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Crippling America Health: Care Fraud Incentives

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Introduction

Clearly an imbalance is occurring in the system as health care fraud claims reach new bounds. There are many types of health care fraud, but the most general analysis involves the submission of claims that never occurred for reimbursement. This thesis will analyze the incentives acting upon different groups affected by the specific act of health care fraud of submitting fraudulent claims, and also possible solutions to change these incentives into the public's best interest. An analysis of the incentives given to the key players in this game will hopefully show where legislators can focus to improve the current state of affairs.

Three basic assumptions need to be made in order to perform a cost-benefit analysis on health care fraud. First, fraud is a rational crime. Fraud is not a crime of passion but instead a crime of reason and calculation. Second, if the benefits from performing an act outweigh the costs of performing the act, the individual has an incentive to perform the act. Lastly, if the costs equal the benefits the individual will make decisions based off of his or her aversion to risk. Legal acts are generally considered to be less risky than illegal acts.

Interpreting the current statistics on fraud using the assumptions previously made, fraudsters must be finding the benefits of committing health care fraud to be greater than the costs. By analyzing not only the incentives and disincentives the current system provides to fraudsters but also the incentives and disincentives to all players in the game, a better understanding will be found of why things happen and what can be done to initiate a change.

Background

In 2006 Americans spent 2.16 trillion dollars on health care and are expected to spend 3.3 trillion dollars in 2012 on health care.[1] Health care costs have grown dramatically compared to the gross domestic product, GDP, almost twice as fast.[2] In 1960 health care accounted for only 5.2% of the GDP, but in 1990 and 2006 it represented 12.4% and 16.5% of GDP respectively.[3] One explanation for the accelerated growth of health care services is an increase in fraud. Fraudulent claims are predicted to account for around 3-10% of all health care claims.[4] The actual percentage of fraudulent claims is unknown since not all cases of fraud are detected. A survey in the Journal of the American Medical Association reported 39% of physicians admitted to committing health care fraud "sometimes" or more often in the last year.[5] Perhaps fueled by public acceptance of fraud as a justified act, fraud has become a part of society.[6]

Current figures of recoveries are not actually good predictors of current levels of fraud. Instead those figures only reflect on the amount of discovered fraud and how well the justice system reacts to it.[7] Comparing trends of fraudulent claims across years can only measure detection of fraud but never its prevalence. The methods of fraudsters are constantly adjusting to actions by insurers and the government to stay hidden; therefore, comparing trends of fraudulent claims across years measures only detected fraud and provides as only a vague predictor of the true prevalence of fraud. An actual prediction of the amount of fraud occurring is not necessary to properly manage fraud however, for spending more money than is recoverable is illogical.

Terminology

This thesis will focus primarily upon the perceived values associated with fraud instead of the true values. A distinction must be made between the true values and the perceived values. A probability exists a person submitting fraudulent claims will be detected although this probability is incalculable because of the multitude of the incalculable variables affecting it, such as the skill level of the fraudster. Instead of using true values fraudsters, insurers, patients, and the government use what they perceive the values to be. The estimations of the true value will not be precise and will differ across individuals and cases. The player's estimations will vary from the true values due to incomplete or incorrectly interpreting information.

Instead of using the true probability someone gets caught committing a crime, criminals use what they perceive as their probability of detection. The perceived probability of detection is influenced by knowledge of previous detections of criminal acts and a comparison of the criminal's skills of evasion to the criminals who were caught and the criminals who got away.

On the other side of the issue, insurers and the government have to try and perceive the probability they catch someone who commits health care fraud. The insurers and the government determine this probability partly by using the same information available to fraudsters by analyzing previous prevalence and detection. The insurers and the government have an advantage compared to the public however because they know the current capabilities of their detection technology.

Five possible outcomes will be considered for resolutions for an act of health care fraud; undetected, detected but not prosecuted, detected and settled, detected and convicted, detected and not convicted. By calculating the cost of each resolution and

multiplying by the probability it occurs the expect value of the costs associated with health care fraud can be determined. Obviously some cases will warrant different probabilities so this needs to be done on a case-by-case basis when calculated in real life. The costs associated with undetected fraud will be assumed to apply to detected fraud as well.

