148497

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Crime and Criminal Justice
Committee on the Judiciary
House of Representatives

For Release on Delivery
Expected at
10:00 a.m.
Thursday,
February 4, 1993

HEALTH INSURANCE

Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse

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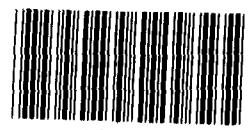

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GAO/T-HRD-93-3

SUMMARY

The size of the health care sector and sheer volume of money involved make it an attractive target for fraud and abuse. Health insurance experts estimate that fraud and abuse contribute to some 10 percent of the $800-plus billion currently spent on health care. Relative to the magnitude of the problem, GAO believes that resources devoted to combatting health insurance fraud are small.

Profiteers are able to stay ahead of those who pay claims, in part, because of the obstacles to preventing and pursuing dishonest practices. 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. Insurers have difficulty discerning wrongful acts amidst the multiple activities that take place at the time of processing claims. Furthermore, collaboration on fraud case development among industry members is limited due to concerns over violating privacy and antitrust laws.

Once detected, moreover, fraud is expensive and time-consuming to pursue both criminally and civilly; even convictions often do not result in the recovery of losses. In particular, limited resources can constrain state and federal prosecutors from pursuing health care cases involving relatively small dollar amounts. In several jurisdictions, for example, federal prosecutors said they generally accept only criminal health care cases that are clear-cut and involve $100,000 or more, because caseloads for such crimes as savings and loan fraud and drug-trafficking consume substantial prosecutorial resources.

Two federal agencies significantly involved in pursuing health care fraud are the Department of Justice and the Office of the Inspector General in the Department of Health and Human Services (HHS). Both cite limited resources as a problem. The number of Inspector General investigators has declined over the last 5 years, while the Inspector General's statutory responsibilities and the size and complexity of the federal programs that the Inspector General investigates have increased significantly. Without adequate resources, effective investigation and pursuit of health care fraud is not possible.

Added resources alone, however, will not succeed in overcoming fraud and abuse in the health insurance industry. Structural issues such as limitations on information-sharing among insurers and incompatible data systems hamper efforts to detect the providers' aberrant billing patterns. Because of the complexity involved in remedying these problems, GAO asked the Congress to consider establishing a national commission to develop comprehensive solutions to health insurance fraud and abuse.

Dear Mr. Chairman:

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. Essentially, our work has shown that (1) all health care payers are vulnerable to fraud and abuse, (2) significant obstacles hinder the prevention of dishonest billing practices and the pursuit of health care profiteers, and (3) the resources devoted to detection and prosecution are not adequate.

Now I would like to discuss these issues in greater detail. First I will address the size and nature of health insurance fraud and abuse, followed by resource and other problems associated with investigation and prosecution.

HEALTH INSURANCE FRAUD AND ABUSE

Last May, we issued a report citing an estimate that fraud and abuse adds some 10 percent to U.S. health care's current costs,[2] which currently exceed $800 billion. We would like to reiterate that this estimate, although often cited by health experts, is uncertain because of the hidden nature of fraudulent and abusive practices.

The magnitude of this loss stems from several problems in the health insurance system that allow unscrupulous health care providers to cheat health insurance companies and programs out of billions of dollars annually. The problems do not fall into mutually exclusive categories, but in general they include the following:

-- Health insurers operate independently and are constrained legally and administratively from collaborating on efforts to confront 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

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[1]Medicare Claims (GAO/HR-93-6, December 1992).

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

providers convicted of health care fraud from billing the public programs.

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

The vulnerability of the health care system to fraud is illustrated by a California scheme that has resulted in the loss of millions of dollars. The case is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. This scheme centered around getting people with health insurance to go to mobile labs, called "rolling labs," that did noninvasive tests, such as heart and blood-pressure measurements. Frequently, the labs 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. And third, efforts to investigate, prosecute, and recover losses from those involved in the schemes are time-consuming and costly.

Next, I will focus on the problems of investigating and prosecuting health insurance fraud.

PROBLEMS INVESTIGATING AND PROSECUTING HEALTH INSURANCE FRAUD AND ABUSE

Insurers face significant legal hurdles and expense in investigating, prosecuting, and recovering losses from fraudulent or abusive providers. Investigative and prosecutorial resources and priorities vary by jurisdiction, often constraining state and federal prosecutors from pursuing health care cases involving relatively small dollar amounts. In several jurisdictions, for example, federal prosecutors told us that they generally accept only criminal health care cases that are clear-cut and involve $100,000 or more, because caseloads for such crimes as savings and loan fraud and drug-trafficking consume substantial prosecutorial resources. An official from a large insurance company with an active fraud detection program told us that only about 1 percent of all cases referred to federal prosecutors were accepted.

An irony of the criminal prosecution approach is that 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 (FBI) 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.

One GAO study that examined how Medicare contractors review complaints they receive alleging fraud illustrates the potential cost of not pursuing these leads. Beneficiary complaints of provider fraud and abuse are Medicare's first line of defense against misspent program dollars. Inadequate investigation of these complaints can result in missed opportunities to recover overpayments and to send a message that fraudulent or abusive behavior will not be tolerated.[3]

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

In fiscal year 1990, Medicare contractors reported receiving about 18 million calls--most of which were from program beneficiaries. In our review of calls at five contractors, however, we found over half of the complaints that involved allegations of fraud or abuse were not referred to contractor investigative staff. Not all complaints that were properly referred, moreover, were adequately investigated.

The importance of investigating complaints is illustrated by a recent case against a national laboratory. The laboratory led doctors to believe it could perform additional tests, though medically unnecessary, at little or no cost when doctors ordered a routine battery of chemistry tests on a blood specimen. In fact, when billing Medicare, the laboratory filed claims for the full price of the additional tests. The doctors were unaware of how the laboratory represented its charges to Medicare because the laboratory submitted its claims directly to Medicare. This problem had been ongoing since 1987 and resulted in big payment increases to the laboratory for certain tests. The HHS Office of the Inspector General became aware of the scheme after the laboratory's competitors advised the Office of the lower prices the national laboratory charged doctors compared to what it charged Medicare. The competitors' complaints led to a grand jury investigation in 1990. In December 1992, the laboratory pleaded guilty to submitting false claims to the government and agreed to repay more than $110 million in civil settlements and criminal fines.

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, effective investigation and pursuit of 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 to conduct a more fruitful attack on health care fraud.

In addition, as we discussed in our May 1992 report cited earlier, structural issues, such as limitations on information-sharing among insurers and incompatible data systems, allow unscrupulous providers to move from one insurer to another. The complex issues involved in developing remedies present a dilemma to policymakers: on the one hand, safeguards must be adequate for prevention, detection, and pursuit; on the other, they must not be

unduly burdensome or intrusive for policyholders, providers, insurers, and law enforcement officials.

A national commission, composed of diverse members with balanced viewpoints, could foster communication and identify ways to address obstacles that prevent the efficient pursuit of fraud and abuse. Therefore, we have previously recommended that the Congress consider establishing a national health care fraud commission composed of private and public payers, providers, and law enforcement agencies. Such a commission would be best suited to weighing such important trade-offs as greater information-sharing among insurers vs. concerns over privacy and antitrust issues and greater regulation of provider ownership arrangements vs. concerns about restraint on competition. The commission could also be responsible for developing recommendations addressing (1) how insurers can coordinate case development and prosecution efforts, (2) whether and how to regulate unlicensed medical facilities, and (3) how insurers can standardize claims information and billing rules.

* * * *

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

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