United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Legislation and National Security and on Human Resources and Intergovernmental Relations, Committee on Government Operations
House of Representatives

For Release on Delivery
Expected at
10:00 a.m., EST
Thursday
March 17, 1994

HEALTH CARE REFORM

How Proposals Address Fraud and Abuse

Statement of Leslie G. Aronovitz
Associate Director, Health Financing Issues
Health, Education, and Human Services Division

SUMMARY

Weaknesses within the current health insurance system allow unscrupulous health care providers to cheat insurance companies and programs out of billions of dollars annually. Fraud and abuse flourish in a health care system that collects little information on provider practices, encourages high profits at the expense of cost-effective care, and has ineffective laws and enforcement mechanisms to punish and recover money from those who take advantage of system weaknesses. Legislative actions in three areas could help lessen these problems.

First, the nation's current health care information systems need to be streamlined and enhanced to reduce fraud and abuse. Standardized data and unique identifier numbers, for example, would have detected much sooner a major laboratory scheme, where physicians certified medical diagnoses and billed a variety of payers for thousands of unnecessary tests under many different provider numbers. Further, provisions for electronic interchange of data among payers are crucial.

Second, consumers should be provided with adequate protections and empowered to make better health care choices. Greater attention needs to be focused in particular on potential underservice to avoid the kinds of fraudulent or abusive practices more likely in managed care settings. When plans are not adequately financed, or when the financial risk of treating patients is transferred to the level of an individual physician or group, there is the temptation to cut corners on appropriate or needed services. Greater reliance on managed care plans will require an increased focus on effective quality assurance mechanisms, consumer-grievance processes, and fiscal-solvency requirements.

Third, making a dent in the fraud and abuse problems of our health care system will require the development of stronger legal and administrative mechanisms for insurers and the resources to enforce them. Extending to the private sector those laws and administrative mechanisms available under Medicare and Medicaid programs would greatly strengthen insurers' ability to take action against unscrupulous providers. The weak link in the chain of actions needed to successfully pursue and recover money from such providers, however, is often the lack of enforcement resources.

The administration's health care reform plan and other recent reform proposals provide the basis for reducing the vulnerability of our health care system to fraud and abuse. However, legislative language is only the first step. Without adequate investment in the technological and human resources needed to gather and analyze health care information and to take enforcement action against wrongdoers, these fraud and abuse protections will be of little benefit.

Mr. Chairmen and Members of the Subcommittees:

We are pleased to be at this joint hearing of your respective Subcommittees today to discuss remedies that we believe will lessen the health care system's vulnerability to fraud and abuse, and whether such remedies are contained in the current health care reform proposals.[1]

Expected to total over $1 trillion in 1994, health care spending will account for over one-seventh of our economy. This level of spending and its rapid growth have triggered concern over whether the nation is getting full value for its health care dollar. In some cases, loosely controlled billing arrangements have permitted unscrupulous providers to bill for unnecessary services or services not provided. In other cases, in such prepaid plans as health maintenance organizations (HMO), some providers have been found to increase profits by excessively limiting treatments. Regardless of provider reimbursement method, a tangled web of payers, providers, and law enforcement organizations complicates the pursuit of wrongdoers.

In summary, remedies we have identified that we feel would contribute to a comprehensive approach to more successfully combat health care fraud and abuse include

-- streamlining and enhancing health care information systems, resulting in better information for fraud and abuse detection and prevention, and for more prudent consumer and provider health care decisions (see app. I);

-- protecting and empowering consumers by establishing adequate safeguards against excessive cost-cutting by prepaid plans that could result in limiting access to health care (see app. II); and

-- strengthening the laws and enforcement mechanisms used to pursue and recover money from fraudulent providers (see app. III).

As shown in table 1, recent legislative proposals to reform the health care system, including the administration's proposal, address each of these elements to some extent.

---

[1]We reviewed four health care reform proposals: (1) H.R. 3600, introduced by Representative Gephardt and others and commonly referred to as the Clinton or Administration plan; (2) S. 1770, by Senator Chafee and others, commonly referred to as the Chafee plan; (3) H.R. 3222, by Representative Cooper and others, commonly referred to as the Cooper plan; and (4) H.R. 1200, by Representative McDermott and others, commonly referred to as the McDermott plan.

Table 1: Do Health Care Reform Proposals Address Essential Elements to Reduce Vulnerability to Fraud and Abuse?

