’s treatment method. People had very little exposure to medicine, so they did not have any other option besides trusting the doctor (Sultz and Young, 2006).

With globalization and the internet, the doctor patient relationship has changed. Doctors are not the only ones with the answers anymore. Now, people can research symptoms on

WebMD, get a second opinion from an online doctor, or chat about different treatments with other patients who have experienced the same illness. Even with all of these new resources it is suggested that the average patient still ‘has neither the knowledge nor inclination to question a doctor’s recommendations’ (Morris, 1993). The patient is weak and vulnerable, and just wants to feel better, so the doctor is able to take advantage of this. The physician is able to run pointless tests, try ineffective treatments, prescribe useless medications, and recommend the use of unnecessary equipment while charging it all to a third party payer who is oblivious to the “true” necessity of these things. Medical professionals are responsible for committing 72 percent of health care fraud (Stats, 2001).

#### *The Ambiguity of the Payment System*

The rules governing the coverage and reimbursement of medical services are ambiguous and always changing, which makes the rules confusing for all involved. In 1993 the Medicare program had 34 different carriers that administered Part B of the program, and each different carrier had the authority to set their own guidelines for coverage and reimbursement (Morris, 1993). The number of carriers administering the Medicare program has only increased, adding more complications and confusions for medical providers, and making excuses easier for those intending to abuse the system.

Sometimes medical providers are unaware of the mistakes they make. On the other hand, because of the confusion providers who intend fraud often rely on the excuse that it was an accident, and the government has limited means to prove otherwise. “Many billing disputes involve complex and ambiguous issues. Government suffers from what economists call “information asymmetries.” In other words, in many cases, and especially those involving coding, the government can find it hard to distinguish among proper billing, minor mistakes, and

a deliberate effort to skim off small extra payments from a large number of claims” (Stanton, 2001). Medical providers need better training on the correct ways to code, how to read the guidelines, and/or they need to have more options to hire an office administrator who has been trained in coding, third party payment systems, and reimbursement guidelines.

### *Limited Knowledge on Fraud*

The United States only began to focus on health care fraud control in the past fifteen years. Because of this, experts know very little about health care fraud control as a science or an art. There are not many available experts for guidance in the field, causing us to always act after the fact, and most times too late to have the effect necessary (Sparrow, 1996). Until recently, there have not been any generally accepted fraud audit field standards, leaving investigators to make it up as they went along. The only thing that investigators really knew how to deal with was internal corruption (employee embezzlement), rather than outside corruption (criminal attacks) (Sparrow, 1996).

### *Fraud Investigators Limited Medical Knowledge*

Another problem investigators have is challenging health care professionals. Investigators are often some kind of law enforcement who have very little experience in the medical field. When investigators find themselves challenging respected health care professionals they feel greatly disadvantaged (Sparrow, 1996).

### *Acceptable Targets*

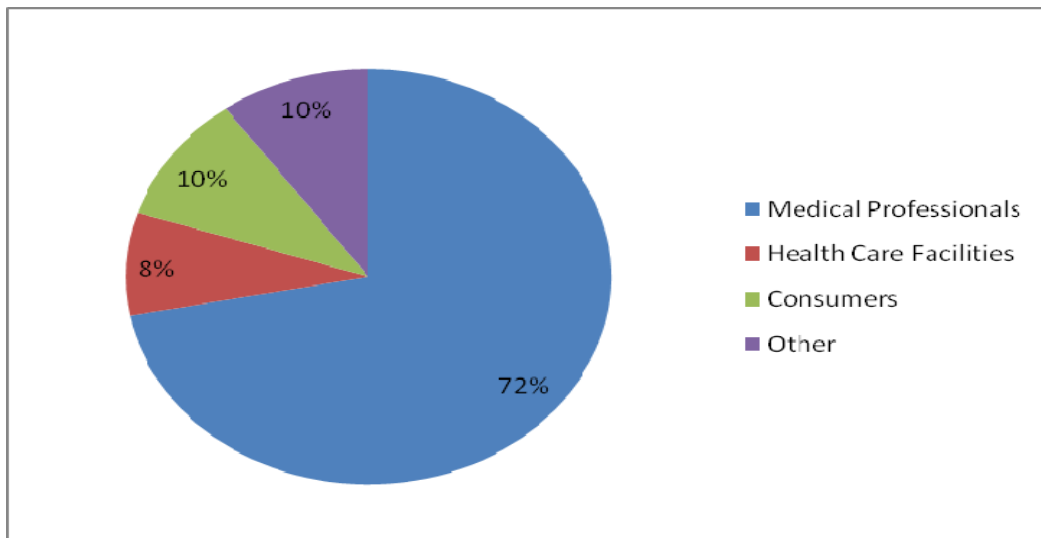
The United States health care system is very complex and part of what makes it so complex are the private third party payers, insurance companies. Insurance companies are often viewed as rich, greedy, exclusionary corporations out to take advantage of the working class