Incentives for Fraudsters

The amount of money stolen times the perceived probability of not getting caught is the benefit someone can expect to receive from committing health care fraud. The individual's perceived probability of getting caught not the actual probability the individual gets caught is used because the actual probability is unknown. The individual must try and calculate the probability they get caught based on how skillful their deceit is thought to be in relation to the believed quality of the controls set in place by the insurers and the government. The estimation of those factors varies across individuals due to differences in skill, ego, and knowledge of the system.

Fraudsters have certain costs even if not detected. The actual cost of committing the fraud is easiest to identify. The cost involves purchasing computers and software to summit claims, paying off patients or buying patient numbers, and paying for wages for any workers. The most intriguing cost is the opportunity cost. Doctors or other professionals committing fraud have a very high opportunity cost. Other types of fraudsters, who are career criminals, have a very low opportunity cost. Finally, a price must be placed on an individual's morality. Pricing morals must be done to explain why some people who would otherwise have a positive expected value from committing

health care fraud abstain. A fraudster escapes legal punishment if he or she is never detected. This is the best category to fall in for fraudsters because all costs besides the ones already mentioned are avoided.

Resolutions after detection follow a different analysis then the fraud since the question is no longer if a crime occurred but instead if a crime can be proven, the cost of proving the crime, and ability for reparations if a guilty judgment is achieved. Many fraudulent cases are detected but lack sufficient evidence to warrant a prosecution. In financial year 2006 the Federal Bureau of Investigation investigated 2423 cases but only indicted 588, or 23%.[8]

If health care fraud is detected but not prosecuted new financial costs arise. Doctors identified as fraudsters or investigated for fraud face a risk of losing patients. Rush Limbaugh has described the American society's reaction to criminal proceedings as, "the nature of the evidence is irrelevant, its the seriousness of the charge that matters."[9] Therefore even innocent practitioners suffer because of fraud and have incentives to summit claims with caution.

In FY 2006 63.4% of investigations led to prosecution recommendations.[10] If the government, insurer, or whistle blower decides to prosecute the case legal fees begin to accrue. If the probability of a guilty verdict times the judgment is greater than the cost of the fraudster's attorney fees then settling out of court is the best course of action for the defendant. Making the assumption that prosecutors are acting solely in the interest of receiving the maximum expect value of money for their clients, they will settle out of court for an amount greater than the probability of a guilty conviction times recoverable amount of the judgment. Making the assumption all attorneys will always act in the best

interest of their client always is debatable since they may have incentives to take a case to trial to increase earnings although settling would be the best resolution for their client.

Of those health care fraud cases recommended to prosecutors by the FBI, 64.4% ended in sentencing[11]. If convicted a person committing health care fraud can be forced to repay up to three times the amount of money stolen and pay a fine from $5,500 to $11,000 per false claim. Exclusion from Medicare and Medicaid programs is an optional punishment. In the financial year 2006 91.5% of convictions resulted in incarceration with an average duration of 43 months.[12] Excluding the fraudster and his or her family from participating in Medicare and Medicaid is also a possibility for prosecutors to pursue.[13]

If the jury fails to deliver a guilty verdict, many costs still arise. The practitioner is still minus his or her legal fees. The opportunity cost of time spent at the trial is also not reimbursable nor is the stress forced upon the practitioner and his or her family.

Incentives for Patients

For patients participating in fraud, money dominates the reasons that patients are assisting in health care fraud. Assisting with health care fraud, patients can make a small amount of money compared to the costs their participation imposes on society. The cost of the fraud is spread across all other individuals in the system so the patient committing health care fraud only pays small fraction of that cost. Another costs facing patients is the always-present opportunity cost. In response to a patient's opportunity cost, fraudsters have targeted low wage earners with health coverage, people on Medicare or

Medicaid, and children to assist with fraud. Patients entering into fraudulent activity also face a cost on their morals.

Patients do not have to be involved to foster the growth of fraud. Many patients have their patient id number stolen and distributed on the black market.[14] False claims are then submitted using that id number. Patients catch many types of this fraud on their bills after payments have been made. Vigilant consumers catch other cases of fraud, such as double billing, or actual legitimate mistakes.