Essential element	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Streamlining and enhancing health care information systems				
Standardized data	Yes	Yes	Yes	Yes
Unique identifier numbers	Yes	Yes	Yes	Yes
Electronic interchange	Yes	Yes	Yes	Yes
Privacy provisions	Yes	Yes	Yes	Yes
Protecting and empowering consumers				
Financial solvency requirements	Yes	Yes	Yes	Yes
Minimal enrollment to limit financial risk	Yes	Yes	Yes	Yes
Quality assurance program	Yes	Yes	Yes	Yes
Grievance procedures	Yes	Yes	Yes	Yes
Additional intermediate sanctions	No	Yes	No	No
Provisions to limit risk-sharing	No	No	Yes	No
Strengthening laws and enforcement mechanisms				
New criminal penalties	Yes	Yes	No	Yes
Larger civil penalties	Yes	Yes	No	No
Restrictions to eliminate kickbacks	Yes	Yes	No	Yes
Disallow routine waiver of copayments	Yes	Yes	No	No
Self-referral	Yes	No	No	No
Relief from antitrust laws	Yes	Yes	Yes	No

BACKGROUND

Instances of fraud and abuse can be found involving all segments of the health care industry in every area of the country. Though the effects are similar--wasteful spending and inappropriate patient care--the nature of fraud and abuse and the approaches used to address it are generally different for fee-for-service and prepaid health care providers.

Fraudulent or abusive practices in the fee-for-service reimbursement system include overcharging payers (typically insurance companies or the government) for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services. These practices are consistent with the incentives of the fee-for-service reimbursement system to enhance providers' income by ordering too many services. Because fee-for-service providers bear little financial risk for the costs of services they prescribe, they can inflate fees, services provided, or services billed.

In contrast, prepaid health care providers, typically HMOs, are both insurers and providers of care. They bear the financial risk for their members' care in exchange for a fixed, predetermined fee per member. HMOs can, however, enhance their profits by minimizing spending on patient care; that is, by underserving their members. Consistent with this incentive, fraudulent or abusive practices found among some prepaid health plans in the Medicare and Medicaid programs tend to involve avoiding expensive treatments, underfinancing health plan operations, disregarding member complaints, providing poor-quality care, or using deceptive marketing practices, such as failing to reveal significant plan restrictions to consumers.[2]

STREAMLINING AND ENHANCING INFORMATION TO DETECT FRAUD AND ABUSE

Regardless of reimbursement method--fee-for-service or prepaid health care--there is consensus that streamlined and enhanced health care information is needed. Each proposal has provisions that would, in effect, create a new health care information infrastructure by standardizing insurance forms and allowing for the electronic interchange of information. Such information can enhance the detection and pursuit of fraudulent and abusive providers. Each proposal also recognizes the need for safeguards to protect personal privacy.

---

[2]See Related GAO Products section at the end of this testimony for a listing of reports and testimonies addressing these issues.

Current Information Inadequate to Pursue Wrongdoers

Under our current health care system, a multitude of autonomous payers and providers produces incompatible health care data that hinder the pursuit of wrongdoers. Using different payment methods and billing regulations, over 1,000 payers process 4 billion health care claims a year to pay hundreds of thousands of providers. Because there are so many payers, it is difficult to detect patterns of billing abuses. For example, under one scheme that plagued southern California for most of the last decade, a single organized group of providers fraudulently billed public and private payers an estimated $1 billion in claims for unnecessary diagnostic tests. The scheme persisted for so long by using more than 600 different organizational names and provider numbers to avoid detection and moving from one insurer to another. Collaboration among payers to detect such improper billing is hindered by incompatible claims data, as well as by antitrust and privacy concerns. So, too, is the effort of state and federal agencies to collect such basic management information as spending trends, which would allow identification of unexpected cost increases that warrant further investigation.

Despite its limitations, information on service provision is much more readily available about fee-for-service providers than about prepaid providers. To receive payment under fee-for-service, providers must prepare claims, which contain information on beneficiaries' use of health care services. Insurance companies and others use this information to monitor for excessive provider billing and excessive patient services. In contrast, because HMO providers receive payment for services in advance, they do not submit claims, making data unavailable to monitor the level of patient services provided.

Standardizing Information Lessens System Vulnerability to Fraud and Abuse

From a fraud and abuse perspective, the main benefit to be derived from standardizing health care information across payers and providers is reduced vulnerability. This benefit would result because it will be easier to identify providers who use abusive practices, such as billing multiple insurers for an improbably high volume of services. Assigning uniform provider identification numbers would also lessen the chances that abusive providers may move undetected from one insurer to another. Also, uniform information (or encounter data) from prepaid health providers would establish a basis for assessing the level of services they provide.

Key features identified in one or more of the plans we reviewed that should accomplish these benefits include

-- a single set of fee-for-service claims forms and prepaid health provider encounter forms containing standard data elements, definitions, and instructions for completion;

-- unique identifier numbers for policyholders, employers, health plans, and providers;

-- uniform requirements for the exchange of electronic data among health information systems; and

-- electronic health security cards containing, at a minimum, enrollment information.

