

U.S. House of Representatives
Committee on Oversight and Government Reform
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Medicare Experience Suggests Americans
Should Expect Massive Fraud with
Nationalized Health Care

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I. Democratic Proposal for More Government-Run Health Care

“My experience with the federal government is if the government runs something it usually costs me more and gives me less.”¹

Driven by President Barack Obama’s campaign promise to “fix a broken health care system,”² House Democrats have introduced a health care reform bill, the “America’s Affordable Health Choices Act (H.R. 3200),” to implement universal health care. The legislation creates, extends or expands 33 entitlement programs, and creates 53 additional government offices, bureaus, commissions and programs.³

Using individual mandates, employer mandates and tax penalties, H.R. 3200, the Democrat bill, forces every individual to maintain a certain government-determined minimum level of coverage or, if found out of compliance, pay a tax. Employers must offer their employees a choice of an approved health plan or pay an 8% tax on their payroll. To achieve universal coverage, a government-run public health insurance plan will be created to compete with private insurance plans. The reforms will be paid for in part by a heavy surtax on wealthy families and individuals: up to 5.4% of adjusted gross income above \$350,000 for joint filers. These taxes will likely rise as health care costs increase.

The government-run “public option” plan may mirror another government-run health care program: Medicare. Medicare – a federal entitlement program established in 1965 to provide health insurance to individuals 65 and older – has been expanded over the last four decades to cover certain individuals under 65, and now covers 45 million people at a cost of \$492 billion per year.⁴ The average yearly cost to the program per beneficiary is \$10,933. In contrast, the average cost per year for a Federal employee obtaining coverage under the Federal Employees Health Benefits Program is only \$5,573.⁵ The bulk of Medicare funding comes from tax dollars – payroll taxes and taxes on benefits account for nearly 48% of the program’s income, while 40% comes from general revenue.⁶ Beneficiary premiums only make up 12% of Medicare’s income.⁷ Without transfers from the general fund of the Treasury, the Medicare program would already be insolvent.⁸

¹ Luke Russert, Barbour Decries Government Health Care, <http://firstread.msnbc.msn.com/archive/2009/06/23/1975193.aspx> (last visited July 16, 2009)(quoting Hon. Haley Barbour, Gov. of Miss.).

² Organizing for America, <http://www.barackobama.com/issues/> (last visited July 13, 2009).

³ Press Release, House Republican Conference, Democrat Health “Reform” By the Numbers (July 20, 2009).

⁴ Congressional Research Service, R40425 Medicare Primer (Mar. 10, 2009).

⁵ FEHBP’s Prescription Drug Benefits Before the Subcomm. on Fed. Workforce, Postal Serv., & the D.C. of the H. Comm. on Oversight & Gov’t Reform, 111th Cong. (2009) (statement of Nancy Kichak, Assoc. Dir. for Strategic Human Res., Office of Pers. Mgmt.).

⁶ Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [hereinafter Trustee’s Report], 2009 Annual Report (May 12, 2009).

⁷ *Id.*

⁸ Email from Cong. Research Serv. To Minority Staff dated July 28, 2009(citing Trustee’s Report stating “For SMI (Part B), transfers from the general fund of the Treasury represent the largest source of income, currently covering about 79% of program costs.”)

According to the Congressional Budget Office (CBO), Medicare expenditures represent 3.5% of gross domestic product (GDP).⁹ In comparison, total defense spending amounts to only 4.3% of the GDP, and this is likely to decrease as we drawdown in Iraq. Spending on Medicare is increasing more quickly than the economy, and the Medicare Trust Fund will become insolvent in 2019.¹⁰ If unchecked, Medicare expenditures are expected to increase to almost 13.5% of GDP by 2080.¹¹

Using the Medicare model will open the public option to the same pitfalls as Medicare. Because the government sets Medicare payments at below-market rates, there is a tremendous amount of cost shifting in the current system. Cost shifting occurs when, as a result of federally initiated payment cuts, providers – both hospitals and physicians – shift costs to, and ultimately increase prices for, private payers.¹² “When providers’ prices rise and neither public nor private payers’ compensation follows suit, consumers pay more. The result is that people lose coverage.”¹³

