United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health,
Committee on Ways and Means,
House of Representatives

For Release on Delivery
Expected at
2:00 p.m.
Monday
March 8, 1993

HEALTH INSURANCE

Remedies Needed to Reduce Losses From Fraud and Abuse

Statement of Janet L. Shikles, Director
Health Financing and Policy Issues
Human Resources Division

SUMMARY

Health insurance experts estimate that fraud and abuse contribute to some 10 percent of the $800-plus billion currently spent on health care. Unscrupulous billing practices by physicians, medical equipment suppliers, and other suppliers constitute a significant part of the fraud and abuse problem. These practices include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

Several obstacles frustrate insurers' efforts to prevent or detect and pursue cases involving fraudulent or abusive billing: (1) Health insurers operate independently and face various constraints on coordinating detection and investigation efforts. (2) Criminal prosecution and civil pursuit of fraud are expensive and time-consuming, and private insurers as a group cannot take administrative actions, such as stopping a provider convicted of fraud by one payer from billing other payers. (3) Insurance and law enforcement resources are seriously limited for detecting and pursuing health care fraud.

Overcoming these obstacles will require insurers, law enforcement agents, regulators, and providers to collaborate systematically on problems involving health insurance fraud and abuse. In 1992, GAO suggested that the Congress establish a national commission to develop recommendations on such issues as greater standardization of claims, the need for greater regulation of nonhospital facilities, model state statutes covering kickbacks and other fraudulent practices, and the use of administrative remedies by private insurers. More recently, a federal task force--composed of the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and the Attorney General--has made recommendations addressing many of these same health care fraud and abuse issues.

Resource constraints also add to the problems of pursuing health care fraud. Federal agencies significantly involved in this pursuit cite limited resources as a problem. For example, in the Office of the Inspector General of the Department of Health and Human Services, the number of investigators has declined over the last 5 years, while the agency's statutory responsibilities covering investigations of federal programs have increased significantly. Without adequate resources, investigation and pursuit of much of the health care fraud is not possible.

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to testify today on health care fraud and abuse and the need for better remedies and more resources to combat the problem. Recently we reported on such federal programs as Medicare that are at risk of substantial losses to waste, fraud, and abuse.[1] We have also, over the past year, issued several other reports addressing aspects of health care fraud and abuse. Briefly, our work has shown that all health care payers are vulnerable to fraud and abuse and that significant obstacles hinder the prevention of dishonest billing practices and the pursuit of health care profiteers.

To discuss these issues in greater detail, I will address the size and nature of health insurance fraud and abuse, and review the obstacles that frustrate efforts to detect and investigate health care fraud cases.

SIZE AND NATURE OF HEALTH INSURANCE FRAUD AND ABUSE

In our work we cite an estimate made by health industry experts that fraud and abuse add some 10 percent to U.S. health care's costs,[2] which currently exceed $800 billion. Because of the hidden nature of fraudulent and abusive practices, however, the exact magnitude of the problem cannot be determined.

Fraud and abuse encompass a wide range of improper billing practices that include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services. Both fraud and abuse result in unnecessary costs to the insurer, but fraud generally involves a willful act.

As a practical matter, whether and how insurers pursue a wrongful act can depend on the size of the financial loss incurred and the quality of the evidence establishing intent. For example, small claims are generally not pursued as fraud because of the cost involved in investigation and prosecution.

Health care fraud has expanded beyond single health care provider fraud to organized activity affecting health care programs in both the government and private insurance sectors. For example, one fraudulent scheme that has troubled public and private payers

---

[1]Medicare Claims (GAO/HR-93-6, December 1992) and Government Management--Report on 17 High-Risk Areas (GAO/T-OCG-93-2, Jan. 8, 1993).

[2]Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

in California over the past decade is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. The scheme centered around soliciting people with health insurance to go to mobile labs, called "rolling labs," for noninvasive tests, such as heart and blood-pressure measurements. Frequently, the laboratories and the referring physicians used phony diagnoses in submitting the insurance claims.

Thus far, the outcome of this scheme is that the owners have been both sued and prosecuted successfully, yet virtually no monies have been recovered. Also, at least six similar schemes are known to be operating in southern California. Schemes of this nature highlight several serious problems facing public and private payers. First, large financial losses to the health care system can occur as a result of even a single scheme. Second, fraudulent providers can bill insurers with relative ease. Third, efforts to prosecute and recover losses from those involved in the schemes are costly. Finally, schemes can be quickly replicated throughout the health care system.

Losses to fraud and abuse stem from several problems that do not fall into mutually exclusive categories, but in general include the following:

-- Health insurers operate independently and are constrained legally and administratively from collaborating on efforts to pursue fraudulent providers. Ultimately, even when fraudulent providers get caught by one insurer, they can continue billing other insurers.

-- Criminal prosecution and civil pursuit of fraud is expensive, slow, and has been shown to have little chance of recovering financial losses. Moreover, private insurers are largely without access to the administrative remedies of the public payers, such as the ability to exclude providers convicted of health care fraud from billing the public programs.

-- Insurance and law enforcement resources are not sufficient to detect and pursue much of the health care fraud.