While each of these key features should aid in reducing the health care system's vulnerability to fraud and abuse, they raise issues about how to protect personal privacy and ensure that personal medical information will not be used for unintended purposes. The health care reform proposals we reviewed, however, contain privacy protections to safeguard and limit access to sensitive or confidential information.

Proper Use of New Information Could Also Aid Decisionmaking and Reduce Waste

The use of new health care information to better understand the costs and effectiveness of medical care can help to reduce wasteful expenditures. Little information is available to consumers, purchasers, or providers to assess the reasonableness of health care prices or the relative benefits of alternative treatments. Consumers, for example, generally lack information to assess the reasonableness of either health care prices or quality; purchasers frequently have insufficient information to reliably compare providers; and providers often lack information to compare the relative effectiveness of alternative treatments or devices for their patients. The effect of these limitations is that wasteful practices can flourish unrecognized by those in a position to avoid them.

Key features identified in one or more of the plans we reviewed that should help consumers, purchasers, and providers make better health care decisions and avoid wasteful practices or providers include

-- plan-by-plan and state-by-state consumer surveys concerning access to care, use of health services, success of health outcomes, and extent of patient satisfaction;

-- information on the costs, risks, and benefits of alternative strategies for the prevention, diagnosis, treatment, and management of a given health condition; and

-- programs to educate consumers on quality, costs, and other information relevant for choosing health plans.[3]

Successfully implementing such reforms could require considerably more spending on data collection and analysis activities than current spending. Even for federal health programs, the government has made relatively little use of the substantial fee-for-service claims data it collects. Moreover, the government has little data to compare prepaid health plans or to assess their cost or quality on any systematic basis even though the federal government has nearly two decades of experience using such plans to serve program beneficiaries. Given the substantial neglect of data collection and analysis activities in recent years, reform proposals should also consider building in mechanisms to adequately and reliably fund such activities.

COST-CONTAINMENT INCENTIVES COULD LIMIT ACCESS TO HEALTH CARE

Each of the health care reform proposals we reviewed embrace explicit cost-containment strategies aimed at counteracting the fee-for-service incentive to add to health care costs by overproviding services. As an alternative to fee-for-service health care, however, the use of prepaid health care through HMOs raises other financial and quality-of-care concerns. To the extent that prepaid health care is intended to become a major factor in a reformed health care system, safeguards are needed to protect the consumer against the HMO becoming insolvent and, thus, unable to provide patient care and then, against the incentives of such a system, to underprovide services.

Over the past decade, our reviews of HMOs serving Medicare enrollees have shown that consumers can be harmed when quality or financial standards are not in place or are not adhered to. The problems that some enrollees experienced were poor quality of care, high out-of-pocket costs, inappropriate billings, and denied access to services. In many cases, these kinds of problems persisted due to the lack of aggressive enforcement and the weakness of existing enforcement tools.

The most significant problems tended to occur in HMOs that were not adequately financed, and did not operate effective quality assurance programs. The failure of Medicare's largest HMO contractor in 1987 illustrates the nature and interrelatedness of

---

[3]See appendix I for a summary of the health care information standardization proposals and the likely uses of the information that would occur under the four health care reform bills we reviewed.

financial and quality assurance problems. Before becoming insolvent and losing its license to operate, the HMO failed to follow up potentially serious medical conditions, such as a patient with a breast mass and a patient with a lung mass identified on a chest X-ray.[4] During the time these quality-of-care problems occurred, the HMO's financial condition was deteriorating. Moreover, the HMO had transferred a significant portion of its financial risk to subcontractors--individual physicians, physician groups, and clinics, many of which were also experiencing financial difficulties.[5] As the financial viability of the HMO and its providers decreased, their incentive to reduce needed services increased.

Key features identified in one or more of the health care reform proposals that should enhance consumer protections include

-- the establishment of financial solvency requirements,

-- the setting of minimum enrollment requirements necessary to assume the financial risk inherent in such a system,

-- the establishment of limits on risk-sharing arrangements between HMOs and the physicians and other medical providers serving their enrollees,

-- the operation of internal quality assurance systems capable of detecting and correcting underservice and poor-quality care,

-- the establishment of a grievance process,

-- the appointment of an ombudsman, and

-- the strengthening of enforcement mechanisms that can be taken against Medicare HMOs that fail to meet stipulated standards.[6]

---

[4]Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

[5]Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

[6]See appendix II for a summary of the financial solvency and consumer protection proposals contained in the four health reform bills we reviewed.

