The U.S. Health Care System and the Challenges of Fraud

The National Health Care Anti-Fraud Association
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The health care system in the United States is exceedingly complex and in a constant state of change. At its most essential level, the delivery of health care takes place between a provider and a patient. However, in order to function, the U.S. health care system depends upon countless people, facilities, entities, companies, organizations, programs, professions, specialties, systems and relationships.

National Health Expenditures and Population

National health expenditures in the United States reached $3.2 trillion in 2015 and represented 17.8% of the nation’s gross national product (GDP).¹ This equated to an average annual per person health expenditure of $9,990. Compare that with the Organisation for Economic Co-operation and Development’s (OECD) 2015 per capita health care spending average of $3,759 across 36 developed nations² from Australia to the United Kingdom.

Annual health care spending in the U.S. is projected to grow steadily over the next several years, exceeding $5.5 trillion in 2025 and accounting for 19.9% of GDP.

The U.S. population is estimated to be 323.1 million people³ which essentially represents the nation’s pool of patients. The current U.S. population falls roughly into the following age categories:

- Percentage of persons under 18 years of age (children): 23%
- Percentage of persons age 19 to 64 (adults who have not reached the traditional retirement age of 65): 62%
- Percentage of persons 65 years of age and older (adults who have reached what is traditionally considered to be retirement age): 15%

Understanding the health care provider population in the United States, particularly in comparison to the nation’s population of patients, is useful. Consider the following estimates of several provider categories in the U.S.:

- As of 2015, there were 931,921 physicians with an active medical license in the U.S.⁴ This is expected to increase to 971,817 by 2020.⁵
- As of 2015, there were 5,564 registered hospitals in the U.S.⁶
  - 4,862 U.S. Community Hospitals
    - 2,845 Non-government Not-for-profit Hospitals
    - 1,034 For-profit Hospitals
    - 983 State & Local Government Hospitals
  - 212 Federal Government Hospitals
• 401 Non-federal Psychiatric Hospitals
• 79 Non-federal Long Term Care Hospitals
• 10 Hospital Units of Institutions (prison hospitals, college infirmaries, etc.)

- As of 2014, there were 5,446 Medicare-certified ambulatory surgical centers in the U.S.
- As of 2014, there were 15,639 nursing homes in the U.S.\(^7\)
- There are approximately 1.5 million providers in the Medicare Program.

**Health Care Coverage and Payment Systems in the U.S.**

The systems and programs through which Americans typically receive financial coverage or assistance for their health care costs are numerous and varied. The United States does not have national or universal health care like some nations around the world. The Affordable Care Act (ACA) enacted in 2010 under President Barack Obama did put into place a requirement that individuals carry health care insurance coverage and are subject to a penalty if they do not.

The U.S. health care coverage system is a patchwork whereby some citizens receive health care insurance coverage through a government or “public” program, some through their employers, some people obtain their own health insurance through the individual health insurance market and some people are simply uninsured. According to the National Center for Health Statistics within the Centers for Disease Control and Prevention (CDC), there are approximately 28.4 million non-elderly Americans who are uninsured (before the ACA went into effect, 43 million people lacked coverage\(^8\)).

The Affordable Care Act established a federal health insurance Marketplace where the uninsured could purchase health insurance coverage. In response to the law, states were required to participate in the federally-facilitated Marketplace, establish their own health insurance Marketplace or implement a hybrid Marketplace program. The Marketplaces are often also referred to as health insurance exchanges.

As of 2017:

- Twenty-eight states participate in the federally-facilitated “healthcare.gov” Marketplace program;
- Eleven states and the District of Columbia host their own state-based Marketplace;
- Five states host a state-based Marketplace built upon the information technology platform of the federal Marketplace; and
- Six states have a state-federal partnership Marketplace where the state is responsible for some functions of the Marketplace and the federal government is responsible for others.\(^9\)
Government-sponsored Health Care Programs

Many government-funded and government-administered health care programs operate in the United States. These programs typically have eligibility requirements defined by statute and regulation, are funded in large part by taxes, and serve a defined population, whether it’s based upon age, health status, income or other eligibility factors. Some government health care programs are considered to be entitlement programs, meaning they guarantee certain benefits to a particular group or segment of the U.S. population.

Medicare

Perhaps the most well-known entitlement health care program in the U.S. is Medicare. This social insurance program was signed into law on July 30, 1965 by President Lyndon Johnson to provide health insurance to people age 65 and older, regardless of income or medical history. Medicare is a national health care program administered by the federal government through the Centers for Medicare and Medicaid Services (CMS), a component of the United State Department of Health and Human Services (HHS). American citizens and legal permanent residents of at least five continuous years age 65 and older are eligible for Medicare.

In 1972, Medicare was expanded to provide coverage for people younger than 65 who have permanent disabilities who receive Social Security Disability Insurance (SSDI) as well as people who have end-stage renal disease (ESRD). In 2001, eligibility for Medicare was further expanded to provide coverage to younger people with amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig’s disease).

Since 1965, Medicare has seen many changes including expansion of coverage to include various benefits such as speech, physical and chiropractic therapy and hospice care. Today, Medicare is comprised of four “Parts”:

- **Medicare Part A** provides hospital insurance coverage. It helps to pay for inpatient hospital stays and limited skilled nursing facility care, home health care and hospice care.
- **Medicare Part B** is optional medical insurance, covering among other things, doctors’ visits, outpatient medical and surgical services and supplies, diagnostic tests, and durable medical equipment. Part B requires that beneficiaries pay a premium to participate (the standard monthly premium in 2017 was $134). Medicare Parts A and B don’t pay for all hospital or medical expenses, co-pays, co-insurance or deductibles, so many Medicare beneficiaries also purchase private Medicare Supplemental Insurance Policies known as Medigap insurance to help cover those costs. In 2015, there were 7.3 million people who purchased Medigap coverage.
• **Medicare Part C** was created in 1997 by Congress and called Medicare+Choice. It was later renamed Medicare Advantage (MA) pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Medicare Advantage allows Medicare beneficiaries to join privately operated managed care plans. In 2016, there were 17.6 million people enrolled in a Medicare Advantage.¹²

• **Medicare Part D** was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect in 2006. It is a voluntary outpatient prescription drug benefit that Medicare beneficiaries may purchase. The Part D drug benefit is accessible through private plans that are approved by the federal government. Nearly 41 million people were enrolled in Medicare Part D in 2016.¹³

In 2015, there were 55.5 million Medicare beneficiaries¹⁴, which equates to approximately 17% of the U.S. population.¹⁵ National Health Expenditure Data produced by CMS reveals that in 2015, there were $646.2 billion in health expenditures under the Medicare program.

