

Fighting Health Care Fraud:
An Integral Part of Health Care Reform



The National Health Care Anti-Fraud Association

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June 2009



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I. THE NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION (NHCAA) – WHO WE ARE AND WHAT WE DO

Established in 1985 by several private health insurers and Federal and state government officials, the National Health Care Anti-Fraud Association (NHCAA) is the leading national organization focused exclusively on combating health care fraud. We are unique among associations in that we have always been a private-public partnership—our members comprise the nation’s most prominent private health insurers as well as those Federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

NHCAA’s Mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud.

NHCAA pursues that Mission by:

- Maintaining a strong private/public partnership in combating health care fraud;
- Providing unparalleled learning opportunities through The NHCAA Institute for Health Care Fraud Prevention;
- Providing opportunities for private- and public-sector information sharing on health care fraud investigations and issues;
- Serving as a national resource for health care anti-fraud information and professional assistance to government, industry and the media; and



- Recognizing and advancing professional specialization in the detection and investigation and/or prosecution of health care fraud through accreditation of health care anti-fraud professionals.

Our Members include 84 private-sector insurance members representing 200+ corporate entities, 69 public-sector members representing Federal, state and local government departments and agencies, and 400+ individual members who are typically health care fraud investigative personnel.

NHCAA represents those professionals who serve as the first line of defense against health care fraud, which we estimate conservatively accounts for 3 percent of our nation's annual health care spending—or \$68 billion. Other estimates by government and law enforcement agencies such as the FBI place the loss due to health care fraud as high as 10 percent of our annual health care expenditure—or an astounding \$226 billion.

IMPORTANT NOTE: This White Paper is not intended to represent the official view of any Federal, state or local government department or agency nor does NHCAA purport to speak in official capacity on behalf of these entities.

II. THE PROBLEM OF HEALTH CARE FRAUD

- Fraud Costs Our Health Care System Tens of Billions of Dollars Each Year

Health care fraud is a pervasive and costly drain on the United States health care system. In 2007 (the most recent year for which full statistics are available), Americans spent \$2.24 trillion dollars on health care.¹ Of those trillions of dollars, the Federal Bureau of

¹ See Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Health Expenditures Web Tables, at Table 1, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.



Investigation (FBI) estimates that between 3 percent and 10 percent was lost to health care fraud.² In other words, between \$67 billion and \$224 billion was stolen from the American public through health care fraud *in a single year*. To put the size of the problem into perspective, \$224 billion is approximately the Gross Domestic Product (“GDP”) of Portugal and is higher than the GDP of 138 countries, including Denmark, Ireland and New Zealand.³ Because the cost of health care is projected to rise rapidly over the next ten years⁴, see HHS Projections, at Table 1 (projecting increase in annual expenditure from \$2.24 trillion to \$4.35 trillion between 2007 and 2018), the cost of health care fraud is likely to rise as well. See FBI Report, at 9 (“Health care fraud is expected to continue to rise as people live longer. . . . These activities are becoming increasingly complex and can be perpetrated by corporate-driven schemes and systematic abuse by providers.”). In other words, health care fraud is already a massive problem and is only going to get worse – unless we do more to stop it.

- The Fraud Problem Affects the Public and Private Sectors

The enormous costs of health care fraud are borne by all Americans. Whether you have employer-sponsored health insurance, purchase your own insurance policy, or pay taxes to fund government health care programs, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits or coverage. As Colin Wong, head of California’s Medi-Cal fraud unit has explained, “[h]ealth care fraud often gets overlooked and even trivialized, because it’s seen as a victimless paper crime. . . . But, in reality,

² See Federal Bureau of Investigation, Financial Crimes Report to the Public, Fiscal Year 2007 at 9 (“FBI Report”), *available at* http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health.

³ See World Bank, Gross Domestic Product 2007, PPP, *available at* http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP_PPP.pdf.

⁴ See Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Health Expenditure Projections (“HHS Projections”), at Table 1, *available at* <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.



the financial burden falls on all of us. We pay for it with heightened health care premiums, increased taxes to pay for social service programs or . . . the reduction of services.” Erin McCormick, *Defrauding Medicare—No End to Flood of Schemes*, San Francisco Chronicle, Apr. 18, 2005.