American (Sparrow, 1996). Often times because of this view, insurers are regarded by significant segments of the population as socially acceptable targets for fraud (Sparrow, 1996; Coccia 1997).

### **Fraudulent Techniques and Who Commits Them**

Although fraud between medical professionals and patients is suspected to be the most common type of fraud, it is not the only type. Fraud exists in many areas of the health care system. It is estimated that health care facilities, such as hospitals and prompt care centers, are responsible for 8 percent of health care fraud, patients are responsible for 10 percent, while the remaining 10 percent are still unknown (Datawatch, 2000). However, it is suggested that health care fraud committed by patients/consumers is increasing as the number of underinsured and uninsured Americans increases (Farber, 1997).

#### **Who Commits Health Care Fraud?**



As the health care system expands, becomes more complicated, and involves more people, the acts of fraud committed also continue to become more complicated, involve more

people, and encompass many different sectors of the health care system. In order to decrease health care costs, fraud must decrease as well. It is important that we understand the types of fraud that have been committed in the past, so that we may initiate ways to stop those same kinds of fraud from happening in the future.

In order to understand how the most common types of fraud are committed, one must recognize how medical professionals and health care facilities are reimbursed for their services. In most cases a patient does not pay for a service directly. Most payments to medical professionals and health care facilities are made by a third party payer, whether it is private insurance or a government program like Medicare. The third party payers and the health care providers have come up with a system made up of a series of numbers and descriptors which are used for reimbursement among many other things (Lieberman and Rolle, 1998). This system is known as “coding”. Coding is very complicated, and encompasses more than 500 groups that include more than 3,500 medical procedures and 12,574 diagnostic codes (Lieberman and Rolle, 1998).

### *Upcoding*

Upcoding occurs when a healthcare provider claims a code that legitimizes a higher reimbursement level than they actually provided (Lieberman and Rolle, 1998). Upcoding is very easy to accomplish, and difficult to detect. All a physician has to do is embellish a patient’s diagnosis to justify higher payments from both the patient and the third party payer. It is easy to do, because the patients and the payers know very little about medicine and what the correct diagnosis should be. Upcoding accounts for an estimated 22 percent of health care fraud (Datawatch, 2000).

### *Phantom Billing*

Phantom billing happens when providers are charging for services not actually provided to patients (Lieberman and Rolle, 1998). Phantom billing can happen two different ways. The first way happens when a physician codes that a patient has received a procedure, but does not provide the service. This type of fraud is simple to accomplish, because many patients are unaware of what they are billed for and third party payers often do not share the details with the patients. The second type of phantom billing takes place when a physician codes a procedure for a non-existent patient. This activity occurs frequently in home care and nursing homes. For example, a nursing home could submit claims for a patient who had died. Phantom billing accounts for an estimated 34 percent of health care fraud (Datawatch, 2000).

### *Bogus Billing*

Bogus billing takes place when a billing code is altered to cover services that are not supposed to be covered (Lieberman and Rolle, 1998). Many providers do this when new drugs and experimental treatments are not yet covered under Medicare or private insurance. Instead, of coding them properly they code them as a similar drug or procedure that they know is currently covered and will be paid for by a third party.

### *Unnecessary Services*

Billing unneeded services happens most in ambulatory care facilities (Lieberman and Rolle, 1998). Routine blood tests, urinalyses, and radiographs can be categorized as unnecessary billing when a patient does not need them, or they are perfectly healthy. These cases are sometimes hard to prove, because physicians can claim they were just erring on the safe side. Billing unneeded services accounts for an estimated 18 percent of health care fraud (Datawatch, 2000).

