OBAMA-BIDEN TRANSITION PROJECT

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Fighting Medicare Fraud

More Bang for the Federal Buck

prepared for

Taxpayers Against Fraud Education Fund

by

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President
Economic and Social Research Institute

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Statement of Purpose and Summary of Findings

"For every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives fifteen dollars back in return."

The Medicare program is projected to spend $327 billion in federal fiscal year 2006.[1] The program, which serves about 42 million people, has been expanded to include an outpatient prescription drug benefit, reflecting a new commitment of some $1.2 trillion in federal spending over the next decade. Thus, both taxpayers and Medicare beneficiaries have enormous financial exposure under Medicare. With all of this money in the program, the temptation to commit fraud is significant. The federal government must remain vigilant in fighting health care fraud, and maintain an arsenal of strong weapons to prevent and investigate fraud, and prosecute it vigorously when it occurs.

This report is an update of three earlier publications estimating the benefits and costs of the federal government's efforts to reduce health care fraud. It estimates the recoveries from government contractors associated with health care fraud cases (the benefits) as well as the costs incurred by federal agencies to investigate and prosecute this fraud. Bipartisan efforts to reduce fraud led in 1986 to amendments strengthening the False Claims Act (FCA), which establishes liability for contractors that commit fraud by submitting false or fraudulent claims for reimbursement to the federal government. These amendments enhanced the role of whistleblowers with inside information about fraudulent practices of government contractors, facilitating their ability to sue fraudulent contractors on behalf of the federal government and increasing the amount of allowable recoveries.

The False Claims Act and its whistleblower provisions have been particularly effective in the fight against Medicare fraud. In previous studies conducted for Taxpayers Against Fraud (TAF) in 2001, 2003, and 2005, we have found that the return on anti-fraud efforts has been rising—from about $8 for every $1 invested in health-related FCA enforcement activities, to $13. By far, the most significant portion of the government's recoveries were attributable to FCA cases. Now, as documented below, we find that the return on the taxpayers' investment continues to rise.

Based on an analysis of data for the five-year period FY 2000–FY 2004, we conclude that the U.S. taxpayers are getting a return on their dollars invested in fighting health care fraud that is nearly double the rate of return identified in our first study. *Specifically, federal government recoveries from civil health care fraud over this period totaled approximately $7.3 billion as shown in figure 1; after deducting payments to whistleblowers, the net recoveries to the federal government amounted to $6.64 billion over the 2000–2004 period. We estimate the*

1. Net Medicare mandatory outlays (mandatory outlays less total offsetting receipts including premiums and amounts paid by the states) are projected by CBO to reach $326.8 billion in FY 2006. This is only the cost to the federal government; Medicare enrollees also pay a very large share of the cost through premiums, deductibles, and co-payments. A more inclusive measure from the National Health Expenditure (NHE) Amounts shows that when the enrollees' share of spending is added, total Medicare outlays in 2006 will be about $420 billion.

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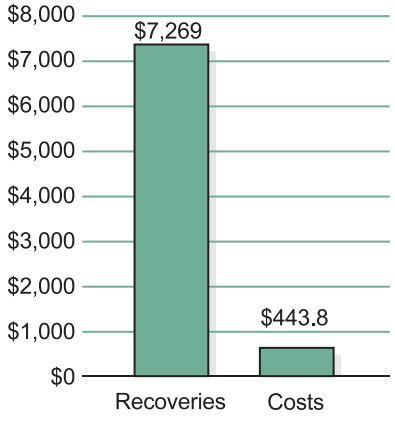
Figure 1 Recoveries and Costs of Federal Government Anti-Health Care Fraud Activities. FY 2000–2004 (in millions)



government's costs over this five-year period to be $443.8 million. Thus, for every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives $15 dollars back in return.

Why did the federal government's return on investment improve from 8 to 1 over the 1997–2001 period to 15 to 1 from 2000 to 2004? This jump occurred because the federal government's recoveries between FY 2000 and FY 2004 increased far more rapidly than its enforcement costs. Civil health care fraud recoveries in FY 2004 were $1.8 billion, about two and half times the level recovered in FY 2000. Government enforcement costs were also a little higher over this five-year period than the previous ones, and total outlays related to civil health care fraud enforcement were about $100 million in 2004. But the overall estimated increase of about $32 million between 2000 and 2004 was not nearly as large as the gain in recoveries.