HEALTH INSURANCE SYSTEM HIGHLY VULNERABLE TO FRAUD AND ABUSE

Now I would like to explore a few characteristics of the environment in which the billion-dollar rolling-labs scheme was able to flourish.

-- First, over a thousand payers process 4 billion claims a year to pay hundreds of thousands of providers using different payment methods and billing regulations.

-- Second, providers' claims are paid by many insurers, making billing patterns hard to identify. Thus, a provider who bills for more services than can normally be provided in a single day might not be discovered when claims are split among many insurers.

-- Third, sharing data among autonomous insurers for the purpose of detecting aberrant billing patterns is largely not feasible for two reasons. First, laws protect the privacy of patients' medical records. And second, the data collected on insurance claims are quantitatively and qualitatively different for each insurer.

Additional factors hamper efforts to develop a case against a provider suspected of health care fraud. For example, many "freestanding," or nonhospital, facilities, which perform such procedures as diagnostic testing and pain management, are not licensed in many states and are therefore more difficult to monitor. Insurers are limited in their ability to trace and hold accountable the source of fraudulent billings in these unlicensed medical facilities. Also, physicians frequently invest in medical facilities and are not always required to disclose their investment in facilities to which they refer patients. Insurers, however, have no systematic way of monitoring referral patterns.

Finally, prosecuting health insurance fraud entails another set of problems:

-- Successful prosecutions may take years, involve an investment of considerable staff time and financial resources, and may not result in insurers recovering their money.

-- The nature of certain laws can impede private insurers' efforts to pursue fraud. For example, some states lack anti-kickback statutes that prohibit physicians from profiting from referrals. Furthermore, the language of anti-kickback statutes is so broadly written that in states with these laws there is much debate surrounding their use and therefore a reluctance to enforce them.

-- In some jurisdictions, federal prosecutors may not accept criminal health care cases involving less than $100,000 because of limited resources.

Diverse and autonomous insurers have few established means of collaborating systematically to solve these problems. In our view, if the efforts of independent payers, public payers, and state insurance and licensing agencies, as well as state and federal law enforcement agencies, were more coordinated, the attack on health care fraud and abuse would be more fruitful.

In 1992, we asked the Congress to consider establishing a national health care fraud commission to develop recommendations on such issues as

-- greater standardization of claims,

-- mechanisms to allow for the exchange of information among insurers and others without undermining privacy and antitrust concerns,

-- the need for greater regulation of nonhospital facilities, and

-- model state statutes covering kickbacks and other fraudulent practices.

More recently, a federal task force consisting of the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and the Attorney General has made recommendations addressing many of these same health care fraud and abuse issues.

RESOURCE CONSTRAINTS HAMPER INVESTIGATIONS AND PROSECUTIONS

Resource constraints also add to the problems of pursuing health insurance fraud. A single large fraud case can consume significant investigative and prosecutorial resources, leaving other cases unpursued. For example, in the case of the rolling labs scheme, California state investigators told us that similar schemes allegedly operating in the same geographic area were not likely to be investigated or prosecuted until the rolling labs case had gone to trial.

The lack of investigative resources has constrained two federal agencies significantly involved in pursuing health care fraud--the Department of Justice and the Office of the Inspector General in the Department of Health and Human Services (HHS).

At least until recently, Department of Justice efforts to combat health insurance fraud have been adversely affected by resource constraints. Recognizing the need for additional resources to address health care fraud, the Federal Bureau of Investigation reassigned 50 agents from other areas to health care. This means that a total of 150 agents nationwide will be devoted to health care cases. At the same time, the Department of Justice assigned 10 new positions to enforce a health care fraud initiative and formed a health care fraud unit within its criminal division.

The HHS Inspector General continues to cite resource limitations as a major impediment to investigating and pursuing many types of fraud and abuse. For example, the number of Inspector General investigators has declined during the last 5

years, though the Inspector General's statutory responsibilities, and the size and complexity of the federal programs that the Inspector General investigates has increased significantly. What this means is that in many localities the Inspector General has few people to investigate health insurance fraud. For example, until recently, the Inspector General had less than two full-time people working on health fraud in southern California, where rolling-labs schemes have been prevalent.

Such investigative resource limitations can discourage Medicare claims processors--involving some 80 contractors across the country--from developing cases to refer for further action. That is, the contractors depend on the Inspector General to pursue fraud cases, and when contractors anticipate that few cases will be accepted for further investigation, they have little incentive to develop any but the most egregious cases for referral.

CONCLUDING OBSERVATIONS

Only a fraction of the fraud and abuse committed against the health care system is identified and prosecuted and that which has been detected has involved substantial sums. Without adequate resources, investigation and pursuit of much of the health care fraud is not possible. Currently, dishonest providers can continue operating, in part, because of the lack of staff and money dedicated to pursuing them.

However, added resources alone will not succeed in overcoming fraud and abuse in the health insurance industry. We believe that the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies need to be better coordinated. This would facilitate overcoming the systemic obstacles that hamper efforts to address health care fraud.

* * * *

Mr. Chairman, this concludes my testimony. I'd be pleased to answer any questions.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1000
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (301) 258-4066.

United States
General Accounting Office
Washington, D.C. 20548

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100