A Social Problem That Comes in Many Shapes and Sizes

After spending two weeks recovering from heart and lung problems, a Florida man in his early nineties was released from an Orlando-area hospital. His condition was too unstable for him to return home, so his doctor arranged for a short stay at a nursing facility. On his discharge from the hospital, the patient told staff members that someone was available to drive him to his new quarters. But the hospital staff insisted he make the short trip by ambulance, assuring him that “Medicare will pay for it.”

The ambulance ride went smoothly, and the patient, fully conscious and aware of what was happening during the trip, arrived safely at the nursing center. Several weeks later, he received a $627 invoice from the ambulance company. The bill for the eight-mile journey included charges for services such as the availability and actual use of oxygen (two separate charges) as well as something called an “OSHA sanitary procedure.” The oxygen, for which he was charged, was never provided, and, contrary to what he was told by hospital personnel, Medicare balked at paying for the ambulance service.

This case is a personal one because the elderly man I am describing is my father. At ninety—two, his mind was sharp. He kept up with current events through his three reading staples—the Orlando Sentinel, the Wall Street Journal, and Time magazine. And with a lucidity that was rare for his age, my father knew exactly what services he received during his short ambulance ride, a ride that forced him to deal
with Medicare red tape (he was told his appeal was “on file”) as well as threats by the ambulance company to refer his bill to a collection agency “within ten days.” To protect his credit rating, I advised him to pay the charges and then seek reimbursement from Medicare. After making a dozen or so telephone calls and enduring needless hassles, he finally settled his account by paying a $42 fee. My father always tried to play by the rules. He should not have been forced to waste time dealing with a shady ambulance company and Medicare bureaucrats during the last months of his life.

Many of the cases discussed here involve frauds totaling hundreds of millions of dollars. By comparison, my father’s unwanted ambulance ride seems positively banal. But I use it to introduce this book, however, precisely because of its banality. The cumulative effect of the many “nickel-and-dime” frauds is perhaps even more devastating to the U.S. health care system than the high-profile cases that make front-page news. Clearly, reform is needed.

But will reform occur? Federal prosecutors have long been aware of Medicare and Medicaid fraud. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control Program (HCFAC) under the auspices of the U.S. Attorney General and the Department of Health and Human Services (HHS). And funding to the HHS, Office of Inspector General (OIG) and the FBI—both key players in the fight against health care fraud—has increased significantly since the late 1990s.

The Obama administration proposed an initial budget of $634 billion for health care reform. These measures were designed to provide Americans with greater access to health care. As was the case with the Clinton and Bush administrations, President Obama claimed that fighting Medicare and Medicaid fraud was a priority. Obama’s Medicare Fraud Strike Force, operated jointly by the Department of Justice and the Department of Health and Human Services, with the cooperation of state and local law enforcement, set its sights on persons who were filing false Medicare claims, billing the government for unnecessary or bogus treatments, and soliciting illegal kickbacks. In the wake of indictments against fifty—three doctors, health care executives, and beneficiaries during June 2009, HHS secretary Kathleen Sebelius said, “The Obama administration is committed to turning up the heat on Medicare fraud and employing all the weapons in the federal government’s arsenal to target those who are defrauding the American taxpayer.”

A month later, thirty health care providers, including doctors, in New York, Louisiana, Massachusetts, and Texas, found their bank accounts frozen and assets seized—including Rolls Royce automobiles and million-dollar houses—as part of a Medicare fraud bust. In this series of frauds, providers were billing Medicare between $3,000 and $4,500 for “arthritis kits” that contained nothing more than knee and shoulder braces and heating pads. The perpetrators also billed Medicare for thousands of dollars in liquid foods such as Ensure that were never delivered to patients.
In late January 2010, the Obama administration held a health care fraud summit. This initiative was followed in March 2010 with the announcement of new measures to employ private auditors or “bounty hunters” to look for erroneous Medicare and Medicaid payments. In 2009 alone, bogus payments amounted to an estimated $98 billion, of which $54 billion came from Medicare and Medicaid. The plan calls for paying bounty hunters a portion of the recovered funds.

But are these efforts enough to stop white-collar criminals who are stealing from consumers, insurers, and tax payers? Is this reform real and lasting, or is it political grandstanding? The billions of dollars spent by the Clinton, Bush, and Obama administrations to fight health care fraud and abuse sounds impressive until we realize the enormity of health care fraud and abuse. The numerator—that is, the federal government’s spending almost $2 billion a year on antifraud measures—sounds great until we see the size of the denominator—that is, the $75 billion to $250 billion a year that is being stolen by health care fraudsters.

Except for a handful of lawmakers—most notably Senator Charles “Chuck” Grassley, R-Iowa—Congress has given little attention to this major social problem. And they have not shown the same indignation over fraudulent health care billings as they did over financial crimes at Enron, WorldCom, and Bernard L. Madoff Investment Securities.

A lack of attention to this pressing social problem goes beyond the halls of Congress. Health care reform was a hotly debated topic during 2009 and 2010. Except for oblique references to waste and mismanagement, however, the pundits were silent on the topics of fraud and abuse. Price Waterhouse Coopers did release a report in 2009 that placed a “focus on fraud and mistakes” at number four on its top-ten list of health care concerns. But the Price Waterhouse Coopers report appears to be the exception, not the rule. Although think tanks, interest groups, and the media have paid close attention to many of the problems plaguing U.S. health care, they have said little about fraud and abuse.