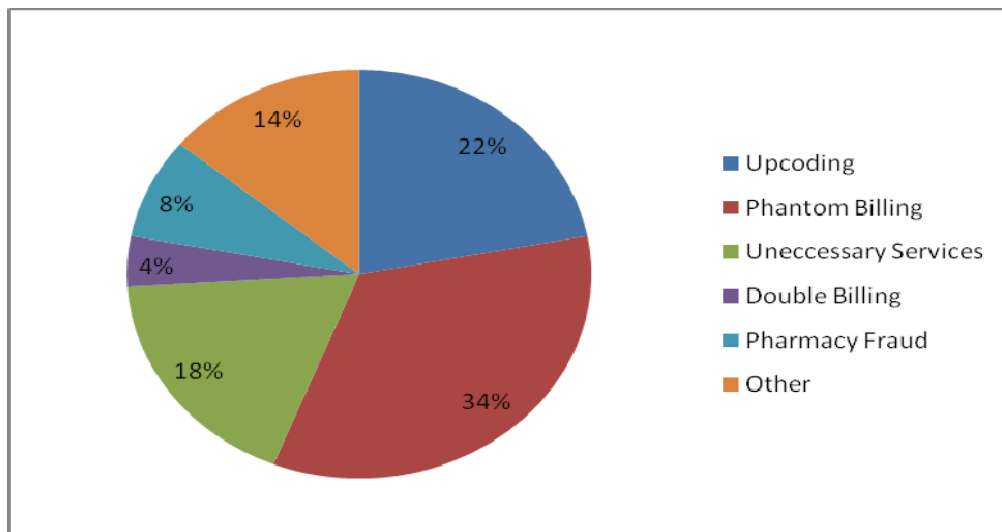
### *Double Billing*

Double billing/unbundling occurs when duplicate bills are sent to the same payer or when the bills are sent to different payers (Lieberman & Rolle, 1998). Double billing accounts for an estimated 4 percent of health care fraud (Datawatch, 2000).

### *Pharmacy Fraud*

Pharmacy fraud can take place along two distinct lines. The first instance takes place when a generic brand of drugs is dispensed to a patient while the payer is charged for the brand name, which is more expensive. The difference can then be pocketed. Secondly, a pharmacy can fill prescriptions paid for by a third party, buy them back from the patients, and then sell them to other patients at a higher price (Lieberman and Rolle, 1998). Pharmacy fraud accounts for an estimated 8 percent (Datawatch, 2000).

Types of Fraud Committed:



## **Physician Defense to Health Care Fraud:**

Because medical providers are responsible for 72 percent of health care fraud, there are many resources dedicated to the defense of physicians. These resources are often from the view point of physicians, and should be examined to offer a better understanding of why and how unintentional fraud is committed, and how it can be minimized.

Most physicians claim that the coding system is complicated and confusing, even to those who are supposed to be experts. It is suggested that many physician practices are busy and sometimes physicians erroneously code a service. They feel that they should not be blamed, because they were trained in medicine not in coding. Physicians also think that it is unreasonable to hold the physician responsible for the coding mistakes of employees. Physicians also feel as if they are treated as if they are guilty until proven innocent instead of the other way around. They feel like they have no chance to correct their error, before they are prosecuted (Friedman, 1996).

Even if they have a chance to defend themselves, some physicians feel it is still unfair because the government has a massive fraud enforcement program that has access to far more resources than they do leaving them at a disadvantage to defend themselves (Sage, 1999; Stanton, 2001). Physicians also have very little information to use for their defense. Because physicians are very busy and pressed for time, they often only write brief notes describing what was done for a patient and why in the medical record. So if they are prosecuted all they have as evidence is the chart with notes on it, and they see so many patients that they may not be able to remember exactly why they did what they did (Friedman, 1996).