For employers, health care fraud increases the cost of purchasing health care for their employees, which in turn drives up the cost of doing business. For individuals the effects are more immediate and more devastating: the increased cost of health insurance due to health care fraud can mean the difference between being able to afford health insurance or not. For governments, health care fraud means higher taxes, fewer benefits and increased budgetary problems.

Moreover, it is clear that many of the same individuals and entities that perpetrate fraud against government health care programs also perpetrate fraud against the private sector. Accordingly, any effective steps in the fight against health care fraud must address and incorporate both the public and private sectors.

- Health Care Fraud Harms Patients

In addition to being a financial problem, health care fraud has a human face. The victims of health care fraud include unsuspecting patients who are subjected to unnecessary or dangerous medical procedures, whose medical records are falsified or whose personal and insurance information is used to submit fraudulent claims. According to the FBI:

[o]ne of the most significant trends observed in recent health care fraud cases includes the willingness of medical professionals to risk patient harm in their schemes. FBI investigations in several offices are focusing on subjects who conduct unnecessary surgeries, prescribe dangerous drugs without medical necessity, and engage in abusive or sub-standard care practices.

FBI Report, at 10.

For example, in June 2006, Ohio doctor Jorge Martinez was sentenced to life in prison under a statute punishing health care fraud resulting in death. After a five-week trial, a jury convicted Dr. Martinez of 56 charges in connection with his illegal prescription of painkillers that resulted in the death of two of his patients. A contemporary news story described how “Martinez



prescribed painkillers only after patients agreed to receive injections to treat pain. . . . Martinez could then bill Medicare, Medicaid, the Ohio Bureau of Workers' Compensation and private insurers for the injections.” Mike Tobin, *Physician Gets Life for Drug Deaths*, Cleveland Plain Dealer, June 10, 2006. According to one Federal prosecutor, Dr. Martinez, “gave patients only cursory exams but billed insurers for sophisticated treatment . . . He submitted \$60 million in fraudulent claims to insurers and received payment on about \$12 million.” *Id.* Another prosecutor bluntly summed up the case: “[Dr. Martinez] pumped people full of pills, jabbed them with needles and lied to insurers solely to get rich . . . And people died.” *Id.*

Even when health care fraud does not result in death, the victims whose bodies are placed at risk by unscrupulous health care providers are often among the most vulnerable members of society. In March 2004, the Wall Street Journal reported that an FBI investigation had revealed that more than 100 Southern California clinics had “bilked [insurers and employers] out of somewhere between \$300 million and \$500 million in recent years by claims for unnecessary surgeries.” Vanessa Fuhrmans, *FBI Raids Surgery Clinics in Probe—Investigators Say Patients Were Paid to Have Surgery In a \$300 Million Scam*, Wall Street Journal, Mar. 19, 2004. According to the Wall Street Journal, “doctors perform medically unnecessary and overpriced procedures on patients recruited with cash rewards. The scam has involved thousands of willing patients, often low-income workers recruited from factory floors or assembly lines across the country, and has affected most large health insurers.” *Id.* Investigators reported that “this scam stands out for its scope and level of organization, and because people involved underwent unnecessary surgeries and other procedures, including endoscopy and sweat-gland removal.” *Id.*

The toll of this sort of health care fraud on patients whose bodies are risked for personal gain is both obvious and severe, but even less-obviously harmful forms of health care fraud can have subtle effects that may not reveal themselves for years after the fraud is committed. For example, if a health care provider alters a patient’s medical record in order to support reimbursement for a more expensive treatment than is warranted (whether or not the treatment is



actually provided), this false diagnosis becomes part of the patient's documented medical history. Such an erroneous medical history can have serious, unseen consequences: the victim may unknowingly receive the wrong medical treatment from a future provider; he may have difficulty obtaining life insurance or individual health insurance coverage or may find coverage much more expensive; or he may fail a physical examination for employment because of a disease or condition wrongly recorded in his medical record.

