

Reduce Waste, Fraud, and Abuse in Health Care

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Waste, fraud, and abuse increase the cost of health care and may harm patients, either by giving them unneeded care or by withholding needed care. Enhancing already extensive enforcement activities and strengthening conflict-of-interest rules could reduce inappropriate spending while yielding net savings. Reducing waste, fraud, and abuse would save money for Medicare, Medicaid and private payers, improve the efficiency of the health care system, and savings could contribute to funding for health reform. How extensive are waste, fraud, and abuse? What can be done about them? This Fact Sheet describes the problems and highlights some solutions.

What Is the Problem?

Waste, fraud, and abuse appear in all segments of the health care system and in all areas of the country. Fraudulent and abusive practices include overcharging or double-billing health insurance companies or the government for services provided, charging for services not provided, and rendering inappropriate or unnecessary care.

Our current health care system makes detection and pursuit of wrongdoers extremely difficult. Experts have identified structural features of the U.S. health care system that make it particularly vulnerable to fraud and difficult for enforcement activities to control it. Some of these features include the fee-for-service payment system, the fragmented nature of the private health care insurance and delivery system, and the highly automated claims processing system.¹ The fact that there are more than 1,000 payers and billions of annual claims paid to hundreds of thousands of providers illustrates the immensity of the task.

In the past, inadequate funding has also frustrated government efforts to detect

and prosecute fraud. Federal health care enforcement efforts are funded by recovery of funds from inappropriate Medicare and Medicaid reimbursement, together with related fines and penalties.

Private-sector payers have met with less success in combating fraud and abuse because they lack the legal and administrative tools available to the federal government.

Eliminating Fraud and Abuse: What's at Stake?

Since its inception in 1997, the national Health Care Fraud and Abuse Control Program has returned more than \$11 billion to the Medicare Trust Fund.

The Department of Health and Human Services' Office of Inspector General reported savings and expected recoveries of more than \$20 billion for 2008.²

Broader federal efforts to close loopholes, reduce improper payments, and discourage inappropriate conduct saved about \$39 billion during fiscal year 2007, \$30 billion for Medicare and \$9 billion for Medicaid.³

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Some examples of health care fraud and abuse enforcement and recoveries include the following:⁴

- A drug manufacturer paid \$328 million in settlement to resolve charges of illegal drug pricing and marketing activities, including promoting unapproved “off label” uses of its drugs, inflating prices, and paying kickbacks to doctors and pharmacies to purchase its products.
- A Medicaid health maintenance organization was fined \$334 million for engaging in a “cherry-picking” scheme to enroll disproportionately health individuals by refusing to enroll pregnant women and people with pre-existing conditions.
- A large physician practice paid \$1.7 million in recoveries for inappropriately retaining overpayments from Medicare, Medicaid, and private insurers over a 10-year period.
- The operator of a bogus health insurance company was fined \$20 million and sentenced to 25 years in prison for defrauding private employers and employees of millions of dollars in premiums.
- In 2007, a Medicare Fraud Strike Force in southern Florida indicted 120 defendants who improperly billed Medicare for durable medical equipment (DME) and HIV infusion therapy services. Among those convicted, prison sentences averaged 52 months. Although estimating the deterrent impact of enforcement activities is difficult, a year later, Medicare claims for DME had fallen from \$1.87 billion to \$661 million, a drop of \$1.2 billion.

How Much Does Wasteful Spending Cost?

Many activities increase unnecessary and wasteful health care spending. Health care spending for patients with similar conditions varies widely across the United States.⁵

To the extent that ineffective or harmful interventions could be reduced, geographic variations in health care spending represent unnecessary and wasteful use of services. One report found that Medicare spending would fall by almost 30 percent if spending in medium- and high-spending regions were reduced to the same level as that in low-spending regions.⁶

Wasteful Spending and Conflicts of Interest

Variations in health care spending appear to be attributable primarily to differences in local patterns of practice and professional norms, rather than differences in price of services or the health of the population.⁷

In some cases, financial conflicts of interest encourage wasteful practice patterns. Studies have found that self-referral to physician-owned facilities, such as diagnostic imaging (e.g., CT and MRI), clinical laboratories, and specialty hospitals, results in higher use of these services and higher health care spending.⁸

Even scientific research to determine which interventions are best for patients can be influenced as much by the personal financial interest of researchers and physicians as by scientific data. Financial ties have transformed the traditional system of medical research such that financial conflicts of interest emerge at every stage of the scientific process.⁹

What Can Be Done?

- **Increase funding for fraud and abuse control.** The Congressional Budget Office estimates that increased enforcement would save Medicare and Medicaid about \$2 billion over 10 years.¹⁰

Increased fraud and abuse control in the private sector could yield additional savings, although it is difficult to estimate how much. The National Health Care Anti-Fraud Association, a trade group of large private insurers and employer health plans, has estimated that 3 percent of all health care spending (about \$68 billion) is lost to fraud.¹¹

Studies have found that the return on investment for selected fraud and abuse control efforts is high and could go higher. For instance, the Department of Health and Human Services' Office of Inspector General estimates that for every \$1 spent on health care oversight, the government receives about \$17 in return.¹²

- **Spend all funds recovered from federal and state fraud and abuse control efforts for further enforcement activities.** According to government reports, funds recovered from enforcement activities cannot be fully accounted for and may have been spent by federal agencies for other, non-Medicare-related activities.¹³ If recoveries are not needed to further fraud and abuse control, they could be redirected to related health care programs, rather than to unrelated purposes.
- **Prioritize spending on fraud and abuse control activities to yield the greatest societal impact.** Funds for enforcement activities could be better allocated to provide the greatest net benefit to society (total

public and private benefits net of costs).¹⁴

- **Increase transparency to earn the trust of patients and the public.** Drug and device manufacturers could be required to publicly disclose all payments and grants to doctors for consulting, speaking, research, and education.¹⁵
- **Reduce conflicts of interest for providers.** Loopholes in the self-referral ban and anti-kickback rules could be eliminated, such as the “in office ancillary exception” which allows self-referrals for services, such as imaging and laboratory tests, located in the physician’s office.
- **Establish clinical practice guidelines for overused services.** Prior authorization by benefit managers could be required for “overused” services, such as diagnostic imaging and clinical laboratory services.¹⁶
- **Restrict industry marketing practices.** Direct-to-consumer advertising and drug detailing by manufacturers’ sales representatives to physicians could be limited.

Industry gifts to health care providers and researchers could be banned, with *de minimis* exceptions.
- **Take a balanced approach to fraud and abuse control activities to avoid negative effects on patient health care.** The effectiveness of enforcement activities could be better monitored to ensure that they remain appropriate and do not adversely affect patient access to care.

Health care providers could be better educated regarding compliance and to prevent or correct unintended errors. Innocent billing errors should not be prosecuted as intentional fraud.

Endnotes

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⁸ Ibid.

⁹ “Hidden Interest – A Special Report: When Physicians Double as Entrepreneurs.” *New York Times*, Nov 30, 1999.

¹⁰ Congressional Budget Office, *Budget Options, Vol. 1, Health Care*, Option 115, Dec. 2008.

¹¹ National Health Care Anti-Fraud Association, Anti-Fraud Resources Center. Available at www.nhcaa.org.

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¹⁶ Congressional Budget Office, *Budget Options, Vol. 1, Health Care*, Option 41, Dec. 2008.

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