STRENGTHENED LAW ENFORCEMENT COULD ADDRESS FRAUDULENT AND ABUSIVE HEALTH CARE PRACTICES

Most of the health care reform bills we reviewed would significantly strengthen the laws and enforcement mechanisms used to deal with fraudulent or abusive providers. They raise concerns, however, about how the increased efforts should be financed, and whether new enforcement responsibilities should reside principally at the state or federal levels. The proposals would extend to the private sector many of the legal and administrative mechanisms available to the Medicare and Medicaid programs. Some would also expand the responsibilities of the Department of Health and Human Services' (HHS) Office of Inspector General to serve as a focal point for coordinating nationwide efforts to identify and pursue fraudulent or abusive providers.

Legal and Administrative Mechanisms Should Be Strengthened

Efforts to prosecute and recover money from fraudulent or abusive providers are meeting with limited success for a combination of reasons. Both public and private sector payers face serious constraints that limit their successful pursuit of wrongdoers. The private sector payers are even more disadvantaged, however, because they have a much less comprehensive array of legal and administrative tools to combat the problem than the federal payers. For example,

-- many states lack adequate antikickback statutes, although payments for the referral of patients and the waiver of copayments are integral parts of many schemes to defraud insurance companies;

-- when abusive providers are detected by one insurer, they can simply move to another because insurers have no systematic way of notifying other insurers of the problem or precluding the unscrupulous providers from billing their companies;

-- in most states there are no prohibitions against physicians or other providers referring patients to facilities in which they have an ownership interest, though such conflicts of interest can encourage overutilization;

-- private payers generally have less authority to recover overpayments than is available under the Medicare and Medicaid programs; and

-- generally, insurers do not have access to civil monetary penalties, such as those used successfully in the public sector to penalize unscrupulous providers.

Several proposals would extend to the private sector many of the protections against unscrupulous providers that are currently available to public payers and would empower states and private parties themselves to take legal action directly against such providers. This action could greatly reduce the health care system's vulnerability to fraud and abuse. Key features, contained in one or more of the health care reform proposals we reviewed that should strengthen enforcement against fraud and abuse include

-- new criminal penalties, specifically for health care fraud involving activities such as bribes or gratuities to influence the delivery of services or coverage;

-- larger civil monetary penalties against providers who submit false claims;

-- asset forfeiture when providers are convicted of fraud;

-- tighter restrictions to eliminate referral kickbacks in the private sector;

-- explicit disallowance of routine waivers of copayments;

-- stricter standards barring doctors from prescribing services to be delivered by clinics or other facilities in which they hold a financial interest;

-- exclusion from participation in health plans of any provider convicted of health care fraud;

-- a national database to identify, track, and coordinate information about health care providers who have engaged in fraud and abuse in the delivery of and payment for health care services; and

-- the provision of adequate authority and resources for the investigation and enforcement of standards.

More Collaboration and Strengthened Enforcement Agencies Needed

Other reasons for insurers' relative lack of success in reducing fraudulent or abusive practices are the cost and time involved. The costs of individual insurers' efforts weigh heavily against the deterrent and financial benefits that they are likely to achieve. Privacy and antitrust concerns inhibit insurers' willingness to share information with other insurers and combine resources to jointly pursue unscrupulous providers. Moreover, unlike the public sector, insurers that have direct access to the resources of federal and state investigative agencies, private insurers must each fund their own investigations. Because the losses to any one insurer from a fraudulent provider may be only a

small portion of the total losses incurred by all insurers, individual insurers can find it more cost-effective not to pursue fraudulent or abusive providers than to do so.

Key features, contained in one or more of the health care reform proposals we reviewed, that would help correct these problems and provide the infrastructure to undertake and coordinate broadened enforcement activities include

-- providing for the compilation and exchange of health care information sufficient to identify and prevent provider fraud and abuse while maintaining appropriate confidentiality;

-- addressing antitrust concerns by expressly authorizing activities and procedures to permit the exchange of information and coordination of strategies;

-- expanding the authority of HHS' Inspector General to pursue fraud and abuse, in coordination with the Attorney General, anywhere in the health care system and to coordinate with state and other federal agencies, and

-- expanding the role of the states in investigating and pursuing fraudulent or abusive providers (similar to the fraud control units in the Medicaid program).