## **THE PROBLEM: HEALTH CARE FRAUD WITHIN MEDICARE/MEDICAID**

Many Americans who are unable to afford health care rely on the government for assistance through programs like Medicare and Medicaid. Medicare and Medicaid are government assistance programs introduced in the 1965 through the Social Security Act. The goal of both programs is to supply and finance a range of medical benefits to specific populations of Americans who can not afford health care. In 2003 Medicare and Medicaid were responsible for financing 26.3 percent of health care in the United States (Grayson, 1998). Because, these government programs serve so many people and provided a significant portion of funding in the health care field, they are often targeted for fraudulent behavior. In 2004 Medicare and Medicaid estimate that 14 percent of their health care costs were spent fraudulently (Grayson, 1998). Since these programs spent about 2 trillion dollars total on healthcare, about 90 billion dollars were spent fraudulently (Allmon, 2005). In comparison, credit card fraud, widely perceived to be a huge problem, results in annual losses of 788 million dollars annually in 2004 (Allmon, 2005).

Health care fraud is a massive problem for the entire health care system, not just government programs such as Medicaid and Medicare. But because of the large amount of money lost fraudulently every year through the Medicare and Medicaid programs the government has taken notice of the issue, and begun to make attempts along with other private entities to minimize and abolish its occurrence. The Department of Justice has declared health care fraud to be its second highest priority, following violent crimes (Kalb, 1999). In the past fifteen years the government has spent millions of dollars fighting health care fraud. The governments have committed millions of dollars more to fighting health care fraud in the future, new agencies have been created as well as new policies, and new ideas are always in development.

## **Medicare/Medicaid Fraud and Abuse Legislation**

One of the first noticeable attempts at minimizing health care fraud came in 1996 through the Health Insurance Portability and Accountability Act. The act was passed with the goal of decreasing expenses to the Medicare and Medicaid programs through various reforms, and by focusing on reducing the occurrence of fraud and abuse in the government health care programs (Faddick, 1997). Through these reforms the government wanted to gain more tools for detecting and weapons for fighting fraud and abuse, recover money that had previously been spent fraudulently, and produce settlements (Faddick, 1997).

The Health Insurance Portability and Accountability Act (HIPAA) was created under good intentions, but from a practical perspective it has some problems. The new programs initiated under the HIPAA come with a substantial price tag. In 2002 the new initiatives cost an estimated 310 million dollars, without any sunset provisions for the future, which means the programs and costs of the programs have no definite end. HIPAA also has the potential to harm many health care providers by producing the unintended consequences of fewer settlements, more court battles, and the entanglement of the innocent in the intricacies of the governments new and very broad punishment tools (Faddick, 1997; Stanton, 2001).

HIPAA represents one of the most expansive programs the government has ever initiated to fight fraud and abuse in the health care system (Stanton, 2001). Specifically HIPAA focuses on fighting fraud and abuse proactively. HIPAA does this through these three major programs: the Fraud and Abuse Control Program, the Medicare Integrity Program, and the Beneficiary Incentive Program. HIPAA also amends the permissive exclusion provisions, provides certain minimum exclusions periods, expands the scope of civil monetary penalties, instructs the

Secretary to issue advisory opinions, protects certain risk-sharing arrangements from illegal anti-kickback penalties, creates new crimes relating to health care fraud, and establishes a national data base to house reports of adverse actions relating the delivery of health care services (Faddick, 1997).

The Fraud and Abuse Control Program was created through HIPAA to coordinate federal, state, and local health care anti-fraud enforcement programs. This program focuses on conducting investigations, financial and performance audits, inspections, and evaluations; and maintaining a public database, establishing and modifying safe harbors, and issuing advisory opinions. Specifically this program establishes a procedure to solicit recommendations at least annually, to publish proposals to modify existing procedures and add new safe harbors, and to issue special fraud alerts. This program is jointly administered by the Attorney General and the Secretary of Health and Human Services. It is funded through the Medicare Hospital Insurance (Part A) Trust Fund. Fines, penalties and other fraud and abuse recoveries also aid in funding this program (Faddick, 1997). So far this program has been successful at convicting health care fraud offenders, and collecting fines. Between 1997 and 2006 this programs has collected more than \$10.4 billion in fines and restitution returned to the Medicare Trust Fund (United States. Dept. of Health, 2007) . Since this program began it has saved taxpayers more than \$38 billion, and has increased convictions and other successful legal actions by more than 240 percent (Comprehensive, 1999).