In addition to having one's medical records altered, patients can often become the victims of medical identity theft. Untangling the web of deceit spun by perpetrators of medical identity theft can be a grueling and stressful endeavor. The effects of this crime can plague a victim's medical and financial status for years to come. See, e.g., Joseph Menn, *ID Theft Infects Medical Records*, Los Angeles Times, Sept. 25, 2006, at A1 (describing ordeal of victim of health care related identity theft as a "40-hour-a-week job"). See also Konrad, *Medical Problems Could Include Identity Theft*, New York Times at B1 (June 13, 2009).

Given the impact on individual victims—both direct and indirect—described above, it is clear that "[h]ealth care fraud is not a victimless crime." FBI Report at 14. The seriousness of the threat and the enormity of the challenge posed by health care fraud cannot be overstated. As the FBI has bluntly summarized the problem, "[health care fraud] increases healthcare costs for everyone. It is as dangerous as identity theft. Fraud has left many thousands of people injured. Participation in health care fraud is a crime. Keeping America's health system free from fraud requires active participation from each of us." *Id.*

- [The Florida Example](#)

Health care fraud can strike anywhere, from small towns to major metropolitan areas, and from the East Coast to the West Coast, and everywhere in between. Some areas appear to have a bigger fraud problem than others – and these may serve as an example of how this problem can be addressed.

The State of Florida – particularly South Florida – has been a hotspot for health care fraud for more than a decade. Despite repeated efforts, the amount of fraud in this area



continued to grow. In recent years, aggressive, coordinated efforts have been directed at fraud by the Federal and state governments, working cooperatively with law enforcement agencies and the private health insurance industry. And, even while these efforts have created some important successes – and stopped hundreds of millions of dollars in fraud – these problems continue.

What we see in South Florida (and in many other places) captures many of the overall weaknesses in our health care system.

- A lack of effective controls in public and private health care programs, particularly when attempting to identify fraud prior to the payment of a fraudulent claim;
- The enormous losses which can be generated by a small segment of the system (one small geographic region generating hundreds of millions of dollars in fraudulent claims from just a few health care services);
- The impact from fraud affecting both public and private health care programs;
- The need for improved information sharing and cooperation between public law enforcement agencies;
- The additional – and equally important – need for information sharing between those public agencies and the private health insurance industry.

One example in Florida stands out – the problem of “phantom” health care providers – providers that do not exist except on paper, but who manage to defraud public and private programs of millions of dollars. A recent project in Florida to validate durable medical equipment (DME) providers demonstrated that nearly one third – 481 – of the 1600 DME providers simply did not exist. These phantom providers across South Florida collected hundreds of millions of dollars from Medicare, Medicaid and other public programs in a matter of years.

To deal with this problem, the Department of Justice (DOJ) has organized a Health Care Fraud Strike Force, led by DOJ criminal prosecutors. The government's efforts in South Florida



have focused on an experimental approach, designed to identify fraud more quickly, with aggressive follow-up action to promptly to cut off fraudulent payments and punish wrongdoers. These health care fraud “Strike Forces” work cooperatively at the state and Federal level, and include prosecutors, FBI agents, the HHS inspector general, state investigators, contractors who handle claims for Medicare, banks, and the Federal Centers for Medicare and Medicaid Services (CMS), the agency that administers the program. Recent statistics indicate that this strike force has helped deter approximately \$1.8 billion in fraud attempts against Medicare in South Florida alone. In the 12 months before the strike force arrived in Miami, South Florida DME firms billed Medicare for \$2.8 billion. Medicare paid \$687 million in claims. In the 12 months after it began its prosecutions, DME billings from the area fell 63 percent, to \$1 billion; Medicare payments fell 49 percent, to \$353 million.

Yet, while this Strike Force was investigating, much of the information about these phantom providers was also beginning to be developed by private health insurance entities, much of it driven by information provided by beneficiaries – individuals who received Explanation of Benefit forms from their public or private insurer for services they had not received. Once information began to be shared between the public and private sectors, NHCAA member company investigators and others were able to review beneficiary information to determine that the same social security numbers were being used repeatedly by these phantom providers. A search of claim histories showed short, intense billing cycles by these providers, use of the same SSN numbers, billing numerous services within a week or two, and many checks returned as non-deliverable or stale dated. When these alleged providers were contacted by telephone, the phone calls typically reflected disconnected numbers or full mailboxes. Messages that were left by investigators were never returned. In the few instances when a live person answered the phone, they did not speak English (or pretended not to speak English), could not provide any information, or simply hung up.



