Medicare Fraud:
Moratoria Miss the Mark

Statement for the Record

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"Improving Competition in Medicare:
Removing Moratoria and Expanding Access"

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Chairman Brady and members of the committee, thank you for the opportunity to submit written comments about ways to improve competition in the Medicare program. I am John R. Graham, a senior fellow at the National Center for Policy Analysis. We are a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

Summary

Medicare fraud is a serious problem. The Medicare bureaucracy has the power to impose moratoria on new providers in geographic or program areas it deems susceptible to fraud. However, preventing new competitors from providing Medicare benefits reduces competition and cannot reduce fraud by incumbent providers. A better way would be to give Medicare beneficiaries a financial interest in combatting fraud.

Background

Last February, the Government Accountability Office issued its annual report on federal programs that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement. Medicare is a longstanding member of the list: "We designated Medicare as a high-risk program in 1990 due to its size, complexity, and susceptibility to mismanagement and improper payments". A quarter of a century has gone by and Medicare is still on the list.

In 2013, Medicare spent $586 billion taxpayer dollars. The FBI has estimated that three percent to 10 percent of all health spending is fraudulent. For Medicare, that would amount to at least $17 billion and up to almost $60 billion.

The Obama Administration has ramped up antifraud efforts, with notable success. Last year, the Government Accountability Office reported that Medicare had strengthened its antifraud activities considerably, but noted further progress was needed.

The U.S. Department of Health & Human Services and the U.S. Department of Justice collaborate on the Health Care Fraud and Abuse Control (HFAC) Program, which was established in 1997 and received a cash infusion from the Affordable Care Act (ACA) of 2010. In its 2014 annual report, the HFAC Program reported a return of $7.70 on every dollar spend on antifraud efforts, recovering $3.3 billion in 2014 and over $27.8 billion since 1997.

This success is largely due to good investigative work by the Department of Health & Human Services, Federal Bureau of Investigation, and other agencies. Despite their efforts, they are only catching no more than one fifth of the dollars lost to Medicare fraud.

The (ACA) gave the Secretary of Health & Human Services a new power to combat fraud: The authority to impose temporary moratoria on new providers if the geographic area or applicant type indicates a significant risk of fraud, waste, or abuse. Some in Congress have been frustrated that the Secretary has not used this power enough. In 2011, Senators Hatch and Grassley wrote a letter to former Secretary Sebelius insisting that she start imposing them. They followed up with

a letter on March 28, 2013, which noted that despite the moratoria rule having been in force for over two years, none had yet been imposed.

In July 2013, the CMS issued its first set of moratoria. Further announcements were made in January 2014, July 2014 and January 2015.

More and Different Provider Regulation Unlikely To Stop Fraud

Moratoria are unlikely to prevent fraud and likely to have unintended consequences by reducing competition. It is a little like solving bank robberies by preventing people from entering banks. Indeed, effective fraud protection and prevention should encourage, not prevent, new providers from entering Medicare and shaking up the *status quo*. If the only way to reduce fraud is to prevent new providers from entering a market, it suggests that the market itself is perversely structured to invite fraud.

Imposing moratoria is the extreme case of focusing antifraud efforts on regulating providers. While this focus has improved recovery, the burden of compliance has become so great that it is interfering with honest providers' ability to do business with Medicare. Enrollment by providers is already highly bureaucratized. The ACA actually made honest providers pay explicitly for auditing fraud by imposing a new application fee of $505 for enrolling each new practice location.

Many trade and professional associations have complained that the burden of antifraud compliance is increasing their members' costs and frustrating their businesses. Many complaints address Recovery Audit Contractors (RACS), to whom Medicare pays a share of the spoils from claims they challenge. This has resulted backlog of 500,000 denied claims being appealed. Although honest providers are susceptible to the temptation to "upcode" claims, it is unlikely that this backlog comprises many claims from actual fraudsters, who are unlikely to appeal a denied claim.

Indeed, the bureaucratic burden might have become counterproductive. The largest Medicare fraud in history was uncovered in 2012 and executed by a Texas doctor who billed Medicare $375 million for care that was not provided. He recruited homeless people and paid them $50 to sign forms evincing that they had received treatment from him. "Jack Fernandez, a Florida lawyer who formerly prosecuted healthcare fraud for the federal government, whistled out loud when he heard the dollar amount in the Roy case. But he said the red tape and complex laws and regulations that come with filing Medicare claims made it easy to slip false claims through the system," according to the *Los Angeles Times*.

Dialing up the pressure on providers even more, to the extreme of imposing moratoria on new entrants, is unlikely to improve fraud recovery and prevention for two reasons: Fraud is a common feature of insurance markets; and government does not have the right incentives to prevent fraud. Combining these results in a toxic brew in which fraudsters can breed happily.

In proper markets, insurance only comes into play for unforeseen and catastrophic events. This is because third-party payments are unavoidably susceptible to attempted fraud. Consider the classic case of a businessman who has unsold inventory, hires someone to torch his warehouse,

and submits a claim to his property insurer. The desperate and unethical businessman has to take extreme measures to defraud the insurer. In Medicare, and U.S. health care in general, so many low-cost and routine items and services are run through insurance claims that fraudsters can easily pick holes in the system.

Because Medicare is spending taxpayers' money, not its own, it cannot have the right incentives to effectively prevent and recover from fraud. Private insurers invest in effective measures, because their investors require it. When people spend their own money directly, they are also vigilant against fraudsters.

A Better Way: Reward Beneficiaries for Preventing Fraud

Medicare makes a faint-hearted attempt to enlist seniors' support in preventing fraud. Between 1997 and 2012, Senior Medicare Patrols have resulted in saving Medicare more than $106 million. That is good work for volunteers, but it is only $7 million annually – a drop in the bucket.

A better way to prevent fraud from the demand side would be to give beneficiaries direct control of more of the money Medicare spends on their behalf. Consider an obvious example: Certain categories of medical equipment are notoriously susceptible to Medicare fraud. Durable Medical Equipment (DME) incudes power wheelchairs, electrical hospital beds and diabetic test strips. In 2011, Medicare began a competitive bidding program for these items. Since then, DME bidding has saved $2 billion for Medicare.

Note that all these savings accrue to the government: They are invisible to Medicare beneficiaries. Much more could be saved if Secretary Burwell were able to tell America's seniors something like this:

> "Medicare has been paying over $4,000 for your power wheelchairs. We know that they can be purchased for around $3,000, or even less in some parts of the country. So, go find a power wheelchair for less than $4,000, send Medicare the invoice, and we'll add a share of the savings to your Social Security deposit, Medical Savings Account, or Health Savings Account as soon as we've verified the transaction."

Of course, this means that Medicare beneficiaries have to control more Medicare spending directly, as recommended by NCPA Senior Fellow and former Medicare trustee Tom Saving. Currently, Medicare beneficiaries can enroll in Medicare plans with Medical Savings Accounts, but these have limited availability. Further, current Medicare beneficiaries do not have access to savings in fast-growing Health Savings Accounts, because they are only a decade old.

Optimizing Medicare beneficiaries' ability to combat Medicare fraud through prudent purchasing power will require reforms that include shifting a significant proportion of current Medicare spending away from providers who submit claims to federal Medicare contractors and into seniors' Health Savings Accounts and Medical Savings Accounts.

Continuing to focus antifraud efforts solely on playing whack-a-mole with fraudsters, to the extreme of preventing new competitors by imposing moratoria, is unlikely to reduce fraud much further.

Thank you for the opportunity to submit these written comments.