Created though HIPAA the Medicare Integrity Program gives the Department Health and Human Services (HHS) the right to contract with private companies to perform fraud and abuse detection, cost report audits, provider payment determinations, and utilization reviews. The program also is in charge of providers, beneficiary, and public education; and developing a list of

durable acceptable medical equipment. This program is also administered by the Secretary of HHS, and funded by the Medicare (Part A) Trust Fund (Faddick, 1997). In 1997 alone, this program returned \$14 for every \$1 spent, and saved taxpayers an estimated \$7.5 billion (Comprehensive, 1999).

HIPAA created the Beneficiary Incentive Program to entice Medicare beneficiaries and others to aid in identifying fraud and abuse. The program offers incentives such as monetary payments to beneficiaries who provide information that leads to monetary recoveries or other criminal or civil sanctions under the Medicare Program. This program has had some trouble with efficiency, because it struggles with a way to encourage beneficiaries to report incidents of fraud and abuse against the Medicare Program without reporting frivolous or irrelevant information. In order to encourage Medicare beneficiaries to be responsible for monitoring their own health care for fraud and abuse, this program provides each individual with an explanation of benefits for every item or service Medicare pays for. Then if an individual finds a discrepancy and reports it and that report leads to at least 100 dollars in recovery from the provider, they may receive a monetary reward (Faddick, 1997).

All of these programs aim at reducing fraud and abuse throughout the health care system. They increase the tools used for investigating fraud and abuse by unifying resources; setting standards; educating the providers, beneficiaries, and the public; working together with external entities; and by encouraging users of health care to get involved. HIPAA also discourages fraud and abuse by expanding the reasons and opportunities for penalties, increasing the amount of civil monetary penalties, increase prosecution and charges of criminal offenses, and by increasing the likelihood of exclusion from Medicare and Medicaid Programs (Faddick, 1997).

The Medicare and Medicaid Patient Protection Act (Anti-Kickback Statute) was another statute created by the government to decrease fraud and abuse. This statute prohibits providers from knowingly and willfully paying or receiving any payment directly or indirectly, overtly or covertly, in cash or kind, in exchange for prescribing, purchasing, or recommending any service, treatment, or item for which payment will be made by Medicare, Medicaid, or any other federally funded health care program (Bennett and Medearis, 2003; Kalb, 1999). Violations of the Anti-Kickback Statute can receive up to \$25,000 fines, 5 years in prison, or both. In order to convict a provider the government must prove that a provider solicited or received payments, the payments induced a referral related to a government program, and the transaction was knowingly and willfully entered into by the provider. Conviction under the Anti-Kickback Statute is often difficult, because the government must prove that the defendant acted with *specific intent* (knowingly and willfully). The program also protects against relationships that could result in conflicting interests, such as: discount arrangements, incentives given to providers, payments for services, and the practices of manufactures giving gifts and other business courtesies (Bennett and Medearis, 2003; Kalb, 1999).

The problem with this statute is that kickbacks are not specifically defined, which means that technically anything a provider receives from a manufacturer may be considered a kickback, even box of donuts or a pizza from a pharmaceutical company. This issue is being addressed presently by the American Medical Association (AMA). AMA suggests that providers only accept gifts that primarily benefit patients, such as educational materials (Bennett and Medearis, 2003; Kalb, 1999).

Another statute created to minimize fraud and abuse in the health care system was the False Claims Act. The False Claims Act is the most important law enacted by the federal government to enforce fraud and abuse legislation (Kalb, 1999; Stanton, 2001). The False Claims Act (FCA) has penalties for inaccurate billing practices and laws concerning false statements and overpayments, which penalize organizations that make false statements to the government or fail to return overpayments (Shane, 2000). If convicted of violating the False Claims Act, the government can receive up to three times the amount billed, and fines up to \$10,000 for each false claim. These claims can be brought against any government contractor by the government or a private citizen. The act also includes *qui tam* provisions, which allows private citizens the right to file a lawsuit on behalf of the government and receive a monetary reward (up to 15%) from the recoveries (Bennett and Medearis, 2003; Cady, 2007; Kalb, 1999; Stanton, 2001). These types of provisions that encourage whistleblowers are important especially when addressing types of fraud like upcoding or bogus billing. Upcoding and bogus billing are hard to prove, because if caught providers can claim “honest mistake” (Stanton, 2001). Therefore, this type of fraud is best proven by the testimony of an insider (whistleblower), such as the billing clerk, who can outline the scheme and illustrate the provider’s fraudulent intent (Morris, 1993; Cady 2007, Stanton, 2001).