Expanded health care enforcement responsibilities will require substantial additional funding to build the staffing and expertise needed by federal and state agencies. Recent experience, however, shows that relying on state or federal appropriations for this additional funding would place fraud and abuse activities at risk. Public funding for health care enforcement activities has not kept pace with the growth in health care expenditures. For example, the number of HHS Inspector General investigators has actually declined over the past 5 years, although the Inspector General's statutory responsibilities and the size and complexity of the federal programs that the Inspector General investigates have increased significantly. In the current budget environment, additional budget cuts are likely, further diminishing the agency's responsiveness. Legislative features directed at this problem include

-- establishing a fraud and abuse control account funded through fines, penalties, forfeitures, and donations to help cover the costs of inspecting, auditing, investigating, and prosecuting and

-- making the funds available without fiscal year limitation.[7]

Need to Delineate State and Federal Enforcement Responsibility

As well as providing adequate funding for the agencies involved in enforcement, designating their roles and relationships will also be necessary. Although none of the legislative proposals seems to envision enforcement activities residing solely at any one level of government, the proposals do not specify in detail how the responsibility will be shared between federal and state agencies. This omission could make the work load unmanageable for the federal or state agency given predominant enforcement responsibility.

CONCLUDING OBSERVATIONS

As we have outlined, each of the reform proposals we reviewed include, to some extent, important safeguards against fraud and abuse, namely:

-- A streamlined and enhanced health care information system and features addressing the privacy of medical records. This would include enacting provisions to collect similar data across payers and to use that data to help consumers, payers, and providers to make better health care decisions.

-- Consumer protection and empowerment to safeguard against stringent cost-containment measures that could result in denied or poor care. Provisions to accomplish this would include explicit financial solvency requirements, limitations on the financial risk that payers could transfer to providers, and effective quality assurance mechanisms.

-- Stronger legal and enforcement mechanisms, such as criminal and civil penalties, and antikickback and self-referral statutes, as well as the adequacy of resources to enforce fraud and abuse provisions.

The Clinton and Chafee proposals, because they include many of these features, provide a general framework for combatting health care fraud and abuse. All the proposals we reviewed, however, have particular elements worth incorporating into final legislation.

- - - - -

[7]See appendix III for a summary of the strengthened law enforcement provisions contained in the four health care reform bills we reviewed.

Mr. Chairmen and Members of the Subcommittees, this concludes my prepared statement. We would be happy to answer any questions you may have.

COMPARISON OF PROVISIONS FOR STREAMLINING AND ENHANCING HEALTH CARE INFORMATION SYSTEMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Standardized data				
	Establish health information system with uniform standards for collection and transmission of data in electronic form (sec. 5102).	Establish health care data interchange system to make health data available on a uniform basis to all participants in the system (sec. 3301).	Require collection and reporting of information in standardized, electronic form (sec. 1203).	Require establishment of uniform reporting standards to ensure that an adequate database on health providers, services, and finances be established (sec. 401).
Forms	Require use of standard enrollment, clinical encounter, and claim forms (sec. 5130).	Require standard format for information including model forms and use of standardized claim forms (sec. 1118).	Provide for establishment of timetable to achieve uniformity in format and content of basic claim forms (sec. 6004).	No specific provision.[a]
Instructions	Each form shall include instructions that define data elements and standardize codes (sec. 5130).	No specific provision.	No specific provision.	No specific provision.
Unique identifier numbers	Establish system to provide unique identifier numbers for each eligible individual, employer, health plan, and health care provider (sec. 5104).	Require development of unique identifiers for each participant in health care system (sec. 3307).	Provide for establishment of timetable to achieve uniformity in use of common identification numbers for beneficiaries and providers of items of service under health plans (sec. 6004).	Provide for assignment of unique identifiers, which each state health security program must use, to each eligible individual and provider (sec. 414).
Electronic interchange	Establish electronic data network consisting of regional centers that collect, compile, and transmit data (sec. 5103).	Establish minimum requirements for integrated electronic health care data interchange system (sec. 3301).	Provide timetable for eliminating unnecessary paperwork and achieving standardization in electronic receipt and transmission of plan information (sec. 6003).	Require each state health security program to develop and use uniform electronic database with designated uniform software (sec. 504).

[a]The need for some specific reforms, such as the need to standardize claim forms, will be lessened or eliminated under a single-payer system, such as that under McDermott.

APPENDIX I

COMPARISON OF PROVISIONS FOR
STREAMLINING AND ENHANCING HEALTH CARE INFORMATION SYSTEMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Health security cards	Each individual entitled to a card from their alliance or health plan (sec. 1001). Regulations prescribing uses and form of card and information to be encoded (sec. 5105).	No specific provision.	No specific provision.	Require each state health security program to provide for issuance of health security card for purposes of identification and processing claims for benefits (sec. 103).
Privacy provisions	Detailed requirement to establish standards safeguarding privacy of individually identifiable information (sec. 5120) and educational programs emphasizing privacy protections (sec. 5122). Development of detailed proposal for legislation to provide comprehensive scheme of privacy protection (sec. 5122). Establishment of National Privacy and Health Data Advisory Council (sec. 5140).	As basis for regulations, develop requirements to protect privacy of participants and ensure confidentiality of information in the data interchange system taking into consideration the National Association of Insurance Commissioners and other model laws (sec. 3308).	Require promulgation of standards for ensuring confidential treatment of individually identifiable information in electronic environments (sec. 6002).	Require establishment of standards to protect confidentiality of information in databases and identity of individuals (secs. 412 and 504).