### Medicaid and CHIP

Medicaid is another social insurance entitlement program signed into law alongside Medicare on July 30, 1965 by President Lyndon Johnson. It provides health insurance to people with limited income and resources, including low-income families and low-income aged, blind and disabled individuals. Medicaid is jointly administered by the federal government and the states (including the District of Columbia and U.S. territories).

Medicaid programs vary from state to state because individual states establish their own benefit packages, eligibility requirements, payment and reimbursement rates, and administrative processes. They must, however, be consistent with established federal parameters. For instance, there are several federally mandated Medicaid benefits as well as many optional benefits.¹⁶

The cost to administer Medicaid is shared by the federal government and the state governments. Federal contributions toward the program vary based upon the wealth of the state and the amount the state contributes toward its program.

The Affordable Care Act included a significant expansion of the Medicaid program, including federal matching funds. The law expanded Medicaid eligibility to individuals under age 65 with incomes below 133% of the Federal Poverty Level (FPL). If a state chose not to expand its Medicaid program, the ACA would have eliminated all federal Medicaid funding to that state.

Several aspects of the Affordable Care Act were legally challenged. In a historic June 28, 2012, ruling,¹⁷ the U.S. Supreme Court upheld the law, including its controversial individual mandate provision, requiring individuals to purchase health insurance providing a minimum level of coverage or face a penalty. However, the Court struck down the provision which would have
eliminated all federal Medicaid funding to states that chose not to comply with the Medicaid expansion. The Court concluded that states that choose not to comply would not risk losing their existing funding.

As of January 1, 2017, 31 states and the District of Columbia had expanded their Medicaid programs in accordance with the ACA.18

The State Children's Health Insurance Program (SCHIP), now known more simply as the Children’s Health Insurance Program (CHIP), was created by statute in 1997 and provides federal matching funds to states to provide health care coverage to children of families with incomes that are too high to qualify for Medicaid, but who can't afford private health insurance coverage. Like Medicaid, CHIP is administered by the states, according to federal requirements and parameters. All states have expanded children's coverage significantly through their CHIP programs, with nearly every state providing coverage for children up to at least 200 percent of the Federal Poverty Level (FPL).

As of April 2017, there were 74.5 million individuals enrolled in Medicaid and/or CHIP in the United States.19 In 2015, national health consumption expenditures under Medicaid reached $545.1 billion.

TRICARE

TRICARE is a regionally managed health care program for active duty, guard, reserve, and retired members of the uniformed services and their families and survivors. It is managed by the Defense Health Agency (DHA). TRICARE combines the resources of military hospitals and clinics with civilian health care networks. It offers several health plan options, all of which meet the minimum essential coverage requirements established under the Affordable Care Act.

According to the TRICARE.mil website, there are nearly 9.4 million TRICARE beneficiaries around the world20 and $48.5 billion was spent on the program in 2015.21

FEHBP

The Federal Employee Health Benefit Program (FEHBP) is the name of the health insurance program for civilian federal government employees and postal workers, retirees and their dependents and survivors. Established in 1960, the FEHB Program is the largest employer-sponsored health benefits program in the United States and it is administered by the United States Office of Personnel Management (OPM).

Participation in the FEHB Program is voluntary and paid for by a combination of employee and employer contributions. On average, the federal government, as the employer, pays approximately 70% of health benefit premiums under FEHBP and there are nearly 300 different
plan choices. In 2015, the federal government contribution to employer-sponsored private health insurance premiums was $33.9 billion. The FEHB Program provides health insurance coverage for roughly 8.2 million individuals and covers annual health care benefits in excess of $47 billion.

**State and Local Employee Health Insurance**

State governments, county governments, city governments and other local and municipal governments are also employers that often provide employer-sponsored health insurance to their employees. It is typically funded, at least partially, by taxes.

According to Governing.com, state and local governments employed 7.4 million full-time employees in 2014. The National Conference of State Legislatures (NCSL) reports that in 2013 there were nearly 5.3 million state government employees covered by state-sponsored insurance. In 2015, state and local government contributions to employer-sponsored private health insurance premiums totaled $177 billion.

**Private Health Insurance**

**Employer-sponsored Group Health Insurance**

Americans who do not have access to health insurance through a government program most often get health care coverage through their employer through a group insurance policy. Applicable regulatory framework for employment-based health insurance varies based on whether the employer purchases coverage, self-insures, or uses a combination of approaches.

Employers who offer health insurance through commercial insurers usually negotiate on behalf of their employees for specific benefits at a specified monthly premium per person or family. The employer generally determines which plan(s) it will offer and whether or not it will pay any portion of the employee’s monthly premium amount. On average, private employers that offer health insurance pay 71.6% of the cost, while the employee is responsible for the remainder.

Some employers choose to self-insure their employees’ health insurance plans by assuming 100% of the risk up to a certain limit, with any excess liability covered by stop-gap insurance. Many employers create self-insured plans but contract with commercial insurance companies to act as a third-party administrator or TPA for claims processing or for access to a provider network.

In 2016, there were 7.4 million private sector employers in the U.S. (classified as “private-sector establishments” by the Agency for Healthcare Research and Quality) employing 123.2 million people. Of those 7.4 million employers, 45.2% of them offered health insurance to their employees.
In 2015, there were 172.2 million enrollees with employer-sponsored private health insurance\(^2\) and expenditures toward employer-sponsored private health insurance totaled $948.9 billion. The employer contribution was $697.6 billion and the employee contribution was $251.3 billion, roughly a 73.5% and 26.5% split.

**Individual Private Health Insurance and Marketplaces**

In addition to employer-sponsored, group health insurance, many insurers have traditionally sold individual health insurance policies as well. With the creation under the ACA of the federal and state health insurance exchanges, or Marketplaces, the individual market is now comprised of plans that are sold on and/or off the exchanges.

Private health insurers are not required to sell policies through the federal or state Marketplaces and make the decision whether to do so annually. In fact, some insurers that initially participated in the exchanges have since left that market while others have entered. Under the exchanges in the individual market, coverage may be subsidized by the federal government through tax credits based upon an individual’s income. As a result, there have emerged two distinct segments in the individual market:

- Coverage sold on the exchanges, mostly to Americans who qualify for a subsidy; and
- Coverage sold off the exchanges to people who pay full price.