The benefit/cost ratio of $15 to $1 is likely to underestimate the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. That is because, in addition to the actual monetary recoveries resulting from FCA investigations and prosecutions, there are also deterrent effects that affect the behavior of other firms in the industry. Major settlements with large recoveries have a ripple effect that reduces the likelihood of similar fraud against the Medicare program. These deterrent effects cannot be measured accurately at this time, but may be a substantial multiple of the direct, measurable benefits in the form of actual monetary recoveries.

Firms doing business with Medicare now realize that they have a great deal at stake when they fraudulently bill the federal government. As already noted, they may be liable for huge damages, which may be large enough to substantially weaken the firm. Further, FCA litigation can cause the government to seek additional remedies. Though rarely used in connection with FCA cases, defendants may be excluded from participating in Medicare. Corporate officials have occasionally been subject to criminal prosecution. Criminal investigations at DOJ sometimes parallel civil FCA investigations.

The FCA and its whistleblower provisions are central to the federal government's anti-fraud efforts. They provide the federal government with the insider information it needs to uncover complex business fraud against Medicare and the clout it requires to recover stolen funds and deter future fraud. But the Department of Justice, which administers the FCA, must use its authority in a balanced manner. On one hand, DOJ should resolve as many cases as possible among those that are "new matters." This is defined as newly received referrals and investigations, and newly filed qui tam actions. These new matters are running at a level of nearly 500 per year.[2] Yet, the federal government is resolving less than 100 cases per year. For example, in FY 2005, a little over 90 cases

2. For example, in FY 2005, 494 new matters were brought to the U.S. Department of Justice, of which 394, or about three-fourths, were *qui tam* cases. See Fraud Statistics-Overview: October 1, 1986-September 30, 2005. Civil Division, U.S. Department of Justice.

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"The FCA and its whistleblower provisions are central to the federal government's anti-fraud enforcement."

were resolved, or about one-fifth of the new matters brought to the government in 2005. On the other hand, while the federal government should enforce the FCA with vigor, it must also respect the rights of companies in the health care industry, continue to promote compliance plans that prevent fraud at the front end, and distinguish carefully between honest billing errors and fraud. If the provisions of the FCA are enforced in this fashion, it will continue to save large amounts of money for federal taxpayers and contribute to the financial viability of the Medicare program.

The May 1, 2006, report of the trustees of the Medicare Trust Fund (MTF) indicated that the fund balance will remain solvent only until the year 2018; clearly, some difficult decisions will have to be made to assure Medicare's long-term solvency. The impact of the new outpatient drug benefit on Medicare's "day of reckoning" remains to be determined. Spending estimates have been rising, but the authorizing legislation includes changes to Part B payment methodologies for reimbursement of certain technologies which have already elicited significant savings under the program. The Medicare Prescription Drug Improvement and Modernization Act (MMA) revised the payment methodology for certain drugs and biologicals covered under Part B of Medicare. Beginning in 2004, reimbursement was reduced by about 15 percent below 2003 average wholesale prices. According to the Congressional Budget Office, the changes to the Part B payment methodology will lead to a reduction in spending of $15.2 billion over ten years ($200 million saved in 2004).[3]

With an aging population and sharply rising Medicare spending (even before the baby boomer demographic wave has hit the shore), we cannot afford a major drain on the Medicare program from fraud. Every dollar that is siphoned off from the program's funding sources by fraudulent billing practices makes the painful choices we face in assuring Medicare's solvency even harder. If fraud is not curtailed, it will be paid for by those enrolled in the program in the form of future benefit cuts and by working-age people in the form of higher taxes. Fraud will also be paid for by honest physicians, hospitals, and other health care providers whose rates will be further cut to help control the cost of the program. Each of these parties—seniors, taxpaying workers, and health care providers—has a financial stake in curtailing health care fraud.

The federal government needs strong sanctions to deter health care fraud because the money at stake can frequently be enormous. And, because dishonest practices are now very complex, sophisticated, and difficult to detect, the government will continue to need the help of employees working inside health care providers' companies. Provisions of current law empowering and protecting whistleblowers must be maintained so that they can bring action against those perpetrating fraud without fear of retaliation. Potential damages must be large enough to matter to large corporations who could brush aside or ignore small penalties.