NHCAA is coordinating efforts among its member companies to identify, gather and distribute information about these phantom providers to the law enforcement community. The NHCAA South Florida Work Group, which was created in response to the severe fraud problems emanating from this part of country, continues to meet actively. In fact, results from a recent data collection project for the first quarter of 2009 spearheaded by the Work Group provide a snapshot of the effect of fraud on private health insurers. Seven prominent insurers submitted data identifying 666 unique provider TINs responsible for 16,146 suspect claims that were submitted. Those claims represented \$30.8 million in billed charges of which \$2.4 million were paid, reflecting losses due to fraud. The same insurers offered similar data from January 2007 to December 2008 showing \$529 million in suspect charges, of which \$111 million were paid and lost to fraud. Many of the providers identified in this exercise were found to be phantom. These insightful data were shared with law enforcement through one of NHCAA's regularly scheduled information sharing sessions.

- The Need to Share Information with the Private Sector

Too often, information sharing in health care fraud cases is a one way street with the private sector regularly sharing vital information with the public sector—either voluntarily or through mandate—without reciprocal information sharing to bolster the fraud fighting efforts of the private sector. This inequity works counter to a coordinated fraud fighting effort because the private sector – whether in commercial products or for government-sponsored programs such as Medicare Part D – plays an important role in safeguarding our nation's citizens against health care fraud.

The willingness of private insurers to share information with law enforcement is well documented. For the past several years, NHCAA has conducted a biennial survey of its private sector members called the *NHCAA Anti-Fraud Management Survey*, which is intended to be an industry benchmarking tool aimed as assessing the structure, staffing, funding, operations and



results of health insurer investigative units. In the most recent survey report reflecting 2007 data, 98 percent of respondents report that they respond to NHCAA Requests for Investigation Assistance (RIA) from law enforcement and 78 percent of respondents report that they share case information at law enforcement-sponsored health care fraud task force meetings.⁵

With its history as a private-public partnership, NHCAA remains committed to facilitating information sharing between both sectors. An excellent example of effective information sharing is a meeting NHCAA held in January 2009 in Florida which brought together representatives of private insurers, FBI headquarters and 10 FBI field divisions, the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Justice Department, the Miami U.S. Attorney's Office, the Office of Personnel Management Office of Inspector General (OPM-OIG), the Department of Defense (DOD) TRICARE, and local law enforcement to address the health care fraud schemes which have emerged in South Florida and are beginning to spread to other areas of the country. The details of the emerging schemes, investigatory tactics, and the results of recent prosecutions were discussed with the dual goals of preventing additional losses in South Florida and preventing the schemes from spreading and taking hold in other parts of the country.

Unfortunately, in many circumstances government representatives believe that they do not have the authority to share information about fraud investigations with private insurers, creating a serious obstacle in coordinated fraud fighting efforts. However, guidelines developed by the Department of Justice and the Department of Health and Human Services for the operation of the Coordinated Health Care Fraud Program established by HIPAA provide a strong basis for information sharing. "The Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans"

⁵ See *The NHCAA Anti-Fraud Management Survey for Calendar Year 2007*, National Health Care Anti-Fraud Association, May 2008.



(<http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm>) recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud.

Additionally, the government has recovered large sums in connection with various lawsuits related to health care fraud. In these cases, there has been no consistent effort to incorporate any component of private insurance money lost to fraud. While private insurers would like to see all commercial health care dollars lost to fraud incorporated into integrated settlement agreements involving health care providers who have defrauded both public and private programs, at a minimum the government should incorporate into their settlements the private component of Federal program dollars, primarily programs such as Medicare Parts C and D, where there is a joint administration between public and private payers of a public program.

