

Medicare Fraud Estimates: A Moving Target?

By Nancy Aldrich

Health Benefits ABCs

\$ 850 billion? \$100 billion? \$60 billion? Just how much does health care fraud cost the nation each year?

While there are no exact figures on the cost of health care fraud in the United States, estimated annual losses are definitely in the billions of dollars. “The units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. ... These are staggering sums of money to waste, and the task of controlling and reducing these losses warrants a great deal of serious attention,” says health care fraud expert and Harvard University Professor Malcolm K. Sparrow.

All health care programs are subject to fraud; however, the Medicare and Medicaid programs are the most visible, the most frequently cited and, unlike the private sector, are required to release certain data, according to the Federal Bureau of Investigation (FBI).¹

“There is no requirement for private insurers to report their fraud rates,” Bill Corr, Deputy Secretary, Department of Health & Human Services (HHS), told the Senate Judiciary Committee at an Oct. 28, 2009, hearing on preventing health care fraud.

A 2009 study by the George Washington University School of Public Health and Health Services concluded, “National reporting systems on health care fraud fail to capture private sector fraud.”²

Estimates of fraud, both public and private, run

between 3 and 10 percent of total health care expenditures. The United States expects to spend \$2.6 trillion on health care in 2010.³

Why is there no firm data on the cost of Medicare fraud? There are several reasons:

1. **Broad Definitions.** Estimates for misspent dollars may not distinguish fraudulent payments from those that involve waste or error. Or they may focus on the entire health care system, not just on Medicare fraud.

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or ploy to defraud the Medicare program.⁴

Abuse is defined as incidents or practices of providers that are inconsistent with accepted sound medical, business or fiscal practices.⁵

Waste, depending on whose definition you use, can include inefficient claims processing and health care administration, defensive medicine (redundant, inappropriate or unnecessary tests and procedures), preventable hospital readmissions, medical errors, unnecessary emergency room visits, hospital-acquired infections and money spent on preventable conditions (such as obesity or smoking).⁶

2. **Higher Stakes.** The dollar amount that occurs in a single incidence of fraud is rising, according to the U.S. Department of Justice (DOJ), making it harder to estimate fraud based on prior statistics. An individual case of fraud now may involve perhaps \$30 to \$50 million, instead of a \$1 million figure that would have been eye-popping a decade ago, DOJ says.

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3. **Unknowns.** Most fraud is undetected, and therefore difficult to count. “It is not possible to measure precisely the extent of fraud in Medicare and Medicaid,” HHS Inspector General Daniel Levinson told the Senate Special Committee on Aging in May 2009.

Estimates for dollar losses, including waste, in all health care arenas include:

- \$1.2 trillion a year, based on a 2008 report by PricewaterhouseCoopers’ Health Research Institute.⁷
 - \$600 to \$850 billion a year, according to a Thomson Reuters report⁸ that uses a broad definition of “waste” (defined as “healthcare spending that can be eliminated without reducing the quality of care”).
 - \$98 billion in improper health care payments (\$54 billion from Medicare and Medicaid) in fiscal 2009, Peter Orszag, director of the White House Office of Management and Budget (OMB), said at a Nov. 17, 2009, media briefing. This was a 37.5 percent increase above \$72 billion in 2008, partly due to a change in the way CMS calculates improper payments.⁹ The two areas with significant increases in errors were inpatient services and Durable Medical Equipment. “Improper payments” are those made in the wrong amounts, to the wrong person or for the wrong reason.¹⁰
 - \$24.1 billion in improper payments was made to Medicare fee-for-service (FFS) providers in 2009, according to the Centers for Medicare & Medicaid Services (CMS).¹¹ This is based on a national paid-claims error rate in the FFS program of 7.8 percent (due to items such as missing or insufficient documentation, medically unnecessary services or incorrect coding). Each year the Medicare FFS error rate is reported in both CMS’ and HHS’ audited financial reports. The FFS error rate is not a measure of fraud but does provide an assessment of errors that need to be fixed.
- \$1.2 billion in Medicare and Medicaid audit disallowances (findings of unallowable costs), according to the HHS Office of Inspector General (OIG).¹² In its FY 2008 report on the Health Care Fraud and Abuse Control Program, HHS reported it collected approximately \$662.5 million in disallowances of improperly paid health care funds.¹³
 - \$209 million in improper payments for Medicare home health claims alone for the 12-month period ending September 30, 2007, according to the federal Comprehensive Error Rate Testing (CERT) program, which monitors payment accuracy in the Medicare FFS program. (Fraudulent claims may not be reflected in the CERT error rate estimate, according to the Government Accountability Office (GAO).¹⁴)
- Estimates for health care fraud and abuse that do not include “waste”:
- \$125 to \$175 billion, according to the Thomson Reuters report.¹⁵
 - \$75 to \$250 billion a year, according to the FBI, based on the assumption that fraudulent billings to public and private health care programs are 3 to 10 percent of total health care expenditures.¹⁶
 - \$60 billion a year, according to the National Health Care Anti-Fraud Association, an organization of about 100 private insurers and public agencies.¹⁷
 - \$32.7 billion or 10 percent (including a federal share of \$18.6 billion) of state Medicaid claims paid in 2007 were improper, according to the GAO.¹⁸
- Estimates for Medicare/Medicaid fraud:
- \$100 billion annually in Medicare and Medicaid fraud, according to the Center for Health Transformation, a public-private collaborative formed by former Speaker of the House Newt Gingrich.¹⁹

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President Barack Obama and Office of Management and Budget Director Peter R. Orszag, Jan. 26, 2009. (Official White House Photo by Pete Souza)

- \$80 billion annually in Medicare fraud, according to the Coalition Against Insurance Fraud, an anti-fraud watchdog group for consumers, insurers, legislators, regulators and others.²⁰
- \$1 billion in costs for fraud involving the Medicare home health care sector alone, according to the American Association for Homecare.²¹
- Millions of dollars every year are lost due to Medicare fraud, CMS says.

