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Healthcare Fraud and Abuse: An Investigation of the Nature and Most Common Schemes

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Introduction

Fraud against Medicare/Medicaid or private health insurance providers is a deliberate act committed to gain a financial advantage. This form of fraud not only results in monetary losses, it also cripples the healthcare system by reducing the resources available to provide legitimate and safe care that patients need. It may also negatively affect the public's perception about their healthcare system. Most healthcare providers are honest and ethical; however, there are those few who disregard the rules resulting in major abuse of the nation's resources.[1] The federal government has stepped up its efforts to combat fraudulent healthcare practices for various reasons. Medicare/Medicaid fraud cost the federal government a significant amount of U.S. taxpayers' money that can be used to benefit the general public. In addition, fraud against the government is considered a criminal act. Therefore, the government is responsible for protecting its citizens from criminals and must dedicate sufficient resources to do so. Lastly, the U.S. government is charged with regulating the healthcare system.

According to a U.S. Government Accountability Office report, considerable amounts of money were either incorrectly paid or should not have been paid totaling an estimated sixty billion dollars in 2014 (GAO, 2015). Another source estimates healthcare fraud at eighty billion dollars a year (FBI, 2013). Regardless of the source of the reports and despite the government's tremendous efforts in fraud detection and prevention, healthcare fraud continues to capture the public's attention (FBI, 2013; Daily News, 2013). Healthcare fraud results in higher costs for both consumers and the government. In addition, there are some who believe that fraud may cause reduced benefits as providers decide to establish strategies to prevent people from committing fraud (NHCAA, 2009).

Healthcare fraud cases have been on the rise in recent years and will most likely continue this trend in the future. Various factors have contributed to this rise, including the explosion in the size of healthcare spending and the growing number of network of providers and subscribers of healthcare services resulting in much wider access to the system. National health expenditures grew to 2.7 trillion in 2011, or 17.9 percent of GDP, compared to 1.5 trillion, or 14.5 percent of GDP, ten years earlier. Considering the U.S. population, heath care spending in 2016 represents an average of $10,345 per person compared to $4,788 per person in 2000 (Keehan et al., 2016). It has been estimated that over the ten years, 2015–2025, healthcare spending will increase at an average rate of 5.8 percent annually (Keehan et al., 2016). These projections are based on several factors including the aging of the population, provisions of the Affordable Care Act (ACA), and other social and economic conditions. Another contributing factor to the projected increase in healthcare spending is the ACA which was relatively recently signed into law by President Obama and is designed to add healthcare coverage for millions of uninsured Americans (ACA, 2010).

To combat fraud, the 2018 budget for the government's Healthcare Fraud and Abuse Control program was increased to $751 million, seventy million dollars more than was allocated for fiscal year 2017, which represents an increase of 10.3 percent over the previous year's budget (Swann, 2017). Due to the harmful effects of healthcare fraud on consumers, this exploratory study is designed to investigate the public's views towards healthcare fraud. Fraud in the healthcare system is widespread (Sorrel, 2009). Medicare/Medicaid fraud are only one of many different schemes used to defraud the healthcare

[1] According to the National Healthcare Anti-Fraud Association, "The majority of healthcare fraud is committed by organized crime groups and a very small minority of dishonest healthcare providers." Healthcare providers include the following group: doctors, nurses, hospitals, clinics, nursing homes, adult family homes, home healthcare providers, assisted living facilities, ambulance and other transportation companies, medical equipment suppliers, pharmacies, pharmaceutical manufacturers, and testing facilities.

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system. However, due to the rate of Medicare/Medicaid abuses and because of being funded by public resources, the government has focused most of its attention on preventing these cases of fraud. For example, in 2011 it is estimated that payments for improper government-wide services amounted to $115.3 billion (GAO, 2012a). More than half of that amount, or $64.8 billion, was attributed to Medicare/Medicaid fraud (GAO, 2012a).

Healthcare Fraud in the U.S.

Since the mid-1800s, the U.S. federal government has consistently worked towards discouraging citizens from committing healthcare fraud. One of the earliest laws, the False Claims Act (FCA) dates back to 1863 during the Civil War. At that time, the federal government was concerned with frauds committed by suppliers of goods and services to the Army (31 U.S.C. Sections 3729-3733). According to the FCA all false or fraudulent claims to the federal government are subject to civil penalties, such as fines, and could possibly result in criminal penalties, including imprisonment.