- The Importance of Pre-payment Review

Many of the problems with health care fraud arise from a key fact about the health care system that holds true for both public and private programs: payment to providers is essentially built on the honor system, and various laws require both public programs and private health insurers to pay claims quickly or face penalties. This “honor system” derives from the combination of state-law based “prompt pay” requirements and the enormous volume of health care claims. While data analysis systems are improving (and may be improved even more as additional health care information moves into electronic data), most claims are not reviewed until after they are paid, if at all. Therefore, a key means of improving the fight against fraud is to both enhance the current efforts to share information – so that information about fraudulent providers can be distributed more efficiently – and to provide additional payment leeway to private and public programs in resolving suspected fraudulent claims. While hundreds of millions of dollars have been recovered in health care fraud enforcement efforts, this “pay and chase” mentality – where claims are paid and subsequent investigations are conducted – will never sufficiently



address fraudulent providers, particularly the kind of “phantom providers” who simply can take their fraudulent financial windfall and disappear.

- Dedicated Resources

The recent fraud-fighting successes in Florida demonstrate the importance of dedicating specific resources to the problem of health care fraud. On the whole, the Department of Justice reports that since the inception of the Health Care Fraud and Abuse Control Program in 1997, the government’s health care fraud enforcement efforts “returned nearly \$4.50 for every dollar spent on health care fraud enforcement.”⁶ The focused South Florida effort demonstrates how creative, efficient operations, relying on investigators and prosecutors with specific health care experience specifically dedicated to the operation, can make a significant difference in the fight against health care fraud.

In May 2009, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius issued a joint press release announcing a new interagency effort, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat health care fraud in public programs⁷. Included in the multi-faceted mission statement of the HEAT effort is the intention to “marshal significant resources to prevent waste, fraud and abuse in the Medicare and Medicaid programs.” In addition, the press release announced the expansion of the joint DOJ, CMS and HHS Medicare Strike Forces operating in South Florida and Los Angeles to also include Houston and Detroit. Fraud prevention efforts are also highlighted in President Obama’s proposed Fiscal Year 2010 budget. The President’s budget reflects a 50 percent increase from 2009 funding to strengthen

⁶ See Fact Sheet: Department of Justice Efforts to Combat Health Care Fraud and Abuse (May 28, 2008), available at http://hcca-info.org/Content/NavigationMenu/ComplianceResources/ComplianceNews/DoJ_EffortsCombatHealthCareFraudAbuse.pdf.

⁷ See U.S. Department of Justice Press Release, “Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention & Enforcement Action Team (09-491)”, available at <http://www.usdoj.gov/opa/pr/2009/May/09-ag-491.html>.



program integrity activities within the Medicare and Medicaid programs. In total, these recent actions seem to indicate a renewed political will to dedicate increased resources to combating health care fraud.

Anti-fraud resources yield significant results on the private side as well. Through its biennial *Anti-Fraud Management Survey* over the last several years, NHCAA has been able to demonstrate that the anti-fraud investigative units operating within our member companies consistently use the financial resources dedicated to their departments to yield impressive returns for their organizations. The *NHCAA Anti-Fraud Management Survey for Calendar Year 2007* shows an average return on investment of 7.6 to 1. So for every dollar entrusted to a private insurer's investigative unit, \$7.60 is returned to the company through recoveries, savings and prevented losses.⁸

- Lack of Effective Controls for Entry and Re-entry into the System

The health care system is also subject to access by unscrupulous providers, sometimes with little or no scrutiny. Providers can easily enter the system and begin submitting claims so long as they have what appears to be a valid license and a tax ID number. For example, in South Florida, front companies were being created to enter the system and submit claims, only to move on and go through the process all over again to re-enter the system under a new name and tax ID number. In fact, CMS took the significant step of decertifying all of the DME providers in the area and requiring them to seek re-entry into the Medicare system. It has also had to take similar action for home health care providers for the same reasons.

In addition to these initial licensing issues, state medical boards are inconsistent in their license suspension and revocation actions arising from fraudulent activities on the part of the

⁸ See *The NHCAA Anti-Fraud Management Survey for Calendar Year 2007*, National Health Care Anti-Fraud Association, May 2008.



providers they are responsible for licensing. These state boards – intended to be a frontline in the protection of health care consumers – often do not act effectively when confronted with health care fraud by licensed health care professionals. For example, in 1998 the Coalition Against Insurance Fraud published a report⁹ that examined the disciplinary actions of state medical boards against providers convicted of insurance fraud. The study examined records of medical providers convicted of felony charges related to insurance fraud in 12 states and compared those individuals with adverse licensing actions taken by state medical boards. The report found that “licensing boards often fail to take any actions against those licensees who commit felony offenses related to insurance fraud.” This lack of action, particularly when patient harm is a possible concern, is perplexing, particularly when state medical boards have several remedies at their disposal short of revocation of a medical license: reprimand, probation, suspension, sanctions, etc.

