Conclusion

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CONCLUSION

Back to the Beginning

My father’s ambulance ride and the fraudulent charges billed for that ride marked the beginning of an ordeal for my family. He spent the last weeks of his life in and out of hospitals and finally in a nursing home. But at ninety-two his deteriorating health had finally caught up with him, and he passed away quietly one early Sunday morning. Losing an elderly parent is traumatic not only because of the personal grief but because of the complications that follow. My father understood the importance of having good insurance coverage. He also kept detailed records, making sure his affairs were in order so that we could settle matters quickly and get on with our lives.

Trouble began in the weeks following my father’s death. My mother received over $150,000 in medical bills for my father’s care during his final days. The bills seemed to come from every direction, and they were submitted by a variety of providers, most of whom my mother did not recognize. Were the charges for these services legitimate? My mother had no idea what treatments and drugs my father may have received. They were often given to him when she was not present at the hospital or nursing home. Furthermore, some of the explanations on the EOB statements were so complicated that they were nearly impossible to decipher. How were the amounts listed on the bills calculated? When we contemplate buying a new car, for example, we search the Internet to determine the manufacturer’s suggested retail price, and then we get firm quotes from several dealers before deciding on which car to purchase. But in health care, we
accept—often blindly—the charges presented to us. The traditional economic forces of supply and demand seem to have little relevance to doctor's bills and hospital charges, and shopping for the best deal and haggling over price are unheard of in health care.

She had to deal with insurance coverage. How much of my father's medical expenses were covered by insurance? Which insurance plan—Medicare or Blue Cross Blue Shield—had primary responsibility for paying the charges? How did the deductibles and copayments apply? Listening to the recorded telephone instructions and getting the runaround from Social Security and health insurers is part and parcel of trying to settle the affairs of someone who has recently died. Should my mother pay the bills she received or wait for the insurers to pay? Could she expect my father's insurers to identify fraudulent charges? If the insurers dragged their feet or refused to pay some of the charges, then what recourse would she have in trying to settle my father's affairs? Once you are faced with the dilemma of losing a loved one and are forced to work "down in the trenches," health care issues and the prospect of fraud take on a new meaning. These issues also bring a deeper meaning to our earlier discussion of the complex—and seemingly criminogenic—U.S. health care system, with its vast flows of money and its many points of accessibility for fraud perpetrators (Fig. 1).

Back to the Basic Questions

At the outset, I delineated several broad questions that are integral to health care fraud and abuse. Now that we have explored the salient issues, I would like to return to these questions.

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 her 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?

The definitions of fraud and abuse have broadened over time, and neither these definitions nor the laws designed to stop health care fraud and abuse should be expanded further. But we need to be more persistent and aggressive in using the existing definitions and laws to curtail this major social problem. Federal and state authorities should probably spend their investigative and prosecutorial dollars on the mainstream frauds and avoid venturing into questions of overutilization. The latter should be addressed by the AMA or other professional associations and only when a doctor or other provider clearly places his financial needs above the legitimate needs of his patient or client. Of the cases discussed
in this book, almost all involve flagrant violations of the law—usually to the extreme detriment of patient care. Since the vast majority of these cases fall well outside the gray areas, I believe that those working in the criminal justice system should be able to make intelligent evaluations and decisions about health care fraud and abuse. Of course, allowing those without health care education and training to make these decisions hastens the deprofessionalization of the health care professions.

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 types of health care fraud and abuse? Are more antifraud 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?

The current laws, as written, should provide effective measures for dealing with major and repeated violations of fraud and abuse. These laws and their accompanying, regulations, administrative manuals, and advisory opinions, however, go too far in trying—and I emphasize the word “trying”—to cover every conceivable aspect and scenario of health care fraud. Unfortunately, this regulatory quagmire not only leads to micromanaging by government officials, it also imposes severe burdens on the vast number of honest health care providers. Time and money spent on regulatory activities is time and money taken from patient care.

Economic theory posits that we should continue with an endeavor until its marginal costs exceed its marginal benefits. So, following economic theory, the government should continue prosecuting cases until the costs incurred—such as the investigation, court, and imprisonment costs—exceed the benefits derived from these cases. Benefits include settlement payments, the forfeiture and sale of property acquired through criminal means, better patient care, and less fraud in the future. As noted earlier, the government has obtained substantial yields for every dollar spent on prosecuting a high-profile health care fraud and abuse case. Of course, the government has gone after the low-hanging fruit with the deepest pockets—namely, the pharmaceutical firms, the hospital chains, and the large medical supply companies. The government is also just adding up the costs of arresting, investigating, trying, and incarcerating violators and comparing these costs with the settlement amounts they extract—usually on the courthouse steps. They have no way of precisely measuring the economic, psychological, and social toll of health care fraud on its victims.

Even though the economic theory suggests that the government should continue to prosecute fraud and abuse cases until marginal costs equal marginal benefits, such an analysis creates two problems. First, government prosecutors have cases outside the health care arena that are vying for their
Prosecutors, whether they admit it or not, are susceptible to public pressure—especially the pressure to give priority to the prosecution of violent crimes (e.g., murders, terrorist activities, and violence induced by drug trafficking). This pressure, in part, explains why nonviolent crimes such as health care fraud often end up in civil courts. Not surprisingly, prosecutors may take action only on those cases where the marginal benefits vastly exceed the marginal costs.