Fraud and improper payments are also rampant in Medicare. According to the Government Accountability Office (GAO), improper payments in the Medicare Fee-for-Service (FSS) and Medicare Advantage programs were estimated to be \$17.2 billion for fiscal year 2008.¹⁴ GAO estimates that as much as 10% of overall health care spending is lost to fraud.¹⁵ More troubling, the “America’s Affordable Health Choices Act” will apply the same ineffective anti-fraud and abuse protections to the public insurance plan that the Medicare program uses, leaving the door open to the same types of waste and fraud as those currently plaguing Medicare. The following sections of this report discuss in greater detail the improper payments and fraud in the current government-run system.

II. Medicare and Its Failings: An Overview

“In a decade and a half of public service, this was the most disheartening, disgusting day I have ever spent. We have to fix this.”¹⁶

Medicare is rife with waste, fraud and abuse. This is particularly troubling because all dollars flowing into the program for administrative costs, benefits and oversight are taxpayer dollars. Likewise, all dollars flowing out of the program for legitimate claims, fraudulent or false claims, and improper payments are also taxpayer dollars.

⁹ *The Long Term Budget Outlook Before the S. Comm. on the Budget*, 111th Cong. (2009)(statement of Douglas W. Elmendorf, Director, Cong. Budget Office.-

¹⁰ Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009 Annual Report (May 12, 2009).

¹¹ *The Long Term Budget Outlook Before the S. Comm. on the Budget*, 111th Cong. (2009)(statement of Douglas W. Elmendorf, Director, Cong. Budget Office).

¹² Jason S. Lee, et al., Medicare Payment Policy: Does Cost Shifting Matter? *Health Affairs* (Oct. 8, 2003).

¹³ *Id.*

¹⁴ Government Accountability Office, GAO-09-628T Improper Payments: Payments Made but Challenges Remain in Estimating and Reducing Improper Payments (Apr. 22, 2009).

¹⁵ *Criminal Prosecution as a Deterrent to Health Care Fraud: Hearing Before the Subcomm. on Crime and Drugs of the S. Comm. on the Judiciary*, 111th Cong. (2009) (statement of Lanny Breuer, Asst. Att’y Gen., Criminal Div., U.S. Dept. of Justice).

¹⁶ Mark Potter, Blatant Medicare Fraud Costs Taxpayers Billions, <http://www.msnbc.msn.com/id/22184921> (last visited July 16, 2009) (quoting Hon. Michael Leavitt, former U.S. Sec’y of Health & Human Serv., who was visiting S. Fla. to examine the Medicare fraud).

Since 1990, the GAO has placed Medicare on its High Risk Series due to “growing concerns about the quality of fiscal oversight, which is necessary to prevent inappropriate spending.”¹⁷ There is no reason to believe the Democrats’ proposal for government-run health care would offer greater oversight.

In a revealing *ABC News* investigative piece on Medicare fraud, a Department of Health and Human Services’ Office of the Inspector General (HHS-IG) agent, Christopher Dennis, noted the ease of committing Medicare fraud against the Government.¹⁸ He attributed the simplicity of carrying out the schemes to the antiquated methods of preventing and detecting fraud. Agent Dennis said:

I think you’ll find it’s easy...because Medicare is set up on rules and regulations that were set up decades ago. We’re trying to govern, detect and prevent fraud with a system that was established many years ago, in 2009.¹⁹

To reiterate, H.R. 3200, the Democrats’ universal health care bill, utilizes the same anti-fraud framework as the current Medicare system. Crooks are evading the current framework, and it is inevitable that they will perpetuate their schemes to an even greater extent under a government-run universal health care system.

A. Improper Payments

GAO estimated the government made a total of \$72 billion worth of improper payments in fiscal year 2008. The Medicare FFS program suffered \$10.4 billion in losses due to improper payments, and Medicare Advantage lost \$6.8 billion.²⁰ By statute an improper payment is defined as:

Any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payments for services not received, and any payment that does not account for credit for applicable discounts.²¹

According to GAO, improper payments can be attributed to the provision of services that are not medically necessary, mistakes in coding, and insufficient documentation.