COMPARISON OF PROVISIONS FOR STREAMLINING AND ENHANCING HEALTH CARE INFORMATION SYSTEMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Consumer information				
	Before each open enrollment period, each alliance shall make available to eligible enrollees information that allows such enrollees to make valid comparisons among health plans offered by alliances (sec. 1325).	Secretary shall analyze health care data, prepare reports, and distribute them to states, plans, and others (sec. 3002).	Before each enrollment period, alliances must distribute comparative information on prices, health outcomes, enrollee satisfaction, and other information pertaining to plan quality (sec. 1104).	No specific provision.
Consumer surveys	Periodic surveys of health care consumers to gather information concerning access to care, use of health services, health outcomes, and patient satisfaction. To be administered on plan-by-plan and state-by-state basis (sec. 5004). Results of surveys shall be reported annually to public (sec. 5005).	Develop requirements for participants in health care system to transmit data on patient satisfaction (sec. 3304). Medicaid risk-contracting entities must provide for continuous monitoring to include patient surveys, spot checks, or other appropriate methods (sec. 6021).	Each alliance shall collect, analyze, and distribute information on satisfaction of individuals using standardized survey instrument and make it available to enrollees (sec. 1108).	Requires regular surveys to be conducted by capitated health plans on members' satisfaction. No provision for dissemination of consumer survey information (sec. 303).
Cost/benefit information	Require establishment of practice guidelines incorporating information on effectiveness and costs of alternative strategies for prevention, diagnosis, treatment, and management of health conditions (sec. 5006).	Establish clearinghouse to compile and make available information and research data concerning clinical trials undertaken (sec. 3101).	No specific provision.	No specific provision.
Educational programs	Establish regional professional foundations to develop innovative patient education systems that enhance patient involvement in decisions relating to their health care (sec. 5008).	No specific provision.	No specific provision.	No specific provision.

COMPARISON OF PROVISIONS FOR PROTECTING AND EMPOWERING CONSUMERS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Quality				
Financial solvency requirements	Each health plan must meet minimum capital and other requirements relating to fiscal soundness and participate in a guaranty fund (sec. 1408).	Insurers offering qualified access plans must meet financial solvency requirements assuring enrollee protection with respect to potential insolvency (sec. 1114).	States must establish satisfactory enrollee protections with respect to potential insolvency of the insured plans. Commission may require other plans to provide for such bond or other satisfactory assurances under which enrollees are protected with respect to potential insolvency (sec. 1206).	Prepaid health organizations must meet federal requirements relating to financial solvency (sec. 303).
Minimum enrollments to limit financial risk	Plan may be permitted to limit the number of enrollees because of its capacity to deliver services or to maintain financial stability (sec. 1402).	Upon request, a plan may be permitted to cease enrolling individuals if it demonstrates that its financial or provider capacity will be impaired otherwise (sec. 1111).	Upon request, a plan may be permitted to cease enrolling individuals if it demonstrates that its financial or provider capacity will be impaired otherwise (sec. 1208).	Prepaid health organization must meet minimum enrollment requirements but may limit enrollment to avoid overtaxing its resources (sec. 303).
Provisions to limit risk-sharing	No specific provision.	No specific provision.	Extends current provisions applicable to Medicare HMOs (sec. 1207).	No specific provision.
Quality assurance program	Establish performance-based quality management and information program under the National Quality Management Council. Develop quality performance measures to assess provision and accessibility of health care services (sec. 5001, et seq.).	Establish standards for quality assurance programs to be met by facilities and network providers (sec. 3001).	Commission required to establish minimum quality standards that health plans are required to meet (sec. 1202). Specialized centers of care required to submit quality information and be rated by the Commission (sec. 1308).	States required to establish qualified entities to conduct quality reviews in accordance with federal standards (sec. 502).

