1993

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HEALTH CARE REFORM AND FRAUD BY HEALTH CARE PROVIDERS

BY PAMELA H. BUCY**

THE amount of money lost to health care fraud, waste and abuse,1 estimated to be $90 billion per year,2 would more than cover the cost of extending health care to all uninsured Americans.3 Moreover, the loss to fraud, waste and abuse is not just economic. Providers who see their patients as the "raw mater-
rial for profits" 4 too often deliver inadequate, incompetent or unnecessary health care. 5

The bad news continues. More than any other type of white collar crime, 6 fraud by health care providers is hard to detect, in-

4. Medicare and Medicaid Frauds: Hearing Before the Subcomm. on Health and Long Term Care of the Senate Special Comm. on Aging: Part 5, 94th Cong., 2d Sess. 544 (1976) (statement of Patricia G. Oriol, Chief Clerk, Senate Comm. on Aging) [hereinafter Medicare and Medicaid Frauds: Part 5]. Ms. Oriol participated in an eight month investigation of Medicaid abuse sponsored by the United States Senate. Id. at 539. Ms. Oriol posed as a Medicaid recipient and visited numerous health care facilities around the country. Id.

5. For a discussion of health care fraud by providing unnecessary or substandard health care services, see generally Pamela H. Bucy, Fraud By Fright: White Collar Crime By Health Care Providers, 67 N.C. L. REV. 855 (1989) [hereinafter Fraud by Fright]. "With so many incentives to overtreat patients, it seems inevitable that a sizeable fraction of American medical care must be simply unnecessary, if not downright harmful." Wasted Health Care Dollars, supra note 2, at 439.

A recent Rand study found that 32% of elderly patients who received an operation to remove atherosclerotic plaque from the carotid artery did not need it and that 14% of heart bypass operations were unnecessary. Id. Another study, by Value Health Sciences, found that 27% of hysterectomies, 17% of surgeries for carpal tunnel syndrome, 16% of tonsillectomies and 14% of laminectomies were unnecessary. Id.

One dramatic example showed the regional variation in the frequency of procedures. Id. In the 1960s in Stowe, Vermont, the probability of having a tonsillectomy by age 15 was about 70%. In Waterbury, Vermont, which is over the hill from Stowe, the probability was 10%. Id. at 441.

Investigations by congressional committees in the 1970s and 1980s may have produced the most alarming examples of poor health care rendered when providers practice more fraud than medicine. See, e.g., Medicare and Medicaid Frauds: Part 5, supra note 4, at 521-65; Medicare and Medicaid Frauds: Joint Hearing Before the Subcomm. on Long-Term Care and the Subcomm. on Health of the Elderly of the Senate Special Comm. on Aging, Part 1, 94th Cong., 1st Sess. 68-69 (1975) [hereinafter Medicare and Medicaid Frauds, Part 1]. In Chicago, entire families of five or six children were given mass tonsillectomies with janitors left to monitor postoperative recovery. Healthy United States Senators and staffers traveling undercover to Medicaid clinics, as well as many patients they interviewed, were given false diagnoses of allergies, hypertension and glaucoma. Medicare and Medicaid Frauds: Part 5, supra note 4, at 521-65; Medicare and Medicaid Frauds, Part 1, supra, at 68-69.

In another instance, in massive "rolling labs" fraud, where patients were given false diagnoses to further the fraud, patients also suffered. GAO, ONE SCHEME ILLUSTRATES VULNERABILITIES TO FRAUD 1 (1992) [hereinafter One Scheme Illustrates Vulnerabilities to Fraud]. For example, one healthy athlete "was astounded when he learned months after his tests [showing false illnesses] that a life-insurance application had been rejected." Health Care Fraud, supra note 1, at 36. This patient explained: " 'All of a sudden, this glaring thing comes up on my record stating that I have all these diseases, including heart defects and obstructive pulmonary emphysema. According to their diagnosis, I was ready to die.' " Id.

6. Like other white collar crimes, health care fraud blurs the distinction between civil and criminal law. Fraud by Fright, supra note 5, at 871-75; John C. Coffee, Jr., Does "Unlawful" Mean "Criminal"?: Reflections on the Disappearing Tort/Crime Distinction in American Law, 71 B.U. L. REV. 193, 193 (1991) (Professor Coffee discusses the "dominant development in substantive criminal law over
vestigate and prove. The difficulties extend from top to bottom: the hundreds of thousands of different reimbursement fee schedules generated by a multi-payer system; the fact that a third party to the services rendered is paying the bill; the fee for service reimbursement mechanism that encourages inflation of charges. These difficulties need not exist to the extent they do. Considerable attention has been given to health care fraud lately, and hopefully, some of the recommendations made by law enforcement experts in this area will be implemented. Beffing up law enforcement techniques and tools, however, is only part of the answer to health care fraud. It also is necessary to examine and restructure the systemic incentives for fraud in various reimbursement mechanisms. The most conscientious and skilled law enforcement efforts can never overcome the incentives in our current health care system for providers to inflate, create and lie.

As the United States moves toward health care reform, there
is a unique opportunity to benefit from the relationship between fraud by providers and health care reimbursement systems. To benefit from this link, we must restructure health care delivery and reimbursement systems in ways that discourage fraud and make it easier to detect and prove.

On September 22, 1993 President Clinton officially unveiled his health care reform package. It contains the following elements: a standard package of benefits available to all Americans and legally resident aliens; the organization of consumers into regional or corporate health alliances that collect premiums, negotiate with providers for consumers, and collect and distribute information about the providers; an annual enrollment during which consumers decide whether to remain with their current provider-group or enroll with another group.

President Clinton is not the only policy maker proposing health care reform. In recent years numerous proposals for health care reform have been introduced in Congress. Currently, there are proposals that emphasize managed competition (competition among providers within prescribed guidelines), utilize a single payer mechanism, and employ a voucher system to achieve coverage of more persons. Unfortunately, all of these proposals—to the extent they address fraud and abuse—focus on law enforcement solutions. None of these proposals...

11. Id. §§ 1300-1330.
12. Id. §§ 1322-1323.
13. For an excellent summary of recent legislative initiatives, see Theodore Marmon and Michael Barr, Making Sense of the National Health Insurance Reform Debate, 10 YALE L. & POL'Y REV. 228 (1992). There have been over 40 different national health care proposals presented to Congress. Id. at 228 n.6. These proposals illustrate numerous approaches to health care reform: tax credit plans, malpractice reform, state insurance plans, single payer plans, and employer based plans. Id. at 270-71.

Under the Senate Republican bill, federal vouchers for health insurance would be made available to individuals with incomes below a specified percentage of the poverty level. Id. §§ 1003-1004.

Although it is difficult to assess the fraud potential in a voucher system without more details, the food stamp program provides a possible example: rampant fraud could exist in a black market for health care vouchers. One way to help deter this would be by coding the voucher with sufficient information about an individual's physical characteristics and health that makes selling vouchers impossible.

17. Although they focus on law enforcement techniques to address fraud,
examine the causal relationship between reimbursement mechanisms and fraud and abuse.

This Article analyzes these health care reform options from a fraud and abuse perspective, suggesting how some will encourage fraud by providers, while others will discourage fraud. Purely from an anti-fraud perspective, this Article suggests that the optimal health care system contains the following four features: (1) capitation reimbursement (reimbursing a provider a set amount for all services rendered to a person in a given period of time, usually one year); 18 (2) managed competition; (3) required copayments by all patients who are financially able; and, (4) standardized billing and payment procedures. Although this system would be superior to our current system, some fraud would still exist. Thus, this Article notes the ways in which this suggested reformed health care system remains vulnerable to fraud and details anti-fraud steps that can be implemented regardless of which reform plan is passed.

Part I of this Article analyzes the impact of fraud by health care providers in the fee for service reimbursement mechanism...
that has dominated the twentieth century American health care system. Part II describes the components of the optimal anti-fraud system, while Part III evaluates its vulnerabilities to fraud. Part IV focuses on the potential for fraud in various options for collecting the funds needed to pay for health care. Part V concludes by suggesting how best to employ law enforcement resources to detect and prove the types of fraud that will exist in whatever type of health reform that is implemented.

Prior to this analysis, three caveats must be noted. First, whatever impact on fraud that exists in any reform model exists only to the extent that the model is implemented. If health care reform is implemented piecemeal, current incentives for fraud will continue, at least in part, and the efficacy of any disincentives to commit fraud contained in reform efforts will be diminished. Second, the full impact of fraud on any reform effort cannot be analyzed fully until all details of reform proposals are available. For example, considerable fraud is inherent in the organization and duties of the regional health purchasing alliances proposed by the Clinton Administration and others.19 However, because the details of how these alliances will work remain sketchy,20 it is not possible to assess fully the types of fraud that will occur because of this new structure or what detection, investigation and deterrence techniques will be needed to combat such fraud. Third, the emphasis herein on fraudulent health care providers should not obscure the fact that most health care providers are honest professionals who make good faith efforts to treat their patients competently and to comply with complex and rapidly changing billing regulations. It is this professionalism that makes some of the suggestions contained herein viable.

I. LESSONS FROM THE PAST

A. Fraud Analysis of the Fee for Service Reimbursement Mechanism

Fee for service reimbursement has dominated most of American twentieth century medicine.21 From an anti-fraud perspec-


21. The “Clinton” Plan and the “McDermott” Plan preserve fee for service
tive, it is a disaster. Fee for service, which pays per service rendered, encourages overutilization.\textsuperscript{22} Under this system, “the more doctors do, the more they get paid.”\textsuperscript{23} To the fraudulent provider, fee for service reimbursement encourages the following types of fraud: (1) billing for services not provided; (2) billing for a more expensive service than what was actually provided; (3) providing and billing for unnecessary services while representing that the services were necessary; and, (4) paying kickbacks for referrals, including self-referrals.\textsuperscript{24}

Reported cases exemplify each of these types of fraud.\textsuperscript{25} The first two types of fraud, billing for services not rendered and misrepresenting the type of service actually rendered, are easiest for the fraudulent provider to accomplish when the services occur in high volume when legitimately performed, are difficult to verify by subsequent physical exam, and are administered to patients incapable of accurately recalling their treatment.\textsuperscript{26} Examples of services typically billed for when they did not occur include doc-

\textsuperscript{22.} Practitioner Fraud and Abuse, supra note 9, at 418. James C. Robinson, a health care economist at the University of California, Berkeley, offered the following analogy in explaining how our fee for service insurance system feeds our health care appetite: “Imagine if we sold auto-purchase insurance and said, go and buy whatever car you want and we’ll pay 80 percent of it. Under those conditions, a lot of people would go buy a Mercedes.” Wasted Health Care Dollars, supra note 2, at 435.

\textsuperscript{23.} Wasted Health Care Dollars, supra note 2, at 438 (quoting Dr. Philip Caper, M.D., health care policy analyst at Dartmouth Medical School).

\textsuperscript{24.} See generally Fraud by Fright, supra note 5, at 933. For a further discussion of the types of fraud encouraged by a fee for service reimbursement plan, see infra notes 25-46 and accompanying text.

\textsuperscript{25.} For a discussion of several cases that exemplify the fraud prevalent in a fee for service reimbursement plan, see infra notes 27-29, 31-40 & 43-45 and accompanying text.

\textsuperscript{26.} Fraud by Fright, supra note 5, at 893-99. To successfully prove fraud by billing for services not rendered, it is critical that the prosecution call expert witnesses to testify that based on their physical examination of the patient, the services in question were not rendered. Cf. United States v. Gordon, 548 F.2d 743, 744 (8th Cir. 1977) (affirming conviction of physician based on expert witness’ testimony that he had examined the patient and, in his opinion, the services billed for were not performed); United States v. Varoz, 740 F.2d 772, 776-77 (10th Cir. 1984) (reversing conviction of physician because government expert witness based testimony on lack of documentation in file rather than physical examination of patient).
tors' visits, disbursements of medicines, and simple procedures such as x-rays.