And although the Healthcare Integrity and Protection Data Bank (HIPDB)—established by HIPAA—was designed to capture information regarding licensing actions, civil judgments, criminal convictions, and exclusions from Federal and state health care programs, it has not been as successful as it needs to be at ensuring that unscrupulous providers do not re-enter the system. In order to curb the ease with which convicted providers (or regrettably, phantom providers) re-enter the health care system, public programs could consider implementing safeguards such as provisional participation and mandatory background checks. Private health insurers often do have policies in place that address the exclusion of providers from their networks in response to actions taken by medical boards to impair the licenses of convicted providers. For instance, an insurer may require that a provider be eliminated from its network so long as the medical license is probated, and then allow the provider to apply to be reinstated after a certain amount of time following the probationary period.

⁹ See Coalition Against Insurance Fraud, *Licensed to Steal: Action and Inaction by State Medical Boards*, available at http://www.insurancefraud.org/med_providers_report.htm#summary



III. IMPROVING THE FIGHT AGAINST HEALTH CARE FRAUD

So what can be done to advance the fight against health care fraud? While it may be nearly impossible to completely eradicate health care fraud, a few simple changes can make anti-fraud efforts more effective in controlling costs and protecting patients.

- The Importance of Information Sharing

As a result of the HIPAA Statute (enacted in 1996), the Department of Justice and the Department of Health and Human Services developed guidelines for the operation of the Coordinated Health Care Fraud Program¹⁰ established by HIPAA, building on the general language of the statute¹¹. These provisions recognized the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud. Samples of a couple key statements from those Guidelines, which highlight the importance of information exchanges between the public and private sectors, include:

“The Department of Justice recognizes that fraudulent activity in the health care system can affect both public and private sector health plans, and that often cooperation between the public and private sectors can assist in the detection, investigation, prosecution and prevention of fraud.”

“The Department of Justice will make its best efforts to provide general information concerning health care fraud to private health plans, and specific information concerning specific health care frauds to those private health plans that the Department of Justice believes likely are affected by the fraud.”

Unfortunately, many of the principles articulated in the Guidelines have not been implemented or have fallen by the wayside in the intervening years. Accordingly, we believe that

¹⁰ See United States Attorneys' Manual, Title 9, Criminal Division, Criminal Resource Manual 978, Health Care Fraud and Abuse Control Program and Guidelines, *available at* http://www.usdoj.gov/usao/eousa/foia_reading_room/usam/title9/crm00978.htm#intro.

¹¹ See Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, *available at* <http://aspe.hhs.gov/admsimp/pl104191.htm>.



these principles should be reincorporated and clarified in new legislation, to ensure that the goal of an effective and coordinated health care fraud program can be developed and sustained.

NHCAA would propose the following draft Guidelines language to be incorporated into health care reform legislation to address health care fraud and ensure proactive information sharing between the government and private health insurers to combat it. It is based primarily on the *Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans*.¹²

Not later than _____, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall expand and refine the ongoing program to coordinate Federal, state, and local law enforcement programs to control fraud and abuse with respect to health plans to ensure that private health plans are appropriately included in such program and protected by such program. Specifically, in carrying out this program, the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans, and shall ensure that private health plans are included in investigative and data sharing programs to the maximum extent feasible. Further, as the Secretary and the Attorney General issue additional guidelines to carry out this program, such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans in the overall program). As part of these guidelines, and within _____ days of passage, the Attorney General shall identify any existing legal impediments to the sharing of information with health plans, and shall propose legislative or regulatory steps to remove or reduce the impact of these impediments on these data sharing activities.