The Prescription Drug Marketing Act (PDMA) prohibits the sale or trade of drug samples. It was created by the government to correct abuse by individuals who repackage, distribute, and sell sample drugs that often resulted in misbranded and contaminated products. Violation of the PDMA can result in up to 10 years in prison, and fines of up to \$250,000 (Bennett and Medearis, 2003). Due to the broad definition of “drug sample” these cases are often complicated and hard to prove.

## **Government Organizations Responding to Health Care Fraud**

The government has committed numerous organizations to investigating health care fraud. A few of these organizations are: the U.S. Department of Justice (through the Criminal Health Care Fraud Division and the Civil Health Care Fraud Division), the Internal Revenue Service, the Department of Health and Human Services Office of Inspector General, the Federal Bureau of Investigation, and state Medicaid fraud control units (Shane, 2000). These organizations along with the programs, listed above, and other internal anti-fraud programs such as corporate compliance programs have helped minimize fraud and abuse to an extent.

In 1998, alone, the Federal Bureau of Investigation (FBI) obtained 322 criminal convictions, up from 105 in 1993, and recovered \$480 million in fines, recoveries, and restitutions, representing \$13.65 for each dollar spent on the actual investigation. In the same year the state Medicaid Fraud Control Units, secured 683 convictions and recovered \$42.8 million in fines, restitution and overpayments. Meanwhile, the Office of Inspector General in the Department of Health and Human Services, recovered \$5.4 billion in fines, settlements, restitutions, and other recoveries involving federal health programs, and excluded 3,021 individuals and entities from government programs (Kalb, 1999; Sparrow, 1996).

The conviction and recovery amounts continue to increase, as investigators understand more about fraud, and the public is educated further. From 2001-2005 the FBI alone recovered \$3.8 billion in restitutions, \$477 million in recoveries, \$1.11 billion in fines, and \$102.8 million in seizures (United States Dept. of Justice, 2005). In 2006, the Department of Health and Human Services (DHHS) recovered \$2.2 billion in judgments and settlements, and \$378.4 million in recoveries (United States Dept. of Health, 2005). In 2000, the Health Insurance Association of

America revealed that 58 organizations responding have saved a total of \$232 million through internal anti-fraud efforts, and had a return on investment of \$11 saved for every dollar spent. Since 1994 the Federal Bureau of Investigation has quadrupled the number of health care fraud investigators, causing them to obtain 560 federal convictions for health care fraud, and recoveries around \$290 million in 2001 (Stats, 2001). From 2001-2005 the FBI had 4,952 convictions, and 2,775 indictments (United States Dept. of Justice, 2007). As government organizations continue to find success with health care fraud recovery they continue to increase the size and budget of the investigation units, with hopes of further recoveries made.

## **SUGGESTIONS TO PREVENT HEALTH CARE FRAUD**

These programs and statutes have unified federal efforts to minimize fraud and abuse, encouraged education, given more tools to use for investigation and prosecution, and increased penalties and punishments for fraudulent behaviors, but it is not enough. It seems like all of these organizations have done a decent job of recovering money spent fraudulently, and they have done so with a reasonable cost to recovery ratio. However, recovering fraudulent money is not enough. Only 4 percent of fraudulent claims have been recovered or identified before payment (Allmon, 2005). It is important to anticipate weak spots in the health care system where fraud is likely to occur and continue to monitor and build in new ways to effectively prevent fraud and abuse from happening in the future.

As our health care system evolves and gets more convoluted the ways that fraud are committed evolve and become more complex. The health care system we have is mostly run by computers with minimal or no scrutiny of suspicious claims (Grayson, 1998). Often times because of this, once a computer's fraud warning is triggered it is often too late to catch the

criminal. Most criminals simply disappear with their loot or even more troubling start more innovative schemes under different names and addresses (Grayson, 1998). Some new suggestions for preventing fraud are to implement a measurement program, use more human scrutiny of payment records and claims processes along with innovative deception detection software, encourage the use of corporate compliance programs, and involve consumers in the fight against health care fraud.