COMPARISON OF PROVISIONS FOR PROTECTING AND EMPOWERING CONSUMERS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper (H.R. 3222)	McDermott (H.R. 1200)
Grievance procedures	Each health plan must establish a grievance procedure for enrollees to use in pursuing complaints (sec. 1405).	No specific provision except that a provider under contract with the state to provide health care services to Medicaid recipients must implement a grievance system, inform enrollees in writing on how to use the system, and ensure that grievances are addressed in a timely manner and reported to the state (sec. 6021).	Require plans to provide effective procedures for resolving grievances that meet standards set by Health Care Standards Commission (sec. 1207).	A prepaid health organization must have in effect a patient grievance program (sec. 303).
Ombudsman	Alliances required to establish and maintain an office of an ombudsman to assist consumers in dealing with problems that arise with health plans and alliances (sec. 1326).	No specific provision.	Plans required to provide an ombudsman to investigate complaints, assist enrollees in resolving grievances, and issue public reports on the performance of plans' complaint processes (secs. 1101, 1107, and 1207).	Establishment of an independent ombudsman for consumers to register complaints about the organization and administration of the state health security board and to help resolve complaints and disputes between consumers and providers (sec. 405).
Additional intermediate sanctions	No specific provision.	Grants HHS discretion to opt for intermediate sanctions against an HMO for failure to carry out its Medicare contract (sec. 4117).	No specific provision.	No specific provision.

COMPARISON OF PROVISIONS FOR STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Fraud				
	Establish an all-payer health care fraud and abuse control program (sec. 5401).	Establish an all-payer fraud and abuse control program (sec. 4101).	No specific provision.	Extend certain disclosure, civil monetary, and criminal penalty provisions of the Social Security Act related to health care fraud and abuse to state health security programs now applicable to state Medicaid programs (sec. 411).
Fraud and abuse control account	Provide for deposit of donations and amounts resulting from the imposition of fines, penalties, or assessments, or the forfeiture of property, in cases arising from federal health care offenses, into a separate account to fund, without fiscal year limitation, the all-payer health care fraud and abuse control program (including the costs of prosecutions, investigations, audits, and inspections (sec. 5402).	Establish an antifraud and abuse trust fund containing donations, appropriations made to it, and amounts derived under title XI of the Social Security Act, to fund, without fiscal year limitation, the all-payer fraud and abuse control program (sec. 4101).	No specific provision.	No specific provision.
Central database on fraud and abuse	Provide for establishment of a health information system to include facts necessary to determine if a plan or provider has complied with laws pertaining to health care fraud (sec. 5101).	Provide for government agencies and health plans to report most final adverse actions taken against health care providers and others to HHS and for public access to such information (sec. 4121).	No specific provision.	Provide for establishment of database containing information, as specified by the IG at HHS, relating to health care fraud and abuse and including certain final adverse actions taken against providers (sec. 412).

COMPARISON OF PROVISIONS FOR STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Enforcement tools				
New criminal provisions	Impose criminal penalties for a broad range of new federal health care offenses including health care fraud (sec. 5431), false statements relating to health care matters (sec. 5433), bribery and graft in connection with health care (sec. 5434), theft or embezzlement in connection with health care (sec. 5437), and misuse of health security card or unique identifier (sec. 5438).	Impose criminal penalties for separate new offense of health care fraud (sec. 4131), extend application of criminal penalties under section 1128B of the Social Security Act to protect all payers (sec. 4102), and expand the federal definition of racketeering activity to include federal health care offenses (sec. 4134).	No specific provision.	Extend application of criminal penalties under section 1128B of the Social Security Act to state health security programs as now applicable to state Medicaid programs (sec. 411) and create new criminal offense of submitting false information to national health care fraud database or denying access to information (sec. 412).
Larger civil penalties	Increase maximum from $2,000 to $10,000, and impose maximum of $50,000 for some new violations (sec. 4043).	Increase maximum from $2,000 to $10,000 for each item or service (sec. 4114).	No specific provision.	No specific provision.
Asset forfeitures	Permit courts to order forfeiture of property used in or derived from commission of health care offense that poses serious threat to a person's health or has significant detrimental impact on the health care system (sec. 5432).	Permit courts to order forfeiture of property used in or derived from commission of health care offense that poses serious threat to a person's health or has significant detrimental impact on the health care system (sec. 4132).	No specific provision.	No specific provision.
Medicare/Medicaid antikickback amendments	Raise maximum criminal penalty from $25,000 to $50,000, provide for treble criminal damages, permit imposition of civil monetary penalties, create new exceptions and clarify others, strengthen enforcement, and extend civil monetary penalties to protect all payers (sec. 4041).	Authorize HHS to identify community service opportunities that a court may impose on those convicted of violations and extend remedies to all payers (sec. 4102), create a civil monetary penalty, and clarify the employment exception (sec. 4115).	No specific provision.	Extend criminal penalties now applicable to state Medicaid plans to state health security program (sec. 411).