Individuals typically sign up for coverage through the federal and state Marketplaces during what is called the “open enrollment period,” which lasts from November 1 through January 31. During the 2017 open enrollment period 12.2 million people enrolled in a Marketplace plan.\(^3\)

The health insurance products offered by insurers, and the benefits they extend, vary widely and are regulated based upon the program or jurisdiction under which they apply and are sold. For instance, for a plan to be offered on the exchanges it must include “essential health benefits,” that cover ten broad categories of health care services per ACA requirements.

**Other Private Insurance**

New health care coverage products are developed and considered all the time in the private market in the U.S. For instance, several years ago, a new type of savings account called a health savings account (HSA) was created that allows a person to set aside money on a pre-tax basis to pay for qualified medical expenses. An HSA can be used only in conjunction with a High Deductible Health Plan (HDHP), which usually has lower monthly premiums than plans with lower...
deductibles. The HSA funds are applied to expenses incurred prior to reaching the deductible as well as for other out-of-pocket costs such as co-payments. HSA funds “roll over” year after year and may even earn interest.

Private health insurers also play a significant role in many government health care programs. For instance, Medicare Parts C and D, while federal programs, are actually programs where the enrollee obtains coverage through a private insurer. In addition, many state Medicaid and CHIP programs also depend upon participation by private insurers that provide the health plan coverage to beneficiaries.

Health care consumption expenditures under private health insurance reached $1.07 trillion in 2015, representing roughly one-third of all health care spending in the United States.31

**Percent of National Health Expenditure (2015)**

- Medicare: 20%
- Medicaid: 17%
- Private Insurance: 33%
- Out-of-Pocket Spending: 11%
- Investment: 5%
- Other health insurance programs: 4%
- Other 3rd Party Payers & Programs: 2%

**Health Care Fraud in the United States Health Care System**

Fraud has long been defined as a crime in U.S. statute, and therefore can seem very black and white from a legal standpoint. However, for someone investigating possible health care fraud, defining it isn’t always so simple. For those professionals responsible for ensuring the integrity of health care services and programs and the payments made for them, the boundaries of health care fraud can seem to be distorted beyond the strict legal definition. Related, yet separate concepts such as waste and abuse come into play. In addition, “improper payments” is
a key term often used in assessing the integrity of government-funded health care programs and encompasses the concepts of not just fraud, but waste and abuse as well.

A basic point-of-reference definition for fraud, generally speaking, is found in §455.2 of Title 42, Public Health of the United States Code of Federal Regulations: “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.”

The health care system that serves the United States is extremely complicated. The sheer numbers involved are astounding. Every year in the U.S., millions of patients and health care providers submit billions of health care claims for trillions of dollars in health care expenses.

Health care is fundamentally about the relationship between a patient and a provider, and historically and culturally in the United States that relationship has been a sacred one, grounded in trust. Unfortunately, it is proven that a significant amount of fraud exists in the U.S. health care system, perpetrated largely by individuals who manipulate and betray that trust for financial gain.

**How Big is the Problem of Health Care Fraud?**

The National Health Care Anti-Fraud Association (NHCAA) has been asked for more than 30 years how much health care fraud exists. Unfortunately, it’s a question that is impossible to accurately answer. By its very nature, fraud is something that the perpetrator is intent on concealing. It’s exceedingly difficult to measure the true size of the problem when we can’t be sure how much of it goes undetected.

On a national level, fraud infects and undermines the U.S. health care system and is a drain on finite resources—both public and private. The extent of financial losses due to health care fraud in the United States, while not entirely known, is conservatively estimated by the NHCAA to range in the tens of billions of dollars annually. Consider these other health care fraud estimates for the U.S.:

- The Institute of Medicine of the National Academies estimates health care fraud at $75 billion a year.\(^{33}\)
- The FBI previously estimated that health care fraud costs the United States $80 billion a year (however, their website has since been adjusted to read, “Health care fraud costs the country tens of billions of dollars a year”).
• A study co-authored by a RAND Corporation analyst, Andrew D. Hackbarth and a former CMS administrator, Donald M. Berwick estimated that “fraud and abuse” represented between $82 billion and $272 billion in 2011 across the U.S. health care system and cost Medicare and Medicaid as much as $98 billion in 2011.35

• In May 2014, The Economist repeated Hackbarth and Berwick’s estimates in an article titled, “The $272 billion swindle.”36

• The Centers for Medicare and Medicaid Services (CMS) has estimated that Medicare and Medicaid made $97 billion in “improper payments” in FY 2016.37

• A January 2016 Government Accountability (GAO) report titled, “HEALTH CARE FRAUD: Information on Most Common Schemes and the Likely Effect of Smart Cards,” includes the following statement: “While there have been convictions for multimillion dollar schemes that defrauded federal health care programs, there are no reliable estimates of the magnitude of fraud within these programs or across the health care industry.”38

To be sure, the financial losses are considerable, but health care fraud is a crime that also directly impacts the quality of health care delivery. Patients are physically and emotionally harmed by it and as a result, fighting health care fraud is not only a financial necessity; it is a patient safety imperative. The perpetrators of some health care fraud schemes deliberately and callously place trusting patients at significant risk of physical injury or even death. There are documented cases where patients have been subjected to unnecessary or dangerous medical procedures simply due to greed. They may unknowingly receive unapproved or experimental procedures or devices. Patients, as well as the providers who care for them, can also have their identities stolen, which causes a different kind of harm. The effects of medical identity theft are pernicious and can plague a victim’s medical and financial status for years.

Health care is in a state of perpetual change and evolution, yet fraud is seemingly a constant. It is a complex crime that can manifest in countless ways. In the United States the many payers—both private and public—together with the sheer volume of health care claims and the data they generate make fraud detection a challenge. There are many points of susceptibility along the path of a health insurance claim. And fraud can be committed by anyone: physicians and other providers, employees with access to medical and claims records, enterprise crime organizations, and even patients and their loved ones.
Common Health Care Fraud Schemes

The types of health care fraud are numerous and ever growing. There are schemes that emerge quickly, only to dissipate just as fast when law enforcement shifts focus and dedicates resources to intervene. There are millions of providers of health care services and products in the United States who bill insurance. Those committing fraud have the full range of medical conditions, diagnoses, treatments and patients on which to base false claims. Plus, detecting health care fraud often requires the knowledge and application of clinical best practices, as well as knowledge of medical terminology and specialized coding systems, including CPT and CDT codes, DRGs, and ICD-10 codes.