In addition, the Department of Justice and the Secretary shall issue guidelines for the Coordinated Health Care Fraud Program, to be distributed and applied by all participating law enforcement and regulatory agencies that ensure:

- *Appropriate recognition that fraudulent activity in the health care system can affect both public and private sector health plans, and that the investigation and prosecution of fraud against private health plans is integral to the overall effort to combat health care fraud.*
- *Appropriate encouragement is given to private health plans to provide information concerning suspected health care fraud to the Department of Justice and other agencies participating in the Coordinated Health Care Fraud Program whenever possible, as well as information concerning useful investigative resources and services developed or offered by particular private plans or associations of private health care payors.*

¹² See "Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans", available at <http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm>.



- *Whenever practicable, authorized by law, and consistent with ongoing law enforcement activities, the Department of Justice and other participating agencies will make their best efforts to include private health plans in local, regional and national health care fraud task forces, and in task force activities.*
- *The participating agencies will provide general information concerning health care fraud to private health plans, and specific information concerning specific health care frauds to those private health plans that the participating agencies believe likely are affected by the fraud, whenever such an exchange is practicable, permitted by law, and will not jeopardize ongoing law enforcement activities.*
- *Victims of health care fraud have a right to receive restitution as part of the Federal criminal law enforcement process, and that the Department of Justice and other participating agencies will make available to private health plans relevant investigative information including, but not limited to, information concerning the nature and scope of the fraud, the outcome of the investigation, the nature of any enforcement action, the assets of the parties charged, and the procedures for an affected victim to make a claim for restitution.*

The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

- Immunity Enhancement and Clarification

The current immunity language contained in the HIPAA Statute (which is confusing and given little attention) should be modified to clarify the limited immunity provided in connection with health care fraud investigations and to ensure that this limited immunity applies regardless of the recipient of the investigative information. These changes are consistent with similar laws at the state level (such as the laws in Pennsylvania, Arkansas, New York and elsewhere) that provide limited immunity in connection with insurance fraud investigations. This immunity will apply to the sharing of information in connection with health care fraud investigations, unless the information provided is false *and* the entity providing the information knew or had reason to know it was false.



The following is draft language that NHCAA offers with relation to immunity enhancement for health care fraud investigations. It is based largely on the immunity section found in the HIPAA statute¹³:

QUALIFIED IMMUNITY FOR PROVIDING INFORMATION -- No person providing information to the Secretary, the Attorney General or any other public or private entity concerning suspected health care fraud or in conjunction with a health care fraud investigation shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof). Such immunity shall apply unless such information is false and the person providing it knew, or had reason to believe, that such information was false. The party bringing any such action shall plead specifically any allegation that this immunity does not apply because the person providing information knew, or had reason to believe, that such information was false.

- Mandating the Inclusion of Private Sector Government Program Dollars (Parts C and D and Med Supp) into Federal Cases.

The government has recovered enormous sums in connection with various lawsuits related to health care fraud. In virtually all of these cases, there has been no effort to incorporate into these cases any component of private insurance money. While private insurers would like to see all commercial health care dollars lost to fraud incorporated into integrated settlement agreements involving health care providers who have defrauded both public and private programs, at a minimum the government should incorporate into their settlements the private component of Federal program dollars, primarily programs such as Medicare Parts C and D, where there is a joint administration between public and private payers of a public program.

Beyond this step, the Department of Justice should include within its information sharing efforts described above additional information about the fraud schemes and the factual support for these investigations so that the government can assist the private entities to help themselves in connection with these health care fraud matters.

¹³ See HIPAA, 42 USC 1320a-7c(3)(b)(iii); Fed. R. Civ. P. 9(b); Ark. Code Ann. 23-66-506(b).



These provisions should be incorporated into the Guidelines identified above. We suggest the following additions to the Guideline language:

Further, the Department of Justice and other participating agencies shall develop guidelines to incorporate, wherever feasible, sums lost by private health plans in connection with Federal health care programs into settlements and/or demands made by the Department or other participating agencies in connection with health care fraud investigations. Where such sums cannot feasibly be incorporated into settlements and/or demands, the Department of Justice and other participating agencies shall develop guidelines to ensure its best efforts to provide additional information to health plans affected by a health care fraud investigation concerning the factual details of such investigation, whenever such an exchange is practicable, permitted by law, and will not jeopardize ongoing law enforcement activities.