The fact remains, however, that the U.S. health care system, with its network of providers, consumers, and insurers, is a major target for criminal activity. A report issued by the Department of Justice and the FBI indicates that health care fraud is the most prevalent of the major frauds in the United States, far outdistancing corporate fraud, securities fraud, identity theft, mortgage fraud, insurance fraud, and mass-marketing fraud. According to the FBI:

All health care programs are subject to fraud, however, Medicare and Medicaid programs are the most visible. Estimates of fraudulent billings to health care programs, both public and private, are estimated between 3 and 10 percent of total health care expenditures. The fraud schemes are not specific to any area, but are found throughout the entire country. The schemes target large health care programs, public and private, as
well as beneficiaries. Certain schemes tend to be worked more often in certain geographical areas, and certain ethnic or national groups tend to also employ the same fraud schemes. The fraud schemes have, over time, become more sophisticated and complex, and are now being perpetrated by more organized crime groups.10

At the outset, it is important to note that most health care providers place their professional obligations above their personal and financial needs. These individuals and their organizations provide quality services and products to patients and clients at a fair price. They abide by the laws, regulations, and ethical guidelines of their regulatory bodies and professional associations, and they play by the rules when seeking reimbursements from Medicare, Medicaid, or private insurers. But unscrupulous health care providers—and these include a surprising number of supposedly upstanding professionals—often have a different agenda.

Many of the perpetrators of health care fraud and abuse come from the upper crust of society—board-certified doctors, surgeons, hospital CEOs, attorneys, and even renowned physician-academics working at some of the world’s top medical schools. In some cases, they steal or misappropriate resources. In other cases, they engage in scandalous over- and undertreatments that cost people their health or even their lives. Yet few of these “perps,” as they are often called on TV cop shows, ever go to jail. Indeed, some of them are among the most disturbing of repeat offenders. What does this predicament tell us about our health care system and about our society and values?

In a scenario that has become all too commonplace, a physician practicing in South Florida was sentenced to forty—six months in prison and three years of supervised release. She was also ordered to pay over $2.3 million in restitution for her participation in a massive kickback scheme involving pharmacies, medical equipment companies, and Medicare patients. In addition, she was sentenced on charges of conspiracy to violate the antikickback and false claims statutes, along with tax evasion. The doctor landed in hot water after she agreed to provide bogus prescriptions in return for cash.

Beginning in spring 1999, this doctor established referral relationships with the owners of medical equipment companies. The owners brought “patients” to her office and specified the medications and equipment they wanted her to prescribe. She conducted cursory physical examinations and then signed the requests, regardless of their medical necessity. For these services, she collected kickbacks ranging from $50 to $200 per patient. The medical equipment companies delivered the unneeded items to the patients and submitted Medicare reimbursement claims. In addition, prescriptions signed by the physician were filled by Miami pharmacies in return for a referral fee. As a result of this scam, Medicare
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paid more than $2.3 million for unnecessary equipment and medications.\textsuperscript{11} One aspect of this case, however, is different—this fraudster was sentenced to time behind bars. Many other white-collar criminals who steal from the health care system never see the inside of a prison cell.

Pharmaceutical and medical equipment companies are often in the health care fraud limelight. In 2009 two major pharmaceutical fraud cases were noteworthy—Pfizer agreed to pay $2.3 billion and Eli Lilly $1.4 billion for their illegal off-label promotions of major drugs.\textsuperscript{12} Furthermore, medical equipment firms, ranging from small-time operators of phony shell companies to providers of kidney dialysis machines, have been subjected to fraud charges and huge monetary settlements.

Some newsworthy cases center on the largest institutions in the United States. Hospital chains such as Tenet Healthcare Corporation, the Hospital Corporation of America (HCA), and HealthSouth have forfeited hundreds of millions of dollars to settle a variety of fraud and abuse charges. Extended care facilities, home health care firms, and even hospices have also been charged with a laundry list of fraud and abusive practices.

Persons from all walks of life—some highly paid professionals and others common street criminals—are attracted to the tremendous moneymaking potential of health care fraud. Law enforcement agencies have discovered that organized crime groups are leaving the dangerous work of trafficking drugs and migrating to the safer and more lucrative work of health care fraud.\textsuperscript{13} Crooked business people and lawyers with no formal training in the health care professions have also gotten in on the action, licking their chops and viewing the U.S. health care system as a proverbial gold mine. Health care fraud seems to offer high payoffs with few risks to people whom we do not usually regard as "criminals." These developments do not bode well for government efforts to protect patients, honest providers, insurers, and taxpayers against more fraud and abuse.