While there is always a creative criminal out there trying to devise something new, there exist several broad categories of health care fraud. Some of the more common health care fraud schemes include:

- Billing for services or treatments that were never rendered
- Billing for more expensive services or procedures than were actually provided or performed, commonly known as "upcoding"
- Performing medically unnecessary services solely for the purpose of generating insurance claims payments
- Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance claims payments
- Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that aren’t medically necessary
- Unbundling, which is billing for each step of a procedure as if they were separate procedures
- Accepting kickbacks for patient referrals
- Failing to provide necessary services pre-paid under a health plan
- Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract
- Double charging, often concealed in dense jargon
- Medical Identity Theft (Medical ID theft is often an element of a broader health care fraud scheme)
- False store fronts and phantom providers
- Organized criminal enterprises (they often invoke several types of fraud schemes but they seem to depend significantly on medical identify theft—whether it’s theft of patient and/or provider identities)
The previous list reveals several common health care fraud schemes that may occur across health care specialty areas, provider types, services or procedures. Fraud schemes and trends also often emerge from particular medical specialty areas or involve very specific treatments, diagnoses or procedures. NHCAA offers the following as examples of some of the areas of health care that seem to currently present amplified susceptibility to fraud:

- Infusion Therapy
- Pain Management (office-based opioid therapy, known as OBOT)
- Pharmaceutical/Drug Diversion
- Durable Medical Equipment
- Behavioral health and community mental health centers
- Home Health Care
- Cardiology
- Ophthalmology
- Physical therapy and occupational therapy (medical necessity, spa vacations)
- Transportation (ambulatory)

Health care fraud is an exceptionally complex crime that can play out in innumerable ways. Fraud trends and schemes are constantly changing, developing, shifting, migrating and morphing and the task for anti-fraud professionals to stay ahead of the threat is daunting. Considering the size of the United States and its bifurcated federal and state-based systems, geography also plays a prominent role. It is typical to see a fraud scheme established in one geographic region move to a different region once the payer and law enforcement communities in the original region react to the scheme.

Some frauds are impressively sophisticated while others are remarkably absurd. And in many cases—such as with phantom providers—speed is the key. Someone who sets up a false storefront with the intention of filing false claims will submit many claims, receive payment and then abandon the property before investigators are able to intervene.

Although billions of dollars are lost to health care fraud every year, it is clearly not just a financial crime, and it is certainly not victimless. The risk of patient harm is very real. With its size and complexity, the U.S. health care system can be susceptible to creative, nimble and aggressive perpetrators who have a knack for identifying weaknesses. Health care fraud is a serious and costly problem that affects every patient and every taxpayer in America. In acknowledgment of the dangers of health care fraud, the United States has put into place many legal, regulatory and policy tools to combat it.
U.S. Health Care System - Legal Framework

A. The Regulation of Commercial Health Insurance -- Federal v. State Authority

The oversight of private health insurance in the United States is complex because of the multi-layered statutory and regulatory structure of the federal system. Moreover, this complexity further is compounded by the fact that a significant percentage of health insurance coverage is provided as an employee benefit by employers, resulting in private health insurance also being subject to federal regulations applicable to employee benefits. For example, in 2015, 49% of the U.S. population received health insurance through an employer, compared with 36% covered by Medicare, Medicaid and other public programs.39

In 1945, the United States Congress passed the McCarran-Ferguson Act which left the regulation of all lines of insurance to the states. To this day, a company offering insurance in a particular state must be licensed in that state and is subject to the state’s regulation. This can be a significant regulatory challenge for national companies selling insurance in multiple states. As a result, health plans offered by an employer to its employees for which the employer pays all or part of the premiums (with the employees paying the remaining percentage of the premium) is subject to all state regulatory requirements. These requirements usually include coverage mandates, appeal processes for claim denials, and prompt pay laws under which insurers must pay provider claims within a set period of time or face penalties.

In addition to the state regulations, employer-sponsored plans must also comply with federal regulations arising out of the Employee Retirement Income Security Act of 1974 (“ERISA”) which was passed by Congress to provide for the national regulation of employee benefits. Although the driving force behind ERISA was the regulation of employee retirement plans, its provisions apply to all employee benefits, including health insurance benefits. The ERISA regulations are issued by the U.S. Department of Labor and, like the state regulations, also include mandatory appeals processes for claim denials. Normally, the employer-sponsored plan will comply with the regulations which provide the greater protection to the plan enrollee.

The exception to this double layer of regulation arises when an employer decides to self-fund its health insurance plan. In this circumstance, instead of paying premium to the health insurance company with the health insurer taking the coverage risk, the employer self-funds, assuming the coverage risk (usually limited by stop-loss insurance). The employer normally will then engage the health insurance company to administer the plan as a third party administrator (“TPA”). Under this arrangement, the employer’s health plan is not subject to state licensure or regulations and is subject only to the ERISA regulations.
Adding to this complexity was the enactment of the Patient Protection and Affordable Care Act (known as the “ACA”) in 2010. The ACA expands Medicaid in those states which agree to the expansion, mandates the purchase of health insurance for those without coverage, and creates health insurance exchanges, called Marketplaces, in each of the states where individuals can purchase insurance. Government subsidies are available for those who meet the financial criteria. The companies selling plans on the exchange markets must meet state licensing requirements, and the health plans sold must provide coverage consistent with the coverage mandates in the ACA. For the first time, therefore, the federal government under the ACA has begun to regulate the business of health insurance, along with the states, for health plans sold through the exchange markets.

In the seven years since the ACA’s enactment, the Republican party has voiced its desire and intention to repeal it. With both houses of Congress and the White House under GOP control beginning in January 2017, there have been stepped up efforts to pass a bill that would repeal and/or replace the Affordable Care Act. Although several measures have been introduced, as of August 2017, none have been passed.

B. Federal Health Care Anti-Fraud Laws

Although the prevention, detection and investigation of health care fraud pose significant challenges in both public and private health care programs, the arsenal of legal tools for federal prosecutors and regulators are extensive and provide significant penalties for those criminally convicted of fraud or for those who have been found liable in a civil proceeding.