¹⁷ *Eliminating Waste and Fraud in Medicare and Medicaid Hearing Before the Subcomm. on Fed. Fin. Mgmt., Gov’t Info., Fed. Serv., and Int’l Sec. of the S. Comm. on Homeland Sec. and Gov’t Affairs*, 111th Cong. 5 (2009) (statement of Kay L. Daly, Director, Fin. Mgmt. and Assurance, U.S. Gov’t Accountability Office (hereinafter GAO)) (noting that Medicare has been on the High Risk List since 1990 and Medicaid since 2003).

¹⁸ Pierre Thomas, et al., Taxpayers Funding the ‘Good Life’ for Criminals: Medicare Fraudster Said He Could rip Off Government Millions in Just Months, <http://abcnews.go.com/TheLaw/FedCrimes/story?id=7508614&page=1> (last visited July 17, 2009).

¹⁹ *Id.* (quoting Christopher Dennis, Special Agent In Charge, HHS-IG).

²⁰ GAO, Daly statement at 5.

²¹ *Id.*; Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002).

Additionally, “errors in transferring data, interpretation of data, payment calculations, and incorrect diagnoses resulting in incorrect beneficiary risk scores” cause improper payments in the Medicare Advantage program.²²

Currently, the U.S. Department of Health and Human Services (HHS) does not estimate improper payments for Medicare Part B, the Supplementary Medical Insurance, and Medicare Part D, the prescription drug benefit. Were Parts B and D added to the analysis, it is almost certain these improper payments would be even higher. While a portion of these improper payments are honest mistakes, there is little doubt that a large portion are outright fraud against the government.

B. Out of Control Fraud: By the Numbers

The U.S. Department of Justice (DOJ), HHS, the HHS-IG, and GAO routinely uncover fraud and other abuses that cost taxpayers billions of dollars each year. The government-run health care system proposed by President Obama and Congress will undoubtedly suffer the same failings. The dollar amounts lost due to fraud in our existing government-controlled health care programs are astounding.

In 2007, all health care spending in the U.S. exceeded \$2.2 trillion.²³ The federal government pays more than one third of this total.²⁴ With regard to fraud in the current government system, Attorney General Eric Holder stated: “By all accounts, every year we lose tens of billions of dollars in Medicare and Medicaid funds to fraud.”²⁵

In 2008, the DOJ filed 502 criminal health care fraud cases charging 797 defendants. These cases culminated in 588 convictions. At the end of fiscal year 2008, DOJ had another 773 criminal health care fraud cases pending that involved 1,335 defendants.²⁶ Since 1997, DOJ and HHS have recovered more than \$14 billion in criminal fines and civil settlements.²⁷

Although DOJ recovered \$1.48 billion in fiscal year 2008, taxpayers fronted \$1.13 billion for “program integrity activities and health care fraud enforcement” to recover this money.²⁸ In essence, only \$350 million were recovered – an amount equal to %.012 of the annual federal budget. This figure is a pittance when compared to the \$60 billion total dollars lost annually to health care fraud. Despite our federal law enforcement officials’ best efforts, these numbers provide more evidence that a government-run health care system is not the answer.

²² *Id.*

²³ *Criminal Prosecution as a Deterrent to Health Care Fraud Before the Subcomm. on Crime and Drugs, of the S. Comm. on the Judiciary*, 111th Cong. 3 (2009) (statement of Honorable Lanny A. Breuer, Assistant Att’y Gen., Crim. Div., U.S. Dep’t of Justice)(The figure cited reflects at least Medicare and Medicaid costs).

²⁴ *Id.*

²⁵ Hon. Eric Holder, Att’y Gen., U.S. Dep’t of Justice, Press Conference on New Medicare Initiative (May 20, 2009).

²⁶ *Criminal Prosecution as a Deterrent to Health Care Fraud Before the Subcomm. on Crime and Drugs, of the S. Comm. on the Judiciary*, 111th Cong. 3 (2009) (statement of Honorable Lanny A. Breuer, Assistant Att’y Gen., Crim. Div., U.S. Dep’t of Justice).