Misrepresentations regarding services actually rendered fall into two types, each type highlighting a different aspect of the fee for service reimbursement mechanism. One type of misrepresentation reflects the fact that insurers pay fees for some, but not all, services. In this type of fraud, the services actually performed by the provider were not compensable under pertinent payment guidelines yet the fraudulent provider misrepresents the service as compensable. Examples include: a podiatrist who represented that his patients were treated for complex and compensable podiatric ailments when in fact he performed simpler procedures, such as trimming toenails; an optometrist who sold noncompensable sunglasses to patients but claimed he had supplied compensable cataract eye-glasses; a physician who represented that he provided compensable injections for joint pain but actually supplied noncompensable injections of routine vitamins or medicines; a shoe store proprietor who claimed to have sup-


29. People v. American Medical Ctrs., 324 N.W.2d 782, 787 (Mich. 1982), cert. denied, 464 U.S. 1009 (1983). The procedure at issue in this case was anything but simple. Here, the defendant-physicians were convicted for billing Medicaid for “direct laryngoscopies” that had never been performed. Id. at 787. A direct laryngoscopy is an examination of the exterior and the interior of the larynx using an instrument that is inserted down a patient’s throat. Taber’s Cyclopedic Medical Dictionary 931 (15th ed. 1985). The patients testified that they did not undergo this procedure. American Medical Ctrs., 324 N.W.2d at 791.

30. Fraud by Fright, supra note 5, at 896-99.

31. United States v. Rousseau, 534 F.2d 584, 585 (5th Cir. 1976). In Rousseau, the podiatrist submitted medical forms for each of twenty elderly rest home patients falsely representing that he had treated the patients for fungus infections and ingrown toenails. Id.

32. United States v. Gold, 743 F.2d 800, 808-09 (11th Cir. 1984), cert. denied, 469 U.S. 1217 (1985). In Gold, the defendant developed a sales strategy, known as “double cataract sales.” Id. Under this strategy, sales persons urged customers requesting regular cataract glasses to purchase cataract sunglasses as well. Id. The sunglasses, however, were noncompensable under Medicare guidelines, because Medicare beneficiaries were entitled to only one pair of eyeglasses per year, and then only if prescribed by a doctor. Id. Nevertheless, the defendant routinely submitted Medicare reimbursement forms for the cataract sunglasses, representing them as compensable glasses. Id.

33. United States v. Mekjian, 505 F.2d 1320, 1322-23 (5th Cir. 1975). In Mekjian, the defendant was indicted for 60 counts of fraud and was convicted on 16 counts. Id. In addition to being convicted for misrepresenting ordinary vita-
plied compensable orthopedic shoes when in fact he supplied ordinary, noncompensable street shoes; a podiatrist who represented that he treated patients during an office visit, but only spoke to them over the telephone; and, a physician who billed Medicare for allergy shots he allegedly administered but which actually were administered by a nurse.

The second type of misrepresentation regarding services actually provided reflects the fact that insurers compensate more for some services than for others. Providers committing this type of fraud actually performed a compensable service but claim they performed another, more highly compensable, service. Examples include: a medical laboratory that billed for "manual" blood tests when "automated" blood tests were performed; a physician


35. Commonwealth v. Stein, 526 A.2d 411, 413 (1987), rev'd on other grounds, 546 A.2d 36 (1988). In Stein, the defendant billed Medicaid for office visits when, in fact, he had only renewed a prescription over the phone for orthopedic shoes. Id. In addition, the record indicated that the defendant had billed Medicaid for 33 separate office visits for the children of three patients. Id.

36. United States v. Larm, 824 F.2d 780, 782-83 (9th Cir. 1987), cert. denied, 484 U.S. 1078 (1988). Defendant Dr. Larm was indicted on 98 counts of Medicaid fraud. Id. at 782. The first 84 counts charged that Dr. Larm had billed Medicaid for 84 office visits. Id. "Office visits" are billed under code number 90040 and are "[b]rief examination[s], evaluation[s], and/or treatment[s] [of the] same or new illness." Id. In each case in which Dr. Larm billed for an office visit, he never actually saw the patient. Id. Rather, the patient received a routine allergy shot that was administered by a nurse. Id. On appeal from his conviction, Dr. Larm argued that the patients had actually visited his office and that the treatment they received was within the description of an office visit. Id. The court rejected Dr. Larm's argument because billing code 90040, "minimal service," more precisely described the service actually rendered to the patients. Id. at 783. "Minimal services" is defined as, "injections, minimal dressings, etc., not necessarily requiring the presence of a physician." Id. Dr. Larm also was convicted on 10 additional counts of fraud for billing Medicaid for the administration of allergy injections that the patients administered to themselves. Id. at 782.

37. United States v. Precision Medical Lab., Inc., 593 F.2d 434, 438 (2d Cir. 1978). The owners of a medical testing laboratory were convicted on 77 counts of submitting false claims for laboratory services to Medicare and Medicaid. Id. at 436. There are two types of equipment that can be used to analyze blood—an
who billed for single-patient visits when the visits were with multiple patients; a psychiatrist who misrepresented the length of psychiatric evaluations; and, a nursing home that misrepresented the level of care given to patients.

Billing for unnecessary services, the third type of fraud encouraged by the fee for service payment system, is not, by itself, a fraud. It becomes fraud when a bill is accompanied by the false representation that a service was necessary. Because the fee for service system rewards for volume of services rendered, there is strong incentive for the fraudulent provider to perform and bill for unnecessary services. Although difficult to prove as fraud, as opposed to simple malpractice, this type of fraud gives plaintiffs a major advantage by clearly identifying the patient who suffered the unnecessary medical procedures as a victim of the provider’s malfeasance. Most health care fraud prosecutions identify an insurance company or the government as the victim of the fraud because it lost, or could have lost, money due to the defendant’s dishonesty. Insurance companies and governmental agencies, however, are not sympathetic victims in the eyes of most people. By contrast, patients who have received inadequate, incompetent, or unnecessary medical services are genuinely sympathetic vic-

“Auto Analyzer II,” which is manual, and a “SMAC,” which is automated. Id. at 437-38. In this case, the owners submitted claims to Medicare and Medicaid for blood tests done on the manual equipment. Id. at 438. Actually, the tests were done on automated equipment. Id. Medicare and Medicaid pay higher rates for tests done using the manual equipment. Id.

38. People v. Lee, 351 N.W.2d 294, 297 (Mich. 1984). The defendant treated several members of the same family on the same day during the course of a home visit. Id. The defendant billed Medicaid for a full reimbursement for each family member. Id. The Medicaid program provides full reimbursement for only one patient per home visit. Id. Each additional patient treated during the course of the same home visit entitles the doctor to only partial reimbursement. Id.

39. State v. Dean, 314 N.W.2d 151, 154 (Wis. Ct. App. 1981). The defendant conducted psychiatric evaluations for a number of Medicaid recipients. Id. Although the defendant spent less than one hour with each patient, she billed Medicaid for two hour evaluation sessions. Id.

40. United States v. Huckaby, 698 F.2d 915, 916 (8th Cir. 1982), cert. denied, 460 U.S. 1070 (1983). In Huckaby, the defendant owned and managed a nursing home facility in Little Rock, Arkansas. Id. The defendant was indicted for Medicaid fraud. Id. Specifically, the defendant misrepresented the level of care needed by the patients in her nursing home. Id. The Arkansas Medicaid program reimburses long-term care providers according to the level of care each patient needs. Id. The more care a patient needs, the more Medicaid reimburses the long-term care provider. Id. Each long-term care provider must complete a form indicating the level of each patient’s medical care needs. Id. The defendant misrepresented the level of care needed by all of the patients at her nursing home to receive greater reimbursements from Medicaid. Id.
tims and tend to make a plaintiff's case much stronger.41

The incentive for the last type of fraud encouraged by fee for service reimbursement, paying kickbacks for referrals, also derives directly from the emphasis on volume in fee for service reimbursement. Kickbacks are one way for the unscrupulous provider to increase volume. In a fee for service system, the kickbacks routinely flow from one provider to another and are easily concealed in legitimate payments simultaneously flowing between the providers.42 Reported cases exemplify these types of kickbacks: fees paid by medical laboratories to physicians to induce referrals of patient specimens;43 payments by durable medical equipment companies to hospital or nursing home personnel by durable medical equipment companies to induce the purchase of equipment and supplies;44 and, payments to city officials to induce referral of ambulance business.45

41. Fraud by Fright, supra note 5, at 920-32.
42. Id. at 914-20.
43. United States v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985). The defendant was president of Mobile Medical Industries (MMI), a medical management service for Mobile Medical Group (MMG). Id. MMI provided medical care primarily to Medicare recipients. Id. The defendant entered into an agreement with a medical laboratory in which the defendant would refer Medicare business to the laboratory in exchange for a 20% kickback of the revenues generated from such business. Id.; see also United States v. Sadlier, 649 F. Supp. 1560, 1561 (D. Mass. 1986). In Sadlier, the defendant was Chief Respiratory Therapist at a large hospital in Rhode Island. Id. The defendant's primary job was managing the Respiratory Therapy Department. Id. The defendant made purchases of therapy supplies from a particular supplier in exchange for kickbacks and bribes. Id.
44. United States v. Perlstein, 632 F.2d 661, 662 (6th Cir. 1980), cert. denied, 449 U.S. 1084 (1981). In Perlstein, the defendant was convicted of receiving kickback payments in connection with the furnishing of Medicaid services. Id. at 661-62. The defendant was the administrator of two nursing homes whose residents predominantly receive Medicaid. Id. at 662. The defendant solicited certain pharmacies and physical therapists to provide services for the nursing home in exchange for cash payments based on a percentage of the reimbursements from Medicaid. Id. Subsequent to the plan's failure, the defendant instead received $416 per month in alcoholic beverages in exchange for the referrals. Id.; see also United States v. Tapert, 625 F.2d 111, 115 (6th Cir.), cert. denied, 449 U.S. 1034 (1980). In Tapert, five osteopathic physicians were convicted of receiving kickbacks in return for sending their urine and blood samples to a certain laboratory. Id. at 113. Medicare and Medicaid paid for all charges for the laboratory work. Id.
45. United States v. Bay Ambulance and Hospital Rental Serv., Inc., 874 F.2d 20, 23-26 (1st Cir. 1989). Defendant Bay State Ambulance and Hospital Rental Service, Inc. made several payments to a hospital official at the Quincy City Hospital in exchange for the officials efforts to assure that Bay State would win the bid for providing ambulance service to the hospital. Id. at 25. The hospital official received remunerations totaling over $15,000 over the course of a 17 month period. Id.
Kickbacks also may be in the form of self-referrals, for example, where an internist owns the laboratory to which she refers specimens of her patients. Considerable attention has focused on this problem recently, with the promulgation of regulations that provide a "safe harbor" to some self-referral arrangements.\(^{46}\)

Unfortunately, each of the four types of fraud that flourish in the fee for service system are easy to commit and difficult to detect. Billing for services not rendered and misrepresenting the nature of services actually provided are the easiest of the frauds to commit and the most difficult to detect because the actual rendering of services takes place in the privacy of the provider-patient relationship. When these services legitimately occur in large volume, leave no physical manifestations when actually performed, and are performed on patients unable to recall the rendering of services, they become almost impossible to detect or prove. Providing and billing for unnecessary services is difficult to prove because of the subjective nature of medicine. What one provider deems to be unnecessary, another believes to be essential. Proof of intentional fraud becomes difficult in all but the most egregious cases. Kickbacks for referrals are difficult to detect because they occur between a small number of close knit professionals and are easily laundered in legitimate payments.

By themselves, price controls in the form of caps on fees\(^{47}\) do nothing to discourage any of these types of fraud because the fraudulent provider is still financially rewarded for increasing volume. The only way to discourage the volume-enhancing types of fraud that flourish in a fee for service system is to decrease the fee amount when a certain volume—either in terms of the amount of services rendered or in income earned by a provider—is reached.\(^{48}\) The deficiency in such steps is that they do not dis-

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46. 42 C.F.R. § 1001.952(a) (1992) (permitting physicians to refer business to service organizations in which they have financial interest provided that investment relationship between physician and service provider meets certain enumerated standards).


48. Incentives to decrease volume exist in parts of Canada. See Clyde H. Farnsworth, Now Patients Are Paying Amid Canadian Cutbacks, N.Y. TIMES, Mar. 7, 1993, at A1, A10. For instance, in Ontario, physicians whose total billings reflect more than 20% house calls receive only $41.50 per house call exceeding 20% instead of the $71 per house call that the physician would otherwise receive. Id. In addition, fees drop for physicians earning more than $400,000 per year (five percent of Ontario’s physicians). Id. President Clinton’s proposal to cap insurance premiums paid is another potential volume decreaser. The Clinton
courge fraud until the crucial volume is reached. The root problem is fee for service reimbursement and no amount of tinkering will reduce its incentives to inflate fraudulently the volume of services rendered.