What follows is a brief overview of the most significant federal laws. It should be noted that the states also have anti-fraud laws that may be identical or similar to the federal laws. It also should be noted that sentencing guidelines for criminal offenses in federal courts are provided by the U.S. Sentencing Commission, and that the Commission, pursuant to a directive in the ACA, amended the guidelines for health care fraud offenses in 2011, to reflect the serious harms associated with these offenses.

Criminal laws

- HIPAA – The Health Insurance Portability and Accountability Act of 1996 (HIPAA) for the first time made health care fraud a federal offense. It prohibits, among other things, executing or attempting to execute a scheme or artifice to defraud or to fraudulently obtain money or property from any health benefit program. Health benefit programs include plans sold by commercial health insurance companies. The penalties include fines and imprisonment for 10 years; if serious bodily harm results from the fraud, then imprisonment for 20 years; if a death results, imprisonment for life.
• **Anti-Kickback Statute** – The Anti-Kickback Statute (AKS) applies only to Medicare, Medicaid, and any program directly funded in whole or in part by federal funds. It makes it a felony to solicit or receive or offer or pay any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referrals or for the purchase, lease or order of any good, facility or service. The ACA made it clear that knowledge of the statute or specific intent are not elements of the offense that must be proven by the government. Penalties include fines up to $25,000 and imprisonment up to 5 years. The AKS and the regulations implementing the AKS provide for safe-harbors for conduct exempted from the law’s prohibitions.

• **Mail Fraud** – It is a crime to engage in any scheme to defraud any person that involves the use of the U.S. Mail or any other interstate commercial carrier (e.g., UPS, FedEx). The Mail Fraud statute is not limited to health care fraud and encompasses any type of fraud. Penalties include fines and imprisonment up to 20 years.

• Other potentially applicable criminal statutes include: **Wire Fraud**, which applies to the use of interstate electronic communications for the purpose of executing a fraudulent scheme; **Criminal False Statements**, which prohibits knowingly and willfully within the jurisdiction of any branch of the federal government making a materially false, fictitious, or fraudulent statement or representation; and **Money Laundering**, which includes health care fraud as a specific unlawful activity.

**Civil laws**

• **Civil False Claims Act** – Prohibits the presenting or causing to be presented a false or fraudulent claim for payment or approval to the federal government. It also prohibits making, using, or causing to be made or used a false record or statement to get a false or fraudulent claim paid or approved. Because this is a civil statute, the government’s burden of proof is a preponderance of the evidence, as compared with beyond a reasonable doubt in a criminal case. Penalties can range up to more than $21,000 per claim plus treble damages to the federal government. The Act also provides for *qui tam* actions brought by whistleblowers, who can be awarded a percentage of the government’s recovery in a successful action.

• **Stark Anti-Referral Statute** – Named after its sponsor, Pete Stark who was a member of the U.S. House of Representatives from 1973 to 2013, the statute prohibits physicians with direct or indirect financial interests in an entity from making referrals to that entity
for “designated health services” payable by Medicare. There are 10 designated health services covered by the law, including clinical laboratory services and imaging services. Like the Anti-Kickback Statute, Stark provides for statutory and regulatory safe-harbors. The regulatory process initiated by the law (passed in 1993) has stretched over more than 15 years. Penalties include non-payment of services, monetary penalties, and a penalty up to $100,000 for a circumvention scheme.

- **Civil Monetary Penalties Statute** – Applies only to federal programs and provides for civil monetary penalties and exclusion from these health care programs for a wide range of conduct. Examples include false claims, up-coding, non-licensed provision of services, and contracting with individuals already excluded from participation in the federal programs. The penalties vary based on the type of conduct involved and are in addition to any penalties applicable under other statutes.

**Health Care Anti-Fraud Enforcement – Federal and State Agencies**

There are a number of federal and state agencies which play a role in the regulation and enforcement of health care anti-fraud laws. Some have a significant role, while others play more of a supporting role.

**A. Federal Agencies**

In 1996, HIPAA created the Health Care Fraud and Abuse Control Program (the Program) to combat fraud and abuse in health care. The Act appropriates money from the Medicare Trust Fund to an expenditure account in amounts the Attorney General and the Secretary of Health and Human Services (HHS) certify as necessary to finance anti-fraud activities. In FY 2016, the Attorney General and the Secretary certified $282.1 million in mandatory funding, and the Congress appropriated an additional $681 million in discretionary funding for the anti-fraud account.

The federal agencies covered by the Program and involved generally in health care anti-fraud enforcement and regulatory activities include:

- The Department of Justice (DOJ) headed by the Attorney General. The DOJ participating divisions include the Criminal Division, the Civil Division, the various United States Attorneys for the federal judicial district throughout the United States, and the Federal Bureau of Investigation (FBI).
• The Centers for Medicare and Medicaid Services (CMS) which is part of the Department of Health and Human Services (HHS). CMS is responsible for overall regulation and administration of Medicare and, along with the states, Medicaid and CHIP. Within CMS, the Center for Program Integrity (CPI) takes the lead on anti-fraud and abuse activities and coordinates with law enforcement.

• The Office of Inspector General (OIG) for HHS. All federal Departments have an Inspector General who is responsible for conducting audits and investigations to root out waste, fraud and abuse. The HHS-OIG consists of four divisions: audit services, evaluations and inspections, management and policy, and investigations. The investigations division leads the way on fraud and abuse investigations and enforcement and works closely with the FBI and state law enforcement agencies.

B. State Agencies

The states play a significant role in health care anti-fraud enforcement, especially in the Medicaid program, which is funded by both the federal and state governments. The states also regulate, to varying degrees depending on the state, the anti-fraud activities of commercial health plans’ Special Investigation Units (SIUs).

• Medicaid Program Integrity Units (MPIUs) – MPIUs are responsible for the overall integrity of their respective state’s Medicaid programs.

• Medicaid Fraud Control Units (MFCUs) – MFCUs work closely with the MPIUs and are responsible for the investigation and prosecution of Medicaid fraud. The majority of MFCUs reside within the states’ Attorney General’s office.

• Department of Insurance (DOI) – Since the regulation of all lines of insurance is primarily a state responsibility, each state has a DOI which takes on that responsibility. Within the DOI there usually is a Fraud Bureau which is responsible for investigating and overseeing the anti-fraud efforts of commercial insurers. Most states have requirements that insurer SIUs must meet covering such areas as fraud reporting and staff training. The DOIs of the states also cooperate with each other through the National Association of Insurance Commissioners (NAIC) which meets three times a year. The NAIC has an Antifraud Task Force which addresses insurance fraud and abuse issues.