But the United States hardly has a corner on the market for health care shysters. Fraud is a global issue that plagues both developed and developing countries. A key point to remember is that fraud and abuse arise in all health care systems, regardless of their size, structure, or methods of finance and delivery. The magnitude and scope of health care fraud and abuse in the European Union is proportional to that in the United States. Laurie Davies of the NHS Counter Fraud and Security Management Service estimated that of the one trillion euros spent on health care in the EU, 3 to 10 percent (30–100 billion euros) is lost every year to fraud.\textsuperscript{14} Despite the enormity of the problem, the antifraud and abuse measures in the EU lag well behind those of the United States. Beginning in 2004, the European Healthcare Fraud and Corruption Conference held annual meetings throughout the EU to discuss strategies for
fighting health care fraud. According to the European Healthcare Fraud and Corruption Network:

The problem of fraud and corruption is likely to grow with EU enlargement and increased free movement of people, money, rights of establishment and rights to provide service. With expansion comes a greater freedom for EU citizens to live and work in other EU Member States. Although this is a positive step for a better, more productive Europe, it also means an increased risk from healthcare fraud. Whether they are individuals or organised crime cartels, fraudsters will be able to duplicate their crimes throughout the EU due to the unrestricted passage from state to state of people, capital and the provision of services. It is important that the EU realises that healthcare fraud is a cross border problem.\(^{15}\)

Concern for this serious social problem is also growing in post-Communist Europe as well as in Asia, Africa, and Central America. According to Transparency International, a civil anticorruption network founded in 1993:

Corruption in the health sector is not exclusive to any particular kind of health system. It occurs in systems whether they are predominately public or private, well funded or poorly funded, and technically simple or sophisticated. The extent of corruption is, in part, a reflection of the society in which it operates. Health system corruption is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is ruled by effective civil service codes and strong accountability mechanisms.\(^{16}\)

It is beyond the scope of this book to discuss in depth the global problem of fraud and abuse. Instead, I analyze the profusion of fraud cases arising within the U.S. health care system. I examine a variety of corrupt acts and crimes, ranging from the padding of trip miles by ambulance operators to inflated Medicare claims by large hospital chains to shady marketing practices by major pharmaceutical companies. The dollars lost to health care fraudsters are dollars that could be used to fund more care for underserved populations. Dollars recaptured could also provide better wages and benefits to nurses, aides, and caregivers who have traditionally been underpaid.

To fully explore the problem of health care fraud in our system, this book centers on the following questions:

1. Are the current definitions of “fraud” and “abuse” too broad? How does one reconcile the dilemma between a physician’s zealous advocacy for her patients and the physician’s ordering tests and treatments that might be regarded as excessive or unnecessary? Are legal counsel, government officials, prosecutors, judges, and juries with little or no formal training in the health disciplines able to distinguish between quality health care and abusive overutilization?
2. How effective are the current laws and regulations for fighting health care fraud? Do these laws micromanage and hinder the efficient delivery of health care, or do they ignore certain health care frauds? Are more anti-fraud laws necessary or should greater emphasis be placed on enforcing existing laws? How much money is needed to ensure an optimal level of support for fighting health care fraud and abuse? And how will regulators know when enforcement measures have reached an optimal level?

3. Are certain institutional arrangements such as fee-for-service or capitation plans more (or less) conducive to fraud and abuse? What is the role of for-profit health care in reducing this major problem? What health care arrangements, financial incentives, and technologies can be used to curb fraud and abuse?

4. To what extent do health care providers, patients, shareholders in private hospitals, fraud control experts, health insurers, fiscal intermediaries, and government officials share a common ground insofar as reducing health care fraud is concerned? If the interests of these diverse groups are not in sync, what measures can be taken to align them?

5. What demographic changes will affect the future of the health care system? Will these changes exacerbate or diminish health care fraud and abuse?

The U.S. Health Care System: The Genesis of Fraud and Abuse

The U.S. health care system is a Garden of Eden for thieves. As the late Walter Cronkite once put it, U.S. health care is “neither healthy, caring, or a system.”¹⁷ It is, however, a fragmented and diverse collection of 580,000 public and private health care providers employing approximately 14 million workers (out of a total labor force of over 150 million).¹⁸ In the United States, health care generated $2.5 trillion in transactions, or about 17.3 percent of the nation’s GDP, in 2008.¹⁹ Because of the rising cost of health care and the aging U.S. population, the system is expected to grow to $4.3 trillion or 20 percent of GDP by 2017.²⁰

People often refer to health care as an “industry.” But health care in the U.S. is not really an industry (i.e., a group of firms producing the same or similar products and selling them in the same markets).²¹ It is actually a loose system or network of overlapping industries— a diverse collection of businesses with different strategies, markets, and competitors.²² The U.S. Department of Labor, Bureau of Labor Statistics divides health care into nine segments: hospitals, nursing and residential-care facilities, physician offices, dentist offices, home health care, other health care practitioners, outpatient care centers, other ambulatory health care services, and medical and diagnostic laboratories.²³
Although immense, the U.S. health care system consists mostly of small businesses. Over three-fourths of the system is made up of offices run by physicians, dentists, and other health care providers. Hospitals constitute only 1 percent of all health care establishments, but they employ about 35 percent of all health care workers. A great deal of variation exists within each of the nine segments. Hospitals, for example, range from small community facilities offering basic inpatient care and surgical services to major university hospitals serving as centers for teaching, research, and state-of-the-art medical care. The Bureau of Labor Statistics segmentation of health care providers excludes public insurance programs such as Medicare, Medicaid, and TRICARE (the military health care plan) as well as private health insurance companies.

In most developed countries, the government plays a central role in administering and financing health care. The United States, however, is the only industrialized country without a national, tax-supported health care system. The majority of people in the United States under the age of sixty-five—and not participating in Medicare—finance their health care through private insurers rather than through public programs such as Medicaid, Veterans Affairs, or the State Children's Health Insurance Program (SCHIP). As the population ages, the Medicare program will expand. By 2017 the government's share of health care spending will increase to about 49 percent (up from 46 percent in 2006). (The appendix to this book describes the Medicare, Medicaid, SCHIP, and TRICARE programs.)