B. The Hazards of Piecemeal Health Care Reform

Another lesson we should learn about fraud from our past experience with health care reform is that implementing health care reform piecemeal leads to unanticipated, costly, and difficult-to-control types of frauds. Prospective payment, introduced in the mid-1980s and designed to contain costs, is one of the more dramatic reforms in health care reimbursement attempted thus far. Diagnosis related groups (DRGs) are the major prospective payment effort. Under DRG reimbursement, illnesses are assigned to groups based upon the "estimated relative cost of hospital resources used with respect to discharges classified within each group." 49 DRGs went into effect in 1983 and apply only to in-patient hospital reimbursement for Medicare patients. 50 After their implementation, hospitals treating Medicare patients receive a set amount of money from the Medicare program for the treatment of each Medicare patient. If a hospital treats the patient for less than it receives for that patient, it makes money. If it costs the hospital more than the designated amount to treat the patient, the hospital loses money.

Whatever their success in controlling costs, 51 DRGs have encouraged new types of fraud: cost shifting; false reporting of costs; new types of kickbacks; false diagnoses of patients; and, growth of new health care businesses that have evolved too rap-
idly to be regulated properly. These frauds have arisen primarily because DRG reimbursement applies piecemeal: only to the rendering of some services (in-patient hospitalizations) for some patients (Medicare).

Cost shifting and inflation of costs have arisen because hospitals have coped with DRGs, in part, by inflating the costs they bill to privately insured patients. Congressional hearings recently focused on this practice and found examples such as: a $8.05 crutch charged to hospital patients at $103.65; a $.90 rubber arm pit pad charged to hospital patients at $23.75; a $.71 rubber tip charged to hospital patients at $15.95. This cost inflation is an open, systematic, nation- and industry-wide practice. Hospital administrators refer to it as the "cross subsidization" necessary to make a profit. In the long run, this cost inflation affects the Medicare program even though the payment per Medicare patient is capped by DRGs and presumably unaffected by cost inflation. Each year DRG rates are renegotiated based, in part, on prior hospital costs—including inflated costs.

Whereas fee for service reimbursement rewards for rendering, or allegedly rendering, a high volume of services, DRGs reward hospitals for admitting a high volume of patients. Thus, DRGs carry the incentive for hospitals to increase volume by paying kickbacks to physicians for admitting their patients to one hospital instead of another. This is a crime under the anti-kickback statute. Kickbacks may be on the upswing thanks to a new change in reimbursement of providers. In 1992, the equivalent of

52. *Health Care Fraud and Waste*, supra note 8, at 131 (statement of Chairman Dingell). Chairman Dingell of the Senate Committee on Energy and Commerce acknowledged that the impetus to hold the hearing was motivated, at least in part, by recent media attention to the issue of health care fraud. Id.

53. *Id.* at 151, 180-216. Mr. David Jones, Chairman and Chief Executive Officer of Humana, Inc., one of the country's largest health care companies, testified before the Senate Subcommittee on Oversight and Investigations. *Id.* at 180. Mr. Jones addressed the problems of cost containment and cross-subsidization: "[t]he shrinking full charge segment bears an increasingly heavy portion of the cost of hospital care rendered to other patients who do not pay their share. Medicare is among the prime examples. . . .[I]t is first and foremost a distributional problem—a problem of cross-subsidization." *Id.* at 183. Mr. Jones later recognized that it is not the actual patient that bears the increased cost, but the insurance companies. *Id.*

54. *ProPac Report*, supra note 2, at 33-34.

55. 42 U.S.C. § 1320a-7(b) (1991). The statute provides:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind-

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for
DRGs for physicians, known as Resource-Based Relative Value Scale (RBRVS), went into effect. This scale caps the amount a physician receives for treating Medicare patients and may increase the pressure on physicians to increase the volume of patients they handle. One way the unscrupulous provider can increase volume is to pay kickbacks to providers for referring patients.

DRGs also encourage false diagnoses—of an ailment not covered by DRGs such as psychiatric disease, or “upcoding” a patient’s condition to a diagnosis that carries a more substantial reimbursement.

With DRGs, Medicare patients are discharged quicker and sicker. Consequently, they receive more care at home. This has led to a booming business, much of it fraudulent, in home health care and medical equipment for the home. The typical home

which payment may be made in whole or in part under subchapter XVIII or this chapter or a State health care program, or

(B) in return for purchasing, leasing, ordering or arranging for or recommending, purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a State health care program,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years or both.

Id.


57. Robert Pear, Abuse Widespread in Medical Sales For Care at Home, N.Y. Times, Sept. 29, 1991, at A1, A15 [hereinafter Abuse Widespread]. “Changes in the Medicare program since 1983 have drastically shortened the average hospital stay, creating new demand for medical equipment that can be used at home.” Id. Home care is “[o]ne of the fastest growing segments of the health care industry, and thus provides new opportunities for fraudulent health care providers to exploit.” Id. A spokesperson for Blue Cross and Blue Shield of Illinois estimated that the company lost about three million dollars a year to fraud and abuse in the sale and rental of home medical equipment. Id.
Health care fraud begins with a telephone solicitation from a fraudulent provider. The caller attempts to give the impression that he or she is with the federal government. The caller elicits health information, and uses that information to obtain a Certificate of Need. Certificates of Need must be signed by a physician. Some physicians falsely sign certificates because they are too busy to pay attention. Others sign because they are paid for doing so. Regardless, once the provider has a Certificate of Need, it delivers the equipment and bills Medicare. This type of fraud has been made easier by two aspects of the Medicare program: (1) there are no standard definitions of medical equipment so providers can easily “unbundle,” that is, bill Medicare for each piece or component of the equipment; and, (2) until 1992, home health care companies providing equipment could bill the Medicare carrier where the order was received, rather than where the equipment was delivered. This allowed shopping among carriers for the highest reimbursement rate. Because the rates vary consider-

An example of one such scheme involved the former owner of a television rental business who filed at least 2,200 fraudulent claims in 1988, which cost the Medicare program several million dollars. Health Care Fraud, supra note 1, at 36. Specifically,

[the defendant's] plan relied on a telemarketing operation employing teenage girls operating out of boiler rooms in Philadelphia-area shopping centers. The girls called local Medicare beneficiaries who had responded to newspaper advertisements offering a “free Medicare covered package.” The telemarketers would obtain the seniors' Medicare numbers and ask them if they had any physical complaints. If so, the caller said, their firm could get equipment that would help. Though Medicare requires beneficiaries to pay 20 percent of the cost of any supplies, the seniors were told that Medicare would pay ‘100 percent for everything,’ according to the complaint. Teenagers who had no medical training were making medical diagnoses upon which sophisticated, expensive equipment was being purchased for patients that neither needed nor wanted the equipment.

Id.

According to Edward Kuriansky, New York’s special Medicaid-fraud prosecutor, fraud in home health care is attracting the “sharks” and is especially difficult to investigate “because you’re talking about finding out what’s going on behind closed doors in hundreds of thousands of individual homes, where there may be no other witness than an incompetent, vulnerable elderly person.” Id. at 38.


[e]ach carrier is responsible, using the payment rates applicable or the State of residence of the beneficiary, including a qualified Railroad Retirement beneficiary, for processing claims for items listed in paragraph (b) of this section for beneficiaries whose permanent residence is within the area designated in paragraph (c) of this section. A beneficiary’s permanent residence is the address at which he or she intends to spend 6 months or more of the calendar year.

Id.
ably among the carriers, such shopping was very advantageous for providers.\textsuperscript{59}

Even legitimate suppliers have been able to reap large profits because of Medicare's inability to keep pace with the decreasing cost of the rapidly changing technology needed in home health care. For example, as recently as 1990, suppliers could purchase a Trans Cutaneous Electrical Nerve Stimulator (TENS), which generates a pulsating electrical current to relieve pain, for seventy dollars. Medicare reimbursed the supplier $475 per unit.\textsuperscript{60} Profit margins like this are like honey to bees. Now there are too many bees. Between 6,000 to 7,000 companies sell home health equipment.\textsuperscript{61} Only one-third of these belong to the industry's trade association and most do not need a license to practice.\textsuperscript{62} It is alarmingly easy for these unregulated, unlicensed companies to become Medicare providers.\textsuperscript{63}

\textsuperscript{59} Abuse Widespread, supra note 57, at A1, A15. For example: while fraud occurs throughout the United States . . . it varies in scope, depending on . . . the amounts paid for various items. Private companies that work under contract and serve as the Government’s agents in reviewing and paying Medicare claims, have some discretion in setting payment levels. The 34 Medicare agents . . . have paid widely varying amounts for the same . . . items in different parts of the country.

\textsuperscript{60} Id.

\textsuperscript{61} Id.

\textsuperscript{62} Id.

\textsuperscript{63} The GAO’s report on the “rolling labs” $1 billion fraud in California discusses how ease in securing provider numbers allowed this scheme to grow: To avoid detection, rolling labs’ operators relocated, changed names.
As our experience with DRGs indicates, changes in a system as complex and interconnected as health care causes fraud to crop up in new and unanticipated ways. As the United States embarks upon health care reform much more dramatic than DRGs, we must attempt to assess the impact of our reform efforts on fraud by providers, and also, we must be wary of piecemeal reform.

II. THE OPTIMAL ANTI-FRAUD REIMBURSEMENT SYSTEM

As opposed to the fee for service system of health care delivery and reimbursement, a capitation system of managed competition discourages volume-enhancing types of fraud and contains built-in checks that should help detect the types of fraud that will occur instead. These positive aspects of a capitation-managed competition system are amplified if uniform reimbursement and billing procedures and mandatory copayments are also implemented.

Because of the diversity of services patients need, any capitation system would likely result in groups of diverse providers organizing to service consumers. The level of care given to enrolled members would be managed by each group of providers so as to control costs while also (it is anticipated) meeting the health care needs of the members. Most HMOs exemplify capitation reimbursement. Experience in the HMOs has shown that the major way they monitor costs is by discouraging the rendering of unnecessary services, especially expensive services such as hospitalizations and referrals to specialists.

In a capitation reimbursement system, there is no incentive and used a multitude of provider numbers. The U.S. Attorney concluded that, from 1981-87, the rolling labs' owners operated under at least 30 different corporate names and Medicare provider numbers. The owners used these different corporate names to obtain multiple provider numbers . . . . The ease with which laboratories obtain Medicare provider numbers and the absence of medical licensing make it relatively easy for providers to obtain multiple provider numbers. Their use greatly complicates carrier safeguard activities and thus enhances abusive providers' ability to avoid having their unusual billing patterns detected. The ability to easily obtain new numbers also helps abusive providers avoid Medicare's efforts to recover overpayments.

ONE SCHEME ILLUSTRATES VULNERABILITIES TO FRAUD, supra note 5, at 8.

64. The “McDermott” Plan, for example, encourages a capitated reimbursement mechanism. H.R. 1200, 103d Cong., 1st Sess. §§ 303, 612(a)(2) (1993).

65. STARR, supra note 18, at 40-42.

66. Id.
to overutilize services. Thus, for the fraudulent provider, there is no incentive to engage in the types of fraud that flourish in a fee for service system. With capitated payments, however, there are incentives to commit the following types of fraud: submit false cost data to obtain a higher capitation rate; register fictitious enrollees; underprovide necessary services; and, pay kickbacks for referrals of certain patients—healthy patients. Part III addresses the significance of this trade-off in fraud incentives.

Managed competition is the second characteristic of the optimal anti-fraud health care system. Under “managed competition” providers compete among themselves to obtain enrollments of consumers. Consumers decide on the provider with which they will enroll from information about the competing providers. The competition is “managed” in that an entity (the government, a private entity or a commission composed of governmental and private interests) develops guidelines for the competition between managed care groups. According to several of the current proposals, for example, these guidelines include a required standard benefit package and a ban on discrimination against persons with chronic health problems. Any providers wishing to compete for enrollments must comply with the guidelines. Because providers compete with each other for periodic se-

67. Practitioner Fraud and Abuse, supra note 9, at 418-20 (suggesting that, regardless of payment structure of government medical programs, creation of strict norms for determining necessity and adequacy of health care rendered is necessary to successfully detect and prove health care fraud). For a discussion of the potential fraudulent activities that may be committed under a capitation plan, see infra notes 83-114 and accompanying text.

68. See generally Starr, supra note 18, at 47-50.

69. President Clinton’s proposal for national health care reform recognizes the importance of allowing individuals to choose their own health care providers. Adam Clymer, Clinton Asks Backing for Sweeping Change in the Health System, N.Y. Times, Sept. 23, 1993, at A1, A21. “We have to leave some choice in this system because Americans want to be able to pick their own doctors . . . .” Id. at A21 (quoting President Clinton). In addition to a choice of health care providers, President Clinton has identified five other guiding principles that must drive health care reform legislation: health care security; guaranteed savings; simplification of the health care system; high quality health care; and, individual responsibility for health. Id.


