

On My Mind

Scamming Uncle Sam

Why is Medicare fraud so rampant? By Merrill Matthews

FANS OF THE RECENT HEALTH CARE legislation say that it will strengthen the Medicare program by cracking down on fraud, waste and abuse.

Good luck. The Centers for Medicare & Medicaid Services acknowledge \$47 billion a year in “questionable claims” (i.e., fraud) in Medicare—about 10% of the program’s \$480 billion budget. Attorney General Eric Holder puts fraud even higher, at maybe \$60 billion. In contrast, private-sector health insurers, which spend more than \$600 billion a year on claims, keep the fraud rate to 1.5% (by my colleagues’ and my estimate).

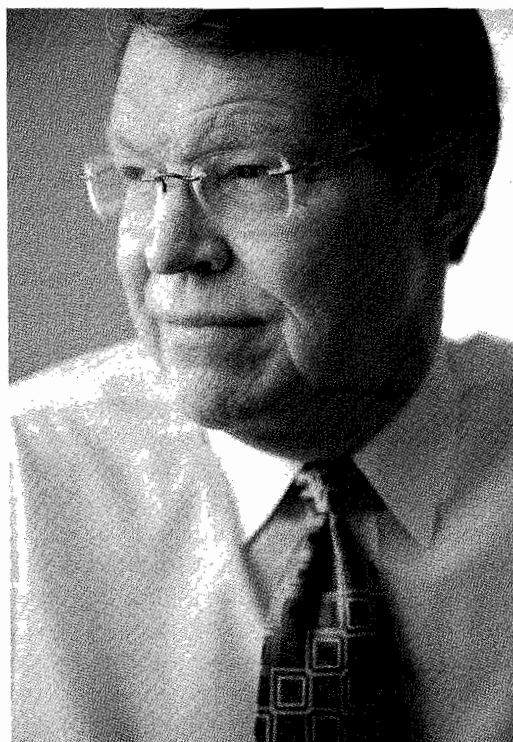
Why the difference? The government writes reimbursement checks without investigating claims, while private-sector health insurers monitor claims before they pay them.

Government agents go after the crooks if they see a pattern of abuse—a system referred to as “pay and chase.” This approach has created a bonanza for criminals who can stay one step ahead of the agents. But when a claim comes into a private company it is entered into the computer system, which performs several routine checks. If a red flag emerges, the insurer will check further, perhaps calling the provider for clarification and holding the reimbursement until any discrepancies are resolved.

Of course, there is a cost (roughly 3% of claims paid) for asking extra questions about a selected subset of claims. But properly adjudicating claims is money well spent on the front end because it saves billions of dollars on the back end.

If Medicare were to adopt even some of the private sector’s preclaim-adjudication processes, the government could save a lot of money. Getting Medicare’s fraud rate down to the private sector’s 1.5% would mean a savings of perhaps \$40 billion or \$50 billion a year. This sum does not include what could be saved by reducing fraud in Medicaid.

To be sure, Congress and several federal agencies have tried over the past few years to reduce fraud, and those efforts have paid off. But it’s a pittance. The Department of Justice claims to



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have recovered \$1.48 billion in 2008—but it spent \$1.13 billion to get it. The Obama Administration says the new health care reform law will do more, but it’s mostly more of the same pay and chase.

Why is defrauding Medicare such a big business?

First, it’s easy to break in (so to speak). All you need is a computer and a database of seniors’ Medicare information, which is often available for sale on the black market. Second, the profits are much bigger than what can be obtained from other criminal activities, like bank robbery. Third, scamming Medicare isn’t as dangerous as some other crimes. Criminals can scam Medicare and Medicaid from anywhere. If they get caught, there are no back-alley murders.

Finally, penalties are much lower. Get caught dealing drugs and they may lock you up and throw away the key. Get caught defrauding Medicare and you may be out in a few years with good behavior, whereupon you can start up the business again.

But apart from comprehensive changes, even smaller steps would help. Former Kentucky Health & Family Services Secretary Mark Birdwhistell says that state Medicaid agencies can’t coordinate with Medicare. That’s a problem, since about 9 million Medicaid recipients also belong to Medicare (dual eligibles). That lack of coordination, Birdwhistell says, opens the door to duplication of services and fraud. California tried sharing the databases a few years back and saved an estimated \$60 million.

The Administration should be commended for increasing its antifraud efforts, but it doesn’t have long to get it right. Health care reform will soon put most health insurance under federal oversight. If the federal government doesn’t get much better at stopping fraud before it occurs, health care reform will do more for the crooks than for the uninsured. **F**

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