Advocates of the capitalistic private-sector market in health care contend that, at least in theory, a for-profit health care system should encourage innovations and efficiencies that reduce health care costs and improve quality. In reality, the U.S. health care system is a model of inefficiency. Woolhandler, Campbell, and Himmelstein studied the differences between the private U.S. health care system and the socialized Canadian system. They discovered a widening gap between the two countries in per capita health care expenditures.

Market theorists argue that although competition increases administration, it should drive down total costs. Why hasn't practice borne out this theory? Investor owned healthcare firms are not cost minimisers but profit maximisers. Strategies that bolster profitability often worsen efficiency. US firms have found that raising revenues by exploiting loopholes or lobbying politicians is more profitable than improving efficiency or quality. Evidence from the US is remarkably consistent; public funding of private care yields poor results. In practice, public-private competition means that private firms carve out the profitable niches, leaving a financially depleted public sector responsible for unprofitable patients and services. Based on this experience, only a dunce could believe that
market based reform will improve efficiency or effectiveness. Privatisation trades the relatively flat pay scales in government for the much steeper ones in private industry; the 15-fold pay gradient between the highest and lowest paid workers in the US government gives way to the 2000:1 gradient at Aetna.28

According to surveys conducted by the World Health Organization (WHO) and the Organization for Economic Co-operation and Development (OECD), the United States spends more on health care per capita than any other high-income country. In 2007 per capita health care expenditures were $7,900.29 By 2017 these annual expenditures are expected to exceed $13,000.30 According to America's Health Rankings: A Call to Action for Individuals and Their Communities released in December 2008 by the United Health Foundation, the health of Americans had failed to improve for four consecutive years: “Key factors contributing to these results included unprecedented levels of obesity, an increasing number of uninsured people, and the persistence of risky health behaviors, particularly tobacco use.”31 Yet countries having smaller per capita expenditures on health care are superior to the United States on measures of infant mortality, obesity, and average life expectancy.32

Another criticism of the system is the rapid rise in health care costs. In most years, these increases have outpaced inflation by a significant margin. Skyrocketing health care costs have been attributed to greedy health care providers, consumer ignorance, bureaucratic inefficiencies, the failure of market forces, and, of course, fraud and abuse. Although Medicare, Medicaid, and other public programs have a fixed price structure, prices in the private sector of the U.S. health care system are largely unregulated—something that can lead to fraud and abuse. Consumer advocate Cindy Holtzman has pointed to outlandish charges, such as a Florida patient being charged $140 for one Tylenol pill and a South Carolina patient paying $1,000 for a toothbrush: “Usually any kind of bill under $100,000, they [the insurance companies] don’t look at the details. And that’s where something like this can be paid in error.”33

As the Obama administration worked feverishly on health care reform during the summer of 2009, hospitals, health care plans, physicians, and unions offered to make changes that could reduce aggregate health care costs by as much as $2 trillion over the following decade—largely by bundling services and charging one fee for an entire course of care. Does this offer suggest that the major players in our health care system were already well aware of its “slack,” inefficiencies or, simply, its “room for improvement?”

But the most overlooked cause of rising health care costs are the dramatic advances in medical technology. Because health care has improved, it has also become more expensive.
 Probably the harshest criticism of U.S. health care—and a major concern of the Obama and earlier administrations—is the number of persons who lack insurance coverage. The federal government estimated that 47 million individuals (15.8% of the population) were uninsured in 2006. Although the number of uninsured persons declined by 1.5 million in 2007, millions of Americans still go without health care coverage. According to Sara R. Collins of the Commonwealth Fund, a private foundation supporting research on health care, “What is notable is how these problems are spreading up the income scale.”

What about those fortunate enough to have health insurance? During tough economic times, even persons with health insurance may be hard-pressed to pay the deductibles, copayments, and for the treatments that are not covered by their health insurance plans. Researchers from Harvard Law School, Harvard Medical School, and Ohio University found that about 60 percent of personal bankruptcies have been fueled by onerous medical debt. And, according to a report issued by consumer advocacy group Families USA, uninsured persons in 2008 received $42.7 billion in unpaid health care. The Families USA report went on to say that this amount forced providers and insurers to pass these costs on to consumers in the form of a “hidden health tax.” This tax amounted to $1,017 per insured family (or $368 per individual).

Some evidence suggests that the U.S. health care system is also becoming more impersonal. A study by University of Chicago researchers published in the Archives of Internal Medicine revealed that patients were often unable to name any of the physicians who cared for them during their hospital stay. A lack of personalization, in which no bond exists between patients and providers, may make it easier for the providers to commit fraud and then to believe it was a victimless crime.

In the World Health Report 2000, WHO cited three goals of a health care system: (1) good health across the entire range of ages, (2) health care providers who respond to people's expectations and treat them with respect and dignity, and (3) an equitable system of health care financing based on one's ability to pay. The U.S. health care system has been blamed, to varying degrees, for falling short on achieving all these goals. Since the mid-1960s, politicians, policymakers, and health care experts have debated how to overhaul a group of industries described as “a non-system, an incoherent pastiche that has long repulsed reforms by private and public stakeholders.” A piecemeal overhaul of the health care system will simply shift problems and costs from one consumer group or industry segment to another. Conversely, little political and industry support seems to exist for a socialized health care system that is controlled by the federal government.