71. H.R. 3600, S. 1757 § 1402(a)-(c) (the “Clinton” Plan); H.R. 1200 § 301(b)(1)(A) (the “McDermott” Plan); H.R. 3222, § 1204 (the “Cooper” Plan); H.R. 3080 § 1101(b)(1)(B) (the “House Republican” Plan); S. 1770 § 1112 (the “Senate Republican” Plan).
lection by consumers, there is an existing incentive for the plans to control their costs while also providing quality care. If a plan fails to control the costs of treating its members, another plan with better cost controls will be able to offer the standard benefit package at a lower rate and may be chosen at the next enrollment period. Similarly, the members of a plan that provides poor quality care would be expected to select another plan at the next enrollment opportunity.

The third feature of the optimal anti-fraud health care system is the creation of a uniform billing and payment system—or as close to a uniform system as is possible. Our experience thus far with a multi-payer system demonstrates the importance of this feature. Currently, there are over 1000 payers, private and public, that process 4 billion claims per year to pay hundreds of thousands of providers using different payment methods and billing regulations. As noted by the General Accounting Office, “[t]he health care insurance system is a myriad of health care payers and methods of reimbursing providers. This complex system itself becomes an impediment to detecting fraud and abuse.”

Uniformity in billing and reimbursement policies would decrease honest mistakes, increase the ability of law enforcement as well as honest employees, patients, and auditors to detect fraud,

72. Vulnerable Payers, supra note 1, at 13-14. Even within one program, Medicare, the different Medicare carriers reimburse at “widely varying amounts for the same or similar items.” Abuse Widespread, supra note 57, at A1, A15. The problems with the Medicare Secondary payer program are a prime example of how fraud is encouraged by a multi-payer system. This program requires that providers treating Medicare patients who also have private insurance seek reimbursement first from the private insurer. Only if the private insurer cannot pay is the provider to seek coverage from Medicare. Too often, however, providers do not seek to collect from private insurers. This failure is due to several factors: providers have been lax in collecting information about primary insurers, Medicare carriers have been “grossly inefficient” in monitoring the possible presence of primary insurance, and private insurers have “capitalized on [these] gross inefficiencies to evade obligations to pay primary claims to Medicare.” Health Care Fraud/Medicare Secondary Payer Program: Hearings Before the Permanent Subcomm. on Investigations, Senate Comm. on Govt. Affairs, 101st Cong., 2d Sess. 2 (1990) (opening statement of Senator Roth).

The Department of Health and Human Services has recommended a number of management and accounting steps that should be taken to remedy this problem including: requiring employers to notify the Medicare program of covered employees over 65, maintaining a clearinghouse for such claims, revising Medicare claim forms, and issuing stricter instructions to Medicare carriers regarding claims on Medicare recipients possibly covered by private insurance. Id. at 16. All of these steps are wise and overdue. The point, however, is that the Medicare Secondary payer problem arose because of our multi-payer system and the resulting manipulation among payers to shift costs.

73. Vulnerable Payers, supra note 1, at 13.
and render less persuasive untruthful defense claims of confusion and mistake. Uniformity in billing and reimbursement also would enhance the opportunity to detect aberrant provider patterns. Use of such patterns is an invaluable technique for targeting abusive providers and proving fraud.\(^{74}\) In addition, uniform reimbursement policies would discourage current efforts by some providers to manipulate regional disparities in reimbursement.\(^{75}\)

Although several of the current proposals for reform call for steps that will help in standardizing billing procedures and claim forms,\(^{76}\) opportunities for billing diversity will continue to exist. Such diversity will remain a problem, either by creating confusion on the part of providers or by making it easier to conceal fraud, primarily with regard to providers who service areas large enough to be covered by multiple billing practices. It is beyond the intent of this Article to weigh the advantages of allowing diversity in billing to exist against the disadvantages of confusion and potential for fraud that such diversity would create. If, however, diversity in billing practices exists throughout the United States, care should be taken to monitor closely providers that service large geographical areas.

The fourth and last component of the optimal anti-fraud health care system is requiring copayments from all financially able patients.\(^{77}\) Copayments serve to neutralize the third party payer component of our current, and presumably our future, health care systems. The fact that a third party to the rendering

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75. See supra notes 73-75 and accompanying text.


77. A copayment is a payment by the consumer of a portion of the charge for health care services rendered. The Clinton Plan, for example, explicitly requires copayments, which it refers to as "cost sharing." H.R. 3600, S. 1757 §§ 1131-1136.
of health care services pays the bill encourages fraud. The third party's inability to know what was actually provided makes fraud easier to commit and harder to prove.\textsuperscript{78} Short of requiring every patient to pay his or her health care expenses out of pocket, copayments are the most efficient way of alleviating the potential for fraud posed by a third party payer system. Requiring copayments should not only encourage patients to examine their health care bills more closely, but should also help deter an unscrupulous provider who thinks that the payer will never know what services were actually provided.\textsuperscript{79} For patients to be effective watchdogs, however, bills, claim forms, and insurance coverage must be simplified. If a patient is covered by several insurers and receives multiple bills from providers who themselves are paid by multiple insurers with different billing requirements, it becomes virtually impossible to determine which charges go with which services. Standardizing and clarifying claim forms and reimbursement procedures should help patients become more effective monitors of fraud.

Requiring deductibles, whereby patients pay an out-of-pocket amount before their insurance kicks in to cover their health care costs, would not encourage patients to monitor the billing by their provider as effectively as would copayments because a deductible is paid up front and not per bill. Because of the strong incentives for fraud, waste and abuse in fee for service reimbursement, copayments rather than deductibles are needed if a fee for service reimbursement system is retained.

There are disadvantages to copayments vis à vis deductibles: copayments can be more difficult to collect and consumers who are heavy users of provider services would be harder hit than if a uniform deductible was collected. Despite these problems, however, the benefits of enlisting citizen-watchdogs to monitor fraud and restoring more citizen responsibility, which can be fostered by copayments, outweigh the problems posed by copayments.

To summarize, the optimal anti-fraud health care system contains a capitation reimbursement system whereby groups of prov-

\textsuperscript{78} Fraud by Fright, supra note 5, at 863-64, 878; Vulnerable Payers, supra note 1, at 3. Editing and reviewing claims prior to payment, however, may provide the third party with some protection against fraudulent billing. Fraud by Fright, supra note 5, at 15.

\textsuperscript{79} Copayments also should help curb overutilization. For example, if a patient is paying a portion of the bill each time he visits the doctor or has the doctor perform tests, the patient may be somewhat discouraged from visiting the doctor as frequently as he may if he were not paying anything.
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iders compete with each other within prescribed guidelines to supply health care; copayment requirements for all financially able patients; and, standardized reimbursement and billing procedures.

III. FRAUD ANALYSIS OF THE OPTIMAL ANTI-FRAUD SYSTEM

Even within the optimal anti-fraud system described in Part II, incentives remain for four major types of fraud by providers: submission of false cost data in hopes of obtaining higher capitation rates; enrollment of fictitious members; underprovision of necessary services while misrepresenting that all needed services have been provided; and, paying kickbacks for referrals of healthy patients.80

Capitation payment creates the incentive to submit false cost data to the entity negotiating the capitation rate because by doing so providers can obtain a higher rate. Unfortunately, false cost reporting is among the most difficult types of health care fraud to detect and prove.81 For example, it is difficult to prove that the cost report actually includes the improper expense. Generally, this is an accounting issue and the accountant preparing the cost report must demonstrate how particular expenses are recorded in the expense provider’s journal and carried forward to the cost report.82 If the books, records, or testimony needed to prove this fact are unavailable, as is often the case, it will not be possible to prove the falsity of a cost report.

Another problem in proving submission of a false cost report is demonstrating that a particular person knew that the report was false. The actual preparer of the report may credibly claim ignorance, legitimately or not, because she likely received cost information from others. The supplier of the actual cost information, assuming that person can even be identified within a large organization, can also credibly claim ignorance, incompetence, or good faith error on the grounds that he was not involved in the actual cost report preparation. Such claims of ignorance are credible

80. For a discussion of the submission of false cost data, see infra notes 81-104 and accompanying text. For a discussion of the enrollment of fictitious members, see infra note 105 and accompanying text. For a discussion of the underprovision of necessary services, see infra notes 106-07 and accompanying text. For a discussion of the payment of kickbacks for the referral of healthy patients, see infra notes 108-112 and accompanying text.

81. Fraud by Fright, supra note 5, at 908-14.

82. But see United States v. Cella, 568 F.2d 1266, 1272 (9th Cir. 1977) (controller of hospital testified to accounting entries resulting from instructions given to him by defendant-officer of hospital).
because of the complex regulations applicable to cost reporting, and the expertise and specialization needed by cost report preparers.\textsuperscript{83}

\textsuperscript{83} Reported cases reveal how the government may attempt to prove that a defendant, who may not have been involved in preparing the cost report or recording expenses, knew that the improper expense was actually included as a proper expense in the cost report.

In United States v. Smith, 523 F.2d 771, 780 (5th Cir. 1975), cert. denied, 429 U.S. 817 (1976), the United States Court of Appeals for the Fifth Circuit addressed this knowledge issue and explained what evidence would suffice to prove it:

It is not necessary that [the defendant] have known which line was incorrect when he approved the [cost report] forms, nor that he be able to properly fill out the forms himself. . . . It suffices that he understood the forms necessarily to include expenses which were not those of the hospital, and that a percentage of the amount claimed would be reimbursed erroneously to the hospital from [the United States Department of Health, Education and Welfare].

\textit{Id.}

A defendant's knowledge also can be shown circumstantially. For example, knowledge has been proven by evidence that the defendant knew the general method by which the Medicare reimbursement program worked. See, e.g., United States v. Huber, 603 F.2d 387, 398 (2d Cir. 1979) (affirming defendant's fraud conviction based on evidence defendant was familiar with mechanics of government funding programs), cert. denied, 445 U.S. 927 (1980); Smith, 523 F.2d at 774 (affirming defendant's fraud conviction based on testimony that established defendant knew general method of Medicare reimbursement program); Commonwealth v. Minkin, 436 N.E.2d 955, 958 (Mass. App. Ct. 1982) (noting defendant's experience and familiarity with procedures for reimbursement from Medicaid as factor in affirming fraud conviction). Knowledge also has been established where the defendant approved all checks for the improper expenses and these checks were taken to him for his approval. See, e.g., Smith, 523 F.2d at 775 (upholding fraud conviction where defendant retained complete financial control of hospital and evidence showed hospital money was used to remodel defendant's home). The courts have found the requisite knowledge element where the defendant accepted delivery and endorsed many of the checks payable for improper expenses. See, e.g., United States v. Jones, 587 F.2d 802, 804 (5th Cir. 1979) (affirming defendant's fraud conviction based on evidence that defendant accepted reimbursements for travel when in fact no travel had been conducted). Moreover, knowledge has been shown where the defendant's exculpatory explanations for how these expenses were handled are contradicted by the facts. See, e.g., Smith, 523 F.2d at 774 (rejecting defendant's claim that simple bookkeeping mistakes were made when evidence showed hospital money was used to remodel defendant's home). Knowledge also has been shown by evidence that the defendant failed to supply his accountant with accurate information or instructions. See, e.g., United States v. Celia, 568 F.2d 1266, 1272 (9th Cir. 1977) (affirming fraud conviction where defendant solicited payment for undocumented expenses from hospital controller); Minkin, 436 N.E.2d at 958 (affirming fraud conviction where evidence showed defendant failed to instruct accountant to segregate, in cost reports, personal expenses from hospital expenses).

Proving that supporting documentation has been falsified to help conceal the misrepresentation in the cost report may help demonstrate the defendant's knowledge of fraud. For this to be successful, there must be credible evidence that the defendant directed or participated in the falsification. Finally, it should be noted that when employees of the
A third problem in proving submission of a false cost report is how to plead the offense properly. Historically, a number of criminal statutes have been used to charge this fraud. When prosecuted in the federal courts, false statements, mail fraud, conspiracy, and transporting in interstate commerce money ob-

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Fraud by Fright, supra note 5, at 912.

84. Fraud by Fright, supra note 5, at 912-13 (text accompanying footnotes 84-102 has been adapted from the author’s previous article Fraud by Fright).

