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Corruption in health care systems: the US experience

Malcolm K. Sparrow[1]

The United States spends more on health care than any other industrialised country, with national health expenditures in 2003 exceeding US $1.6 trillion.[2] This represents 15.3 per cent of the country's GDP, up from 5.7 per cent in 1965, and 8.8 per cent in 1980.[3] Despite the extraordinary level of spending, health care economists have traditionally paid very little attention to corruption, fraud, waste and abuse in the US health care delivery system. They do not factor it into their cost models, they say, because 'there is no data on that'. There is certainly a paucity of reliable data on the extent of corruption in the system, and few reliable estimates of how much of each health care dollar is actually lost to criminal enterprise.

As a risk to be controlled, fraud and corruption in the health care system exhibits all the standard challenges of white-collar crime: well orchestrated criminal schemes are invisible by design and often go undetected. Investments in control are based on

the visible (that is, detected) sliver of the problem, rather than on its underlying scale or any valid statistical or scientific estimates of its magnitude.

Despite the essentially invisible nature of the problem, health care fraud in the United States was deemed sufficiently serious by the Clinton administration (based on cases revealed) that in 1993, Attorney General Janet Reno declared it America's 'number two crime problem', second only to violent crime. This signalled a level of concern over health industry integrity without precedent in the United States, and perhaps around the world.

Characteristics of the US system

Despite high levels of public sector spending on health care,[4] the health system involves comparatively few public sector officials or employees in frontline service delivery roles. Therefore, if one adopts a definition of corruption restricted to 'abuse of *public* authority', most health care fraud issues do not quite fit. But the broader definition, 'abuse of *entrusted* authority', does cover dishonest actions of physicians, hospitals and other health care professionals, who are generally afforded high social and professional status and are expected to exercise professional medical judgement unbiased by private financial interests. The majority of fraud within the system, perpetrated by medical providers, can therefore be understood as corruption under this definition. For example, when physicians accept payment to hand out unnecessary prescriptions as part of pharmaceutical recycling scams, 'con' patients into treatments they don't need, or submit bills to public programmes for services that were never provided, they would surely be seen by most members of the public as having abused the trust placed in them as medical professionals.

The US health system has a number of distinct features that make it vulnerable to corruption:

- **Health care delivery is largely contracted out.** Health care is mostly delivered by the private sector, or independent, not-for-profit entities. But the services are *paid for* by government programmes such as Medicare (federal programme for the elderly) or Medicaid (state-run programmes for the poor), or by commercial insurers who offer health insurance to individuals, to groups or to employers (who buy coverage for their employees as an employment benefit). This means that payers have no reliable information about which services were performed, or were necessary, other than the word of the providers.
- **Fee-for-service structure and payment on trust.** The majority of services are reimbursed on a *fee-for-service* basis, despite the recent development of alternative structures such as capitation (where the entity contracts to deliver necessary care in exchange for a fixed revenue stream per patient per month), and other 'managed care' systems. Under the fee-for-service structure, health care providers (doctors, hospitals, specialists, and so on) are trusted to determine the appropriate levels of care, and then trusted to bill the insurer for the services they perform.