• State Licensing Boards – Each state is responsible for the licensing of health care professionals providing care in the state. This responsibility falls to the various state licensing boards, each licensing a specific type of professional (e.g., physicians, nurses, physical therapists, etc.). Although these boards do not have specific responsibility with
respect to fraud and abuse, they should be notified and can take adverse actions against a provider in cases where fraud has been established.

**Strengths, Weaknesses, Opportunities and Threats (SWOT)**

Following is an examination of the strengths, weaknesses, opportunities and threats (SWOT) with respect to health care anti-fraud efforts presented by the U.S. health care system.

**A. strengths**

**Strong Legal Framework**

The U.S. has a strong “rule of law” culture and tradition. As such, fraud, abuse and corruption in the health care system are not condoned at any level of government. Health care fraud and abuse are viewed by both government and the private sector as problems that, if not realistically capable of being completely eliminated, must be addressed through innovative preventive measures and through aggressive detection, investigation and prosecution, with the goal of minimizing its impact on patients and the integrity of the system.

The U.S. Congress and state legislatures have enacted several significant criminal laws addressing the challenges of health care fraud in both the public programs and in private insurance. These laws – ranging from the Anti-Kickback Statute to the health care fraud law enacted through HIPAA – provide prosecutors at both the federal and state levels with numerous legal tools with which to attack the problem. All of these laws provide for significant penalties, and many of these penalties were recently increased through the U.S. Federal Sentencing Guidelines as a result of the Affordable Care Act.

On the civil side of the ledger, the Federal False Claims Act, the Civil Monetary Penalties Statute and the Stark Anti-Referral Statute provide the government with a broad range of tools through which to recover losses, collect significant fines and penalties, and exclude offending individuals from participation in federally-funded health care programs. The lower standard of proof in a civil action compared with a criminal proceeding, combined with the evidentiary discovery rules provided in civil proceedings, provide government lawyers with a strong framework through which to seek civil enforcement against fraud and abuse.

The states have followed the federal government’s lead by enacting similar criminal and civil laws. Additionally, federal and state governments and law enforcement routinely cooperate with each other when investigating health care fraud cases. A good example of this cooperation has been the Health Care Fraud Prevention and Enforcement Action Team (HEAT) established in 2009. The HEAT program established special Strike Forces made up of federal and state investigators and prosecutors to focus exclusively on regional health care fraud challenges.
Dedicated Resources

Congress recognized that fighting fraud and abuse in Medicare and Medicaid would require dedicated resources that could not be diverted through bureaucratic processes to other priorities or programs. So, in 1996, HIPAA created the federal Health Care Fraud and Abuse Control (HCFAC) Program. The Act appropriates money from the Medicare Trust Fund to an expenditure account called the Health Care Fraud and Abuse Control Account, in amounts the Secretary of HHS and the Attorney General jointly certify as necessary to finance anti-fraud activities. In FY 2016, the Secretary and Attorney General certified $282 million in mandatory funding, and Congress appropriated an additional $681 million to the account. These funds are allocated to the various divisions of the Justice Department, including the FBI, the HHS Office of the Inspector General, and the Centers for Medicare and Medicaid services. The HCFAC Program issues a report on an annual basis detailing how the funds have been used and providing an overview of the HCFAC Program’s recoveries, indictments and convictions.

In Medicaid, federal law also provides for the establishment of state Program Integrity Units and Medicaid Fraud Control Units (MFCUs). The MFCUs must be recertified annually by the HHS-OIG.

Most states also have fraud bureaus within their departments of insurance that oversee anti-fraud activities of insurance companies, including health insurance companies, licensed to do business in the state. On the private side, state laws mandate that commercial health insurance plans maintain Special Investigative Units (SIUs) to prevent and investigate health care fraud. Most states also require that health plans report their anti-fraud activities and cases opened and resolved on an annual basis.

Data Analytics

The strength of the technology sector in the U.S. and its ability to collect and analyze large amounts of data has started to make an impact on the anti-fraud efforts in the health care system. Over the last 15 years, multiple private companies have developed and refined anti-fraud and abuse analytical tools that are now being used by health insurance companies to detect and prevent fraud. In the last survey of its members conducted by NHCAA in 2015, 82% of its members were using data analytical tools to help prevent and detect health care fraud.

In 2010, Congress mandated that CMS begin to use predictive analytics and other analytics technologies to identify fraud in the Medicare program. In response, CMS implemented its Fraud Prevention System (FPS) in 2011. The CMS FPS provides a comprehensive view of Medicare fee-for-service provider and beneficiary activities in order to identify and analyze provider networks, billing patterns, utilization patterns, and high risk for fraud patterns. The FPS
uses other data sources, including beneficiary hot line reports, and uses rules-based models along with anomaly detection, predictive modeling and social network analysis.

All the analytical tools being used by the private and public sectors are constantly evolving as they seek to refine their models to minimize false positives and better identify future trends of fraud and abuse. These tools are critical to success in the fight against fraud as they provide a means to focus limited resources. However, any analytical tool must be combined with adequate human analytical, clinical and investigative resources in order to further examine the leads provided by the analytics.

**Anti-fraud Information Sharing**

No single health care payer, whether that payer be the government or a commercial health insurer, is capable of detecting all of the potential fraud and abuse that it may be exposed to. Each payer has limited anti-fraud resources, and no analytical system can identify all potential fraud. Additionally, fraud schemes and trends tend to migrate geographically, so that a payer which is not experiencing the effects of a specific scheme may very well feel its effects at a later time as the scheme migrates across the country. That is why anti-fraud information sharing among all payers of health care is a critical anti-fraud tool.

In 1985, the National Health Care Anti-Fraud Association (NHCAA) was formed by several private health insurers and government agencies with the express purpose of bringing the private and public sectors together to share information about fraud trends, emerging schemes, and provider investigations. Over the years, NHCAA has expanded and refined its information sharing tools, making it an indispensable player in the fight against health care fraud. Today, NHCAA has more than 85 health plan members and over 140 federal, state and local government regulatory and law enforcement agencies participating in NHCAA information sharing activities and education and training programs.