85. 18 U.S.C. § 1001 (1976). The statute provides:

Whoever . . . knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. Id. Several health care fraud cases have been brought under 18 U.S.C. § 1001. See, e.g., United States v. Alemany Rivera, 781 F.2d 229, 231 (1st Cir. 1985) (charging defendant under § 1001 with submitting, and causing to be submitted, false Medicare cost reports), cert. denied, 475 U.S. 1086 (1986); Huber, 603 F.2d at 390 (charging defendant under § 1001 with making, and causing to be made, false, fictitious and fraudulent statements to Department of Health, Education and Welfare); Jones, 587 F.2d at 804 (affirming defendant’s § 1001 conviction for knowingly submitting false statements to Department of Health, Education and Welfare); Cella, 568 F.2d at 1277 (holding evidence sufficient to sustain conviction under § 1001 for making false statements to government); Smith, 523 F.2d at 773 (affirming defendant’s conviction under § 1001 for knowingly submitting false statements to Department of Health, Education and Welfare); United States v. Simon, 510 F. Supp. 232, 233 (E.D. Pa. 1981) (same); United States v. Braunstein, 474 F. Supp. 1, 3 (D.N.J. 1978) (same).

86. 18 U.S.C. § 1341 (1984). The statute provides:

Whoever, having devised or intending to devise any scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses . . . places in any post office or authorized depository for mail matter . . . shall be fined not more than $1,000 or imprisoned not more than five years or both. If the violation affects a financial institution, such person shall be fined not more than $1,000,000 or imprisoned not more than 30 years, or both. Id. Several cases have applied the mail fraud statute to defendants accused of health care fraud. See, e.g., Huber, 603 F.2d at 390 (charging defendant with using mails to defraud hospitals and government); United States v. Collins, 596 F.2d 166, 167 (6th Cir. 1979) (charging defendant with using mails to defraud Medicare reimbursement system); Cella, 568 F.2d at 1277 (charging that defendant with using mails to defraud hospitals and government); Simon, 510 F. Supp. at 233-44 (charging that defendant mailed or caused to be mailed false and fraudulent Medicaid cost reports to government agency).

87. 18 U.S.C. § 371 (1966). The statute provides in relevant part:

If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined not more than $10,000 or imprisoned not more than five years, or both . . . .
tained by fraud,88 RICO,89 theft of government property,90 tax evasion,91 and filing false tax returns and aiding and abetting in

Id. Several health care fraud cases have been brought under this statute. See, e.g., Huber, 603 F.2d at 390 (affirming defendant's conviction for conspiring to defraud government in its administration of Medicare, Medicaid and Hill-Burton programs); Jones, 587 F.2d at 804 (affirming defendant's conviction for conspiring to defraud United States Department of Health, Education and Welfare); Cella, 568 F.2d at 1277 (affirming defendant's conviction for conspiring to defraud United States Department of Health, Education and Welfare); United States v. Nemes, 555 F.2d 51, 52 (2d Cir. 1977) (charging defendant with conspiring to defraud government by submitting and causing submission of false cost reports for Medicare and Medicaid payments to nursing home); Braunstein, 474 F. Supp. at 3 (charging defendants with conspiring to defraud government and Internal Revenue Service by filing false Medicaid cost statements and false tax returns for nursing home).


Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transports or causes to be transported, or induces any person or persons to travel in, or be transported in interstate or foreign commerce in the execution or concealment of a scheme or artifice to defraud that person or those persons of money or property having a value of $5,000 or more.

Shall be fined not more than $10,000 or imprisoned not more than ten years or both.

Id. For an example of a health care fraud case brought under 18 U.S.C. § 2314, see Huber, 603 F.2d at 390 (charging defendant with transporting stolen money in interstate commerce under § 2314).

89. 18 U.S.C. §§ 1961-1963 (1984 & Supp. 1992) (prohibiting racketeering or any benefit therefrom whereby racketeering includes, but is not limited to, mail fraud and interstate transportation of stolen property). For an example of a health care fraud case brought under §§ 1961-1963, see Huber, 603 F.2d at 390 (affirming defendant's conviction for conducting enterprise affairs through pattern of racketeering activity under §§ 1961, 1962(c), and 1963).

90. 18 U.S.C. § 641 (1976). The statute provides in relevant part:

Whoever embezzles, steals, purloins, or knowingly converts to his use or the use of another, or without authority, sells, conveys or disposes of any record, voucher, money, or thing of value of the United States or of any department or agency thereof, or any property made or being made under contract for the United States or any department or agency thereof; or

Whoever receives, conceals, or retains the same with intent to convert it to his use or gain, knowing it to have been embezzled, stolen purloined or converted.

Shall be fined not more than $10,000 or imprisoned not more than ten years, or both; but if the value . . . does not exceed the sum of $100, he shall be fined not more than $1,000 or imprisoned not more than one year, or both.

Id. For a case brought under 18 U.S.C. § 641, see Cella, 568 F.2d at 1277 (charging defendant with theft of government property under § 641).

91. 26 U.S.C. § 7201 (1989). The statute provides:

Any person who willfully attempts in any manner to evade or defeat any tax imposed by this title or the payment thereof shall, in addition to other penalties provided by law, be guilty of a felony and, upon conviction thereof, shall be fined not more than $100,000 ($500,000 in
their preparation\textsuperscript{92} have been used. When prosecuting in state courts, attempted larceny by false pretense,\textsuperscript{93} Medicaid fraud,\textsuperscript{94} theft,\textsuperscript{95} conspiracy,\textsuperscript{96} and falsifying business records have been used.\textsuperscript{97} Prosecution under any of these statutes presents problems of multiplicity and duplicity. Multiplicity is charging a single offense in several counts. Duplicity is joining in a single count two or more offenses.\textsuperscript{98} A multiplicitous indictment may be

the case of a corporation), or imprisoned not more than 5 years or both, together with the costs of prosecution.

\textit{Id.} Several cases of health care fraud have been brought under 26 U.S.C. § 7201. \textit{See, e.g.}, \textit{Cella}, 568 F.2d at 1277 (affirming defendant’s conviction for tax evasion by failing to pay taxes on embezzled money); \textit{United States v. Smith}, 523 F.2d 771, 773 (5th Cir. 1975) (charging defendant willfully attempted to evade paying taxes on alleged embezzled money).

\textsuperscript{92} 26 U.S.C. § 7206(1)-(2) (1989). The statute provides in relevant part:

\begin{enumerate}
\item \textsc{Declaration under penalties of perjury.} — Willfully makes and subscribes any return, statement, or other document, which contains or is verified by a written declaration that it is made under the penalties of perjury, and which he does not believe to be true and correct as to every material matter; or
\item \textsc{Aid or assistance.} — Willfully aids or assists in, or procures, counsels, or advises the preparation or presentation under, or in connection with any matter arising under, the internal revenue laws, of a return, affidavit, claim, or other document, which is fraudulent or is false as to any material matter, whether or not such falsity or fraud is with the knowledge or consent of the person authorized or required to present such return, affidavit, claim or document . . . .
\end{enumerate}

\textit{Id.} For cases applying this statute to health care fraud violations, see \textit{Cella}, 568 F.2d at 1277 (affirming defendant’s conviction for filing false income tax returns and aiding and abetting preparation of false income tax returns); \textit{Smith}, 523 F.2d at 773 (charging defendant made and subscribed to false income tax returns for exempt organization).

\textsuperscript{93} \textit{See, e.g.}, \textit{Commonwealth v. Cerveny}, 367 N.E.2d 802, 804 (Mass. 1977) (charging that annual reports of nursing home that were submitted by defendant to Rate Setting Commission contained material falsehoods); \textit{United States v. Minkin}, 436 N.E.2d 955, 957 (Mass. App. Ct. 1982) (affirming defendant’s convictions for attempted larceny by false pretense for submission of false reimbursement reports to Rate Setting Commission); \textit{People v. Notey}, 423 N.Y.S.2d 947, 948 (1980) (charging defendant submitted false claims to Medicaid resulting in lost between one and three million dollars).

\textsuperscript{94} \textit{See, e.g.}, \textit{Greco v. State}, 515 A.2d 220, 221 (Md. 1986) (charging defendant included non-reimbursable expenses in annual cost reports submitted to Medicaid).

\textsuperscript{95} \textit{Id. at} 220 (charging that defendant received non-reimbursable expenses due to falsifying annual cost reports submitted to Medicaid).

\textsuperscript{96} \textit{Notey}, 423 N.Y.S.2d at 948 (charging that defendant conspired with his two sons to submit false claims to Medicaid that resulted in defrauding Medicaid program between $1 and $3 million dollars).

\textsuperscript{97} \textit{Id.}

\textsuperscript{98} \textit{See generally} \textit{United States v. UCO Oil Co.}, 546 F.2d 833, 835 (9th Cir. 1976) (holding admissibility problem particularly significant where conspiracy charged due to evidentiary rules about declarations by co-conspirators), \textit{cert. denied}, 430 U.S. 966 (1977); \textsc{C. Wright, Federal Practice and Procedure §} 142 (1982). Duplicity and multiplicity rules concern the fundamental due pro-
A duplicitous indictment may be dismissed because of the danger that the jury would "find a defendant guilty on a count without having reached a unanimous verdict on the commission of a particular offense." Properly pleading this offense becomes difficult when one document contains multiple false statements, although generally it is appropriate to plead each false statement as a separate count whenever different facts are needed to prove the falsity. Nevertheless a statute appropriately drafted to cover all health care fraud would alleviate this problem.

Despite the difficulties for law enforcement that false cost reporting presents, two aspects of the health care system suggested in Part II should serve as built-in checks on some fraudulent cost reporting. If capitation reimbursement is implemented nationwide, applicable to every potential patient and covering all services, there will be no incentive to falsify the costs applicable to noncovered persons or services. As noted previously, providers currently inflate costs in part to shift from a "dry" reimbursement source to a more lucrative one. In a capitation system, in

99. See generally United States v. Conn, 716 F.2d 550, 552 (9th Cir. 1983) (holding that defendant cannot be charged with possession or receipt of several weapons received at same time and same place).

100. UCO Oil Co., 546 F.2d at 835; see also United States v. Morse, 785 F.2d 771, 774 (9th Cir.) (noting that duplicitous indictment precludes assurance of jury unanimity and may preclude subsequent double jeopardy defense), cert. denied, 476 U.S. 1186 (1986); United States v. Aguilar, 756 F.2d 1418, 1422 (9th Cir. 1985) (noting that duplicity in indictment would constitute reversible error only if defendant was misled to his prejudice).

101. 9 DEPARTMENT OF JUSTICE, U.S. ATTORNEY'S MANUAL § 9-40.170 (1985); id. §§ 9-42.220 to 42.221 (1984). The general rule is that as long as different facts are needed to prove each false statement, each false statement constitutes a separate count. See, e.g., Blockburger v. United States, 284 U.S. 299, 304 (1932) (holding that "where the same act or transaction constitutes a violation of two distinct statutory provisions, the test to be applied to determine whether there are two offenses or only one, is whether each provision requires proof of a fact which the other does not"); United States v. Schrenzel, 462 F.2d 765, 771 (8th Cir.) (noting "the test to be applied to determine whether there are two offenses or only one is whether each count requires proof of an additional fact which the other does not"), cert. denied, 409 U.S. 984 (1972).

102. The Clinton Plan, for example, proposes a new criminal statute aimed at health care fraud. H.R. 3600, S. 1757, 103d Cong., 1st Sess. § 5431 (1993). As drafted, this proposed statute would cover submission of false cost reports but does not clarify the multiplicity/duplicity problem. Id.

103. For a discussion of how DRGs have led to cost shifting in hospitals, see supra notes 50-64 and accompanying text.
which a vertically integrated group of providers assumes responsibility for all health care services needed by a patient, there will be no incentive to shift costs and thus no incentive to inflate the costs not limited by capitation.

The more significant check on submission of false cost data, however, is the competition among providers. When multiple providers submit cost data to the entity negotiating the capitation rate, inflation of costs by one provider should be obvious. The danger lies in collusion among the providers. Because collusion tends to exist more frequently in a field with few competitors, care should be taken in crafting health care reform to ensure that sufficient numbers of provider groups compete. 104

The second type of fraud for which incentives will exist in the health care system suggested in Part II is registration of fictitious enrollees by providers. Because payments to providers are made per enrollee, there is incentive for the unscrupulous provider to inflate the number of persons enrolled. Registering of fictitious enrollees should be easy to prevent, however, by allocating the responsibility for enrolling consumers to the government (or quasi-government) entity that organizes the competition rather than to the providers. 105 With or without this structural safeguard, enrollment of fictitious persons should be easy to detect through use of sufficient registration information and computer databases, both of which would be more available and convenient with a uniform reimbursement and billing system.