3. U.S. Department of Justice. Health Care Fraud and Abuse Control Annual Report. 2005.

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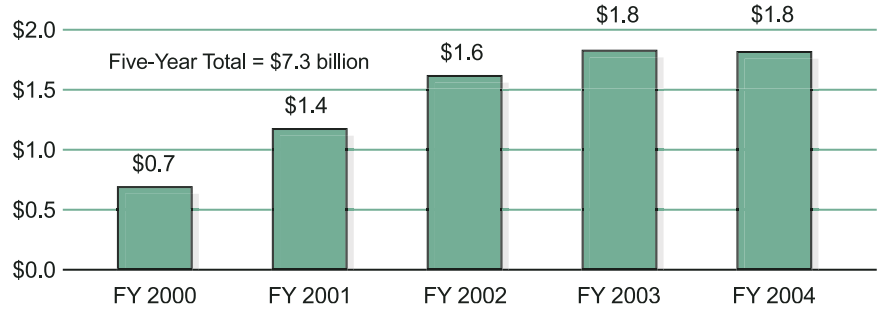
Findings

This section presents the key findings of this project. The report presents data on both recoveries and costs over the five-year period from federal fiscal years 2000 through 2004. The report begins with the latest findings on the federal government's *recoveries* from its work in fighting health care fraud. We identify health care fraud recoveries for each of the five fiscal years over the 2000–2004 period. The next step is to update the trends in the federal government's *costs* in pursuing the perpetrators of fraud. Here we estimate the costs incurred by the DOJ's Civil Division, the United States Attorneys Offices (USAOs), and the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services. This tells us how much the taxpayers are laying out to obtain these recoveries. Finally, these costs are compared to the benefits to demonstrate the cost-effectiveness of the government's effort. What is the "bang for the buck" emerging from government's anti-fraud initiatives?

Trends in Government Recoveries

Our starting point is to estimate total health-related civil fraud recoveries over the five-year period. Over the 2000–2004 period, this amount totaled approximately $7.3 billion. Some $3.6 billion of this amount has been collected in the last two years (see Figure 2).

Figure 2 Health-Related Civil Fraud Recoveries Per Year, FYs 2000–2004 (in billions)



Source: U.S. Department of Justice

Savings of this magnitude can make a modest, but significant contribution to the long-run solvency of this vital program. This occurs because *the bulk of the funds recovered from successful investigations and prosecutions of fraud are returned to the Medicare Trust Fund. (See Figure 3) In fact, the money returned to the trust fund greatly exceeds the amount allocated to fighting health care fraud.*

Trends in Government Costs

What is the federal government spending to achieve these results? Some staff and related costs are paid for out of general revenues. But the more important source of funding for both DOJ and OIG in HHS comes from allocations

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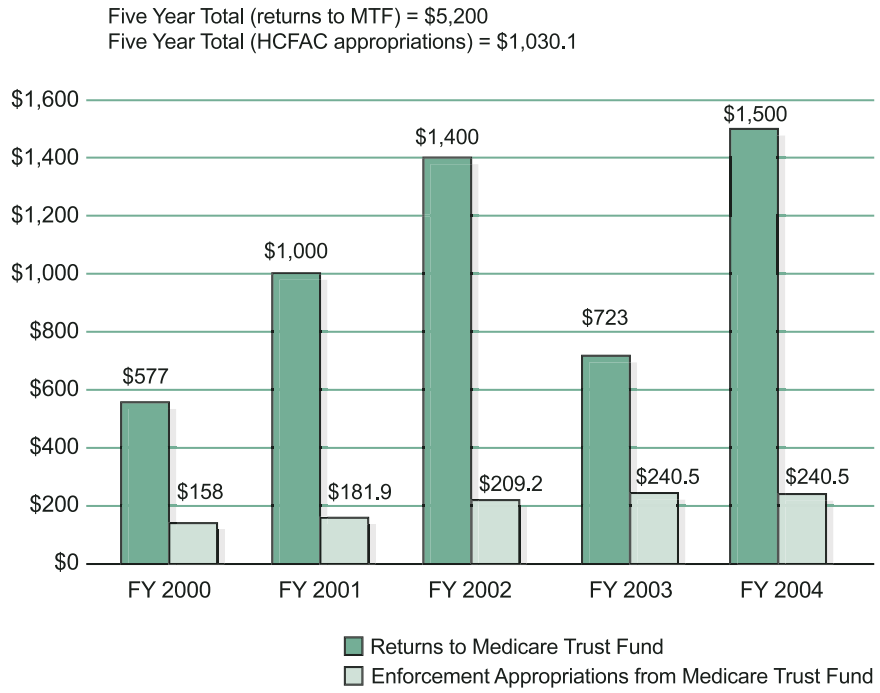
Figure 3 Total Funds Returned to the Medicare Trust Fund (MTF) versus Total Funds Appropriated from the MTF for Health Care Fraud Enforcement, FYs 2000–2004 (in millions)



* The figures for FY 2001 and 2002 are approximate estimates of the amounts returned to the MTF. The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2001 notes that "more than $1 billion of the funds collected and disbursed in 2001 were returned to the Medicare Trust Fund." The same report covering FY 2002 notes that "approximately $1.4 billion was returned to the Medicare Trust Fund."