One way in which we can aim to prevent fraud from occurring is to implement more human scrutiny in the inspection of payment records and the claims processes. Many of the computer programs out there now are not able to detect some things that a trained human eye can. Often times the computer programs that are able to detect fraud as well as the human eye, are either too complicated or too expensive to be a practical purchase. Better detection technology is in the future, but while we wait we should increase training for individuals in fraud detection, coding, etc. and implement more individuals to inspect cost reports, payment records, and claims processes (Grayson, 1998).

Some of the new software systems being introduced to fight health care fraud are: advanced analytics software, decisioning technology software, and predictive modeling software. Advanced analytics software can scan million of records in seconds, comparing every transaction or claim with defined patterns, behaviors, and billing norms (Allmon, 2005). This software will be able to detect if there is any unusual service or payment pattern at a certain location. It will be able to tell if a certain physician charges a patient twice for the same service, if a physician seems to be doing too many mastectomies, etc. Decisioning technology software is being used by some private insurance companies to reduce fraudulent losses, improve productivity, and bottom-line results (Allmon, 2005). This software does analysis of data such as medical records

and claims, in order to find “errors”. It then converts the data into actionable results, and gives each provider or entity a score based on the rate of “errors”. Then claims adjusters, fraud investigators, case managers, and other personnel can focus their review on claims with the highest likelihood of fraud, abuse, or error (Allmon, 2005). This system if used correctly can also help providers, who are unintentionally making errors by showing them where there errors are and how to correct them before they are accused of fraudulent behavior. The most advanced type of software uses predictive modeling, a statistical technique that analyzes historical claims and claims-related data to predict the risk of fraud for each claim or behavior (Allmon, 2005). This type of software is able to detect fraud more accurately over time, thus giving organizations a better opportunity to catch fraud, abuse, and erroneous claims prior to payment and before losses mount. All of these software programs could be used to catch fraudulent activity before claims are paid. This software is important, and has the potential to drastically minimize the amount of money lost to fraud, because once claims are paid the time, effort, and costs of trying to recoup losses rise exponentially (Allmon, 2005).

Compliance programs are another way that many organization are trying to combat health care fraud. Health care compliance programs aid an organization in detecting and fixing health care fraud internally. They do this by creating a series of internal controls and measures to ensure that an organization is following federal, state and local statutes and regulations governing the federally funded health care programs (McKessy and Saner, 1998). More specifically, a compliance program may include: legal reviews of contracts and operating procedures, directives and training for employees, procedures for reporting violations of your specific compliance plan and/or government regulations, and monitoring and auditing mechanisms to discover violations (McKessy and Saner, 1998). In many cases compliance programs establish new positions for

corporate compliance officers to educate employees, develop standards of conduct, and monitor “high- risk” areas. Usually compliance programs also include an anonymous hotline to allow employees to report potential problems, and along with that there are policies requiring no retaliation to encourage reporting (Shane, 2000). Compliance programs are often successful, because they can be designed and/or customized by each individual organization to address their individual needs (Cantone, 1999). Furthermore, having a compliance program in place may help if the government does target a specific organization. Because a compliance program forces an organization to document their efforts to follow the law, it may help avoid criminal prosecution and exclusion from the federal health care programs, and provide an argument for lighter fines and penalties if a mistake is made (Cady 2007; Cantone, 1999; McKessy and Saner, 1998;). Overall compliance programs are very useful to prevent health care fraud. The Medical Group Management Association (MGMA) have supplied resources like: the “Compliance Programs for the Small Group Practice” booklet, an employee educational program plan, packets of research and survey information on compliance in physician practices, a website dedicated to creating compliance programs, and a monthly compliance newsletter called the “Physician Practice Compliance Report”, that can be used to create compliance programs (McKessy and Saner, 1998). Many other organizations, including the federal government, have also developed resources for organizations to use to create their own compliance programs.