The future of the U.S. health care system is still unclear. The Obama administration's mislabeled “health care reform”— probably better described as “insurance reform”— is supposed to be phased in over a period of several years. If the
plan withstands legal challenges and opposition by politicians, most Americans will be required to buy insurance, perhaps using a government-run exchange with tax credits to defray the cost. But an increase in the number of people covered by health insurance will likely lead to more health care transactions (e.g., more doctors' visits and more prescriptions filled). And as the number of transactions increases, so too will the amount of fraud and abuse.

The Flow of Services, Information, and Money: A Criminal’s Delight

In its simplest form, the U.S. health care system has been depicted as one of money flowing in and money flowing out (represented in bird’s-eye view in figure 1). More accurately, the system is a constant movement of health care services, products, information, and money. Each arrow in the figure represents millions of possible transactions among U.S. health care’s vast network of providers, consumers, and financing mechanisms. From the white-collar criminal’s perspective, this fragmented system has numerous points of entry and a level of security that is incapable of preventing fraud.

Money is the commodity most valued by white-collar criminals. Money may be stolen directly when a physician files Medicare claims for dialysis treatments that were not provided to patients. But, rather than stealing money directly, white-collar criminals may convert information, products, or services to cash. A crooked employee working in a hospital or clinic may transcribe Social Security numbers from patient records as a first step toward committing credit card or insurance fraud. Another might convert stolen or misappropriated goods to cash. Pill-mill schemes employ criminals working for clinics. These individuals divert prescription drugs from their intended use and sell them back to crooked pharmacists or to drug dealers. And outsiders not working in a health care setting may also get in on the act; medical identity theft occurs when an uninsured person uses an insured person’s identity to obtain treatment for an illness or injury.

Causes of Health Care Fraud

Individual Influences

Forensic psychologists and criminologists study the individual causes and patterns of crime. Theories attempting to explain or predict criminal behaviors and patterns of crime are diverse. Some theories focus on individuals, others on crime-facilitative or “criminogenic” environments, and still others on some combination of individual and environmental influences. Each theory of crime
probably contains an element of truth, but none fully explains why certain people engage in criminal or corrupt acts.\textsuperscript{43}

An individual’s decision to commit health care fraud is a rational choice. Few criminals have lost touch with reality. To the contrary, most white-collar criminals are rational; they carefully weigh the risks and benefits of a crime. But some health care fraudsters, although legally sane, may have a personality disorder. Aaron Beam, the cofounder and former chief financial officer of HealthSouth, described the company’s infamous former CEO, Richard Scrushy, in the following fashion: “As brilliant as Richard was in his business dealings, he was equally diabolical, callous and cruel in his justification for attaining success. Unbeknownst to me from the outset was the fact that Richard was an egoist of the highest order, a consummate narcissist, likely a sociopath, and one of the biggest liars and fraudsters to ever lead a Fortune 500 company.”\textsuperscript{44}

Persons committing health care fraud—and white-collar criminals in general—can be divided into four categories: crisis responders, opportunity takers, opportunity seekers, and inadvertent offenders.\textsuperscript{45} Crisis responders commit crimes out of financial desperation. They may be overwhelmed by medical bills, a past-due mortgage, gambling debts, a drug habit, or other “unsharable” problem. Crime,
they believe, is the only way out of their financial embarrassment. Most crisis responders are first-time offenders with no prior arrests. They claim their crime is both their first and their last.46

Opportunity takers, though not experiencing a financial crisis, encounter an illicit offer they cannot refuse. Persons who are enticed into accepting lucrative kickbacks often fall into this category. As with crisis responders, opportunity takers may have no criminal record. In some cases, opportunity takers are first seduced by others into participating in a minor act of corruption. Once ensnared in the trap, they are forced into more serious crimes and, ultimately, into an inextricable situation.

Opportunity seekers are habitual criminals. They may engage exclusively in a life of crime or they may commit crimes on the side, often using their legitimate job or profession as a front for their illegal work. Some opportunity seekers prefer specific crimes such as health care fraud, whereas others are willing to participate in any criminal activity that offers high benefits and low risk. Opportunity seekers have usually had one or more encounters with the criminal justice system.

Inadvertent offenders mistakenly violate a law. The Stark Law, a federal civil statute, prohibits physicians from referring Medicare and Medicaid patients to a business such as a laboratory or radiology service if the physician—or an immediate family member of the physician—has a financial interest in that business.47 The term “financial interest” under the Stark Law is confusing, especially to a physician with no business or legal training. What makes this statute especially treacherous is that it imposes a strict liability on offenders; a physician who unknowingly violates the Stark Law faces civil sanctions no matter how well intentioned he may have been.48

Because fraud and abuse are hard-to-define terms, it is useful to ponder two questions: Are current definitions of “fraud” and “abuse” too broad? And are those who judge these actions—legal counsel, prosecutors, judges, and juries—able to tell the difference between a real crime and an honest attempt by a doctor or a therapist to provide needed care to a patient? The following are some dilemmas encountered by health care workers.

Medicare allows home care services only to patients who are “homebound.” These patients can leave their residences only infrequently and for a short duration; such absences must pose significant difficulty, inconvenience, or danger for the patient. In recent years, the definition of “homebound” has been relaxed to permit home health care patients to go to adult daycare facilities or to attend religious services. But this definition, some home health care nurses might say, is too stringent. Medicare investigators may observe an elderly patient sitting in a park across the street from his apartment and use this as proof that he is not homebound. Yet the man, desperate to leave the confines of his small apartment
to enjoy a breath of fresh air on a nice day, may be unable to clean his house, make his bed, or do his shopping and laundry. Is the visiting nurse service, which receives Medicare payments for providing home health care to this man, committing Medicare fraud?