Source: The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program. Annual Reports for FY 2000–2004.

from the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC is a national health care fraud prevention program set up under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is administered jointly by DOJ and HHS. HCFAC provides an annual source of funds to DOJ and OIG to cover a portion of their costs in fighting health care fraud through the enforcement of the FCA. HCFAC established a special expenditure account with annual appropriations from the Medicare Hospital Insurance Trust Fund (MTF). Funds are disbursed annually from this account to various divisions in DOJ and HHS to fund their anti-fraud activities.

DOJ Costs in Fighting Health Care Fraud

The first step in the estimate of costs is to determine the budget for the activities in DOJ that are directly involved in fighting fraud and generating recoveries. Two components of DOJ meet these criteria—the civil fraud enforcement activities of the Civil Division and the civil fraud litigation activities of the United States Attorneys Offices (USAO).

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Civil Division's Costs. The Civil Division of DOJ is estimated to have spent a total of $89.7 million on civil health care fraud enforcement between 2000 and 2004 (see Table 1). This incorporates past estimates based on DOJ data, updated by our own estimates. Data included in the budget for the U.S. Department of Justice indicate that the number of positions in the Civil Division have been rising at less than 1 percent per year. Since staff costs are the primary component of overall costs, we take this as an indication that there has been only a slight increase in staff costs. Of course, this staff change is for the full division, which works on a number of other types of cases. Lacking precise data related to attorneys and staff working directly on health care fraud, we made a small upward adjustment in costs from 2003 to 2004.

Table 1 DOJ/Civil Budget for Civil Health Care Fraud Enforcement

	Fiscal Years					
	2000	2001	2002	2003	2004	**Five-year Total**
Amount spent on civil health care fraud enforcement (in millions)	$17.2	$17.5	$18.0	$18.0	$19.0	**$89.7**

Source: DOJ/Civil Division and the Economic and Social Research Institute. The data for 2000 and 2001 were provided by DOJ. Data for the subsequent years are ESRI estimates.

USAOs' Costs

Most USAOs have an Affirmative Civil Enforcement (ACE) unit in their General Civil Litigation section that investigates and prosecutes civil FCA cases. Civil *fraud* litigation is not their only area of work, however, and there are clearly cases outside of the health care field.

To estimate the USAO costs attributable to combating health care fraud, we begin with the total USAO budget over the five-year period. This amount is $6.911 billion. On average, 22 percent of the budget went to Civil Litigation over this period. Applying this percentage to the whole budget yields an estimate of $1.520 billion for civil litigation by USAOs over the 2000–2004 period.

The next step is to estimate how much of this amount goes for civil *fraud* litigation. To obtain this estimate, which does not appear in budget figures, we interviewed several U.S. Attorney's offices. Amalgamating their estimates yielded an approximate figure of 26 percent of the salaries and related litigation costs of USAOs' Civil Litigation staff that is dedicated to *civil fraud litigation* (which, according to the USAOs, is virtually 100 percent FCA enforcement). This yields a dollar amount of $395.3 million for the *civil fraud budget of the USAOs* over the 2000–2004 period. We assume that 65 percent of this amount was attributed to fighting health care fraud in 2000 and 2001, and that the corresponding proportion was 80 percent in 2002, 2003, and 2004. This yields an estimate that $312.3 million was devoted to the USAO activities in fighting *health-care related civil fraud litigation* over the five-year period.

Table 2 shows the outlays for USAOs related to civil health care fraud.