The third type of fraud for which incentives will exist in the health care system suggested in Part II is the underprovision of

104. See ANTITRUST, THE MARKET, AND THE STATES: THE CONTRIBUTIONS OF WALTER ADAMS I (James W. Brock & Kenneth G. Elzinga eds., 1991). Collusion is generally addressed by antitrust regulation in monopolistic or oligopolistic market structures. Id. at 165. In a chapter on structural tests aimed at promoting workable competition and effective business performance, Adams has argued that in the absence of competitive variables or direct government interference, industries generally lack the necessary compulsions militating market reforms in the public interest. Id. Although Adams has warned against heavy regulation, he has argued that powerful oligopolies—like the current health care industry—will usually attempt to shield questionable performance from public interference or at least allow reform only through piecemeal efforts. Id. at 167. Where the discipline of competitive market structure is imposed, dramatic changes in performance and efficiency may occur, as evidenced by the formation of the steel industry in the late 1950s. Id.

105. The Cooper Plan, for example, does this by specifying that the "Health Plan Purchasing Cooperative" (HPPC) enroll and disenroll individuals with the "Accountable Health Plan" (AHP). H.R. 3222, 103d Cong., 1st Sess. §§ 1101(d)(1)(C), 1102(f) (1993). The McDermott Plan similarly specifies that the states, through their "state health security program," enroll individuals for health care benefits. H.R. 1200, 103d Cong., 1st Sess. §§ 101(b), 103 (1993).
necessary services. This becomes fraud if reimbursement is obtained upon the false representation that all necessary services have been provided. Any capitation form of payment makes underproviding of necessary services lucrative. In a capitation system, a provider is paid a set amount per patient to render health care services to each patient for a given time period. By skimping on services provided, the provider makes money.

This is one of the most difficult types of fraud to prove. To demonstrate that a provider failed to provide necessary services is hard enough given the subjectiveness of the practice of medicine. But, to prove that such a failure was an intentional act so as to maximize reimbursement is extremely difficult. Once again, however, the managed competition component of the health care system suggested in Part II becomes significant. It does so in two ways. First, efforts by a provider to profit by opting not to provide necessary services are successful only if done on a large scale. A failure to care properly for the health needs of large numbers of ill consumers enrolled in a provider group will not remain a secret. Complaints and malpractice claims will lead consumers to choose another group at the next enrollment period. This built-in check becomes ineffective, however, if many or all providers begin to underprovide services. Again, to avoid this potential for collusion, care should be taken to ensure that a sufficiently large number of providers compete to service consumers.

The second way managed competition counters the incentive in a capitation system to underprovide necessary services also could help prevent collusion. To make enrollment decisions, consumers will need access to information about the quality of care by alternative providers. Several current proposals call for more effective measurements and communication of quality of care. Public dissemination of such information should help detect any collusion to underprovide necessary services, as well as enhance consumers' ability to avoid or disenroll from groups that typically underprovide.

The last type of fraud for which incentives will exist in the

106. Fraud by Fright, supra note 5, at 920-33.
health care system suggested in Part II is paying kickbacks for referrals. This type of fraud should not be as much of a problem as it currently is in our fee for service system, however. To understand why, we must examine how kickbacks work in a fee for service system. As noted previously, in a fee for service system, the kickback typically flows from one provider to another for referrals of patients who need services, or at least for whom services can be billed. In such a system, where volume of services translates into money, kickbacks are designed to enhance volume of services. Common examples of such kickbacks include laboratories, diagnostic centers and hospitals paying physicians for admitting patients or referring specimens.

In a capitation system, by comparison, a kickback would be to encourage or reward referrals of healthy patients who require few health care services but for whom the provider is paid the same amount as it is paid for ill patients. If managed competition also is implemented, a kickback would not flow from one provider to another but from the provider (or the group of providers) to individual consumers, if consumers make their own enrollment decisions. If a representative of consumers (an employer, for example) makes the enrollment decision for individual consumers, the kickback would flow from provider to consumer representative. Either way, the parties involved in the kickback are no longer a few, close knit, health care providers. These differences in the goal of and parties to the kickback mean two things, both of which should help deter, or at least enhance the detection of, kickbacks: (1) in a capitation-managed competition system, kickbacks will be difficult to consummate; and, (2) in such a system, kickbacks will be difficult to hide.

When the kickback is from one provider to another, as it is in a fee for service system, it takes place between two, or at most a few, close knit professionals. In a capitation system of managed competition, the kickback must flow from a provider (or a group of providers, probably represented in the kickback endeavor by one or a few persons) to thousands of individual consumers if individuals make their own enrollment decision. Payments to so many people are logistically difficult and virtually impossible to conceal. If the enrollment decision is made by a representative of individual consumers, then the kickback becomes somewhat eas-

108. See supra notes 42-46 and accompanying text.
109. See, e.g., United States v. Lipkis, 770 F.2d 1447, 1449 (9th Cir. 1985) (involving laboratory kickbacks in exchange for referrals).
ier to manage because the provider (or provider representative) need pay off only the representative of individual consumers. Nevertheless, even kickbacks to a representative will be more difficult to conceal than are kickbacks in our current fee for service system with no competition. In the fee for service system, the kickback can be hidden in legitimate payments already flowing between the providers. Providers paying and receiving kickbacks have, or can arrange to have, legitimate business with each other. The physician who is paid a kickback by a clinical laboratory needs to refer the lab work on her patients somewhere. If the physician refers it to the lab paying kickbacks to her, the kickbacks can be hidden in the financial transactions legitimately existing between the physician and laboratory. By comparison, it would be extremely rare for a provider (or provider representative) and a consumers' representative in a managed competition system to engage in independent, legitimate business dealings wherein they could conceal kickbacks. Although managed com-

110. It also furthers the goal of managed competition more effectively if individual consumers make the enrollment decisions themselves rather than having a representative make the decision for them as a group. If a group has to make the uniform decision to change providers rather than permitting individual choice, changes will infrequently occur, and if they did, some individuals will be displeased. Consumers may avoid change for a variety of reasons. For example, they may feel the health care provided is satisfactory. They may also stay with a health care provider to avoid the disruption associated with changing enrollment. If individual change is avoid, the group as a whole will be chilled from making changes or, if change is made, those preferring the status quo will be equally displeased. Furthermore, group health plans under a managed competition system are logistically difficult. If large groups of consumers change at once, patient files must be transferred and some expense and inefficiency is virtually inevitable.

Finally, the Clinton Plan emphasizes individual responsibility. H.R. 3600, S. 1757 § 1002. This goal will be defeated if a managed competition plan allows or encourages a representative to act on behalf of consumers.

111. Case law favors the prosecution, holding that the payment is an illegal remuneration even if it is in part reimbursement for legitimate services rendered, "if one purpose behind the fee was to improperly induce future services." United States v. Greber, 760 F.2d 68, 69 (3d Cir.), cert. denied, 474 U.S. 988 (1985). Nevertheless, the commingling of legitimate and illegitimate purposes for a payment makes it difficult to prosecute these cases. See generally David M. Frankford, Creating and Dividing the Fruits of Collective Economic Activity: Referrals Among Health Care Providers, 89 Colum. L. Rev. 1861, 1911 (1989) (discussing viability of containing costs of Medicare and Medicaid programs in which providers jointly care for patients); cf. United States v. Bay State Ambulance & Hosp. Rental Serv. Inc., 874 F.2d 20, 23-26 (1st Cir. 1989) (holding that defendant could be found guilty of conspiracy to commit Medicare fraud only if payments were primarily made for improper purpose); United States v. Kats, 871 F.2d 105, 108 (9th Cir. 1989) (holding as correct trial court's admonition that jury could not convict unless it found payment wholly and not incidentally attributable to delivery of goods or services).
petition would make kickbacks more difficult to accomplish, questions arising from the novelty of nationwide managed competition would need to be resolved, such as whether the following constitute kickbacks: offering the standard benefit package at a lower cost than competitors; rebating a portion of a provider group’s year end profits to enrolled members; and/or providing “perks” that also constitute good preventive care, like free flu shots, nutritional counseling or athletic facilities.

There is one last advantage of the health care system suggested in Part II in preventing and detecting fraud. This system offers the opportunity to rely more on the health care industry to regulate itself. If done honestly, self-regulation is always cheaper, more efficient and more effective than governmental regulation. In their recent work, Ian Ayers and John Braithwaite\textsuperscript{112} have extolled the virtues of self-regulation: Industry feels a greater commitment to preventing and detecting wrongdoing when it is entrusted with monitoring. Self-regulation allows tailoring rules to the needs of specific players in the industry. (Such individualization should be especially helpful in the health care industry where there are so many different types of providers, insurers and public interests.) Self-regulation allows an industry to move and change as conditions change.\textsuperscript{113} Such flexibility is difficult to achieve with governmental regulation yet, if there is any field in which such flexibility will be needed in the years ahead, it is in health care. Lastly, self-regulation is cheaper than governmental regulation, which must employ a network of auditors, investigators, and enforcers.\textsuperscript{114}

The provider groups that would exist in a capitation-managed competition system provide a structure for greater self-regulation. Each group could monitor its employees to ensure that they were not committing fraud by developing its own set of rules and regulations to detect and deter fraud; by implementing an education system for employees to ensure that they know how to comply with all applicable requirements; by establishing a monitoring system to ensure that employees are complying with legal requirements; and, by establishing an internal investigatory and sanctioning mechanism to handle instances of alleged abuse.\textsuperscript{115}

\textsuperscript{112} Ian Ayers & John Braithwaite, Responsive Regulation 1 (1992) [hereinafter Responsive Regulation].

\textsuperscript{113} Id. at 110-16.

\textsuperscript{114} Id.

\textsuperscript{115} The Organizational Sentencing Guidelines promulgated by the United States Sentencing Commission went into effect on November 1, 1991.
There would be opportunity for great variety in the anti-fraud, anti-waste and anti-abuse programs developed by the groups. Each group could determine the extent to which it would rely on tools such as training sessions, unannounced inspections, hotlines, ombudsmen, internal and external audits, and discipline of aberrational employees. These provider groups also would have the expertise to supervise the practice of medicine, a difficult and subjective task at best. Such supervision is essential, however, to ascertain whether all necessary services have been provided and to detect fraudulent provider practices.

Because self-regulation has the built-in weakness of leaving the fox to guard the hen-house, some supervision of the self-regulator is needed. John Braithwaite and Ian Ayers propose a model of "enforced self-regulation" whereby industry submits its rules and regulatory scheme to the appropriate governmental agency for approval. The agency then suggests changes or amends the rules before approving them. Once approved, the government enforces the rules against that industry or against that player in the industry. The type of supervising agency needed for this "enforced self-regulation" model to work already exists in the managed competition model of health care. Several of the current proposals, for example, include a national health board that would devise guidelines by which groups of providers compete as well as supervise their operation. Reviewing and supervising the implementation of anti-fraud programs by providers would be consistent with the other duties of a national supervisory health board. Serious instances of fraud, waste and abuse would be referred by the alliances or the board to law enforcement agencies.

Cyclopedia of Federal Procedure, United States Sentencing Commission, Guidelines Manual Ch. 8, Introductory Comment (3d ed. 1992). They allow organizations convicted of crimes to reduce substantially their punishment by demonstrating use of many of the programs suggested herein. Id.


117. Responsive Regulation, supra note 112, at 131-32.

Although presenting some benefits in detecting and deterring fraud, waste and abuse, the organizational structure needed for a managed competition system of health care also presents two potential problems from a fraud perspective. The first problem concerns the exclusion remedy. Exclusion, whereby a provider is excluded from participating in Medicare and Medicaid,\textsuperscript{119} can be the equivalent of capital punishment because many providers face financial ruin if they are unable to treat Medicare and Medicaid patients.\textsuperscript{120} In our current system, most providers practice as individuals or in small groups, and thus exclusions, if they occur, are on a small scale.\textsuperscript{121} Although excluding a provider may be disruptive for some patients, the disruption is usually minimal because most patients can switch to another provider.\textsuperscript{122} If man-

\begin{footnotesize}
\textsuperscript{119} 42 U.S.C. § 1320a-7 (1991); 3 Medicare & Medicaid Guide (CCH) Exclusion for Program-Related Abuses ¶ 13,927 (1993) [hereinafter Medicare and Medicaid Guide]. The Secretary of Health and Human Services is required to exclude providers from Medicare and Medicaid that have been convicted of program-related crimes or offenses relating to patient abuse. The Secretary has the discretion to exclude providers that have:

- been convicted of fraud (other than program related fraud), obstruction of justice, controlled substance offenses;
- had their license to provide health care revoked or suspended or have surrendered such a license while a formal disciplinary proceeding was pending;
- been excluded from participating in other federal or state programs;
- been found to have filed excessive charges or charges for unnecessary services;
- engaged in fraud and kickbacks;
- are controlled by an individual who has been sanctioned;
- failed to disclose required information;
- failed to supply requested information on subcontractors and suppliers;
- failed to supply payment information;
- failed to grant immediate access to specified government officials;
- failed to take required corrective action; have defaulted on health education loan or scholarship obligations.