- **Medical suppliers and providers constitute main loci of corruption.** The principal opportunity for theft lies with providers rather than patients. Patients can only cheat on their own accounts, and to a limited extent if they are to avoid tripping various flags or alarms. So the prevalence of patient-orchestrated fraud is constrained to some degree by the proportion of dishonest patients. By contrast, providers and their billing agents are in a position to submit false or inflated bills in high volumes, spreading the activity across hundreds or thousands of patient accounts. Providers thus have a *business opportunity* in dishonest conduct, and relatively few dishonest actors can do disproportionate amounts of economic damage to the system. Most significant cases of corruption have involved medical professionals, providers and corporations in the health care delivery supply chain.
- **Highly automated payment systems.** Fee-for-service payment systems are now consolidated into massive, highly automated payment systems. Electronic submissions transmitted into the system (in the form of claims for services rendered) result in computerised dispatch of electronic payments. The bulk of such claims are paid through *auto-adjudication*, which means the claim was received, subjected to a rules-based examination, approved and paid, all electronically, with no human scrutiny. Such payment systems make very attractive targets for fraud. An extraordinary range of actors have been found lining up to defraud these systems, ranging from blue-collar individuals (who can sign on as suppliers of medical equipment for a small fee, without any training, and proceed to submit bills without ever seeing a patient); to major corporations, such as hospital chains and pharmaceutical companies; to drug traffickers (reported by the FBI as switching to health care fraud because it was safer and more lucrative than trafficking, and with lower chances of detection); to organised crime groups and gangs.[5]
- **Absence of verification and focus on processing accuracy.** The bulk of claims are therefore paid electronically, and on trust. The whole system is designed with honest physicians in mind, incorporating the values of speed, efficiency, accuracy, predictability and transparency. The edits and audits (automated sets of rules) built into computerised claims-processing systems serve the purpose of checking pricing, policy coverage and medical orthodoxy (based on the diagnosis reported in the claim). But the control systems generally assume the claim itself to be true, and do little or nothing to verify that the patient actually received the services claimed, or even that the diagnosis was real. To exploit these systems, those intent on stealing need only to ensure that they *bill correctly*. If they do that, they can fabricate or alter diagnoses, or invent entire medical episodes. If, by some mischance their claims are selected for audit, they need only create and submit medical records that support the fictitious billing, and – provided perpetrators are capable of lying twice, and consistently – they will survive such audit scrutiny without much fear of detection. The controls in place within the industry therefore deal better with billing errors and with honestly reported medical unorthodoxy than they do with outright criminal deception in the form of falsified claims. They deal better with poorly documented services than with well documented

lies. Investigators in the industry are starting to use a broader range of controls to address this problem (see below).

- **Multiple methods of cheating, and centrality of the false claims problem.** The incentives produced by the fee-for-service payment structure lead to submission of false or inflated bills. Other more sophisticated scams involve illegal kickbacks for referral of patients, physicians' acceptance of bribes for prescribing particular pharmaceuticals, inflating cost reports in systems where reimbursement rates for services depend on the reported costs and self-referral (referring business to other entities in which the referrer has an ownership or other financial interest), among others. Nevertheless, submission of *false claims* (claims that contain some material deception) represents perhaps the central and most persistent form of cheating in the US system.
- **Poor measurement of overpayment rates.** The Medicare programme and several Medicaid programmes have conducted measurement studies recently,[6] producing loss rates varying from 3 per cent to 15 per cent of overall costs, and with most results in the 5–10 per cent range. The studies draw random samples of claims paid, but then tend to apply somewhat weaker audit protocols than those necessary to produce true estimates of overpayment rates. The audit protocols used often replicate document-based or 'desk' audits, which check that the claims were processed correctly, and that they are supported by medical records requested and received by mail. But these audit methods generally include minimal or no attempts to track down the patients and verify that the services were both necessary and actually delivered. Hence the overpayment rates obtained by these measurement programmes generally miss many of the more sophisticated types of fraud, and often miss the ordinary phenomenon of *billing for services not provided* in cases where perpetrators take the precaution of submitting a false medical record to match the claim. These estimates therefore significantly understate the overall loss rates. This deficiency has been recognised by the Government Accountability Office, which acknowledges that use of more rigorous audit protocols designed to detect fraud would have made the derived estimates for overpayment rates 'greater – how much greater nobody knows'.[7]
- **Investments in control do not match the scale of the problem.** Despite loss rates that could easily exceed 10 per cent of programme costs, investments in controls for fraud and corruption remain pitifully low – as is typical of white-collar crime control. In the health industry, levels of investments in programme integrity and fraud control average roughly 0.1 per cent of programme costs. This ratio holds true remarkably consistently across the industry, irrespective of whether the insurer is public, commercial or not-for-profit. Investments in control are therefore woefully lacking, when viewed against potential losses.

