

Fighting Medicare Fraud

More Bang for the Federal Buck

prepared for

**Taxpayers Against Fraud Education
Fund**

by

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Statement of Purpose and Summary of Findings

“For every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives nearly thirteen dollars back in return.”

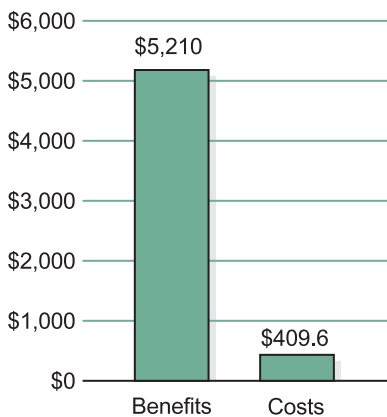
This report is an update of two earlier publications estimating the benefits and costs of the federal government’s efforts to reduce health care fraud. It estimates the recoveries from government contractors associated with health care fraud cases (the benefits) as well as the costs incurred by federal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

The False Claims Act and its whistleblower provisions have been particularly effective in the fight against Medicare fraud. Medicare, the federal government’s second largest social program, spent \$281 billion in 2003 for 41 million elderly and disabled Americans. In two previous studies conducted for Taxpayers Against Fraud (TAF) in 2001 and 2003, we found that anti-fraud efforts returned at least \$8 for every \$1 invested in health-related FCA enforcement activities. By far the most significant portion of the recoveries were attributable to FCA cases.

Because of increasing interest in the False Claims Act on the part of policymakers and the media, TAF requested that we update our study. Based on an analysis of data for the 5-year period FY 1999–FY 2003, we conclude that the U.S. taxpayers are getting a large and growing return on their dollars invested in fighting health care fraud. *Specifically, federal government recoveries from civil health care fraud over this period totaled \$5.8 billion; after deducting payments to whistleblowers, the net recoveries to the federal government amounted to \$5.21 billion over the 1999–2003 period (See Figure 1). We estimate the government’s costs over this five-year period to be \$409.6 million. Thus, for every dollar spent to investigate and prosecute health care fraud in civil cases, the federal government receives nearly thirteen dollars back in return.*

Why did the federal government’s return on investment improve from nearly 9 to 1 over the 1997-2001 period to nearly 13 to 1? This jump occurred because government recoveries in FY 2002 and FY 2003 increased far more rapidly than its enforcement costs. Civil health care fraud recoveries in FY 2002 and FY 2003 averaged \$1.7 billion, up 42 percent from FY 2001 and nearly two and half times the level recovered in FY 2000. Government enforcement costs also increased and reached \$104 million in 2003, but the overall estimated increase of about \$30 million between 2001 and 2003 was not nearly as large as the gain in recoveries.

Figure 1 Benefits and Costs of Federal Government Anti-Health Care Fraud Activities. FY 1999–2003 (in millions)



“Civil health care fraud recoveries in FY 2002 and FY 2003 averaged \$1.7 billion, up 42 percent from FY 2001 and nearly two and a half times the level recovered in FY 2000.”

The benefit/cost ratio of nearly 13 to 1 is likely to underestimate the real return that the taxpayers are receiving on outlays for civil health care fraud enforcement. That is because, in addition to the actual monetary recoveries resulting from FCA investigations and prosecutions, there are also deterrent effects that affect the behavior of other firms in the industry. Major settlements with large recoveries have a ripple effect that reduces the likelihood of similar fraud against the Medicare program. These deterrent effects cannot be measured accurately at this time, but they may be a substantial multiple of the direct, measurable benefits in the form of actual monetary recoveries.

Firms doing business with Medicare now realize that they have a great deal at stake when they fraudulently bill the federal government. As already noted, they may be liable for huge damages, which may be large enough to substantially weaken the firm if not bring it to its knees. Further, they may be excluded from participating in Medicare, which may have similar effects. In certain cases, corporate officials may be subject to criminal prosecution. Criminal investigations at DOJ sometimes parallel civil FCA investigations. These aspects of our methodology suggest that our estimates are likely to be on the conservative side.

The FCA and its whistleblower provisions are central to the federal government’s anti-fraud efforts. They provide the federal government with the insider information it needs to uncover complex business fraud against Medicare and the clout it requires to recover stolen funds and deter future fraud. But the Department of Justice, which administers the FCA, must use its authority in a balanced manner. It must enforce the FCA with vigor, but it must also respect the rights of companies in the health care industry, continue to promote compliance plans that prevent fraud at the front end, and distinguish carefully between honest billing errors and fraud. If the provisions of the FCA are enforced in this fashion, it will continue to save large amounts of money for federal taxpayers and contribute to the financial viability of the Medicare program.