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Table 2 Amount Devoted to the USAO Activities in Fighting Health-Care Related Civil Fraud Litigation, Fiscal Years 2000–2004

	Fiscal Years					
	2000	2001	2002	2003	2004	**Five-year Total**
USAOs Costs (in millions)	$43.7	$47.0	$74.1	$76.3	$71.2	**$312.3**

Source: U.S. Department of Justice, U.S. Attorney's Offices: Ten-Year Display of Budget Authority and Positions, 1995–2004. These numbers were calculated using the annual budget authority multiplied by 0.22. This number was then multiplied by 0.26. This number was then multiplied by 0.65 for 2000–2001, the estimated proportion of civil fraud litigation attributable to health care in those years, and by 0.8 for 2002, 2003, and 2004, the estimated proportion attributable to fraud in those years.

OIG Costs

We now turn to estimating the costs associated with civil fraud incurred at the Office of the Inspector General at HHS. With the assistance of OIG, we estimated the portion of their activity that could be attributable to *civil health care fraud* enforcement. The Department provided data on costs related to civil health care fraud incurred in three areas: (1) the Office of Investigations; (2) the Office of Audit Services; and (3) the Office of Evaluations and Inspections. OIG calculated the number of hours of work that their staff in each of these divisions devoted to civil fraud enforcement, and also provided us with fully loaded hourly rates of compensation reflecting not only salaries but also employee benefits and overhead.[4] Using these figures, we determined the following total costs for each group of OIG employees in fiscal year 2001:

Table 3 OIG Costs Related to Civil Health Care Fraud Enforcement, Fiscal Year 2001

Office	2001 Costs (in millions)
Office of Audit Services	$4.98
Office of Investigations	$3.32
Office of Evaluation and Inspections	$.002
Total	**$8.302**

Source: OIG, HHS

4. In calculating the staff and related costs attributable to civil health care fraud enforcement, OIG excluded certain cost items that are not relevant to our inquiry. These include criminal cases, employee misconduct cases, and grant fraud cases. Note that in some cases tracked as criminal cases, OIG staff may simultaneously be working on the civil fraud implications. OIG also excluded hours of work related to civil health care fraud undertaken in the general counsel's office.

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Comparing this total for 2001 to the HCFAC allocation in that year yields an estimate of HCFAC outlays to the HCFAC allocation. Applying that ratio to 2004 enabled us to update our previous work and resulted in an estimate of $10.2 million for 2004 (see Table 4).[5]

Table 4 OIG Costs Attributable to Civil Health Care Fraud and HCFAC Allocation to OIG, 2000–2004 (in millions)

	Fiscal Years					
	2000	2001	2002	2003	2004	**Five-year Total**
OIG Outlays for Civil Health Care Fraud	$7.6	$8.3	$6.2	$9.5	$10.2	**$41.8**

Source: OIG, HHS. The numbers shown above for 2000 reflect 6.4 percent of the HCFAC allocation reflected back on that particular year. The 2001–2003 numbers are based on actual OIG data. The figures for 2000 and 2004 are estimated.

It is important to note that the Office of the Inspector General figures provided to us for OIG outlays are estimates of only the cases that were opened as civil cases. The OIG believes that many other cases that are opened by the Office of Investigations are criminal matters and are treated as criminal cases, not civil cases. We were unable to obtain data that would include cases opening both as criminal and civil cases (some cases that start out as one of these may later involve the other). In the absence of such data, we made an alternative estimate of the benefit/cost ratio using the assumption that OIG costs were twice as high as reported in Table 4, or about $83 million over the five-year period instead of a little less than $42 million. With this adjustment, the benefit/cost ratio would be 13.7 to 1 instead of the 15 to 1 ratio we report based on data supplied by OIG.

Total Federal Government Costs

We now sum the costs from all three sources to arrive at total federal government costs for each of the five years in our study period. Table 5 shows that total costs equalled $443.8 million over the 2000–2004 period.

Benefit/Cost Ratio

We can now calculate the benefit/cost ratio. To capture the government's net benefit, we need to first remove the portion of the health-related FCA recoveries paid to relators in *qui tam* cases. According to DOJ data, relators were paid $627 million in health-related civil fraud cases in the years 2000–2004. Thus

5. Since we do not have corresponding data on the OIG outlays related to civil fraud enforcement for earlier years, we make the simplifying assumption that this ratio held constant over the period. We then updated the OIG outlays to FY 2002, 2003 and 2004 by assuming that the increase from year to year in the earlier period also applied to the more recent years. While this may be imprecise in either direction, the approximate order of magnitude is likely to be correct as there does not appear to be any dramatic change in the way OIG went about its work in this area over the period of time covered by our study.