Or what about hospice care? According to Medicare, patients are only eligible for hospice services if they are expected to survive six months or fewer. Patient prognoses, however, are often inaccurate. The Medicare program permits a patient’s physician to recertify her for an extended period of hospice care if she survives beyond the six-month limit as long as her condition is still regarded as terminal. Are physicians subject to prosecution for Medicare fraud if their patients live longer than expected or if the patient beats the odds and recovers from a terminal illness? Is this definition so stringent that it places an otherwise honest physician in an untenable position?

Or what of the obstetrician who knows her patient’s insurance plan does not cover annual checkups? In a well-intentioned effort to get her patient’s visit covered, she makes a notation in the patient’s medical records that she was complaining of a headache when, in fact, she was not. Does the doctor’s fudging the facts constitute fraud?

I also consider the flipside of this issue—whether the definitions of fraud and their associated penalties are sometimes too lax. Government prosecutors have extracted huge fraud settlements from large pharmaceutical firms and hospital chains. And, amazingly, it is usually the organization that bears the brunt of the punishment—along with its customers, shareholders, and other stakeholders. While these corporations take the heat, the actual perpetrators who engineered the fraud—the crooked administrators, doctors, or pharmaceutical-marketing representatives—may get away scot free. The real crooks not only avoid prison, but they often continue on with their professional lives without missing a beat. What does this historically lenient attitude toward white-collar criminals—especially those in the health care professions—tell us about our judicial system?

The stature of some health care fraudsters makes them unlikely criminal suspects; they may be board-certified physicians or professionals with advanced degrees who are leaders in their medical specialties and who are looked up to as role models and teachers. This fact raises questions about our health care system as well as about the educational institutions that produce the nation’s physicians. Given the undue influence of commercial interests on physician practices, are doctors being educated and mentored in ways that sometimes promotes unethical behavior?

But not all health care fraud perpetrators are highly educated professionals. Some are little more than street thugs who have acquired a superficial level of medical knowledge. Others have acquired an in-depth knowledge of health care information systems and insurance claims procedures. Professional differences aside, however, they often share traits such as insatiable greed, a sense of entitlement (“I will take
what is rightfully mine”), super optimism (“I am too smart to get caught”), and a superb ability to rationalize their illegal acts and assuage their guilt. Criminals may justify Medicare or Medicaid fraud, for example, by claiming these programs are operated by corrupt government officials bent on shortchanging health care providers and consumers. As Stanton E. Samenow, a forensic psychologist with more than forty years of experience evaluating criminals, has observed: “Despite a multitude of differences in their backgrounds and crime patterns, criminals are alike in one way: how they think. A gun-toting uneducated criminal off the streets of Southeast Washington, D.C., and a crooked Georgetown business executive are extremely similar in their view of themselves and the world.”49

Organizational Influences

Organizations both encourage or discourage criminal activities through their culture and compensation practices. As noted, organized crime groups traditionally involved in gambling, prostitution, drugs, loan sharking, and pornography have begun to turn their attention to health care fraud. Some health care institutions not associated with organized crime, however, have also grown increasingly corrupt. Health care executives in these institutions may engage in unethical behaviors, sending a strong message to their associates that mendacious practices are acceptable. The for-profit sector of the health care system—hospital chains such as Tenet, HCA, and HealthSouth as well as the major pharmaceutical companies such as the former TAP (now the Takeda Pharmaceutical Company) and Serono Laboratories—has witnessed some spectacular health care frauds. It seems that unprincipled executives in these corporations have developed a groupthink mentality that fosters feelings of invincibility. For repeat offenders, it appears that this sense of invincibility is chronic.

Some health care organizations have fixated so intensely on bottom-line finances that fraud seems to be an integral part of their business strategy. Others inadvertently encourage crime through poor financial controls, lack of secure information systems, and lax peer review. Furthermore, large organizations with complex structures and flexible work environments allow criminals to hide their illegal activities. And, if they are caught, these fraudsters may use the byzantine structure of their organization to sidestep responsibility or to diffuse blame. Thus, when a medical error, false prescription, unnecessary treatment, or inflated insurance claim is detected, it may be written off as an honest mistake rather than viewed as an illegal act.

Widespread health care fraud may be facilitated by hospital boards failing to exercise adequate oversight over institutional executives and managers. Major scandals at Enron and WorldCom were enabled, in part, by compliant boards functioning as rubber-stamp entities rather than as vigilant watchdogs. Similarly,
corrupt health care executives may hide their misdeeds from trusting board members. Hospital boards have been kept in the dark about clandestine illicit activities by hospital executives, or they have turned a blind eye toward fraudulent practices that, in some cases, have become part of the institutional fabric.

The Obama White House health reform director Nancy-Ann DeParle earned more than $6 million during the time she served on the boards of several major healthcare corporations. At least two of these corporations—DaVita and Guidant—were accused of fraud, mismanagement, and regulatory violations during DeParle's tenure on their boards. DaVita, a chain of dialysis centers, was being investigated for its billing and drug prescribing practices. Guidant, a medical equipment supplier, was being investigated for not disclosing the failures of some of its devices. No evidence has been found that DeParle contributed to or was even aware of the alleged illegal activities, but she did serve on board committees that were charged with overseeing legal and regulatory compliance. Is DeParle yet another Obama appointee—along with the "income-tax challenged" Ron Kirk, Timothy Geithner, Nancy Killefer, and Hilda Solis—with skeletons in the closet? And will DeParle's possible lack of vigilance detract from her ability to help bring reform to U.S. health care?