In most circumstances, mandatory exclusions are for five years. With few exceptions, the Secretary determines the length of permissive exclusions. \textit{Id.} § 1320(c)(3)(B)-(C).

\textsuperscript{120} See, e.g., Thorbus v. Bowen, 848 F.2d 901, 904 n.7 (8th Cir. 1988) (noting that physician, 60% of whose gross income came from Medicare and Medicaid patients, was excluded from Medicare and Medicaid programs); Ritter v. Cohen, 797 F.2d 119, 123 (3d Cir. 1986) (physician, 99% of whose patients were eligible for Medicaid reimbursement, was excluded from Medicaid program).

\textsuperscript{121} See, e.g., Medicare & Medicaid Guide, supra note 119, ¶ 13,927 (discussing exclusions).

\textsuperscript{122} Although the Secretary of Health and Human Services (HHS) is authorized to alter the period of mandatory exclusion “in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.” \textit{Id.}
\end{footnotesize}
aged competition is implemented, however, it is almost certain that the majority of providers will practice in large, vertically integrated groups. Exclusion of such a large group of providers would be disruptive and could make law enforcement officials reluctant to exclude deserving providers. To avoid this, three steps should be taken if managed competition is implemented. First, efforts should be made to ensure that law enforcement has sufficient tools to ferret out the individual malfeasors within a group and exclude only these individuals. Piercing any organizational structure requires access to sophisticated statutes, investigative grand juries, and power to conduct electronic monitoring and grant immunity. Currently these tools are not as widely available as would be needed in a managed competition system.

Second, the fact that exclusion will be applied more often to large corporate providers as well as the fact that many of the grounds for exclusion involve a conviction of a crime, calls for reassessing our current standards of corporate criminal liability. These standards impose vicarious liability on fictional entities by automatically imputing the criminal liability of corporate agents to the corporation. With these standards, it is irrelevant whether the illegal act was committed by a maverick employee acting against corporate policy or was an act encouraged and pro-

123. Starr, supra note 18, at 50.
127. Grand Jury, supra note 125, §§ 9.06 to 9.08.
128. Id. For sources that discuss the extent to which these tools are available in the federal system, see id.; Miller et al., supra note 126, at 382-91.
129. 42 U.S.C. § 1320a-7(a)(1) (conviction of program-related crimes); § 1320a-7(a)(2) (conviction relating to patient abuse); § 1320a-7(b)(1) (conviction relating to fraud); § 1320a-7(b)(2) (conviction relating to obstruction of an investigation); § 1320a-7(b)(3) (conviction relating to controlled substance); § 1320a-7(b)(7) (fraud, kickbacks and other prohibited activities).
moted by the corporation. As a result of these standards of criminal liability, it is difficult for corporations to plan (they never know when a maverick employee may break the law); there is no incentive in the criminal law for corporations to behave responsibly; the criminal justice system is perceived as arbitrary, which diminishes the respect of citizens; and, prosecutorial discretion is unfettered.

The rare circumstance where the entire provider group is fraudulent and should be excluded points to the third step that should be implemented, if exclusion is to remain a viable remedy in a managed competition system. Government regulators must have resources to make exclusion as least disruptive as possible for the members enrolled with the excluded provider. Such resources might include the power to install a trustee to operate the excluded provider group during a transitional period, and the power to entice, reward (or possibly force) competing provider groups to absorb quickly the consumers previously enrolled in the excluded group.

In addition to complicating the use of the exclusion remedy, the organizational structure of a managed competition system has the potential for large scale public corruption, a type of criminality not seen much in the heretofore privately operated health care system. Those individuals employed by the entity that manages the competition between providers will have many lucrative opportunities to extort and accept bribes for favorable decisions in qualifying, overseeing and disciplining the provider groups. The organizing individual(s) of provider groups similarly will

131. Corporate Ethos, supra note 130, at 1102-05.
133. Interestingly, the Cooper Plan appears to provide this authority to the Health Care Standards Commission in regulating the “Health Plan Purchasing Cooperatives” (HPPCs), but not to the HPPCs in regulating the “Accountable Health Plans” (AHPs). See H.R. 3222, 103d Cong., 1st Sess. § 1101(e)(2)(B) (1993) (the “Cooper” Plan) (HPPCs); Id. § 1102(a)(3)(B) (AHPs). The Clinton Plan provides that the Secretary of HHS may seek appointment as trustee for a financially insolvent health care plan. H.R. 3600, S. 1757, §§ 1395-1396 (1993). This power should be expanded to cover appointment as trustee in instances of fraud or abuse.
134. In the Cooper Plan, the Health Care Standards Commission is to “establish a process for termination of agreements” with providers. H.R. 3222 § 1102(a)(3).
135. For a study of the types of health care fraud historically prosecuted, see Fraud by Fright, supra note 5, at 882-933. This study reveals that public corruption prosecutions of health care providers have not been reported in published opinions. Id.
have opportunities to solicit and accept illegal payments for improper exercise of discretion to include individual providers in the group and to negotiate the terms of the providers' participation. This potential means three things. First, the current proposals should take steps to keep these decision making processes as public and accountable as possible.\textsuperscript{136} Second, law enforcement should have the tools necessary to investigate public corruption (e.g., electronic monitoring, resources and training for undercover operations). Third, statutes proscribing health care fraud should address the potential for graft and corruption and clarify ambiguities that currently render public corruption prosecutions difficult.\textsuperscript{137} Questions unique to the health care system also should be addressed, such as who in the "alliance," or "purchasing cooperative,"\textsuperscript{138} is a "public official"\textsuperscript{139} and what separates illegal pay-offs from legitimate contributions and gifts.\textsuperscript{140} Preventive steps to deter extortion and bribery should be

\textsuperscript{136} The Cooper Plan, for example, begins to do this by requiring "network plans" (a provider group with certain characteristics) to select participating providers based upon competitive criteria that are publicly available. H.R. 3222 § 1202(a)(4). Additional steps could be taken such as: requiring oversight of the provider selection process in each network plan by a fraud investigator or auditor; educating providers as to which negotiating tactics are permissible and which are not; and, ensuring the availability of hotlines and ombudspersons to individuals participating in these negotiating processes, et cetera.

\textsuperscript{137} After McCormick v. United States, 111 S. Ct. 1807 (1991), the government must prove that there was a quid pro quo by the public official for the payment in question. \textit{Id.} at 1816. After Evans v. United States, 112 S. Ct. 1881 (1992), the quid pro quo requirement seems to have been watered down. \textit{Id.} at 1189. The United States Supreme Court's struggle with the quid pro quo question showcases the difficulty in distinguishing illegal payoffs from legitimate payments. For an excellent discussion of these difficulties, see Symposia: \textit{Blackmail and Other Forms of Arm Twisting}, 141 U. Pa. L. Rev. 1567 (1993); Michael W. Carey et al., \textit{Federal Prosecution of State and Local Public Officials: The Obstacles to Punishing Breaches of the Public Trust and a Proposal for Reform, Part One}, 94 W. Va. L. Rev. 301, 308-09, 321-33 (1991-92).

\textsuperscript{138} According to the Clinton Plan, the entity that manages the competition among providers is an "alliance"; according to the Cooper Plan, it is a "health plan purchasing cooperative" (HPPC); and, according to the Republican Plan, this entity is a "purchasing alliance." H.R. 3600, S. 1757, 103d Cong., 1st Sess. §§ 1300-1330 (1993) (the "Clinton" Plan); H.R. 3222, 103d Cong., 1st Sess. §§ 1101-1108 (1993) (the "Cooper" Plan); S. 1770, 103d Cong., 1st Sess. § 1404 (1993) (the "Republican" Plan).

\textsuperscript{139} Under most corruption statutes, the defendant must be a "public official," but not necessarily an \textit{elected} public official. \textit{See, e.g.,} United States v. Freedman, 562 F. Supp. 1378, 1384-88 (N.D. Ill. 1983) (private citizens cannot be prosecuted). \textit{But see} United States v. Phillips, 586 F. Supp. 1118, 1120-23 (N.D. Ill. 1984) (private citizens can be prosecuted if victim reasonably believed defendant wielded governmental power). Early clarification of the status of the various individuals in a reformed health care system will be vital to effective deterrence and regulation of corruption in health care.

\textsuperscript{140} \textit{See supra} note 136.
implemented such as educating the individuals employed by these new health care entities as to which gratuities they can and cannot accept and what kind of negotiating they can engage in with providers and what is outside proper bounds.

To summarize, a fee for service system contains the incentive for the following types of fraud: billing for services not rendered; misrepresenting the nature of the services rendered; providing and billing for unnecessary services; and, paying kickbacks to induce referrals of services. All of these types of fraud arise from the emphasis in fee for service reimbursement on volume. All of these types of fraud are easy to commit and difficult to detect because they occur within the privacy of the patient-provider relationship or, in the case of kickbacks, between a small group of close knit professionals.

In comparison to fee for service reimbursement, capitation reimbursement discourages frauds that increase volume of services because the more services performed per patient, the more money the provider loses. Thus, capitation reimbursement provides no financial incentive: to bill for services not rendered; to misrepresent the nature of services rendered; to perform unnecessary services; or, to pay kickbacks to encourage referrals of more services.

Capitation reimbursement, however, provides the financial incentive to commit other types of fraud: to submit false cost data to obtain a higher capitation rate; to enroll fictitious persons with the provider; to underprovide services; and, to pay kickbacks for referrals of certain types of patients. For each of the types of fraud encouraged by the capitation method of reimbursement, there are built-in checks supplied by other components of the optimal anti-fraud health care system proposed in Part II. The competition between providers, all of whom are reporting their costs to the same entity, will serve as a check on the submission of false cost data. Allowing consumers to “vote with their feet” by selecting another provider in the managed competition system serves as a built-in check on kickbacks for referrals and the underprovision of necessary services. The copayment requirement heightens the interest of individual consumers to monitor the bills for their health care. Uniform billing and reimbursement procedures help avoid legitimate mistakes as well as fraud, prevent the enrollment of fictitious persons, and enhance the ability of consumers and law enforcement to detect fraud.

The organizational structure needed for a managed competi-
tion system offers the potential for more effective self-regulation of fraud, waste and abuse by provider groups, but also, poses two problems. Law enforcement may become less willing to employ the exclusion remedy, which will have an amplified impact if providers practice in large groups as they will tend to do in a managed competition system. In addition, the structure needed for managed competition presents potential for public corruption. Both of these problems can be alleviated, somewhat, if sufficient precautionary steps are implemented with managed competition.

IV. Fraud Analysis of Collection Options

Just as with the delivery and reimbursement aspects of health care, there are incentives and disincentives for fraud in the various options for raising the funds needed to pay for health care. The Clinton proposal, for example, estimates that its plan will cost $700 billion, which is to be recouped through “sin” taxes, reductions in the cost of the Medicare and Medicaid programs, and mandatory premium payments from employers and/or workers. There are accounting and normative questions inherent in any collection-of-funds process. This Article does not seek to address these questions but focuses solely on the potential for fraud posed by possible revenue-raising efforts and the subsidies that may be given to some individuals and businesses.

In addressing the revenue-raising question, this Article examines the possible ways to collect funds from employers and/or workers: (1) collect from employers (for this fraud analysis, it

141. Howard Fineman, Clinton’s Hard Sell, NEWSWEEK, Sept. 27, 1993, at 34. Critics in Clinton’s own administration doubt whether the spending and savings figures of the five-year, $700 billion plan add up to a net savings. Id.

