Public attitudes toward healthcare fraud: Reasons to commit fraud and common schemes

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ABSTRACT

Cases of health care fraud have been on the rise in recent years and are likely to continue their rise into the future. Every year a significant amount of the federal healthcare budget is lost to fraudulent claims by providers and/or to be spent by government agencies involved with the enforcement of the healthcare laws for the apprehension and prosecution of offenders (CMS, 2017). This study investigates the reasons for committing fraud by the general public and finds that the primary contributing factors are the explosion in the size of health care spending and the ever expanding network of providers and subscribers of health care services causing wide access to the system.

While fraud is committed against both public and private health care organizations, the primary emphasis for prevention and reporting of fraud is on the public side (Rosenbaum et. al., 2009). This study investigates whether there are any differences in public attitudes towards fraud committed against the public agencies versus the private insurance companies. The study selects two equal samples and mails to each group a survey that includes similar questions pertaining to either Medicare/Medicaid or private insurance companies. The results show that both groups of participants view the fee-for-service payment system where doctors and other providers are tempted to perform or bill for unnecessary services as the most important reason for fraud. In addition, both groups rated double billing and incorrect reporting of diagnosis or procedures as the top two schemes committed against health care organizations.

Keywords: Healthcare, Fraud, Medicare, Medicaid, Insurance companies,

INTRODUCTION

Health care fraud is a deliberate act committed to gain in financial advantage. However, the money lost is not the only concern. Fraud also hinders the health care system from providing the legitimate and safe care that the patients need, and it may also alter the perception of the public about their health care system. Other major reasons for the government's efforts to fight against fraudulent health care practices include: 1) Medicare and Medicaid fraud is a waste of the U.S taxpayers' money. 2) Fraud against the government is considered a criminal act and therefore, the government is responsible to protect its citizens from criminals. And, 3) the U.S. government is charged with regulating the health care system (Sparrow, 2008). While most providers are honest and ethical, there are those few who do not play by the rules resulting in major abuse of the nation's resources.

Table 1
Who Are Healthcare Providers

Provider:
Doctors
Nurses
Hospitals
Clinics
Nursing homes
Adult family homes
Home health care providers
Assisted living facilities
Ambulance and other transportation companies
Medical equipment suppliers
Pharmacies
Pharmaceutical manufacturers
Testing facilities

The health care fraud has far-reaching financial consequences. According to the U.S Government Accountability Office, amounts that either were incorrectly paid or should not have been paid were estimated to be $60 billion in 2014 (GAO, 2015). The FBI, the primary agency responsible for exposing and investigating health care fraud reports that losses due to fraudulent activities are estimated to be 10 percent of the amount of money that is spent for health care expenditures (FBI, 2017). Considering that the U.S. health care spending totaled $3.2 trillion or $9,990 per person in 2015, the amount of money lost to fraudulent activities could be substantial (CMA, 2017). Centers for Medicare and Medicaid Services also reports that the national health expenditures will grow by an average of 5.6 percent annually over 2016-2025 (CMS, 2017). The same report projects health care spending to outpace the GDP growth by 1.2 percentage points or 19.9 percent of the GDP by 2025 (CMS, 2017).

Despite the government's increasing efforts for fraud detection and prevention, health care fraud cases have been on the rise in recent years and will likely continue to climb in both amount and number. The contributing factors are the explosion in the size of health care spending and the ever expanding network of providers and subscribers of health care services demanding wide access to the system. The Department of Justice is so concerned about health

care fraud that in its fiscal year 2012 budget requested $283.4 million for fraud detection and prevention, representing an increase of 22 percent over the last year's budget (Ramonas, 2011).

Health care fraud results in higher costs for both consumers and the government. Also, there are some who believe that fraud may cause reduced benefits as providers decide to establish strategies to prevent people from committing fraud (NHCAA, 2009).

Although fraud in the health care system is widespread, Medicare and Medicaid fraud is the largest one among many different schemes used to defraud the health care system (Sorrel, 2009). For example, it is estimated that in 2011 payments for improper services amounted to $115.3 billion, with more than half or 64.8 billion attributed to Medicare and Medicaid fraud (GAO, 2012). For this reason, the government focuses most of its attention on preventing these cases.

HEALTH CARE FRAUD STATUTES

The U.S. Federal Government has made tremendous efforts to discourage citizens from committing health care fraud. Some of these efforts date back to 1863 when during the Civil War, the Federal Government was concerned with frauds committed by suppliers of goods and services to the Army (CMS, 2015). According to this law all false or fraudulent claims to the Federal Government are subject to civil penalties such as fines and possible criminal penalties including imprisonments.