Furthermore, the Joint Commission on Accreditation of Healthcare Organizations, the accreditation body for health care institutions, has been the target of controversy because of ties between Joint Commission members and hospital board members—especially Tenet Healthcare Corporation, a company with a beleaguered history. In the case of Tenet, shareholders also got in on the act and formed the Tenet Shareholder Committee under the leadership of South Florida physician and attorney M. Lee Pearce. The shareholder committee spent eight years publicizing fraud and abuse at Tenet before dissolving itself at the end of 2008. The committee's parting shot at company executives came in the form of a lengthy web page that, among other things, leveled scathing criticism at Tenet's "overpaid, conflicted, and passive" board of directors.

Compensation practices can also encourage health care fraud and abuse. Many health care providers are paid by the number of patients they see or by the number of treatments or services they render, tempting them to overstate the amount of work they actually perform. And high-salaried health care executives may receive a significant portion of their compensation through stock options. Anyone familiar with recent financial scandals knows about the corrupting influence of equity-based pay—linking executive pay to a company's stock price. The UnitedHealth Group agreed to a settlement of $895 million with two pension plans, the California Employees' Retirement System and the Alaska Plumber and Pipefitter Industry Pension Trust. The lawsuit was precipitated by a stock option backdating scandal centering on UnitedHealth's former CEO, Dr. William McGuire. For his end of the settlement, McGuire agreed to forfeit
$420 million in stock option gains and retirement pay. Antitrust violations represent yet another avenue of health care fraud and abuse, when health insurance companies or providers fix prices at unreasonably high levels. At this writing, the Massachusetts Attorney General's Office was investigating whether the state's largest insurance company, Blue Cross Blue Shield of Massachusetts, and its largest healthcare provider, Partners Healthcare, engaged in illegal price collusion. This case is discussed more fully in chapter 4.

**Societal Influences**

Society influences crime in a general way. The most important societal influence on health care fraud and abuse is the health care system itself. The emphasis on generating high earnings in the for-profit segment of U.S. health care often breeds cutthroat competition. Many cities have several hospitals, creating battles over personnel, patients, contracts, and resources. This commercial warfare may encourage hospitals and suppliers to offer kickbacks, physicians to self-refer, admissions personnel to treat unprofitable Medicaid patients with scorn as well as engaging in other fraudulent, wasteful, and unethical practices.

Western societies, in general, and the United States in particular, equate economic well-being with individual advancement and personal worth. Geert Hofstede's analysis of cultural differences among countries worldwide ranks the United States as the single most individualistic nation: "The high individualism (IDV) ranking for the United States indicates a society with a more individualistic attitude and relatively loose bonds with others. The populace is more self-reliant and looks out for themselves and their close family members." A focus on the individual, rather than on the social good, can encourage people to ignore how their actions might impact others. Furthermore, individuals in the health care fields are among the brightest and most ambitious of all professionals.

Before the economic bubble burst in 2008, the accumulation of wealth—seemingly without much consideration as to how that wealth was obtained—became an obsession for some highly driven, narcissistic, and even antisocial doctors, politicians, lawyers, and executives (both on Wall Street and off). Add to this the fact that health care occupations rank high in status and autonomy. Many physicians—although not always perpetrators—may act as enablers to many forms of fraud and abuse. Why? Is there something about the high status of doctors that, at least in their minds, exempts them from legal and ethical guidelines?

As analysts of professionalism have pointed out, society historically has given physicians the power to regulate themselves because they were supposed to act altruistically to protect their patients. Modern critics have debunked the myth of self-regulation. But has society's traditional hands-off approach encouraged or enabled some health care professionals to misuse their status?
A strict hierarchy of authority exists among health care providers, placing the medical doctor at the top. Being in an unassailable position allows the acts of a crooked doctor to go undetected or unchallenged. Some people joke that M.D. stands for “major deity.” In the case of fraud and abuse in health care, it seems that some M.D.s—albeit a minority—believe they have sole discretion in deciding whether an act is justifiable and ethical and whether to obey the law. Fleecing patients and their insurers by providing overpriced or unnecessary services and then justifying these excesses in the name of free-market forces or better health care is a temptation that some providers cannot resist.

Another aggravating issue is that, when it comes to the health care professions, information asymmetries are everywhere. Doctors, nurses, and other health care professionals have more knowledge of medicine than do their patients, reducing the likelihood that their professional decisions will be questioned. Furthermore, information technology has become an integral part of health care, and it has improved tremendously the management of patient medical information. This technology, however, has also enabled persons—both authorized and unauthorized—to make illicit transfers of money, to steal information, to submit fraudulent insurance claims, to gain unauthorized access to patient medical records, and to cover up acts of fraud.

The Salient Features of Health Care
Fraud and Abuse

Health care frauds come in all shapes and sizes, but they are similar to other white-collar crimes. One obvious similarity is the illicit transfer or misappropriation of money and resources. But there are more.