Various other laws were passed over the years to help strengthen the government's position against healthcare fraud perpetrators. These laws include the Anti-Kickback Statute of 1987, the Physician Self-Referral Law of 1993, and the Civil Monetary Penalties Law of 1989. The issues of healthcare fraud were moved to the forefront in more recent years as the federal government consolidated its efforts to combat fraud under Public Law 104-191 Health Insurance Portability and Accountability Act of 1996 (HIPAA). The legislation required the establishment of a national Healthcare Fraud and Abuse Control Program (HCFAC). This was done under the direction of the Attorney General and the Department of Health and Human Services (HHS). The role of this office is to coordinate both public and private healthcare anti-fraud operations at the Federal, State, and local levels.

However, even with the government's continued efforts towards preventing healthcare fraud, reported cases of fraud are still on the rise. According to the reports by the HHS, the government's efforts resulted in the recovery of $3.3 billion in 2016 up by nearly 37.5 percent compared to the previous year recovery of $2.4 billion (HHS and DOJ, 2017). Since the program's inception in 1997, the HCFAC, run by the HHS and the Department of Justice, has returned more than thirty-one billion dollars to the Medicare Trust Funds. This evidence suggests that while the government's enforcement efforts towards recovery of taxpayer dollars have been successful, more work is still needed in this area.

While the focus of the above laws has been directed primarily towards fighting fraud committed against the government, particularly the Medicare/Medicaid fraud, there are many other reported cases of healthcare fraud.

Research Question

Businesses and households provide more than half of the total U.S. national health expenditure (CMS, 2012a). Healthcare fraud is committed against both public and private agencies; however, the primary emphasis for prevention and reporting of fraud is on the public side (Rosenbaum et. al., 2009). Even though there have been some efforts in recent years to fight fraud directed toward the private sector,[2] there is little evidence to show the extent of the government's enforcement efforts in this area. To date the government's efforts have been primarily directed towards the prevention and detection of fraud against the Medicare/Medicaid system. For example, in June 2011, the government's Fraud Prevention System (FPS) started running sophisticated analytics, including predictive algorithms, against all Medicare fee-for-service (FFS) claims prior to payment (CMS, 2012a, 2014, 2017). In addition, it was estimated that more than half of government wide payments for improper services were attributed to Medicare/Medicaid fraud (GAO, 2012a). Even though annual healthcare spending for Medicare/Medicaid is makes up forty-six percent of total spending (CMS, 2017), the government spends significantly more on combating fraud against the Medicare/Medicaid system compared to combating fraud against private insurance companies.

The purpose of the current study is to investigate public's attitudes towards frauds committed by healthcare providers. There is little or no research investigating the public's perceptions of fraud committed by the healthcare providers. What are the major schemes used to commit fraud by the healthcare providers and whether? Are there any perceived differences in the significance of the schemes committed against Medicare/Medicaid versus those committed against the private insurance companies?

[2] E.g., in 2012 a voluntary collaborative partnership was formed between the federal government, State officials, and some private insurance companies to act collectively against fraud (DOJ, 2012).

Research Question: Are fraud schemes committed against the private sector (i.e., insurance companies) the same as those committed against the public sector (i.e., Medicare/Medicaid)?

Data Collection

A questionnaire was developed to collect the data for this study. The questionnaire was mailed to 1000 business professionals randomly selected from the residents of Southern California.[3] The sample was divided into two equal groups of 500 subjects (Groups A and B). A seven-point Likert-scale was used with "1" representing "Most Important" and "7" representing "Most Unimportant". Two versions of the questionnaire were developed each containing the same set of questions, one directing the participants' attention to Medicare/Medicaid fraud schemes (Group A) and the other focusing on frauds against the insurance companies (Group B). We relied heavily on the work of Piper (2013) to develop the survey questions. The list of fraud schemes was later expanded by using Schemes to Defraud Medicare, Medicaid, and Private Healthcare Insurers reported by General Accountability Office (2000).[4] E-mail was the primary mean of data collection. The participants were asked to complete all sections of the questionnaire including demographic questions. They were assured strict anonymity. A second and third e-mail was sent to increase the response rate, if the questionnaire was not returned within two weeks.[5]

Results

A total of ninety-four and 105 useable responses for Groups A and B, respectively, were collected from multiple mailings of the questionnaire. Table 1 contains a summary of demographic information. Many respondents in both groups were Hispanic, Asian, and White with only a small percentage (2.13% and 3.81% for Groups A and B, respectively) being African American. The vast majority of the respondents were over the age of forty-five (60.44% and 65.71% for Groups A and Group B, respectively). All respondents possessed either a high school or higher education, with around sixty percent of respondents having a bachelor or graduate degree. More than half of the participants were married with the remainder being single, divorced, or widowed. Male participants in Group A made up 47.87% of the sample. Group B had a higher number of female participants making up 56.19% of the sample. A little over a fifth of the respondents indicated that they were self-employed (22.34% and 20.95% for Groups A and B, respectively), with the remaining participants working for public and private organizations including government and education. More than half of the respondents worked in top or middle management positions. Family income for the majority of respondents was below $150,000 (88.29% and 83.81% for Groups A and B, respectively). A small group of the respondents had a family income exceeding $150,000 (11.70% and 16.19% for Groups A and B, respectively).[6] [see Table 1, pg 434]