Over the years several other laws were passed aimed at strengthening government's position against health care fraud perpetrators. These laws include the Anti-Kickback Statute of 1987, the Physician Self-Referral Law of 1993, and the Civil Monetary Penalties Law of 1989. More recently, the issue of health care fraud was moved to the front burner as the Federal Government consolidated its efforts to combat fraud under Public Law 104-191 "Health Insurance Portability and Accountability Act of 1996" (HIPAA). Under the direction of the Attorney General and the Department of Health and Human Services (HHS) the legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC). The role of this office is to coordinate all health care anti-fraud operations, both public and private, at the Federal, State, and local levels (U.S. Congress, 1010).

Despite the government's efforts towards health care fraud prevention, reported cases of fraud continue to rise. According to the reports by the Department of Health and Human Services, the government's efforts resulted in the recovery of $3.3 billion in 2016 up by nearly 38 percent compared to $2.4 billion recovered in the previous year (Department of Health and Human Services, 2017). Also, the same report indicates that in the past seven years (since 2009), the government has returned a total of $17.9 billion to the Medicare Trust Funds compared to $13.1 billion over twelve years earlier, an increase of over 35%. This evidence suggests that while the government's enforcement efforts towards recovery of taxpayers' dollars have been successful, more needs to be done. One of such efforts have been the use of cutting-edge technology by the Centers for Medicare and Medicaid Services to identify and prevent improper payments. According to a report, this Fraud Prevention System has helped to identify or prevent a total of $820 million in improper payment during the first three years of its use (CMS, 2015).

It goes without saying that as the focus of the above laws is primarily on fighting fraud committed against the government, particularly the Medicare and Medicaid systems, fighting fraud against private insurance companies should equally be as important.

PROBLEM STATEMENT

An analysis of the U.S. national health expenditures reveals that more than half of the total expenditures is provided by the private sector mainly the large national insurance companies (CMS, 2017). However, while there is strong evidence that fraud is directed against both public and private health care funding, the primary emphasis of prevention and reporting of fraud is on the public side (Rosenbaum et. al., 2009). Although there have been some efforts in recent years to fight fraud directed toward private sector, (e.g., in 2012 a new voluntary collaborative partnership was formed between the federal government, state officials, and some private insurance companies to act collectively against fraud (GAO, 2012)), there is little evidence to show the extent of government's enforcement efforts in this area. To this date the government's efforts have been mostly directed towards the detection and prevention of fraud against the Medicare and Medicaid system. For example in June 2011, the government's Fraud Prevention System (FPS) started to run predictive algorithms and other sophisticated analytics against all Medicare fee-for-service (FFS) claims prior to payment (GAO, 2012). Also, it was reported that in 2016 payments for improper services under Medicaid amounted to $140 billion, or nearly 12 percent of total Medicare and Medicaid spending (Williamson, 2016). While, the annual health care spending by both the federal and state governments is 46% of the total spending (CMS, 2017), there is a disproportional relationship between the government efforts exerted on the detection and prevention of fraud against Medicare and Medicaid system compared to the private insurance companies.

RESEARCH QUESTION

The purpose of this research is to investigate public's attitudes towards frauds committed by health care providers. While there are many reasons that people resort to fraudulent activities, there could be specific reasons for the health care fraud. In addition, are the reasons for committing fraud against Medicare and Medicaid different from the reasons for fraud against the insurance companies? There is little or no research investigating the public's perceptions of fraud committed by the health care providers.

Research Question One: The reasons for health care fraud committed against the private insurance companies are the same as those committed against the Medicare and Medicaid system.

Hypothesis One: There is little or no difference in the list of reasons for committing fraud against the private sector versus the public sector.

As there could be various reasons for committing fraud, providers use numerous methods to defraud the health care system. This study, additionally, investigates the major schemes used to commit fraud. Are the schemes used to defraud the Medicare/Medicaid system different from those used against the private insurance companies?

Research Question Two: Fraud schemes committed against the private sector (i.e., insurance companies) are the same as those committed against the public sector (i.e., Medicare/Medicaid).

Hypothesis Two: There is little or no difference in the list of fraud schemes used against the private sector versus those used against the public sector.