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Table 5 Federal Outlays for Civil Health Care Fraud Enforcement, 1999–2004 (in millions)

	Fiscal Years					
	2000	2001	2002	2003	2004	2000–2004
DOJ Civil	$17.2	$17.5	$18.0	$18.0	$19.0	$89.7
USAO	$43.7	$47.0	$74.1	$76.3	$71.2	$312.3
OIG Outlays for Civil Health Care Fraud	$7.6	$8.3	$6.2	$9.5	$10.2	$41.8
Total	**$68.5**	**$72.8**	**$98.3**	**$103.8**	**$100.4**	**$443.8**

we remove $627 million from the health-related civil fraud recoveries of $7.269 billion. Therefore, the total amount of the recoveries being returned to the government is approximately $6.64 billion.

Table 6 shows that the ratio of the federal government's direct benefits from civil health care fraud enforcement to its costs is 15.0 to 1.

Table 6 Benefit-Cost Ratio, FYs 2000–2004

	Benefits	Costs	Benefit-Cost Ratio
Estimate	$6.642 billion	$443.8 million	15.0:1

The benefit-cost ratio has nearly doubled since we began estimating it in 2001. The return on federal outlays to fight Medicare fraud has gone from roughly 8 to 1 five years ago to 15.0 to 1 this year, as shown in Table 7.

Table 7 Trend in Benefit-Cost Ratio for Federal Anti-Fraud Initiatives

	Period Studied			
	1997–2000[6]	1997–2001[7]	1999–2003[8]	2000–2004[9]
Benefit-Cost Ratio	8.3	8.7/1	12.7/1	15.0/1

6. Published September 2001; http://www.taf.org/publications/PDF/925_taf.pdf

7. Published June 2003; http://www.taf.org/publications/pdf/fightingmedicarefraud.pdf

8. Published April 2005; http://www.taf.org/MedicareFraud040805.pdf

9. Published June 2006; http://www.taf.org/MedicareFraud06.pdf

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Conclusions and Recommendations

"The benefit to cost ratio of 15 to 1 is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement."

The U.S. taxpayers are getting an excellent return on their dollars invested in fighting fraud against the Medicare program. Our findings show that for every dollar spent to investigate fraud, recover funds obtained through illegal billings, and prosecute these civil cases, fifteen dollars are received in return. This order of magnitude of the rate of return on the government's investment makes this area of government expenditures unusual, if not unique. Civil health care fraud is surely one area of the federal budget where the government is running a substantial "surplus."

The benefit/cost ratio of fifteen to one is likely to be an underestimate of the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. The indirect benefits associated with deterrent effects, described earlier, undoubtedly add substantially to the public's benefit.

As a result of the higher stakes for health care companies, many firms have become far more vigilant about their internal operations in an effort to comply with the law. Our earlier study concluded that firms are less likely to threaten and intimidate employees who detect apparent fraudulent billing practices now that they are aware that such employees could become whistleblowers and be protected from corporate retaliation. Administrative remedies are frequently implemented by OIG in conjunction with FCA investigations and settlements pursued by DOJ. One important area of collaboration between the two federal agencies involves Corporate Integrity Agreements (CIAs). These agreements are developed jointly by OIG and the companies alleged to have committed fraud during FCA settlement negotiations. CIAs are now part of most FCA settlements.

During the course of our work on our in-depth study of health care fraud, we uncovered many examples of the "deterrent effect" emerging from the combined activities of the federal government. In addition to the CIAs, many of the consulting firms apparently switched from advising companies how to "beat the system" to advising them on how to comply with the letter of the law and stay out of trouble. These indirect effects of the FCA's potentially large settlements and its whistleblower provisions are important. If a large settlement agreed to by *one company* not only changes its behavior in the future, but also has a sentinel effect that changes behavior throughout the industry, then the ripple effect of the FCA is very widespread. The indirect effects, which cannot be measured accurately at this time, may be a substantial multiple of the direct, measurable benefits in the form of monetary recoveries.

"The FCA… will continue to save large amounts of money and contribute to the financial viability of the Medicare program."

The government must use its authority with both vigor and caution. The whistleblower and penalty provisions of the law should be retained in order to provide the federal government with the assistance it needs to uncover fraud and the clout it requires to recover stolen funds. But it must also respect the rights of companies in the health care industry, continue to promote corporate agreements that deter fraud at the front end, and distinguish carefully between honest billing errors and fraud.

If the provisions of the FCA are enforced in this fashion, the Act will continue to save large amounts of money and contribute to the financial viability of the Medicare program.