The 2004 report of the trustees of the Medicare Trust Fund (MTF) indicated that the fund balance depletion date moved seven years closer in one year. Clearly, some difficult decisions will have to be made to assure Medicare’s long-term solvency. In this situation, we cannot afford a major drain on the Medicare program from fraud. Every dollar that is siphoned off from the program’s funding sources by fraudulent billing practices makes the painful choices we face even harder. If fraud is not curtailed, it will be paid for by those enrolled in the program in the form of future benefit cuts and by working-age people in the form of higher taxes. Fraud will also be paid for by honest physicians, hospitals, and other health care providers whose rates will be further cut to help control the cost of the program. Each of these parties—seniors, taxpaying workers, and health care providers—has a financial stake in curtailing health care fraud.

The federal government needs strong sanctions to deter health care fraud because the money at stake can frequently be enormous. And be-

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

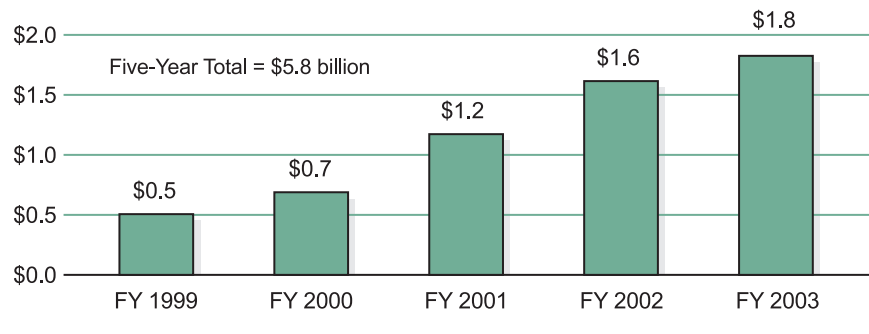
Findings

This section presents the key findings of this project. The report presents data on both recoveries and costs over the five-year period from federal fiscal years 1999 through 2003. The report begins with the latest findings on the federal government's *recoveries* from its work in fighting health care fraud. We identify health care fraud recoveries for each of the five fiscal years over the 1999–2003 period. The next step is to update the trends in the federal government's *costs* in pursuing the perpetrators of fraud. Here we estimate the costs incurred by the DOJ's Civil Division, the United States Attorneys Offices (USAOs), and the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services. This tells us how much the taxpayers are laying out to obtain these recoveries. Finally, these costs are compared to the benefits to demonstrate the cost-effectiveness of the government's effort. What is the “bang for the buck” emerging from government's anti-fraud initiatives?

Trends in Government Recoveries

Our starting point is to estimate total health-related civil fraud recoveries over the five-year period. Over the 1999–2003 period, this amount equaled \$5.8 billion. Some \$3.4 billion of this amount has been collected in the last two years (see Figure 2).

Figure 2 Health-Related Civil Fraud Recoveries Per Year, FYs 1999–2003 (in billions)



Source: U.S. Department of Justice

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

Trends in Government Costs

What is the federal government spending to achieve these results? Some staff and related costs are paid for out of general revenues. But the more important source of funding for both DOJ and OIG in HHS comes from allocations from the Health Care Fraud and Abuse Control (HCFAC) program. HCFAC is a national health care fraud prevention program set up under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is administered jointly by DOJ and HHS. HCFAC provides an annual source of funds to DOJ and OIG to cover a portion of their costs in fighting health care fraud through the enforcement of the FCA. HCFAC established a special expenditure account with annual appropriations from the Medicare Hospital Insurance Trust Fund (MTF). Funds are disbursed annually from this account to various divisions in DOJ and HHS to fund their anti-fraud activities.