Lessons learned from the US experience

The US health system remains vulnerable to attack, and programme integrity and fraud control systems are not yet sufficiently equipped to deal with the problem. Scandalous

revelations of medical professionals or companies stealing millions of dollars from the system make almost daily appearances in the media. As a result, important lessons have been learned about controlling fraud and corruption, some of which include:

- **Attractiveness of automated systems as targets for fraud.** Large, highly automated payment systems make dream targets for fraud perpetrators. Their payment behaviour can be studied and their utter predictability exploited. Quality control and process improvement techniques can only guarantee the correct operation of the payment system, but do nothing to validate the information fed into it. In this environment, *fraud works best when processing systems work perfectly*. This vulnerability extends beyond health care programmes to many other major public assistance or payment programmes that share similar characteristics.
- **Importance of measurement.** Failure to measure losses in a scientifically valid and rigorous fashion creates uncertainty about the scale of the problem. This leaves policy-makers unable to justify greater investments in control or enforcement and keeps resources for control at minimal levels.
- **Importance of whistleblower statutes.** Most of the big cases brought against major corporations for defrauding government health care programmes in the past decade arose from, or relied heavily upon, *qui tam* suits (allowing private citizens to file lawsuits charging fraud in government programmes) brought under the federal False Claims Act.[8] Most often the whistleblower was an employee or ex-employee of the offending corporation. Although the False Claims Act was originally designed to reduce corruption in defence contracting, health care fraud cases now routinely account for more than half of the annual volume of *qui tam* cases taken up by the Department of Justice. Whistleblowers receive a share of any eventual settlement. Providing financial incentives and compensation to whistleblowers has turned out to be one of the most powerful weapons available to the US government in tackling health care fraud and corruption. One prominent example involves the Columbia/HCA hospital chain, America's single largest health care provider. A series of whistleblower lawsuits launched against Columbia in the 1990s resulted in aggregate settlements with the Department of Justice exceeding US $1 billion dollars.[9] The practices whistleblowers reported included paying physicians for patient referrals to the hospitals, funnelling of patients to affiliated home-health services even when the patients preferred another provider, setting performance targets in terms of 'complication rates' (which justify higher levels of reimbursement from Medicare), hiding paperwork and accounts from government auditors, and false billing.
- **Dynamic nature of the game**. Investigators and auditors have learned how quickly fraud perpetrators can adapt to changes in the control system. Control strategies that rely on any static set of controls (such as reliance on a particular set of rule-based edits and audits in the processing system) fail utterly. Fraud control is a game of intelligence and counter-intelligence played against conscious, and highly adaptive, opponents.

- **Limitations of transaction-based analysis and detection methods.** Investigators are discovering the importance of moving beyond transaction-level control systems, which are easily circumnavigated by perpetrators who design their scams so that each claim, viewed in isolation, looks perfect. The more successful detection units within the industry are beginning to use a broader range of structural analysis and pattern-recognition methodologies that can search for patterns of coincidence or clustering (across thousands of claims) reflective of computerised billing scams and organised conspiracies – very few of which would ever be detected by examination of individual claims or individual patient histories.
- **The dangers of rushing to structural solutions.** Normally one would applaud policy-makers for seeking long-term structural solutions to integrity problems. Anti-corruption literature emphasises structural changes in incentives as a method of eliminating known forms of corruption and embezzlement. Many officials, concerned about fraud in the fee-for-service health structure, mistakenly assumed the advent of capitated managed care systems would eliminate the fraud problem by removing the financial incentives for overutilisation and overbilling. What they realise now is that changing the structure without removing the bad actors leads to criminal adaptation, and a whole new class of scams.