²⁷ *Id.*

²⁸ *Id.*

III. Egregious Medicare Fraud Cases

“We’ve seized luxury homes on waterfront properties. We’ve seized boats, we’ve seized bank accounts, jewelry worth thousands of dollars. They’re [the criminals] just killing the Medicare program and living the high-life off of it.”²⁹

A. In Recent Years

Before Congress races to create another massive entitlement modeled after Medicare, existing systemic fraud should be more fully addressed. Since 2005, in the Miami area alone, seven teams of prosecutors, federal auditors and FBI agents have charged more than 700 people for fraudulently billing Medicare for over \$2 billion; only \$350 million has been recouped.³⁰

Scams including fraudulent billing for services not rendered, goods not delivered, or for care given at non-existent clinics are increasingly common, yet these crimes often go unnoticed for years. Medicare anti-fraud “strike forces,” comprised of federal agents and U.S. Attorneys, have made significant gains in routing out Medicare fraud, but their task will balloon if Democrats are successful in enacting universal health care. Anecdotal evidence of the vulnerabilities in the system includes the following cases:

ABC News reports one convicted criminal said he made about \$8 million over seven years by fraudulently billing Medicare.³¹ The convict, now serving time in federal prison, told the media “We would make anywhere between a million to \$2 million in a short time frame, maybe two, three months.”³² He said bilking the government allowed him to purchase “Ferrari, Porsche, Lamborghini, exotic cars – [I] had a nice, I lived a good life.”³³

In October 2008, a Miami doctor named Ana Alvarez-Jacinto was convicted and sentenced to 30 years³⁴ for her role in a massive scheme to defraud the government of \$119 million in HIV-infusion Medicare payments.³⁵ Jacinto and her co-conspirators brought HIV positive patients to a rehabilitation center in Miami, paid them kickbacks,

²⁹ Mark Potter, Blatant Medicare Fraud Costs Taxpayers Billions, <http://www.msnbc.msn.com/id/22184921> (last visited July 16, 2009) (quoting Timothy Delaney, a supervisor for the Fed. Bureau of Investigation’s Miami Office).

³⁰ Jane Sutton, *Government moves to staunch massive Medicare fraud*, Reuters, July 1, 2009.

³¹ Pierre Thomas, et al., Taxpayers Funding the “Good Life” for Criminals: Medicare Fraudster Said He Could rip Off Government Millions in Just Months, <http://abcnews.go.com/TheLaw/FedCrimes/story?id=7508614&page=1> (last visited July 17, 2009).

³² *Id.*

³³ *Id.*

³⁴ Health & Human Serv. Office of the Inspector Gen., Semiannual Rep. to Cong. Oct. 1, 2008-March 31, 2009 at 36.

³⁵ According to DOJ, A number of other convictions flowed from the overall scheme and some indicted co-conspirators remain fugitives.

and administered or prescribed medically unnecessary infusions.³⁶ Jacinto and a nurse who participated in the scheme were ordered to pay approximately \$8.3 million in restitution.³⁷ It is unlikely the government will ever fully recover these taxpayer dollars.

Sadly, the elderly are the most harmed victims in many of these fraud schemes. Crooked doctors prey on elderly people, padding their pockets by ordering unnecessary procedures and then billing taxpayers through Medicare. According to Sacramento, California's *CBS13 News*, in September 2008, seven doctors were implicated in a fraudulent billing scheme.³⁸ One doctor and his co-conspirators shuttled elderly people to an office in Carmichael, California, "so they could be treated for illnesses they didn't have."³⁹ Additionally, the doctors were also accused of "receiving kickbacks for letting their credentials be used, as well as for 'ping-ponging' patients—sharing them and then billing Medicare together."⁴⁰

Purported durable medical equipment (DME) suppliers have discovered methods of exploiting Medicare's vulnerabilities. *ABC News* accompanied federal agents in South Florida as they visited bogus DME suppliers' offices. Together, they visited purported DME facilities, only to find them vacant, set up to perpetrate a scam. Scam artists have stolen "more than \$1.5 billion in the last three years" by setting up fictitious store fronts.⁴¹ Through Operation "Wack-a-Mole," federal agents made unplanned visits to 1,581 DME suppliers and discovered that 491 were fictitious store fronts submitting bogus bills to the government and stealing taxpayer dollars.⁴²