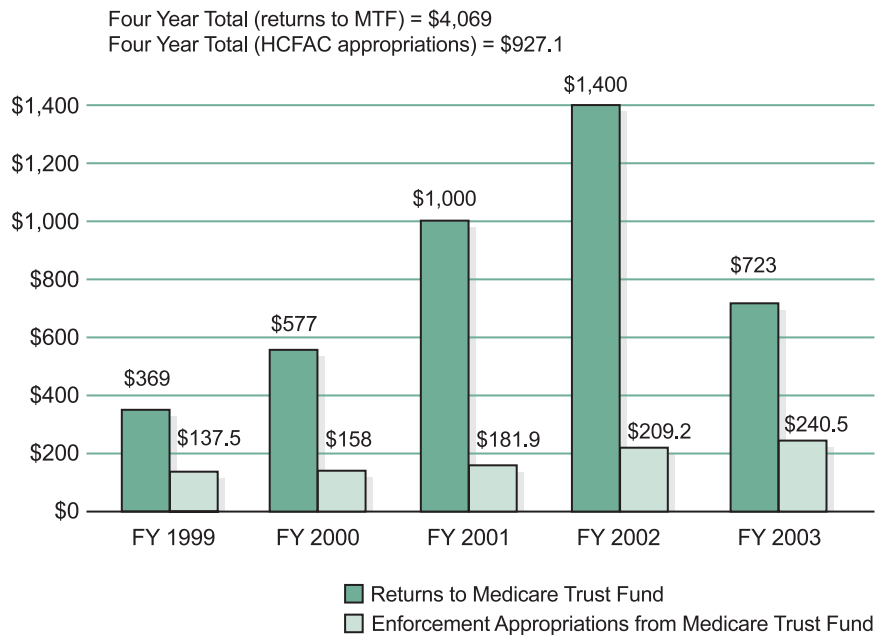
DOJ Costs in Fighting Health Care Fraud

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

CIVIL DIVISION'S COSTS. The Civil Division of DOJ is estimated to have spent a total of \$88.4 million on civil health care fraud enforcement between 1999 and 2003 (see Table 1). This incorporates past estimates based on DOJ data, updated by our own estimates. Data included in the budget for the U.S. Department of Justice indicate that the number of positions in the Civil Division rose by only 0.7 percent between FY 2001 and FY 2003. Since staff costs are the primary component of overall costs, we take this as an indication that there has been only a slight increase in staff costs. Of course, this staff change is for the full division, which works on a number of other types of cases. Lacking precise data related to attorneys and staff working directly on health care fraud, we made a small upward adjustment in costs from 2001 to 2002 and 2003.

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

Figure 3 Total Funds Returned to the Medicare Trust Fund (MTF) versus Total Funds Appropriated from the MTF for Health Care Fraud Enforcement, FYs 1999–2003 (in millions)



* The figures for FY 2001 and 2002 are approximate estimates of the amounts returned to the MTF. The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2001 notes that \$1.3 billion was *collected* in 2001 and that “more than \$1 billion of the funds collected and disbursed in 2001 were returned to the Medicare Trust Fund.” The same report covering FY 2002 notes that “approximately \$1.4 billion was returned to the Medicare Trust Fund.”

Source: The Department of Health and Human Services and the Department of Justice. Health Care Fraud and Abuse Control Program. Annual Reports for FY 1999–2002.

To estimate the USAO costs attributable to combating health care fraud, we begin with the total USAO budget over the five-year period. This amount is \$6.976 billion. On average, 22 percent of the budget went to Civil Litigation over this period. Applying this percentage to the whole budget yields an estimate of \$1.535 billion for civil litigation by USAOs over the 1999–2003 period.

The next step is to estimate how much of this amount goes for civil *fraud* litigation. To obtain this estimate, which does not appear in budget figures, we interviewed several U.S. Attorney’s offices. Amalgamating their estimates yielded an approximate figure of 26 percent of the salaries and related litigation costs of USAOs’ Civil Litigation staff that is dedicated to *civil fraud litigation* (which, according to the USAOs, is virtually 100 percent FCA enforcement). This yields a dollar amount of \$399.0 million for the *civil fraud budget of the USAOs* over the 1999–2003 period. We assume that 65 percent of this amount was attributed

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

	Fiscal Years					Five-year Total
	1999	2000	2001	2002	2003	
Amount spent on civil health care fraud enforcement (in millions)	\$17.7	\$17.2	\$17.5	\$18.0	\$18.0	\$88.4

Source: DOJ/Civil Division and the Economic and Social Research Institute.

to fighting health care fraud in 1999–2001, and that the corresponding proportion was 80 percent in 2002 and 2003. This yields an estimate that \$283.3 million was devoted to the USAO activities in fighting *health-care related civil fraud litigation* over the five-year period.

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

Table 2 Amount Devoted to the USAO Activities in Fighting Health-Care Related Civil Fraud Litigation, Fiscal Years 1999–2003

	Fiscal Years					Five-year Total
	1999	2000	2001	2002	2003	
USAOs Costs (in millions)	\$42.2	\$43.7	\$47.0	\$74.1	\$76.3	\$283.3

Source: U.S. Department of Justice, U.S. Attorney’s Offices: Ten-Year Display of Budget Authority and Positions, 1995-2004. These numbers were calculated using the annual budget authority multiplied by 0.22. This number was then multiplied by 0.26. This number was then multiplied by 0.65 for 1999-2001, the estimated proportion of civil fraud litigation attributable to health care in those years, and by 0.8 for 2002 and 2003, the estimated proportion attributable to fraud in those years.