Clearly these varying estimates can be confusing, but any way you measure it, the reality is that the health care system loses enough money each year to pay for insurance for the uninsured, keep premiums from rising and improve the health of Americans. And taxpayers bear the burden of Medicare fraud, waste and abuse. In addition, the fraud numbers for private health insurance plans, secondary payers and Medigap plans are likely to be high as well; those data are just not available.

The critical message for SMPs is that your work is more important than ever and there is no reason to assume it will diminish in the near future.

Footnotes

¹Federal Bureau of Investigation. *FBI's Annual Financial Crimes Report for 2007, October 1, 2006 - September 30, 2007*, www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health

²Rosenbaum, S., et al. *Health Care Fraud*, George Washington University School of Public Health and Health Services, Department of Health Policy, October 27, 2009, www.rwif.org/healthreform/product.jsp?id=50654

³Foster, R.S., et al. *Updated and Extended National Health Expenditure Projections, 2010-2019*, Centers for Medicare & Medicaid Services, June 29, 2009, www.cms.gov/NationalHealthExpendData/downloads/NHE_Extended_Projections.pdf

⁴National Consumer Protection Technical Resource Center. *SMP Foundations: Volunteer Training*, August 2009, www.smpresource.org/Content/NavigationMenu/ResourcesforSMPs/Training/VolunteerFoundationsTraining/default.htm

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⁵National Consumer Protection Technical Resource Center. *SMP Foundations: Volunteer Training*, August 2009, www.smpresource.org/Content/NavigationMenu/ResourcesforSMPs/Training/VolunteerFoundationsTraining/default.htm

⁶PricewaterhouseCoopers' Health Research Institute. *The price of excess: Identifying waste in healthcare spending*, April 2008 presentation at the 180° Health Forum in Washington, D.C., www.pwc.com/us/en/healthcare/publications/the-price-of-excess.ihtml and Thomson Reuters. *Where Can \$700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?*, white paper, October 2009, <http://thomsonreuters.com/>

⁷PricewaterhouseCoopers' Health Research Institute. *The price of excess: Identifying waste in healthcare spending*, April 2008 presentation at the 180° Health Forum in Washington, D.C., www.pwc.com/us/en/healthcare/publications/the-price-of-excess.ihtml

⁸Thomson Reuters. *Where Can \$700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?*, white paper, October 2009, <http://thomsonreuters.com/>

⁹A significant portion of the new errors found in FY 2009 were due to a strict adherence to policy documentation requirements, signature legibility requirements, the removal of claims history as a valid source for review information, and the determination that medical record documentation received only from a supplier is, by definition, insufficient to substantiate a claim. ... CMS made two distinct changes to the 2009 improper payments review process. First, CMS changed the way it reviewed inpatient hospital claims for error rate measurement. ... Second, CMS implemented three separate revisions to the medical review criteria to more strictly enforce Medicare policies." Source: Centers for Medicare & Medicaid Services. *Improper Medicare Fee-For-Service Payments Report - November 2009 Report*, www.cms.gov/apps/er_report/preview_er_report.asp?from=public&which=long&reportID=15&tab=1

¹⁰The White House, Office of the Press Secretary, March 10, 2010

¹¹Centers for Medicare & Medicaid Services. *Improper Medicare Fee-For-Service Payments Report - November 2009 Re-*

port, www.cms.gov/apps/er_report/preview_er_report.asp?from=public&which=long&reportID=15&tab=1

¹²Levinson, Daniel. *Statement of Daniel R. Levinson, Inspector General, U.S. Department of Health & Human Services*, before the Senate Special Committee on Aging, May 6, 2009, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_senate_hearings&docid=f:52778.wais.pdf

¹³Department of Health & Human Services and Department of Justice. *Health Care Fraud and Abuse Control Program Annual Report For FY 2008*, www.oig.hhs.gov/publications/docs/hcfac/hcfacreport2008.pdf

¹⁴Government Accountability Office. *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185, February 27, 2009, www.gao.gov/new.items/d09185.pdf

¹⁵Thomson Reuters. *Where Can \$700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?*, white paper, October 2009, <http://thomsonreuters.com/>

¹⁶Thomson Reuters. *Where Can \$700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?*, white paper, October 2009, <http://thomsonreuters.com/>

¹⁷National Health Care Anti-Fraud Association, www.nhcaa.org/

¹⁸Government Accountability Office. *High-Risk Series: An Update*, GOA-09-271, Jan. 22, 2009, www.gao.gov/new.items/d09271.pdf

¹⁹Gingrich, Newt. *How Much Fraud?*, Nov. 9, 2009, Center for Health Transformation, www.healthtransformation.net/cs/georgia/georgia_project_news_details?pressrelease.id=3487

²⁰Coalition Against Insurance Fraud, www.insurancefraud.org/medicarefraud.htm

²¹American Association for Homecare, www.aahomecare.org/displaycommon.cfm?an=2 ●