  With capitated systems, the incentives for overutilisation have been replaced by incentives for underutilisation. Dishonest providers take the monthly capitation payments and find a multitude of creative mechanisms to divert resources into their own pockets and away from frontline service delivery. The new forms of fraud that emerge turn out to be harder to detect, harder to control, more difficult to prosecute (because there is no false claim per se around which to build a case), and more dangerous to human health. Examples of abuses include: embezzlement of capitation funds paid by the state; the use of fraudulent subcontracts as a method of diverting funds to friends or family; improper enrolment or disenrolment practices (such as seriously ill patients being driven out or refused admission to a health care plan, or bribes being paid to secure younger and healthier patients); denial of treatment without proper evaluation; failure to inform patients of their rights and entitlements; failure to provide sufficient medical professionals to meet the needs of the enrolled population; and requiring patients to fight their way through extensive appeals processes in order to obtain necessary treatment. Under the fee-for-service structure, crimes were largely financial, with patients often oblivious to what was being billed in their names. With managed care, diversion of capitation payments results in inaccessible or inadequate patient care.

Looking ahead

The battle against health care fraud and corruption in the United States is not over. The Clinton administration paid more attention to the problem than any previous administration, and made some important financial and legislative investments to enhance control. Despite those investments, levels of resources available for monitoring, validation and enforcement remain completely inadequate when compared with the

scope of the problem. The introduction of a new prescription drug benefit for seniors under the Medicare programme,[10] almost guarantees that the federal government will have to pay renewed attention to this issue in years to come, since drug-related fraud remains one of the most prominent fraud threats within other programmes. The recent deceleration of the transition to capitated managed care (and in some regions and segments of the industry, the *reversal* of this transition), means that US health insurers will still have to develop more effective controls within a fee-for-service environment, as there is no prospect of structural change within the industry being able to solve the problem in the near future.

Notes

1. Malcolm K. Sparrow is professor of the practice of public management at Harvard's John F. Kennedy School of Government, and author of *License to Steal: How Fraud Bleeds America's Health Care System* (Denver: Westview Press, 2000), which contains a detailed analysis of the vulnerabilities of the US health system to fraud, waste and abuse.
2. 'Historical National Health Expenditures Aggregate, per Capita, Percent Distribution, and Average Annual Percent Change by Source of Funds: Calendar Years 1960–2003', www.cms.hhs.gov/statistics/nhe
3. Ibid.
4. Public sector spending runs at roughly 45 per cent of national costs. The two largest public programmes are Medicare (federal programme for the elderly) and Medicaid (programme for the poor, administered by the states and jointly funded by federal and state governments). See also national health expenditures in note 2 above.
5. The introduction to *License to Steal* (see note 1) catalogues the extraordinary range of apparent perpetrators and fraud methods seen in the industry over the last decade.
6. Measurement of Medicare overpayment rates was required by the Government Management Reform Act of 1994, instituted by the Office of Inspector General (DHHS) in 1996, and repeated every year until 2002. Derived overpayment rate estimates ranged from a high of 14.1 per cent to a low of 6.3 per cent. For a synopsis of recent measurement studies within Medicaid, see 'Payment Accuracy Measurement Project: Year 2 Final Report', Center for Medicaid and State Operations, Center for Medicare and Medicaid Services, DHHS, April 2004.
7. 'Efforts to Measure Medicare Fraud', Letter to Rep. John R. Kasich (Chair, House Budget Committee), GAO/AIMD-00-69R, 4 February 2000.
8. The 1986 Federal False Claims Act updated Civil War-era laws originally designed to prevent procurement fraud against the Union Army. It became available for use against health care fraud upon its revision in 1986. Penalties for false claims against government programmes were further stiffened by the Health Insurance Portability and Accountability Act of 1996.
9. www.cbsnews.com/stories/2002/12/18/national/main533453.shtml
10. The prescription drug benefit, known as Medicare Part D, comes into full effect in January 2006 under the Medicare Prescription Drug Improvement and Modernization Act of 2003.

Box 1.2 Corruption in Cambodia's health sector[1]

Cambodia's health record is amongst the worst in Asia. The maternal mortality rate is the highest in the region, with 437 deaths per 100,000 live births. Skilled personnel attend less than a third of all births.[2] Almost one in every ten babies does not live to his/her first birthday and more than 60,000 babies die every year of malnutrition or diseases that

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