Second, no comprehensive, nationwide database exists for tracking health care fraud and abuse. The FBI, however, does have a comprehensive database for violent crimes and property crimes. If we cannot measure the magnitude or the damage caused by a social problem such as health care fraud and abuse, then we cannot know how many resources—in this case, how many hundreds of billions of dollars—should be allocated to fighting it. So, without a solid database on which to build good decisions, and with only the roughest notion as to how to measure the psychological and social impact of health care crimes, we are hard put to know when we have met the cost-benefit threshold.

Are certain institutional arrangements such as fee-for-service or capitation plans more 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?

In this book, I have provided an abundance of examples of health care fraud and abuse in almost every major institutional setting. Logically, fee-for-service arrangements and for-profit institutions should be plagued by frauds on the revenue side of the income statement, whereas capitation plans and not-for-profit institutions should be plagued by frauds on the expense side of the income statement. In reality, this distinction does not hold true. Both the revenue and expense sides of the income statement are highly susceptible to fraud. Although for-profit hospitals and clinics seem to have a stronger incentive to cheat than their not-for-profit counterparts, both segments of the health care system—in the United States and elsewhere—have staggering amounts of fraud and abuse. And, of course, fraud and abuse among for-profit pharmaceutical companies, labs, and equipment manufacturers is especially pernicious.

A major theme of this book is that the individual perpetrators—not the particular characteristics of a health care system—are at the root of fraud and abuse. More aggressive prosecution along with harsher penalties for crooked providers, expanding consumer education, better information technology, improved statistical fraud detection devices, and a greater sense of urgency among health insurers to combat fraud all offer the potential for effectively attacking this major social problem.

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?

The common ground for these diverse groups is twofold: first, reducing health care costs and, second, spending time and money on improving the health of the population rather than on detecting and fighting fraud and abuse. As has been illustrated amply throughout this book, the cost of health care fraud is borne ultimately by the consumer in the form of higher hospital and doctor bills, more expensive pharmaceuticals and other health care products, and escalating health insurance premiums. As long as the health care buck—in the form of higher and higher costs—is passed to the consumer, we will see little headway in reducing health care fraud and abuse. A two-pronged approach will be necessary to reduce the problem.

First, we must recognize that fraud and abuse start with health care providers. So, the message must be sent that harsh penalties—incarceration, fines, and forfeiture of assets—will be imposed on individuals who commit major or repeated violations. Providers must also comprehend, perhaps through their professional associations or industry training programs, how fraud and abuse is leading to their depersonalization.

Second, we must understand that the health care consumer is the first line of defense against fraud and abuse. A major mode of attack is to cast a wide educational net—using television and newspaper advertisements, magazine articles, private organizations such as AARP, community volunteer groups, and flyers mailed to Medicare and Medicaid recipients—to inform health care consumers about how fraud and abuse can affect their lives and how they can take an active role in reporting and stopping it.

This two-pronged strategy for reducing health care fraud and abuse is in sync with the interests of public and private insurers and government enforcers. Reducing fraud and abuse should drastically reduce health care costs. But litigation and incarceration costs may rise, at least in the short run, as errant health care providers are prosecuted.

What demographic changes will affect the future of the health care system, and will these changes exacerbate or diminish health care fraud and abuse? Most books about a major social problem end on an optimistic note by suggesting ways to eliminate whatever problem the book was addressing, and I have tried to do the same by suggesting a number of measures that may alleviate the problem. Unfortunately, health care fraud and abuse are not going to disappear—far from it.

Unless preventive efforts are increased substantially, demographic and economic trends suggest that the problem may become even worse. The aging post-World War II baby boomers will be consuming more health care services and products and, within a few years, they will become heavily dependent on the
Medicare program. At this writing, the U.S. economy has plummeted to levels that are unprecedented since the Great Depression. Harsh economic times will place a greater burden on the Medicaid program as unemployment levels rise and as more individuals become eligible for public assistance. Since both the Medicare and the Medicaid programs are major targets for health care fraud, the prospects of reducing the problem appear bleak.

The World Health Report 2000, published by the World Health Organization and mentioned briefly in the introductory chapter of this book, proposed three goals for a health care system. The first WHO objective, ensuring the good health of the population across the entire range of ages, is affected by health care fraud and abuse because of its disproportionate impact on low-income and the elderly people. The second WHO objective, health care providers who respond to people’s expectations and treat them with respect and dignity, is affected less by fraud and abuse, although one could argue that fraud and abuse are clearly affronts to human dignity. The third WHO objective, developing a system of health care financing that is fair and that is based on a person’s ability to pay, is directly affected because fraud and abuse increase all health care— and health care insurance— costs.

Cause for optimism still exists, however. The U.S. health care system and similar systems in other developed countries are amazingly resilient. With size and complexity comes the ability to absorb and jettison problems that, at least in theory, should be catastrophic. But we should not hope that our system of health care will just roll with the punches and absorb the blows of health care fraud and abuse. Fighting back is a far better solution.