DATA COLLECTION

The data for this study was collected through a survey. The subjects included 1000 business professionals randomly selected from the residents of Southern California. The selected sample was randomly stratified into two equal groups of 500 subjects (Groups A and B). The means of data collection was a questionnaire which was prepared on a 7 point Likert-scale with "1" representing "Most Important" and "7" representing "Most Unimportant". Two questionnaires were developed each containing the same set of questions, one directing the participants' attention to Medicare/Medicaid fraud schemes (Group A) and the other focusing on frauds against the insurance companies (Group B). The survey questions were developed by relying heavily on the work of Piper (2013). Later the list of fraud schemes was expanded by using Schemes to Defraud Medicare, Medicaid and Private Health Care Insurers reported by General Accountability Office (2000).[1] E-mail was the primary mean of data collection. The participants were assured strict anonymity and asked to complete all sections of the questionnaire including demographic questions. If the questionnaire was not returned within two weeks a second and third mailing was done to increase the response rate.[2]

RESULTS

The repeated mailings resulted in a total of 196 and 198 useable responses for Groups A and B, respectively, producing response rates of 39.2% and 39.6%.[3] Table 2 (Appendix) contains a summary of demographic information. The majority of respondents in both groups were Asian, Hispanic and White with only a small percentage (3.6% and 2.5%) being Black. The biggest age group was from 45 to 54 years of age representing nearly 40% of the respondents with another 50% in age groups ranging from 18 to 44 years of age. All respondents possessed either high school or higher education. Nearly 50% of them had a bachelor's or master's degree. Two-thirds of participants were married with the remainder who were either single, divorced or widowed. The gender divisions were 52% female and 48% male among Group A and the exact opposite among Group B. Nearly one-fourth of the respondents indicated that they were self-employed (23%), with the others working for public and private organizations including government and education. More than half of the respondents worked in top or middle management positions. As for family

[1] To ensure validity and reliability of the questionnaire, the instrument was pre-tested by using a group of ten professionals in Southern California. As the result of this pre-testing, several questions were added or modified prior to mass distribution. A re-testing of the instrument proved that questionnaire is reliable.

[2] In order to measure the probability of non-response bias, statistical tests were conducted on the early and late responses. The results showed no significant differences between the responses received after the first mailing, leading to the conclusion that the chance of non-response bias was statistically non-existent (P = 0.05).

[3] The first E-mail produced 101 useable responses. Ninety-seven additional useable responses were received after the second and third E-mail, bringing the total to 198 responses.

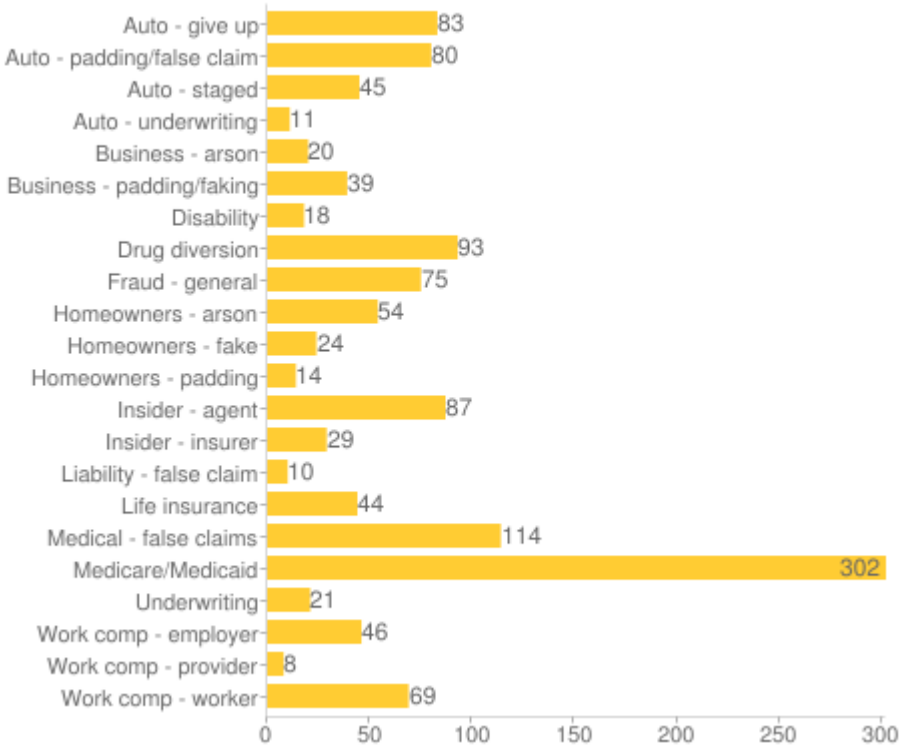
income, the majority of respondents reported an income of over $150,000 (30.5% for Group A and 25.6% for Group B). Only 9.6% of Group A and 18.1% of Group B received less than $50,000 of income.