The success of many crimes, whether perpetrated by an urban street hustler or by a sophisticated white-collar criminal, often depends on gaining the victim’s trust. And health care fraud and abuse often entail an abuse of trust between patient and provider. A Wisconsin psychiatrist was arrested after a criminal complaint charged him with three acts of sexual misconduct with a female patient. The patient told detectives that she and her doctor had sexual contact “during a number of their therapy sessions.” A fifty-six-year-old Delaware pediatrician was charged in February 2010 with the molestation of 103 children. Labeled as “pure evil” and as one of the “worst pedophiles in U.S. history,” the doctor faces a 471-count indictment. If convicted, he faces a life sentence without parole. But putting these doctors behind bars will probably do little to lessen the horrible psychological damage to their innocent victims and their families. These two cases exemplify some of the worst that our health care system has to offer.

As with the Blue Code of Silence for police officers, health care workers and other professionals may feel pressures to protect their own. But perhaps a less-obvious
concern of whistle-blowers is the fear of “no good deed going unpunished.” Doctors at a Tennessee eye clinic turned in one of their colleagues after they discovered he had cheated Medicare out of $1.6 million. For their honesty and because they were saddled with a dishonest business partner, the eye-doctors-turned-whistle-blowers had to pay back hundreds of thousands of dollars to the federal government. They also had to write off about $300,000 in expired drugs (the medicine was seized by federal authorities as evidence), cover the costs of an internal investigation, and endure a civil lawsuit.

Health care fraud often inflicts bodily injury or even death on its victims. Medical injuries and deaths may be precipitated by incompetency, negligence, fraud, and abuse. These injuries have led to a degree of unnecessary human suffering—a suffering that has been described as “the equivalent of a 747 airplane crashing every day of the year.” White-collar crimes are often regarded as nonviolent. But, according to the FBI, a significant trend observed in recent health care fraud cases is the willingness of medical professionals to devise schemes that risk harming patients. Recommending unnecessary surgeries, prescribing dangerous drugs, and engaging in other abusive or substandard practices imperil the lives of unsuspecting patients. In many jurisdictions, the fee-grubbing surgeon who wields a scalpel to remove a healthy gall bladder is subject to the same criminal charges as the street hoodlum who wields a knife to stab his victim during a back-alley mugging.

The Dynamics of Health Care Fraud

Health care fraud is always a moving target. White-collar criminals commit fraud because health care systems or organizations and society provide them with the opportunity to do so. When fraud becomes widespread, society and organizations take measures to stop it. The U.S. Congress and state legislatures have enacted laws to deal with white-collar crimes in general and health care frauds in particular. Furthermore, public officials may beef up the enforcement of existing laws. Media exposure and heightened public awareness of health care fraud may also make such crimes more difficult to commit. Organizations may attack health care fraud by bolstering security, reconstituting auditing practices, training employees in fraud detection, or aggressively prosecuting those caught engaging in illegal activities.

As society and organizations try to curtail fraud, criminals also make adjustments. Some fraud artists may decide that certain crimes have become too risky, so they shift their efforts to other crimes or forego illegal acts altogether. Other criminals adapt to the new societal and organizational measures and continue committing health care fraud by employing new strategies.

Thus, health care fraud is ever changing. Types of frauds committed twenty years ago may have fallen by the wayside only to be replaced by newer and more
innovative ones. Although criminals as a group score lower on intelligence tests than do law-abiding citizens, those committing health care fraud are often quite ingenious, especially when it comes to developing new fraud schemes.

Victims of street crimes such as robbery or assault are immediately aware of their predicament. Victims of financial crimes such as identity theft or credit card fraud are usually aware within a few days of the transgressions against them. Many health care frauds, on the other hand, are invisible. Criminals use the vastness of the health care system or the trust and ignorance of their victims to hide their misdeeds. They depend on the fact that a bogus insurance claim appears normal or that a health insurer is more concerned about processing claims efficiently than about detecting fraud. In other instances, criminals bank on their victims either not realizing a fraud has occurred or not reporting a suspected case of health care fraud to authorities—possibly because of personal embarrassment, fear of legal action by the health care provider, or concerns that they will lose their health insurance coverage.

If a category of crime cannot be detected or reported consistently, then it cannot be measured accurately and analyzed intelligently. Although health care fraud remains an enigma, clear evidence exists that it is a major social problem costing U.S. consumers and taxpayers billions of dollars a year. As health care expenditures also increase, fueled by an expansion of health care insurance coverage and an aging population, fraud and abuse will continue to affect millions of potential victims. It is clear that perpetrators of health care fraud and abuse are usually intelligent individuals who are skilled at avoiding detection, rationalizing their misdeeds, and adapting to changing conditions. They have learned how to leverage their professional status or to capitalize on security weaknesses and legal loopholes in the health care system. Public and private organizations will have to step up their efforts to combat fraud and abuse, and our society will have to examine cherished values and entrenched hierarchies if we want to stop the fraud and abuse that is draining our system of billions of health care dollars and putting patient lives at risk.

The criminals described in this book steal billions of dollars from consumers, providers, insurers, and taxpayers. Thefts committed by these crooks not only inflict pain and suffering on their victims, but they undermine the workings of the U.S. health care system. An understanding of health care fraud and abuse should begin with a discussion of health care law—a topic addressed in the following two chapters. But antifraud and abuse laws are of little value unless resources are provided to enforce them. So, as another presidential administration takes a stab at health care reform, such efforts—no matter how well intentioned—are doomed to failure unless we have both a plan and the resources to fight this monumental problem.