COMPARISON OF PROVISIONS FOR STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Disallow routine waiver of copayment	Prohibit parties from offering or paying any remuneration, including routine waiver of copayments and deductibles, where it is apt to influence others to seek health care from the party (sec. 4043).	Prohibit parties from offering or paying any remuneration, including routine waiver of copayments and deductibles, where it is apt to influence others to seek health care from the party (sec. 4114).	No specific provision.	No specific provision.
Physician self-referral	Clarify application of current prohibitions against physician referrals with respect to holding company type arrangements, eliminate physicians' services exception while amending others and creating still more, expand coverage to all payers (sec. 4042).	No specific provision.	No specific provision.	No specific provision.
Exclusion from participation in Medicare or Medicaid	Establish minimum 1-year period of exclusion and eliminate requirement that provider be excluded only if unwilling or unable to substantially comply with program obligations (sec. 4045), require exclusion as result of any conviction resulting from health care fraud, and permit exclusion in various other cases (sec. 4044).	Establish minimum 1-year period of exclusion and eliminate requirement that provider be excluded only if unwilling or unable to substantially comply with program obligations (sec. 4116) and require exclusion as the result of certain felony convictions in connection with the delivery of health care or respecting any act or omission in a program operated or financed by a government agency (sec. 4111).	No specific provision.	Expand all current mandatory and permissive exclusion authorities under section 1128 of the Social Security Act to state health security program as now applicable to state Medicaid plans (sec. 411).
Whistleblower protection	Extend certain whistleblower protections to parties providing information to assist HHS or the Attorney General in controlling health care fraud and abuse (sec. 5401).	Extend certain whistleblower protections to parties providing information to assist HHS or the Attorney General in controlling health care fraud and abuse (sec. 4101).	No specific provision.	No specific provision.

COMPARISON OF PROVISIONS FOR STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Relief from antitrust laws	Provide that the establishment of fee schedules by states and alliances will, in effect, be covered by exceptions to antitrust laws (sec. 1322), while the current antitrust exemption applicable to insurers will no longer apply to health insurers (sec. 5501).	Establishes safe harbors, which the Attorney General could expand, for certain competitive and collaborative activities, thereby expressly shielding them from antitrust laws (sec. 4201).	Provide for the President to issue explicit guidelines on the application of antitrust laws to health plans and for the Attorney General to render a prompt opinion on the conformity of a plan with such laws (sec. 1231) as well as issue certificates of public advantage providing immunity from such laws to plans meeting certain standards (sec. 1232).	No specific provision.

COMPARISON OF PROVISIONS FOR
STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Enforcement authority				
Federal role	Provide for Secretary of HHS (acting through the IG of HHS) and the Attorney General to establish a program to coordinate federal functions for the prevention, detection, and control of health care fraud and abuse; conduct investigations, audits, evaluations, and inspections relating to the delivery of health care; facilitate enforcement of applicable statutes; and arrange for sharing of data with health alliances and plans (sec. 5401).	Provide for Secretary of HHS to establish program in the office of the IG of HHS to coordinate federal, state, and local law enforcement programs to control health care fraud and abuse; conduct investigations, audits, evaluations, and inspections relating to delivery of and payment for health care; facilitate enforcement of applicable statutes; and arrange for sharing of data with health plans (sec. 4101).	No specific provision.	Establish an IG for the American Health Security Standards Board with authority over the American Health Security Program analogous to that enjoyed by the IG of HHS with respect to HHS and the Medicare and Medicaid programs (sec. 401).
State role	No specific provision but state Medicaid fraud control units would continue to operate.	No specific provision but state Medicaid fraud control units would continue to operate.	No specific provision but state Medicaid fraud control units would continue to operate.	Require for approval of state health security program plan that state establish and maintain a statewide health care fraud and abuse control unit, which can be the state Medicaid fraud control unit, to investigate and prosecute violations of state laws regarding fraud in connection with health care services and providers; review and, when appropriate, act upon patient complaints; and provide for collection of overpayments made under the state health security program (sec. 413).

COMPARISON OF PROVISIONS FOR STRENGTHENING LEGAL AND ENFORCEMENT MECHANISMS

	Clinton (H.R. 3600)	Chafee (S. 1770)	Cooper[a] (H.R. 3222)	McDermott (H.R. 1200)
Private cause of action	Establish private cause of action to enforce health care responsibilities against states (sec. 5235) and alliances (sec. 5237).	Establish a private cause of action on behalf of any person harmed as the result of an activity making an individual or entity subject to civil monetary penalties against the individual or entity (sec. 4114).	No specific provision.	No specific provision.

[a]Unlike the other bills reviewed, the Cooper bill includes no subtitle or other portion with the express purpose of controlling health care fraud and abuse.

RELATED GAO PRODUCTS

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992), and related testimony (GAO/T-HRD-92-29, May 7, 1992).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991), and related testimony (GAO/T-HRD-92-11, Nov. 15, 1991).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

(101304)