ANALYSIS

Research Question One:

Health care fraud require that false information be presented as truth. Most often perpetrators exploit patients by reporting false diagnoses for them or more severe conditions than they actually have. According to the information collected by Healthcare News and Insights (2016), the number of frauds committed against Medicare/Medicaid outweighs those committed against private insurance companies. The following figure shows Medicare/Medicaid fraud occurs at a rate of 2.65 times of other medical frauds.

Figure 1



Source: Healthcare News & Insights http://www.healthcarebusinesstech.com/healthcare-fraud/

Table 3 (Appendix) provides the main perceived reasons for healthcare frauds ranked by mean ratings. The highest reason for committing fraud is the fee-for-service payment system where providers are tempted to perform or bill for unnecessary services. The next reason is the lack of a uniform fraud prevention law. There are at least five major Federal laws designed to combat fraud. Many States have their own similar laws. Complexity of the Medicare/Medicaid claim system is found to be the third reason for fraud. There are four parts included in the Medicare system, each containing many details. The fourth reason is that the system includes a

variety of services. For example Medicare Part A covers hospital care, skilled nursing care, nursing home care, hospice, and home health services while Part B covers clinical research, ambulance services, durable medical equipment, mental health, getting a second opinion before surgery, and limited outpatient prescription drugs. Finally, placing blind faith in doctors is found to provide a temptation for committing fraud.

Two-sample t-test was used to test **Hypothesis One**. The results showed no significant difference between the two groups in rating the reasons for fraud ($p<0.05$). Thus, we concluded that the public finds the reasons for committing fraud against the private insurance companies the same as those reasons against the Medicare/Medicaid system.

Research Question Two:

According to Centers for Medicare and Medicaid Services (2016), in 2015, the United States spent $3.2 trillion for national health expenditures. Of this amount 37% was used by Medicare/Medicaid while nearly the same percentage, 33%, was spent by the private health insurance companies. However, as shown in Figure 1, reported cases of fraud against Medicare/Medicaid are almost three times as those reported for the private insurance companies. It is possible that the disproportionate cases of fraud against Medicaid/Medicare compared to the private insurance are by design. The Medicare/Medicaid system was designed primarily to compensate providers who made health care available to those who were underprivileged, needy and/or old. It was not designed to make prompt reimbursements and had no built-in provisions to safeguard against fraudulent activities (Sparrow, 2008; Sorrel, 2009).

Tables 4 (Appendix) contains the schemes aimed at Medicare and Medicaid ranked by their ratings. The scheme with the highest rating is double billing of both Medicare/Medicaid and the private insurance company or the patient. The second and third highest rated schemes are incorrect reporting of diagnosis or procedures and billing for services not rendered. While the difference between the mean ratings of the first and the second scheme was only 0.01 or less than one percent, this difference for the lowest rated scheme was 0.65 or 29%. The scheme with the lowest mean ratings for this group is waiving of deductibles or co-payments. Thus, it is evident that business professionals who participated in this study consider double billing significantly more important than waiving of deductibles or co-payments. Also, misrepresenting the location of a service and substitution of generic drugs were considered much less important than the other schemes.

Fraud schemes aimed at the private insurance companies are listed and ranked by mean ratings as indicated in Table 5 (Appendix). The top two schemes for this group are the same as those found for Medicare/Medicaid. However, the rankings of the other schemes came out to be somewhat different for this group compared to the Medicare/Medicaid group. While the difference between the mean ratings of the first and the second scheme was only 0.05 or only two percent, this difference for the last scheme was 0.69 or 30%. As with the top two schemes, the bottom two schemes for this group are also the same as those of the Medicare/Medicaid group, exhibiting a similar attitude towards both groups of health care options.

Statistical tests of **Hypothesis Two** ($p<0.05$) proved that there is no significant difference between the public's ratings of top fraud schemes committed against the private companies versus Medicare/Medicaid. However, the average ratings across all fraud schemes proved to be somewhat higher for the Medicare/Medicaid group suggesting that the business professionals place a slightly higher importance on cases of fraud against Medicare/Medicaid compared to the private health insurance companies.

