REFORMING MEDICARE

Option: Increase Penalties for Health Care Fraud

Estimates show that waste and fraud in the health care system cost taxpayers tens of billions of dollars every year. Proposals to reduce fraud include increasing the penalties for fraudulent activities, such as the illegal distribution of Medicare patient and provider information.

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Argument for:

Increasing penalties on providers and others who commit fraud can prevent and reduce fraud. Dollar for dollar, addressing fraud in this way is an effective strategy compared to other approaches. For every dollar spent on such activities over the past three years, the federal government has collected more than seven dollars in return. As funding has increased for antifraud efforts, the federal government is recovering more stolen health care dollars from fraudsters. In 2011, the Office of Inspector General, the primary watchdog for federal health care programs, expected to recover about $25 billion from its oversight and enforcement efforts. This money represents significant savings for taxpayers and is many times greater than the $311 million that was allocated to that office to recover them.

Undetected fraud continues to account for tens of billions of lost dollars in health care costs. stricter penalties, such as higher fines and better conviction rates, could put more criminals out of business for longer and further discourage people from committing fraud.

Argument against:

Unfortunately, there is little evidence that fraud is deterred by harsher sanctions. People who commit fraud may not care about sanctions or may gamble that the payoff is worth the risk—even if the penalty for fraud is substantially increased.

As another matter, the threat of harsher sanctions may intimidate physicians and other providers who fear they may be prosecuted for innocent mistakes. As a result, some providers may drop out of health care programs that impose more severe sanctions. Such defections could limit access for some patients. For these reasons, increasing penalties may not have the desired effect of actually reducing health care fraud.

Finally, increased efforts to identify and penalize those who commit fraud include higher levels of scrutiny of provider claims through audits. Preparing for and going through an audit can be enormously time-consuming and expensive for providers who already feel
underpaid due to pressure from payers. Some providers may stop participating in Medicare or other health care programs to avoid the “hassle” and expense of an audit.

_Avalere Health, LLC is a leading advisory company focused on health care business strategy and public policy._