GAO estimated that between April 2006 and March 2007, Medicare overpaid \$1 billion dollars for DME, a large part of this being false claims.⁴³ Over the course of 2007 and 2008, several owners of DME companies were sentenced to various terms of prison and/or probation and ordered to pay more than \$6.4 million in restitution for submitting false claims for aerosol medications and oxygen concentrators that were not medically necessary.⁴⁴ The criminals colluded with Medicare beneficiaries and a physician giving them kickbacks in order to bill the government for superfluous supplies.⁴⁵

In July 2008, GAO found systemic problems in the screening and enrollment process for Medicare's DME suppliers. Like would-be criminals, GAO investigators were able to set

³⁶Health & Human Serv. Office of the Inspector Gen., Semiannual Rep. to Cong. Oct. 1, 2008-March 31, 2009 at 36.

³⁷ *Id.*

³⁸ David Begnaud, Doctors Indicted For Alleged Medicare Fraud, <http://cbs13.com/local/doctors.medicare.fraud.2.825049.html> (last visited July 17, 2009).

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Pierre Thomas, et al., Taxpayers Funding the "Good Life" for Criminals: Medicare Fraudster Said He Could rip Off Government Millions in Just Months, <http://abcnews.go.com/TheLaw/FedCrimes/story?id=7508614&page=1> (last visited July 17, 2009)(This figure only includes the scams discovered by federal law enforcement.).

⁴² *Id.*

⁴³ GAO, Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process, GAO-08-955, July 2008.

⁴⁴ *Criminal Prosecution as a Deterrent to Health Care Fraud Before the Subcomm. on Crime and Drugs, of the S. Comm. on the Judiciary*, 111th Cong. 6 (2009) (statement of Hon. Lanny A. Breuer, Assistant Att'y Gen., Crim. Div., U.S. Dep't of Justice).

⁴⁵ *Id.*

up a fictitious DME business and get clearance from the Centers for Medicare & Medicaid Services to begin billing the government.⁴⁶

In February 2009, GAO identified systemic practices leading to abuses in the home healthcare program within Medicare.⁴⁷ Specifically, Medicare providers overstated the severity of a beneficiary's condition through a practice referred to as "upcoding," provided kickbacks, and billed for services not rendered.⁴⁸

B. Fraud Occurring by the Minute in Medicare

The fact that new Medicare anti-fraud strike forces continue to be established around the country is a signal that fraud is still rampant in the health care sector, especially in the Medicare program.

In June 2009, the Department of Justice indicted 53 people in Detroit for submitting more than \$50 million in false claims to Medicare. In most of these cases, providers billed Medicare for medically unnecessary treatments that were never provided. The alleged offenses include conspiracy to defraud Medicare and violations of anti-kickback laws in addition to the criminal false claims charges.⁴⁹

In July 2009, three new Medicare fraud cases were reported in one week in the Houston area, home to one of the newest strike forces. In one case, investigators uncovered a "pill mill" that was filing millions of dollars in false Medicare claims for services not rendered, as well as illegally distributing narcotics. In another Houston case, the owner of a physical therapy clinic was accused of bribing patients into signing blank forms for false Medicare claims. Nationally, three other cases were reported the same week, with potential losses to Medicare totaling over \$285 million.⁵⁰

The above referenced incidents are only a few examples of the fraud that runs rampant through our health care system in general and through Medicare in particular. According to FBI Director Robert Mueller, the FBI obtained 408 convictions for health care fraud and recovered \$643 million thus far in fiscal year 2009. Moreover, the FBI is investigating at least 2,400 open cases of health care fraud.⁵¹ The strike forces are to be commended for toiling away at their unending task to recover taxpayer dollars nonetheless this is only a portion of the total losses.

⁴⁶ GAO, Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process, GAO-08-955, July 2008.

⁴⁷ GAO, Medicare: Improvements Needed to Address Improper Payments in Home Health, GAO-09-185 (Feb. 27, 2009).