NHCAA information sharing activities include in-person and secure remote information sharing meetings along with a broad range of in-person and web-based training programs which focus on specific areas of health care fraud. Law enforcement also utilizes NHCAA to reach out to private insurers through a Request for Investigative Assistance process to determine if private insurers may have exposure in investigations opened into Medicare or Medicaid fraud. NHCAA also maintains the SIRIS data-base hosted by LexisNexis. SIRIS is a searchable database of investigations of specific providers opened by NHCAA member health plans. The database is searchable by both member health plans and all law enforcement agencies.
The NHCAA private-public partnership is unique among U.S. associations and has served as a model for other associations based outside the U.S. Its Board of Directors is comprised of representatives from commercial health plans along with three government representatives.

To build on the information sharing being done by NHCAA, the federal government in 2012 created the Health Care Fraud Prevention Partnership (HFPP). The concept behind the HFPP is to take information sharing beyond the level of emerging schemes, trends and investigations, by collecting claims data focused on specific studies from its various partners, including Medicare fee-for-service data, within a trusted third party (TTP). The TTP then analyzes the aggregated data to identify possible fraudulent activity and reports back to the partners who have shared their claims data. To date, the HFPP has 78 partners, including seven federal agencies, 40 private payers, 20 state and local agencies, and 11 associations, including NHCAA. Only a percentage of the partners are currently capable of providing claims data. The HFPP is in its early phases of growth and development, but holds great promise for being a significant factor in the fight against health care fraud.

B. Weaknesses

Complexity

As outlined in earlier sections of this paper, the U.S. health care system is extremely complex, with multiple public and private payers of health care. By way of example, Medicare has four parts: Part A pays for hospital care; Part B is a fee-for-service system that pays primarily for outpatient care; Part C is a system under which beneficiaries can opt to be covered through a commercial health plan reimbursed by the government; and Part D covers prescription drugs through contracts with private health plans. Additionally, some beneficiaries carry supplemental insurance to pay for what Medicare Part B does not pay for. On the private side, health plans have networks of providers reimbursed at negotiated rates under contracts between the plan and the providers, but also pay a percentage of the costs for providers that are out-of-network. And all of this just begins to describe the system’s complexity.

Medicare alone processes more than 4.5 million claims per day. Each payer of health care must contend with a large volume of claims and with the thousands of diagnostic codes and payment codes that underlie the universe of potential claims. Additionally, health care providers – from hospitals and physicians to hospices and durable medical equipment companies – bill multiple payers for reimbursement as a result of the different insurance coverage status of each patient. So, for example, a physician practice with a patient base having a diverse range of insurance coverages, will submit claims to Medicare, Medicare supplemental insurers, and private health plans serving the region in which the provider is located (maybe both as an in-network and out-of-network provider), and bills a patient directly for services not covered by insurance. The
provider may also be part of the network of a Medicare Part C plan and a Medicaid managed care plan.

Given the complexity of the system, those intent on committing fraud and abuse have ample opportunity to take advantage of this complexity by hiding their activities within the noise of billions of annual claims. For this reason, data analytics and anti-fraud information sharing among all payers are critical to any effective anti-fraud effort.

Payment Structure

Any health care payment structure is vulnerable to fraud and abuse. However, the payment structure that provides the greatest incentive and opportunity for fraud is a fee-for-service system under which the more services, and the more expensive services, a health care provider delivers (or claims to have delivered), the more the provider is reimbursed. The reality is that the majority of health care claims paid in the U.S. today are paid under a fee-for-service system or some variation of such a system.

Payers do try to control the fee-for-service incentives with negotiated reimbursement rates and other strategies, such as the diagnostic related groups (DRGs) for Medicare hospital care and the requirement in some health plans that a patient obtain a referral from his or her primary care physician before seeing a specialist. Nevertheless, the reality is that fee-for-service in its many versions still dominates the U.S. health care system. This reality is slowly beginning to change as noted in the Opportunities section below.

Resources and Regulations

Dedicating sufficient resources to meet the problem of health care fraud and abuse is a challenge that must be faced in any health care system, and the U.S. is no different. As indicated above, a total of about $1 billion was allocated to the Health Care Fraud and Abuse Control program in FY 2016 for anti-fraud enforcement in Medicare and Medicaid. Although this amount does not represent the total amount spent by federal agencies on fraud enforcement efforts, it does represent a majority of such funding (over two-thirds of DOJ’s health care fraud budget and over three-quarters of the HHS-OIG appropriated budget are represented by this $1 billion). Even adjusting the number upward by 100% to $2 billion to reflect other federal and state agency efforts, that number still represents just a very tiny percentage of the $646 billion the federal government spent on Medicare in 2015. And that number doesn’t include the more than $545 billion spent by the federal and state governments on Medicaid.

On the private side, health insurance plan budgets for their SIUs also represent a very small percentage of annual revenue. Adding to this disparity is that fact that Medicare plans under Part C and health plans sold under the ACA are limited in the amount of administrative
costs they can incur relative to the amount they spend on medical reimbursements and activities to improve health care quality. Despite the impact fraud has on health care quality, current regulations do not recognize anti-fraud activities as those improving quality. As a result, health plans must account for anti-fraud expenditures within the cap placed on administrative costs, thereby essentially limiting the amounts they can spend.

Another challenge to effective anti-fraud efforts are state prompt pay requirements and limitations on the look-back period health plans may use to investigate potential fraud. Although these laws vary from state to state, most states require that health care claims be paid by insurance plans within 30 days. Although there usually are exceptions for suspected fraud, some of these exceptions are narrow. Additionally, health insurance plans often are evaluated by state regulators on the efficiency and speed with which they pay claims, placing additional pressure on the plan to pay claims and then try to recover money from potentially fraudulent claims after the fact.

C. Opportunities

*Increased Information Sharing and Pooling of Payer Data*

As described in the Strengths section above, the sharing of information among payers (both private and public) concerning emerging fraud trends and schemes and investigative leads is critical to being successful in the fight against fraud. NHCAA continually explores ways in which to increase the quantity and quality of shared anti-fraud information among its members. In the last year, NHCAA invested significant resources to increase the effectiveness of its sharing database with the launch of SIRIS 2.0. The enhanced capabilities of SIRIS 2.0 will increase its use by member health plans and law enforcement leading to increased sharing of anti-fraud information having a direct impact on fraud detection and prevention. SIRIS 2.0, along with NHCAA’s other information sharing tools and its unique ability to bring together the private and public payers of health care, provide a significant opportunity for more timely and effective responses to emerging fraud trends.