SUMMARY AND CONCLUSION

While fraud is committed against both public and private health care agencies, the primary emphasis of prevention and reporting of fraud is on the public side (Rosenbaum et. al., 2009). There is little evidence to show the extent of government's enforcement efforts in fighting fraud against the private sector. To this date most of the government's efforts have been directed towards the detection and prevention of fraud against the Medicare and Medicaid system. The

purpose of this research is to investigate whether there are any differences in public attitudes towards frauds committed against the public agencies versus the private insurance companies.

A questionnaire was prepared with a list of most common reasons for committing fraud as well as a list of widely known fraud schemes and it was distributed among two randomly selected groups of business professionals in California. One group was asked to rate the fraud schemes assuming that they were committed against Medicare/Medicaid. The second group was provided the same list and asked to rate them if they were committed against private insurance companies.

The results showed that both groups viewed the fee-for-service payment system where doctors and other providers are tempted to perform or bill for unnecessary services the most important reason for fraud. Furthermore, both groups placed all reasons exactly in the same order of importance (see Table 2). In addition, both groups rated double billing and incorrect reporting of diagnosis or procedures as the top two schemes committed against health care agencies. However, both groups assigned much lower ratings to misrepresenting location of service instead of an office as a hospital visit. Also, waiving of deductibles or co-payments was not found to be overly significant (see Tables 3 and 4). These results are important for government's efforts toward detection and prevention of fraud. Because of limited resources, officials can use this information for focusing their efforts on looking into the fraud schemes that are most important. The overall results demonstrate that the public perception of health care fraud is generally the same regardless of whether or not it is committed against Medicare/Medicaid or the private insurance companies.

This study focuses on public's perceptions of reasons for health care fraud and schemes widely used to defraud health care organizations. Future research may investigate the number and amount of actual cases of fraud committed against Medicare/Medicaid compared to those against the insurance companies. A study of actual cases may show that the methods used to defraud the public organizations are different from those used against the private health care companies.

As with other survey research, this study is subject to several limitations. (1), the sample was not drawn from a nationwide population. Therefore, the results may not represent the views of business professionals in all 50 states. (2), the subjects were not selected based on their experience with Medicare/Medicaid or private insurance. There is a possible relationship between one's opinion and whether he (she) is under a particular health care coverage. And, (3), it is not clear what percentage of the participants had previously been exposed to fraud cases or if their opinion will differ depending on their exposure.

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APPENDIX

Table 2
Survey Respondent's Demographics

Ethnicity:		**Group A**	**Group B**
Black & African American		3.6%	2.5%
Asian		36.0	33.7
Middle Eastern		7.1	3.0
Hispanic		33.0	34.7
White		16.3	21.1
Others		4.0	5.0
Total		100.0	100.0
Age:			
18-24		17.3%	17.2%
25-34		16.2	12.6
35-44		17.6	15.5
45-54		36.8	43.6
55-Up		12.1	11.1
Total		100.0	100.0
Level of Education:			
High School Degree		35.5%	26.6%
Associate Degree		12.2	15.1
Bachelor's Degree		31.0	34.7
Master's Degree		17.8	15.6
Post Graduate		3.6	8.0
Total		100.0	100.0
Marital Status:			
Single		26.9%	28.1%
Married		67.0	64.8
Divorced / Widowed		6.1	7.1
Total		100.0	100.0
Gender:			
Female		51.8%	48.2%
Male		48.2	51.8
Total		100.0	100.0
Employment:			
Self-Employed		22.8%	23.2%
Publicly-Traded Company		13.7	13.6
Private Industry		15.7	28.6
Healthcare		5.6	4.5
Government		10.2	8.0

Education		7.1	4.0
Others		19.8	15.6
Unemployed		5.1	2.5
Total		100.0	100.0
Employment Position:			
Top Management		34.4%	30.2%
Middle Management		26.4	31.7
Staff		30.6	28.6
None		8.6	9.5
Total		100.0	100.0
Family Income:			
Under $50,000		9.6%	18.1%
$50,000-75,000		25.4	20.6
75,000-100,000		19.8	19.1
100,000-150,000		14.7	16.6
Over 150,000		30.5	25.6
Total		100.0	100.0

Table 3
Public's Perceived Reasons for Heath Care Fraud
Ranked by Importance

Rank		Group A		Group B	
	Reasons	**Mean**	**Var.**	**Mean**	**Var.**
1	The fee-for-service payment system where doctors and other providers are tempted to perform or bill for unnecessary services is the major reason for the healthcare fraud.	2.54	1.02	2.69	1.53
2	Lack of a uniform healthcare fraud prevention law and regulation is the major reason for the healthcare fraud.	2.78	1.63	2.85	2.02
3	Complexity of the Medicare/Medicaid claim system where Medicare includes Parts A, B, C, and D and each state has its own Medicaid system is the major reason for the healthcare fraud.	3.14	1.76	3.14	2.17
4	Variety of services that are allowed by the claims-payment system is the major reason for the healthcare fraud.	3.31	1.48	3.49	1.5
5	Placing blind faith in doctors is the major reason for the healthcare fraud.	3.57	2	3.62	2.69