- Creation of a More Senior Position in DOJ to Coordinate Overall Health Care Fraud Activities and Increased Prosecutorial and Investigative Fraud-Fighting Resources

At various times in the past, primarily following passage of the initial HIPAA law, the Department of Justice has appointed an overall head of its health care fraud efforts, a “Special Counsel” for Health Care Fraud. This individual was assigned primary responsibility at DOJ and across the government for the coordination of the health care fraud program. This position has become diminished in importance in recent years, and has essentially disappeared. This position should be reinvigorated, and this individual should be given primary responsibility not only for the government’s overall anti-fraud efforts but also for ensuring that the public-private partnership is an effective one and that the coordinated goals of the HIPAA anti-fraud guidelines that involve private health plans can be fully realized.

NHCAA is encouraged by the joint DOJ/HHS announcement in May 2009 of the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). A background document published about the project¹⁴ states, “With the creation of the new HEAT team, fighting Medicare Fraud will become a Cabinet level priority for both DOJ and HHS.” The HEAT Team will be comprised of “top level law enforcement agents, prosecutors and staff from DOJ and HHS and

¹⁴ See The Department of Justice & the Department of Health and Human Services release, “Turning up the HEAT on Medicare and Medicaid Fraud” *available at* <http://www.hhs.gov/stopmedicarefraud/background.html>



their operating divisions, dedicated to joint efforts across government to both prevent fraud and enforce current anti-fraud laws around the country.”

As described earlier in this document, the return on investment realized when resources are dedicated specifically to health care anti-fraud efforts is significant. Accordingly, we believe it's most prudent and responsible to invest in proven success and therefore, we encourage Federal and state governments to appropriate more resources to support health care anti-fraud work. These resources could help expand investigative and/or prosecutorial efforts. For example, the statutory establishment and funding of a unit (not just an attorney) in each U.S. Attorney's Office to increase the capabilities and visibility of existing health care anti-fraud efforts coordinated by the DOJ. Experience shows that the severity of the health care fraud problem varies across the country; so of course, these units would vary in size, based on the need in each geographical area.

According to an October 11, 2007 National Public Radio article¹⁵, just .03 percent of the Medicare budget is dedicated to program integrity. In the article, Malcolm Sparrow of Harvard's Kennedy School of Government and author of [License to Steal: How Fraud Bleeds America's Health Care System](#) asks, "Why is this operation not 50 or 100 times the size?"

“Why wouldn't we spend 1 percent of the Medicare budget on program integrity? Then we might get serious about controlling a problem that might be 15 percent or 20 percent of the budget," Sparrow continues.

So while NHCAA recognizes and appreciatively acknowledges the intent expressed in recent months by President Obama and Congress to lend greater focus to the health care fraud

¹⁵ See “Medicare Fraud Acute in South Florida,” by Greg Allen, October 11, 2007, *available at* <http://www.npr.org/templates/story/story.php?storyId=15178883>



issue, we strongly encourage any new investments to be significant and sustainable so that a true impact can be made on the problem.

- Summary

Health care fraud is a serious and costly problem that affects every patient and every taxpayer across our nation. The financial losses due to health care fraud range from an incredible \$60 billion to a shocking \$226 billion a year and we'll likely never be able to adequately calculate the true loss when taking into account patient harm—an unfortunate and insidious side effect of health care fraud.

The recommendations offered in this document are intended to be logical solutions capable of being implemented, and which we believe will have a tangible effect on combating the problem. The National Health Care Anti-Fraud Association has been a private-public partnership since its inception and we know that health care fraud requires a private-public solution—where government entities, tasked with fighting fraud and safeguarding our health system, and private insurers, responsible for protecting their customers, can work cooperatively on this critical issue of mutual interest.

As national health care reform legislation is considered and debated in the halls of Congress and at dinner tables across America, we urge decision-makers and citizens alike to give focus to the problem of health care fraud. Any effort to reform our health care system without seriously and thoughtfully addressing health care fraud will be, in our opinion, tragically flawed. NHCAA's Mission to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud should be applied to the ongoing work on health care reform.

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