In 2015, the United States spent $3.2 trillion for national health expenditures (CMS 2016). Thirty seven percent of this amount was used by Medicare/Medicaid. Private health insurance companies spent slightly less at thirty-three percent. Even though the spending for both groups was quite similar, the reported cases of fraud against Medicare/Medicaid are almost three times as much as those reported for the private insurance companies.[7] This could be due to the way the Medicare/Medicaid system was designed. The Medicare/Medicaid system was designed primarily to compensate providers who made healthcare available to those who were underprivileged, needy, and/or old. The system was not designed to make

[3] Business professionals were selected as the participant in our study as they tend to be more knowledgeable about the value of healthcare and the cost of fraud.

[4] To ensure validity and reliability of the questions, the instrument was pre-tested by using a small group of professionals in Southern California. As a result of this pre-testing, several questions were added or modified prior to mass distribution.

[5] To measure the probability of non-response bias, statistical tests were conducted on the early and late responses. The results showed no significant differences between the responses received after the first mailing, leading to the conclusion that the chance of non-response bias was statistically non-existent ($p = 0.05$).

[6] In addition to the results reported using the full samples for Groups A and B, we partitioned the data into four subsamples; one included only the sample data provided by the White respondents, the second included only the sample data provided by the Asian respondents, the third included only the sample data provided by the Hispanic respondents, and lastly the fourth subsample excluded the data for respondents earning over $150,000. For each subsample, we compared the mean rankings for each of the Fraud Schemes in our instrument with those of the full sample. The results of our t-tests indicated that there are no significant differences ($p < 0.05$) between the mean responses for the full sample and the subsample for the White respondents, the Asian subsample, the Hispanic subsample, and the subsample without the data for respondents earning over $150,000 for both Groups A and B.

[7] Coalition Against Insurance Fraud (http://www.insurancefraud.org/statistics.htm).

prompt reimbursements. In addition, it had no built-in provisions to safeguard against fraudulent activities (Sparrow, 2008; Sorrel, 2009).

The fraud scheme rankings for Medicare/Medicaid and private insurance companies are presented in Tables 2. The rankings for the fraud schemes for both groups were quite different. The scheme with the highest rating in the Medicare/Medicaid group is incorrect reporting of diagnosis or procedures. For private insurance companies, the scheme with the highest rating is billing for unnecessary services. The second highest rated schemes are double billing and kickbacks for the Medicare/Medicaid and private insurance companies, respectively. Both groups considered billing for services not rendered to be the third most important fraud scheme. The Medicare/Medicaid group viewed the substitution of generic drugs to be the least important scheme. On the other hand, the private insurance company group viewed unbundling services, where bundled services such as a tooth extraction are billed separately, as the least important scheme. It is clear from the results that both groups view fraud schemes aimed at Medicare/Medicaid and private insurance companies to be important. However, the importance attributed to each scheme differs considerably depending on whether the fraud is aimed at Medicare/Medicaid or private insurance companies. [see Table 2, pg 435]

Summary and Conclusion

Healthcare fraud is committed against both public and private agencies; however, the primary emphasis for prevention and reporting of fraud is on the public side (Rosenbaum et. al., 2009). The purpose of this research is to investigate whether there are any differences in public attitudes towards frauds committed against public agencies versus the private insurance companies. To collect the data used in the study, a questionnaire was prepared with a list of widely known fraud schemes. The questionnaire was distributed among two randomly selected groups of in California. One group was asked to rate the fraud schemes assuming that they were committed against Medicare/Medicaid. The second group was provided the same list and asked to rate the fraud schemes assuming they were committed against private insurance companies.

The study results showed that the scheme with the highest rating against Medicare/Medicaid is incorrect reporting of diagnosis or procedures, while against private insurance companies, the scheme with the highest rating is billing for unnecessary services. Both groups ranked unbundling services, misrepresenting dates of service and substitution of generic drugs lower than other schemes. However, the importance attributed to each of the fraud scheme differs considerably depending on whether the fraud is aimed at Medicare/Medicaid or private insurance companies. The results of this study can benefit government's fraud detection and prevention efforts. Due to the limited resources available to combat fraud, government officials can use this information to focus their efforts on looking into the fraud schemes that are the most important in each of the two categories. Overall, it is clear from the results that both groups view fraud schemes aimed at Medicare/Medicaid and private insurance companies to be important, yet their perception of each of the schemes differs depending on which healthcare group it is aimed at.