Table 4
Public's Ratings of Fraud Schemes Against Medicare & Medicaid
Ranked by Importance

Number		Group A	
	Health Care Provider Fraud Schemes:	**Mean**	**Var.**
1	Double billing: Billing both Medicare/Medicaid and the private insurance company or patient for the same service.	2.24	1.62
2	Incorrect reporting of diagnosis or procedures: Billing Medicare or Medicaid for a more expensive service than the one diagnosed.	2.25	1.39
3	Billing for services not rendered: Billing Medicare or Medicaid for a service not performed.	2.36	1.41
4	Kickbacks: A provider may receive kickback (e.g., money or gifts) for referring patients to others for services that aren't even necessary, such as x-rays, MRIs, prescription drugs, etc.	2.38	1.74
5	False or unnecessary issuance of prescription drugs: A patient may ask a doctor to write a prescription drug, such as a painkiller, that is not really necessary.	2.39	1.82
6	Unnecessary services: Billing Medicare or Medicaid for services that are not really necessary.	2.40	1.73
7	Misrepresenting dates of service: Reporting a one-day visit as a multiple-day visit to Medicare or Medicaid for more money.	2.48	1.43
8	Unbundling: A provider may bill Medicare or Medicaid for a bundled service such as a tooth extraction as two or more separate treatment.	2.53	1.74
9	Misrepresenting provider of service: Billing Medicare or Medicaid for a service performed by a nurse as a doctor for more money.	2.56	1.63
10	Billing for non-covered service as a covered service: Billing a service that is not acceptable for payment by Medicare or Medicaid as one that is acceptable.	2.59	1.25
11	Substitution of generic drugs: Billing Medicare or Medicaid for the cost of a name brand prescription when in fact a generic substitute was used.	2.64	1.95

12	Misrepresenting location of service: Reporting an office visit as a hospital visit in order to bill Medicare or Medicaid for a higher payment.	2.75	1.75
13	Waiving of deductibles or co-payments: Billing Medicare or Medicaid for the normal charges and waiving the deductible and/or co-payment that according to the health care plan a patient must pay.	2.89	1.84

Table 5
Public's Ratings of Fraud Schemes Against Private Insurance Companies Ranked by Importance

Number		Group B	
	Health Care Provider Fraud Schemes:	**Mean**	**Var.**
1	Double billing: Billing both Medicare/Medicaid and the private insurance company or patient for the same service.	2.30	1.95
2	Incorrect reporting of diagnosis or procedures: Billing Medicare or Medicaid for a more expensive service than the one diagnosed.	2.35	1.74
3	Unnecessary services: Billing the private insurance company for services that are not really necessary.	2.39	1.88
4	Billing for services not rendered: Billing the private insurance company for a service not performed.	2.41	1.62
5	Unbundling: A provider may bill the private insurance company for a bundled service such as a tooth extraction as two or more separate treatment.	2.52	1.56
6	False or unnecessary issuance of prescription drugs: A patient may ask a doctor to write a prescription drug, such as a painkiller, that is not really necessary.	2.53	2.39
7	Substitution of generic drugs: Billing the private insurance company for the cost of a name brand prescription when in fact a generic substitute was used.	2.54	1.89
8	Misrepresenting dates of service: Reporting a one-day visit as a multiple-day visit to the private insurance company for more money.	2.55	1.81
9	Misrepresenting provider of service: Billing the private insurance company for a service performed by a nurse as a doctor for more money.	2.58	1.5
10	Kickbacks: A provider may receive kickback (e.g., money or gifts) for referring patients to others for services that aren't even necessary, such as x-rays, MRIs, prescription drugs, etc.	2.61	1.5

11	Billing for non-covered service as a covered service: Billing a service that is not acceptable for payment by the private insurance company as one that is acceptable	2.75	1.57
12	Misrepresenting location of service: Reporting an office visit as a hospital visit in order to bill the private insurance company for a higher payment.	2.77	1.99
13	Waiving of deductibles or co-payments: Billing the private insurance company for the normal charges and waiving the deductible and/or co-payment that according to the health care plan a patient must pay.	2.99	1.55