OIG Costs

We now turn to estimating the costs associated with civil fraud incurred at the Office of the Inspector General at HHS. With the assistance of OIG, we estimated the portion of their activity that could be attributable to *civil health care fraud* enforcement. The Department provided data on costs related to civil health care fraud incurred in three areas: (1) the Office of Investigations; (2) the Office of Audit Services; and (3)

¹ In calculating the staff and related costs attributable to civil health care fraud enforcement, OIG excluded certain cost items that are not relevant to our inquiry. These include criminal cases, employee misconduct cases, and grant fraud cases. Note that in some cases tracked as criminal cases, OIG staff may simultaneously be working on the civil fraud implications. OIG also excluded hours of work related to civil health care fraud undertaken in the general counsel’s office.

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

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

Source: OIG, HHS

the Office of Evaluations and Inspections. OIG calculated the number of hours of work that their staff in each of these divisions devoted to civil fraud enforcement, and also provided us with fully loaded hourly rates of compensation reflecting not only salaries but also employee benefits and overhead. Using these figures, we determined the total costs for each group of OIG employees in fiscal year 2001 (Table 3).

The next step is to compare this figure of \$8.3 million to the total HCFAC allocation to OIG for 2001, was \$130 million. Thus, we estimate, using OIG figures, that 6.4 percent of the OIG HCFAC allocation in fiscal year 2001 was devoted to civil fraud health care fraud enforcement.

Since we do not have corresponding data on the OIG outlays related to civil fraud enforcement for earlier years, we made the simplifying assumption that this ratio of 6.4 percent also applied to 1999 and 2000. Figures for 2002 and 2003 were based on additional data provided by OIG. Table 4 shows that OIG outlays for civil health care fraud total \$37.9 million.

TOTAL FEDERAL GOVERNMENT COSTS. We now sum the costs from both DOJ and OIG to arrive at total federal government costs for each of the five years in our study period. Table 5 shows that the federal government spent \$409.6 million on civil health care fraud enforcement over the 1999–2003 period.

Table 4 OIG Costs Attributable to Civil Health Care Fraud and HCFAC Allocation to OIG, 1999–2003 (in millions)

	Fiscal Years					Five-year Total
	1999	2000	2001	2002	2003	
OIG Outlays for Civil Health Care Fraud	\$6.3	\$7.6	\$8.3	\$6.2	\$9.5	\$37.9

Source: OIG, HHS. The numbers shown above for 1999 and 2000 reflect 6.4 percent of the HCFAC allocation reflected back on that particular year. The 2001–2003 numbers are based on actual OIG data.

Benefit/Cost Ratio

We can now calculate the benefit/cost ratio. To capture the government’s net benefit, we need to first remove the portion of the health-related FCA recoveries paid to relators in *qui tam* cases. According to DOJ data, relators were paid \$588.5 million in health-related civil fraud cases between 1999–2003. Thus we remove \$588.5 million from the health-related civil fraud recoveries of \$5.8 billion. Therefore, the total amount of the recoveries being returned to the government is approximately \$5.21 billion.

Table 5 Federal Outlays for Civil Health Care Fraud Enforcement, 1999–2003 (in millions)

	Fiscal Years					1999–2003
	1999	2000	2001	2002	2003	
DOJ Civil	\$17.7	\$17.2	\$17.5	\$18.0	\$18.0	\$88.4
USAO	\$42.2	\$43.7	\$47.0	\$74.1	\$76.3	\$283.3
OIG Outlays for Civil Health Care Fraud	\$6.3	\$7.6	\$8.3	\$6.2	\$9.5	\$37.9
Total	\$66.2	\$68.5	\$72.8	\$98.3	\$103.8	\$409.6

Table 6 shows that the ratio of the federal government’s direct benefits from civil health care fraud enforcement to its costs is 12.72 to 1.

Table 6 Benefit-Cost Ratio, FYs 1999–2003

Benefits	Costs	Benefit-Cost Ratio
\$5.210 billion	\$409.6 million	12.72:1

Conclusions and Recommendations

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

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

As a result of the higher stakes for health care companies, many firms have become far more vigilant about their internal operations in an effort to comply with the law. Our earlier study concluded that firms are less likely to threaten and intimidate employees who detect apparent fraudulent billing practices now that they are aware that such employees

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could become whistleblowers and be protected from corporate retaliation. Administrative remedies are frequently implemented by OIG in conjunction with FCA investigations and settlements pursued by DOJ. One important area of collaboration between the two federal agencies involves Corporate Integrity Agreements (CIAs). These agreements are developed jointly by OIG and the companies alleged to have committed fraud during FCA settlement negotiations. CIAs are now part of most FCA settlements.

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

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

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

