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WCC Issue

Health Care Fraud

Definition

Health care fraud includes any scheme involving the health care industry that is designed for illegal financial gain. These schemes may include billing for services not rendered, inflating the cost of the service provided, the deliberate performance of medically unnecessary services, and the payment of "kickbacks," illegal payments designed to guarantee awarding of a contract or the exclusive right to provide a service.[1]

How it Happens

Healthcare fraud generally refers to intentional acts of deception that are designed to fleece a victim.[2] Perpetrators can include dishonest health card providers, physicians, dentists, chiropractors, hospitals, pharmacies, labs, nursing homes, medical equipment suppliers, or by the patients themselves.[3] While the bulk of monetary losses fall on the shoulders of private insurance companies and the federal government, the public incurs indirect costs associated with the reduced quality of care. Some of the more prevalent types of offenses are fraudulent billing schemes in health care services rendered, misleading patients on quality care issues, kickbacks or inducements with the intent to influence the sale of health care, and self referrals for the purpose of financial gain.[4]

One of the primary targets for offenders is the $250 billion-a-year Medicare program. Not only have large hospital chains been charged with bill padding, but the creation of fictitious clinics and laboratories provide effective ways for criminals to bilk the system of millions of dollars. Health care fraud schemes can be found in every region of the country, costing Americans billions of dollars a year. The continued public awareness of the issue, coupled with federal investigative and regulatory efforts, are necessary to stem the tide of a problem that is set to grow at the same rate as legitimate health care expenditures over the next ten years.

Cost/Statistics

By costing billions of dollars in fraudulent claims and threatening the health and safety of all Americans, health care fraud has now become one of the largest initiatives for the Federal Bureau of Investigation (FBI).[5] While exact losses are not known, it has been estimated by the General Accounting Office that fraud accounts for up to 10% of total health care expenditures.[6] With present expenditures in the United States exceeding $1 trillion and expected to climb to $2.6 trillion by 2010[7] this puts annual losses at $100 billion, reaching $200 billion over the next several years. While not a phenomenon, vulnerabilities in the health care system, including the size and complexity of the system, the rising cost of health care, and the attitudes towards insurance companies as socially acceptable targets all have contributed to the growing problem.

1 Federal Bureau of Investigation, *"Health Care Fraud: National and Local Perspective on a Growing Trend"*, August 1999, http://www.fbi.gov/contact/fo/norfolk/hcf.htm

2 U.S. General Accounting Office, Health Insurance: Vulnerable Payors Lose Billions to Fraud and Abuse, Report to the Ranking Minority Member, U.S. General Accounting Office, Washington, DC, 1992

3 Cumberland County Insurance Crime Unit, "Health Insurance Fraud" http://www.helpstopcrime.org/hifraud.htm

4 U.S. Department of Justice, Office of the Attorney General, *Fiscal Years 2000-2005 Strategic Plan* U.S. Department of Justice, September 2000, p.34. http://www.usdoj.gov/jmd/mps/strategic2000_2005/tocpdf.htm

5 Federal Bureau of Investigations, "About the Health Care Fraud Unit" http://www.fbi.gov/hq/cid/fc/hcf/about/hcf_about.htm

6 U.S. General Accounting Office, *Health Care: Information-sharing Proposals to improve Enforcement Efforts*, Report to the Ranking Minority Member, subcommittee on National Security, International Affairs and Criminal Justice, House Committee on Government Reform and Oversight, UI.S. General Accounting Office, May 1996, p.4.

7 Health Care Financing Administration, "National Health Care Expenditures Projections, 1998-2008," *Health Care Financing Administration*, <www.hcfa.gov/stats/NHE-Proj/> (September 19, 2001).

High Profile examples/Case Studies

The FBI recently released information concerning one particular case where 20 individuals were convicted for their involvement in a massive and sophisticated scheme to defraud Medicare. The convictions came from a five-year investigation of a home health agency that was the largest certified home health agency in Miami. The home health agency was paid approximately $120 million in Medicare funds for reimbursement of services, including nursing and home health aide visits. These billed services had either not been provided, were not necessary, or were provided to persons who were not eligible. In some cases, individuals were even deceased when the billed services were reportedly rendered. The two highest-level agency administrators admitted to illegal hidden partnerships in hundreds of subcontractor groups and involvement in hundreds of thousands of dollars of illegal payments to numerous individuals from professional beneficiaries, to home health aides, nurses, etc. The convicted defendants received sentences ranging from 18 months imprisonment to, in the case of the highest level administrator, 12 years imprisonment. A single defendant returned $1.1 million in fraudulently obtained assets.[8]

"For More Information" Links

Federal Bureau of Investigation (FBI)
http://www.fbi.gov/congress/congress00/hcf071800.htm

General Accounting Office Report
http://www.securitymanagement.com/library/000187.html

Federal Bureau of Investigation (FBI)
http://www.fbi.gov/contact/fo/norfolk/hcf.htm

8 Federal Bureau Of Investigation, *"About the Health Care Fraud Unit"* www.fbi.gov/hq/cid/fc/hcf/about/hcf_about.htm