⁴⁸ *Id.*

⁴⁹ Press Release, U.S. Dept. of Justice, Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit (June 24, 2009).

⁵⁰ Cindy Horswell, *Feds strike at Medicare fraud in Houston area*, Houston Chronicle, July 12, 2009.

⁵¹ Robert S. Mueller, III, Director, Fed. Bureau of Investigation, Motor City Strike Force/Health Care Fraud Press Availability (June 24, 2009).

IV. Conclusion

“[Medicare fraud] is an epidemic...It is across the nation, and it is disgusting and it really needs to stop.”⁵²

Once the trillions of dollars that Democrats want to pump into a new government-run health care system is coupled with a lack of any substantive proposal to safeguard against fraud, there will be virtually no limit to the theft of taxpayer dollars. Last year Citizens Against Government Waste testified that there is a “continuing problem of out-of-control fraud in the Medicare program” and because of that “Medicare should be fundamentally restructured and reformed.”⁵³ Enhanced penalties and more money thrown at the problem are not going to effect real reform.

George Washington University’s Medical Center (GWUMC) released a report on the prevalence of health care fraud, both public and private, in June 2009. The report concluded in part that “comprehensive efforts to both detect and deter fraud system-wide are essential to national health reform.”⁵⁴ The report further advised “As the national health reform legislation takes shape, keeping an attentive eye on anti-fraud provisions will be a critical element of reform.”⁵⁵ The experts at GWUMC argued the “central issue” in health reform is “whether anti-fraud safeguards are a firm, fixed feature of final reform legislation.”⁵⁶ Despite some small proposed tweaks, the public system in H.R. 3200 takes the same weak and ineffective approach to reducing fraud as the Medicare model. While private companies have clear profit motivations to reduce fraud, an expanded government controlled health care system run by bureaucrats does not. Expansion of government run health care, based on the Medicare model, threatens to further institutionalize failing anti-fraud provisions and substantially increase the billions of taxpayer dollars lost to fraud and abuse.

The amount of waste, fraud and abuse currently thriving in the health care sector is staggering, and real health care reform must start by addressing it. The National Health Care Anti-Fraud Association cautioned:

As national health care reform legislation is considered and debated in the halls of Congress and at dinner tables across America, we urge decision-makers and citizens alike to give focus to the problem of health care fraud. Any effort to reform our

⁵² Pierre Thomas, et al., Taxpayers Funding the ‘Good Life’ for Criminals: Medicare Fraudster Said He Could rip Off Government Millions in Just Months, <http://abcnews.go.com/TheLaw/FedCrimes/story?id=7508614&page=1> (last visited July 17, 2009)(quoting Hon. Alex Acosta, U.S. Attorney, S. Dist. of Fla.).

⁵³ Elizabeth Wright, Medicare Fraud: Not a New Story, <http://www.cagw.org/site/News2?page=NewsArticle&id=11612> (last visited July 20, 2009).

⁵⁴ Press Release, George Washington Univ. Med. Ctr, New Analysis Examines Fraud in Both Private and Pub. Health Ins. Markets (June 29, 2009).

⁵⁵ Sara Rosenbaum et al., Health Insurance Fraud: An Overview, George Washington Univ. Med. Ctr (June 2009).

⁵⁶ *Id.*

health care system without seriously and thoughtfully addressing health care fraud will be, in our opinion, tragically flawed.⁵⁷

Regrettably, such systemic reforms are absent from the Democrat's "America's Affordable Health Choices Act." Universal government-run health care will offer nothing but a larger scale version of Medicare when it comes to waste, fraud and abuse. Any expansion of existing problems in our entitlement programs will open the door wider for criminals to steal more taxpayer dollars.

⁵⁷ Fighting Health Care Fraud: An Integral Part of Health Care Reform, Nat'l Health Care Anti-Fraud Ass'n (June 2009).

About the Committee

The Committee on Oversight and Government Reform is the main investigative committee in the U.S. House of Representatives. It has authority to investigate the subjects within the Committee's legislative jurisdiction as well as "any matter" within the jurisdiction of the other standing House Committees. The Committee's mandate is to investigate and expose waste, fraud and abuse.

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