As with other survey research, this study is subject to several limitations. The sample used in the current study was not drawn from a nationwide population. Therefore, the results may not represent the views of the general public in all fifty states. In addition, the participants were not selected based on their experience with Medicare/Medicaid or private insurance. It is not possible to determine what percentage of the participants had previous exposure to the fraud schemes or were covered by each of the healthcare plans.

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Table 1: Respondent's Demographics

	Group A		Group B	
Ethnicity:	**Number**	**Percent**	**Number**	**Percent**
African American	2	2.13%	4	3.81%
Asian	33	35.11	32	30.48
Hispanic	31	32.98	41	39.05
White	26	27.66	24	22.86
Others	2	2.13	4	3.81
Age:				
25–34	22	23.40%	23.40	23.81%
35–44	15	15.96	15.96	10.48
45–54	33	35.11	35.11	44.76
55–Up	24	25.53	25.53	20.95
Level of Education:				
High School Degree	24	25.53%	22	20.95%
Associate Degree	13	13.83	20	19.05
Bachelor Degree	31	32.98	32	30.48
Master Degree	21	22.34	22	20.95
Post Graduate	5	5.32	9	8.57
Marital Status:				
Single	30	31.91%	38	36.19%
Married	53	56.38	53	50.48
Divorced/Widowed	11	11.70	14	13.33
Gender:				
Female	45	47.87%	59	56.19%
Male	49	52.13	46	43.81
Employment:				
Self-Employed	21	22.34%	22	20.95%
Publicly-Traded Company	13	13.83	13	12.38
Private Industry	15	15.96	31	29.52
Healthcare	4	4.26	8	7.62
Government	11	11.70	10	9.52
Education	4	4.26	3	2.86
Others	22	23.40	15	14.29
Unemployed	4	4.26	3	2.86
Employment Position:				
Top Management	25	26.60%	32	30.48%
Middle Management	27	28.72	26	24.76
Staff	35	37.23	34	32.38
None	7	7.45	13	12.38
Family Income:				
Under $50,000	26	27.66%	27	25.71%
$50,000–75,000	21	22.34	22	20.95
75,000–100,000	22	23.40	20	19.05
100,000–150,000	14	14.89	19	18.10
Over 150,000	11	11.70	17	16.19

Group A represents the Medicare/Medicaid group.

Group B represents the private insurance group.

Table 2: Fraud Schemes Aimed at Medicare and Medicaid, and Private Insurance Companies

Ranked by Importance

	Group A			Group B		
Healthcare Provider Fraud Schemes:	**Rank**	**Mean**	**Var.**	**Rank**	**Mean**	**Var.**
Incorrect reporting of diagnosis or procedures: Billing Medicare/Medicaid or a private insurance company for a more expensive service than the one diagnosed.	1	2.21	1.57	5	2.34	1.79
Double billing: Billing both Medicare/Medicaid and the private insurance company or patient for the same service.	2	2.22	1.81	4	2.29	2.28
Billing for services not rendered: Billing Medicare/Medicaid or a private insurance company for a service not performed.	3	2.26	1.57	3	2.26	1.62
Kickbacks: A provider may receive kickback (e.g., money or gifts) for referring patients to others for services that are not even necessary, such as x-rays, MRIs, prescription drugs, etc.	4	2.31	1.91	2	2.24	1.89
False or unnecessary issuance of prescription drugs: A patient may ask a doctor to write a prescription drug, such as a painkiller, that is not necessary.	5	2.34	1.80	6	2.46	1.83
Misrepresenting provider of service: Billing Medicare/Medicaid or a private insurance company for a service performed by a nurse as a doctor for more money.	6	2.45	1.35	9	2.50	1.25
Unnecessary services: Billing Medicare/Medicaid or a private insurance company for services that are not really necessary.	7	2.47	1.74	1	2.19	1.77
Unbundling: A provider may bill Medicare/Medicaid or a private insurance company for a bundled service such as a tooth extraction as two or more separate treatment.	8	2.52	1.84	10	2.51	1.62
Misrepresenting dates of service: Reporting a one-day visit as a multiple-day visit to Medicare/Medicaid or a private insurance company for more money.	9	2.56	1.35	8	2.48	1.46
Substitution of generic drugs: Billing Medicare/Medicaid or a private insurance company for the cost of a name brand prescription when in fact a generic substitute was used.	10	2.56	2.10	7	2.47	1.81

Group A represents the Medicare/Medicaid group.

Group B represents the private insurance group.