Supplementing NHCAA efforts will be the HFPP, also described above. The pooling of payer claims data, including data supplied by Medicare Parts A and B, for analysis targeted at specific vulnerabilities holds great promise for the improvement of fraud detection and prevention. The biggest challenge to this effort will be the ability of the trusted third party to collect and analyze data from diverse partner sources in an environment that minimizes the threats to the security of the data. Adequate funding for the HFPP is another challenge facing this initiative. Nevertheless, despite the challenges, the HFPP provides a significant opportunity to take health care fraud detection and prevention to an unprecedented level.
New Payment Structures

One of the weaknesses of the U.S. health care system is the fact that it generally has relied upon a fee-for-service payment structure. However, that reliance has begun to change over the last 20 years or so. Although a majority of claims paid are still fee-for-service claims in both the private and public systems, more innovative payment structures (such as the use of DRGs in Medicare and capitated payments in some managed care plans) have been used with some success at limiting costs. More recently, payment models focused on treatment quality and outcomes are starting to be implemented by both private and public payers.

The opportunity for decreasing the risk of health care fraud and abuse presented by more innovative payment models that provide less incentives for fraud can be significant. A recent U.S. Senate Finance Committee Report by the majority staff exploring the need to improve and modify the Stark law noted that “[t]he risk of overutilization, which drove the passage of the Stark law, is largely or entirely eliminated in alternative payment models. When physicians earn profit margins not by the volume of services but by the efficiency of services and treatment outcomes, their economic self-interest aligns with the interest to eliminate unnecessary services.”

Many private payers are moving toward pay-for-performance models that compensate physicians based on factors that include quality, effectiveness and efficiency. Additionally, private payers are exploring value-based design insurance options which offer better coverage for high-value services but less coverage for services that provide little or no benefit.

Some initiatives by the federal government along these lines include the Medicare Shared Savings Programs, the Bundled Payments for Care Improvement Initiative, and Accountable Care Organizations (ACOs). Federal barriers to gainsharing and pay-for-performance programs also have been eased. These new payment models change the incentives and could provide an environment less favorable to fraud and abuse. Of course, no payment model or structure is immune from fraud once the new incentives become familiar and ways to exploit them are devised. Also, new payment models will not be a good fit for all types of health care providers. Nevertheless, these new payment models do hold the promise of reducing the vulnerabilities and incentives for fraud.

D. Threats

The threats to the U.S. health care system from fraud and abuse evolve over time and can reflect the threats from fraud being experienced in other areas of the national economy. The current threats in health care fraud include:

- **Cyber-attacks** – Health care has been one of the areas of the economy subject to hacking and other theft of data and personal financial and health information. These attacks
disrupt the operations of health care insurers and providers and, as a result, are a direct threat to patient care and safety. The personal information stolen can be used in the future to commit fraud through the submission of claims using the stolen information. Additionally, concerns over cyber security by health care payers can lead them to be more reluctant to share data and information with other payers as part of anti-fraud initiatives, thereby limiting the success these initiatives may have.

- **Identity theft** – Identity theft is a major problem in health care, and to a degree is tied to the challenge of cyber security. The Medical Identity Fraud Alliance (MIFA) conducted a study which found that in 2014 more than 2 million individuals were the victims of medical identity theft and that the number of victims had more than doubled over a five-year period. The survey also found that 65% of victims paid more than $13,000 out-of-pocket to resolve the issues caused by the crime.

- **Enterprise crime** – Health care fraud potentially can be committed by any provider in the system. In many cases, the provider initially entered the system with no intent to commit fraud or abuse. However, over time the provider’s actions began to lead him or her in that direction. In contrast, there are numerous criminal enterprises, some based in the U.S., and others having leadership or direction from foreign entities, which enter the health care system with the specific intent to commit fraud. These enterprises may be relatively small and focused strictly on one segment of the system in a limited geographic location, or they may be large, diverse entities conducting a range of illegal activities of which health care fraud is just one example. In either case, the losses incurred and the damage to patients caused by these enterprises pose a serious threat to the system’s integrity. Monies fraudulently obtained from the health care system may be used to support other activity, including terrorism.

- **Opioid epidemic** – The illegal distribution of prescription drugs always has been an aspect of health care fraud, but the recent dramatic increase in opioid abuse and overdoses pose an especially serious threat to the health care system. The development, marketing and over-prescribing of a range of opiate pain medications over the last decade has fueled the epidemic and increased the financial incentives for those who can find a way to redirect the drugs through fraud to street sale and distribution. The prescribing of these drugs is starting to decrease based on more stringent clinical guidelines, but the human toll and fraud caused by the epidemic will continue to be a threat in the coming years.

**The Way Forward**
Over the near term, success in minimizing the impact of health care fraud in the U.S. must be built on the system’s strengths. Additionally, we must take advantage of the opportunities that are readily achievable. The keys to success will include:

- Maintaining and expanded the opportunities for public and private payers of health care to exchange information on emerging trends and schemes, current investigations, and best practices. Since its founding in 1985, NHCAA has taken the lead on driving this type of cooperation and will continue to do so in the future. Additionally, the unique opportunities presented by the Health Care Fraud Prevention Partnership to collect and analyze claims data from multiple payers on an aggregated basis holds significant promise to be able to take the fight against health care fraud to the next level.

- Cutting edge data analytics will continue to be an indispensable tool for all payers of health care. The majority of private payers and CMS have implemented systems that go beyond mere payment rules to include anomaly detection, predictive modeling, and social network analysis. These systems may be developed internally or obtained from one of the many tech companies working in this area. Continued refinement and improvement of these systems by payers, the tech industry and research universities will be critical to anti-fraud success in the future.

- Investing in the resources necessary to take advantage of the sharing of information and the results generated by data analytics. The best analytics can only provide leads and help focus resources. Payers still need highly trained staffs of investigators, analysts and clinical professionals to follow-through and take the actions necessary to detect, investigate, and resolve cases. This requires adequate funding. Payers, both private and public, also must continue to invest in proven technologies to insure they stay ahead of the curve as new fraud trends and schemes develop. Additionally, governments must insure that adequate resources are provided for the criminal investigation and prosecution of fraud.

Over the longer term, as the U.S. health care system evolves, the payment structures must also evolve into models of payment in which the incentives and opportunities for fraud are minimized. Payment models that are based on the efficient delivery of quality services as opposed to fee-for service will improve overall quality while at the same time reducing the incentives for fraud and abuse. Value based design of insurance that offers better coverage for high-value care and less coverage for service that provide little or no benefit also holds promise for reducing costs and minimizing fraud and abuse.
Endnotes

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