One aspect of health care fraud prevention that is not mentioned enough is the consumer’s role. Consumers need to get involved with there health care, beyond just going to the doctor and taking their medicine. They need to be educated on their insurance plan, how much they pay, the proper names of their ailments, and they need to keep track of the services they receive and why they receive them. Consumers can serve as important allies in the fight against

health care fraud as well. Some recommended methods for consumers to use to identify and reduce fraud are (Lieberman and Rolle, 1998):

1. Be wary of telephone solicitors who promise free checkups, testing, or medical equipment.
2. Be cautious about rolling labs and health fairs, especially when a battery of tests is administered as opposed to a specific test.
3. Do not provide a detailed medical history or sign multiple insurance forms that assign automatic reimbursement authority to a provider.
4. Be skeptical when someone offers a free treatment. A provider may promise to waive part of the bill and suggest that the insurance company will cover the remainder of the cost. This may be untrue.
5. Review all medical bills closely. Any billing discrepancies should be promptly reported to the clinician who provided the service.
6. Do your research. Research each health agency contacted. Try to identify a provider who has been operating for at least five years, licensed by the state, certified by Medicare, and accredited by JCAHO.
7. Report suspected fraudulent acts to proper authorities.

## **CONCLUSION**

There has been some progress made toward minimizing health care fraud and abuse through government statutes and programs, and better education. However, as more money continues to be spent on health care more criminals will be attracted, and more fraud will be committed. As more people commit health care fraud, more complex types of fraud will be created. The best way to prevent health care fraud in the future is to address these issues now, and in order to do so Medicare and Medicaid must spend the money on the new deception detection technology along with hiring and training more fraud investigators. They must continue to research all aspects of health care fraud, train providers, and physicians in the correct way to code claims, and other parts of the claims process, continue to involve the public in their

health care, and pass legislation forcing every provider of health care to have and annually update a compliance program.

First, every step in the claims process needs to include regularly updated preventative deception detection software, in order to stay ahead of the new fraud techniques. Even though these programs are not able to detect everything, they have a good chance of flagging irregularities if linked with the national data base and alert system, created by the Fraud and Abuse Control Program. Along with the new technology we must also increase the number of fraud investigators in every aspect of the claims process, so that the irregularities that the deception detection technology flagged can be checked by trained investigators, and dealt with correctly. It is important that we update preventative deception detection software and hire and train more fraud investigators to achieve maximum success.

Secondly, we need to continue research of fraudulent activities, who commits them, why and how in order to continue to minimize their occurrence. The federal government should create a National Fraud Research Center to be in charge of funding and performing fraud research throughout the country, and training all of the FBI's Fraud Investigators. The research center could be easily funded by the money that is returned from fraud convictions.

The National Fraud Research Center can also be responsible for accomplishing my third recommendation to prevent health care fraud: better education for everyone involved in the health care system. In order to better train providers, physicians, and administrators the National Fraud Research Center could hold mandatory conferences and training sessions throughout the country that each must attend in order to keep their licenses current. They could also pass legislation that forces physicians with a certain amount of patients to hire a certified

administrator who can then be responsible for all of the coding, billing, and claims. In order to educate the public legislation could be passed requiring insurance companies to hold public training sessions on how to read their specific summary of benefits. The National Fraud Research Center could also begin some kind of campaign to educate the public on health care fraud's importance, and how they can aid in the fight against it.

Finally, the federal government needs to pass legislation forcing every provider of health care to have and annually update a compliance program. The legislation at a minimum will outline what is necessary in each program, and if a corporate compliance officer is needed depending on the number of consumers a provider/physician serves. It will also force each organization to do an internal audit to address their weaknesses. Compliance programs have been proven successful, and are relatively inexpensive. They have many benefits for the providers as well as the federal government, and should be easily initiated with all of the resources already available.

Throughout this paper it has been proven that fraud is a huge factor contributing to the growing cost of health care in the United States. If it continues more and more Americans will be unable to afford the health care that they desperately need. In order to stop fraud, it is imperative that the United States government and the citizens of the United States take an active role in pursuing more effective ways to identify and prevent fraud. If we all work together it is possible to control rising health care costs, and fighting fraud, through the ways mentioned above, is a good first step.

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