Incentives for Whistle Blowers

Whistle blowers, before the False Claims Act was amended in 1986, had only two possible incentives for bringing forward critical information about health care fraud perpetrators. Neither incentive was monetary but both left the whistle blower with a satisfaction not easily obtained otherwise. The first incentive for a whistle blower was and still is clearing his or her conscious; no longer having to deal with the guilt of stealing money from companies or hurting patients with ill-advised medical care or sitting by idly watching such thing happen. Revenge constitutes the second reason for coming forth. Many whistle blowers bring suits sometime after being let go from a company.

Under the False Claims Act amendment in 1986, whistle blowers are now allowed to bring Qui Tam lawsuits against companies or individuals submitting false claims against the government. A monetary incentive is added to the emotional incentives to report health care insurance abuse. Under the False Claims Act qui tams can receive 15-15% of the proceeds or settlement of the claim if the government proceeds with the

case.[15] If the government does not proceed with the case the qui tam can act alone and claim 25-35% of the proceeds or settlements.[16] Regardless of the governments choice the qui tam has the right to be reimbursed for reasonable expenses accrued related to the case if a guilty verdict is rendered. The whistle blower obviously has incentives to believe the case will result in a conviction, but many deterrents not explicitly stated in False Claims Act. If the government does not choose to pursue the case and the qui tam does, the qui tam must have sufficient funds to cover the expenses. Qui tams face a substantial opportunity cost because of the length of trials. The opportunity cost for the qui tam is less if the government pursues the case because the qui tam only has to be a material witness instead of managing the case. If the case fails to convict the defendant the qui tam does not recover any money so the qui tam has a monetary incentive to pursue the case only if he or she believes the case has a chance of a conviction.

Incentives for Insurers and the Government

Insurers and the government have obvious incentives for preventing and detecting health care fraud, they save money. The government has the additional incentive that upholding laws is its responsibility. Currently very little effort is exerted into prevention except through legislation and deterrent punishments leaving most of the emphasis on detection. Another preventive measure is making the process to file claims more thorough however this measure has an external cost on all providers.

Detecting health care fraud can be as simple as asking for additional verification as in 1996 that detected $23.2 billion dollars, or 14% of total payments, as

overpayments.[17] Two years later however, the number of fraudulent cases detected with that method dropped almost in half, demonstrating the adaptability of fraudsters.[18]

New advances have been made in sifting through the flood of claims made every year in datamining. By analyzing the skewness of the claims by the number of claims per doctor, the number of claims per type, and the size of claims, suspicious claims can be flagged for closer inspection.[19]

The question facing insurers and the government, "is money better spent on prevention or detection of fraud?" Preventing fraud leaves the insurer with no monetary loss while detection leaves the insurer with the costs of the recovery process. Prevention can also make filing legitimate claims more complicated and payment waits longer. If the costs are equivalent for both methods and both methods are equally effective, then prevention is clearly the better choice for saving money. In reality a combination of prevention and detection is the best course of action.

New Incentives Created by Managed Care

Managed care represents a new game created with new rules and new incentives different from traditional fee for service care. Although managed care solves most of the problems attributed to fee for service, managed care creates new, more abstract problems. Instead of being able to charge for services not performed or marking up the price of services performed, health care practitioners receive a capitation to cover the care of the patient under managed care. Some payment periods the practitioner may spend more money treating patients and some payment periods the practitioner may spend less, but overall in the long run spread out across all of the patients the capitation will provide

adequate payment for services provided. The risk and incentive for cost effective care are therefore passed onto the practitioners.

Cost effective care can differ from the best medical care, so practitioners are now responsible for choosing the most cost and medically effective method possible. Unfortunately for patients the most cost effective method is often inversely related with the most medically effective method. The most cost effective method of treating patients is not treating patients at all. Managed care would thrive in a Utopian society where all participants in medical care strive for providing the best health coverage at a reasonable price. Unfortunately America is not a Utopian society in that sense. Each participant acts to maximize his or her utility under a managed care sometimes creating a worse system than fee for service because it lacks checks and balances.

Conclusion

By changing the probability fraudsters' perceive of detection and the severity of punishments, a change in fraudsters' actions will be instigated. Creating better rewards for whistle blowers will increase the probability they come forth with valuable information. Better detection methods and a heavier emphasis on preventing health care fraud by both insurers and the government will lead to a decrease in fraud, although perhaps an increase in detected fraud. Health care fraud is a serious problem plaguing the American society, but it is also a manageable problem.

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