142. Dana Priest, The Clinton Prescription, THE WASH. POST NAT’L WKLY., Sept. 20-26, 1993, at 10, 11; A New Framework For Health Care, N.Y. TIMES, Sept. 23, 1993, at A22. Employers would pay their share as a percentage of payroll. Employers with more than 50 employees would pay no more than 7.9% of their payroll toward health insurance. This amount would be reduced depending on the businesses’ size and workforce. For example, small firms where workers make less than $12,000 per year would pay 3.5% of their payroll toward health insurance. This amount would be reduced depending on the businesses’ size and workforce. For example, small firms where workers make less than $12,000 per year would pay 3.5% of their payroll. Christopher Connell, Clinton Health Plan Promises Affordable Coverage For All, BIRMINGHAM NEWS, Sept. 11, 1993, at 7B. Self-employed workers would pay 100% of their premium cost and the entire amount would be tax deductible. Id. Premiums are currently expected to be $1,800 per individual and $4,200 per family. Id.

143. There are a variety of views on this. For example, the Clinton Plan requires employers to pay a certain amount of the premium for each employee, H.R. 3600, S. 1757, 103d Cong., 1st Sess. § 6121 (1993); and provides that both the employee and the employer make premium payments to the premium collecting entity (alliance) in the event that the employee owes more than the employer has contributed. Id. § 6101 (family or employer pays family share of premium). The Cooper Plan requires “small employers” to collect most em-
does not matter if this is a levy on the employer, for example, as a percentage of payroll, or on the employee, as a percentage of income earned from that employer); (2) collect from financial institutions on unearned income; or, (3) collect from individuals.

Combined use of the first two options is preferable from an anti-fraud perspective, for two reasons. First, there will be fewer payers (employers and financial institutions only) if the first two options, versus the third, are implemented. This will make collection of funds easier. Second, it is more likely that employers and financial institutions will be skilled and experienced in managing money, calculating the amount of funds due, and filing financial reports than are individual citizens, the payers in the third option. The Clinton proposal, for example, which requires both employers and employees to pay a percentage of premiums, follows Option 1. To ensure that non-working persons with sources of unearned income pay their assigned share, Option 2 should also be implemented. The reallocation of funds, (i.e., subsidizing those who cannot afford to pay their assigned share) is fraught with greater potential for fraud than is the revenue-raising effort, at least if the revenue is collected by way of Options 1 and 2 above.

It is safe to assume that those who qualify for exemption from the health care premium payments, and thus are subsidized by other taxpayers, will fall into four groups: (1) the employed employees’ health care premium contributions, H.R. 3222, 103d Cong., 1st Sess. § 1103(c) (1993). However, the Cooper Plan does not require the employer to contribute to this premium that it collects. Id. § 1103(d). Small employers are defined as employers normally employing fewer than 101 employees during a typical business day. Id. § 1701(c)(2). Inexplicably, the Cooper Plan also provides for employees, whose withholding was not sufficient to cover the entire cost of premiums, to pay “directly to the HPPC” the remaining amount. Id. § 1103(c)(2). This procedure not only will be cumbersome but also will be a fertile ground for evasion by individuals. Collection of the full premium owed by employees should be made by employers and paid directly to the HPPC, or appropriate entity. The House Republican Plan states that “[a]n employer is not required . . . to make any contribution to the pot of [health care] coverage” but that employees may elect to have premiums owed by the employee collected through payroll deductions. H.R. 3080, 103d Cong., 1st Sess. § 1001(a) (1993).


146. The Clinton Plan, for example, provides for subsidies to individuals and businesses unable to pay their allotted amounts. Id. §§ 6101-6131. The Cooper Plan similarly provides for assistance to low income individuals. H.R. 3222, §§ 2001-2101. The McDermott Plan does not include subsidies because only persons and entities with threshold incomes are taxed for health care. H.R. 1200 §§ 811-981.
who are poor; (2) the unemployed who are poor; (3) the self-employed who are poor; and (4) businesses that are unable to pay the full percentage of their employees’ premiums. To qualify for a subsidy, each of these individuals or businesses will have to demonstrate financial neediness. Presumably this will be done by filing financial data similar to filing an income tax return. This means that in the health care subsidy program, as in traditional tax fraud cases, there will be a potential for two types of fraud: (1) individuals or businesses that fail to file the financial data required but seek health care coverage anyway; and, (2) individuals and businesses who file false financial data to qualify for an exemption from the health care “tax” they would otherwise owe. The failure-to-file problem can be deterred by requiring the filing of an income tax return before one is eligible for any health care services—subsidized or not. If an individual cannot see a physician without a health care card and cannot get a health care card without filing an income tax return (or having one’s employer file on one’s behalf), then there will be a strong, new incentive to file income tax returns. 147

Implementing the second revenue-raising effort listed above, requiring financial institutions to collect a percentage of unearned income for health care premiums, is another way to reduce the incentive and opportunity not to file required financial data. Much like the Form 1099, this step also will help highlight nonfilers, or, at least those who keep their assets in financial institutions.

The second type of fraud that is likely to occur in the subsidy program is underreporting of income, much as is seen in typical tax fraud cases. The individuals most likely to engage in this type of fraud will be those self-employed or “unemployed” persons with income from illegal sources or those with income that is difficult to trace (cash). The businesses that underreport income may do so by falsely deflating their reported revenue or by falsely inflating their expenses or other deductions. Unfortunately, there is no systemic mechanism to neutralize this incentive to underreport income. This type of fraud will have to be pursued through traditional law enforcement efforts.

In conclusion, the optimal anti-fraud technique for collecting health care premiums requires employers to collect and remit

147. Such a requirement may bring forth many individuals who have previously failed to file income tax returns. Tracking the prior income history of these new filers could be of great interest to the IRS.
their own share and their employees' share (or just the employees' share, should such a formula prevail). For this to work, deductions and other offsets against this contribution must be kept to a minimum and reported through employers only. Any deductions or offsets requiring filings by individuals will render this option impossible. Financial institutions also must be required to collect and remit a health care tax on all unearned income. Both of these techniques are preferable to collecting health care premiums directly from individual taxpayers because they focus the collection effort on a smaller group of payers who are relatively skilled money managers. Because the exemption from paying the health care premium necessarily relies upon reporting of financial data by individuals and businesses, there is greater risk of fraud in the subsidy program. Fraud in reporting financial data needed to qualify for subsidies will be difficult to detect and prove, although requiring filing of financial data to obtain any health care services would at least discourage non-filers.

V. RECOMMENDATIONS FOR FIGHTING FRAUD BY HEALTH CARE PROVIDERS

The following recommendations assume that for the next decade our health care system will be a hodge-podge, retaining some vestiges of our current health care system and a variety of reform programs. This is unfortunate from an anti-fraud perspective but probably inevitable because health care reform is venturing into the unknown and must be adjusted along the way. In addition, consideration of the financial and normative issues inherent in health care reimbursement, delivery and taxation may weigh in favor of adopting steps that encourage fraud and that make fraud harder to detect. The following recommendations recognize these realities and are offered to make the most of law enforcement efforts within such an accommodation.

1. Recognize that fraud by health care providers will exist in any health care system. Assess the incentives for specific types of fraud in each component of the health care system and direct law enforcement resources accordingly.

2. Recognize that with changes in a health care system, new types and combinations of providers will enter the market quickly. Strict controls on licensing and eligibility of providers should be enforced.148

148. Several of the proposed plans take a step in this direction. The McDermott Plan, for example, requires that providers must be "licensed or certi-
3. Expect to see the following types of fraud wherever fee for service reimbursement is retained: billing for services not rendered; misrepresentations regarding services rendered; providing unnecessary services; and, payment of kickbacks among providers, including self-referrals. Limits on volume (either through a cap on fees or paying reduced fees for services rendered once a certain volume is reached) may neutralize these incentives somewhat, but such limits do nothing to discourage fraud prior to reaching the capped amount. Utilization limits, whereby authorization must be obtained prior to rendering highly abused or easy-to-abuse services, may help deter these types of frauds.149

4. Expect to see the following types of fraud by health care providers in a capitation-managed competition system: false cost reporting; efforts to inflate falsely the number of people enrolled in an alliance or provider group; failure to provide necessary services; and, kickbacks to enroll healthy patients. In addition to the built-in checks on these types of fraud supplied by managed competition, the following steps should be taken to deter and detect these frauds:

A. Specify the individuals within each provider group who must personally sign the report of costs submitted during negotiations on capitation amounts. Ensure that these individuals sign under penalty of perjury.

B. Allow only "certified health care accountants" to prepare reports of costs. Require that to obtain this certification, accountants must receive specified training in health care finance and fraud. Require that each cost report include certification that a compliance audit has been conducted by a qualified health care accountant.

C. Structure enrollment procedures so that the entity

149. For a fuller discussion of the need for such limits, see Health Care Fraud and Waste, supra note 8, at 101.
regulating the providers enrolls consumers with a provider. Do not allow providers to enroll consumers. Establish data collection and retrieval systems to detect fictitious enrollment of consumers. (This presupposes implementation of uniform reimbursement and billing procedures.)

D. Require that all enrollment decisions be made directly by consumers or in the case of incapacity, by power of attorney or appointed guardians. Do not permit representatives of groups of consumers to make enrollment decisions.

E. To reduce the potential for collusion on reporting of costs or underprovision of necessary services, ensure that whenever possible, multiple providers, or multiple groups of providers, compete for patient enrollments.

F. Utilize the opportunities for self-regulation by providers. Require that to qualify to compete for enrollment by consumers, each group of providers must submit and have approved an anti-fraud, waste and abuse plan. Such a plan must address education, monitoring, detection and disciplining policies. In addition to their other duties, the entities managing the competition among providers should be charged with reviewing, approving and enforcing these plans as well as making referrals for prosecution in egregious instances.

G. Require that everyone who is financially able make copayments. Simplify claim forms and require a patient’s signature on the claim form before the claim is submitted by the provider for reimbursement.

H. Recognize that if the poor are relieved from making copayments, greater potential for fraud exists in connection with delivery of care to the poor or the alleged poor. Additional fraud audits should be concentrated in services rendered to this population.

I. Recognize that a managed competition system presents a potential difficulty for enforcing the exclusion sanction. Neutralize this difficulty by giving law enforcement the tools needed to detect individual wrongdoers within an organization; by restructuring standards for
finding organizations criminally liable; and, by protecting consumers in the event their provider is excluded.

J. Recognize that the managed competition system presents a potential for corruption. Ensure that law enforcement has the tools and training it needs to deter, detect and prove this corruption. Clarify the difference between illegal payments and legitimate contributions.

5. Rely on employers and financial institutions to collect and remit health care premiums on earned and unearned income. Require submission of an income tax return (or proof of payment of one’s health care premium contributed by one’s employer) to obtain a health care card. All cards should include sufficient identifying data to prevent theft and forgery of health care cards. Require presentation of a health care card before rendering services.

VI. Conclusion

This Article is based upon two premises. First, fraud by health care providers is influenced greatly by health care reimbursement mechanisms. This influence is pervasive, affecting the amount of fraud committed, the types of fraud committed, and the difficulty of detecting and proving fraud. Some reimbursement mechanisms encourage fraud, others discourage fraud. As discussed in Part I, fee for service reimbursement has encouraged large scale fraud, most of which is of four types and all of which is difficult to detect and prove. Part II described an optimal reimbursement system, from an anti-fraud perspective. This suggested system contains four key features: capitation reimbursement; managed competition; uniform billing and reimbursement procedures; and, copayments. Part IV addressed the collection-of-funds aspect of health care reform and suggested the following: (1) collection of any health care premium should be by employers, whether of amounts owed directly by employees as a percentage of earned income or of amounts owed by employers as a percentage of payroll; collections also should be made by financial institutions on unearned income; these techniques are preferable to collecting the health care premium directly from individuals; and, (2) subsidies for health care to persons or businesses unable to pay their assigned share are fraught with potential for fraud and should be monitored carefully. Requiring submission of an income tax return before qualifying for any health care services is one of the few systemic steps that can be
taken to discourage some of the fraud that will surround the subsidy program.

The second premise on which this Article is based is that while it is possible to devise a health care system that discourages fraud, some fraud by providers always will exist. Our goal should be the creation of a system that encourages as little fraud as possible while making the fraud that is committed easier to detect and prove. Recognizing this, Part III analyzed the incentives for fraud that will remain in the health care system recommended in Part II. Part V detailed general and specific steps that can be taken to discourage, detect and prove fraud by health care providers, whatever type of health care reform is implemented.

In health care, like in everything else, the way we pay people affects the way they cheat. Efforts to combat health care fraud, waste and abuse cannot remain confined to enhancing law enforcement techniques and tools. These efforts should be supported and strengthened, but however valiant they are, they are no match for the pull of reimbursement mechanisms that invite, entice, and lure too many providers to cheat. Rather, a complete approach to fraud by providers must be systemic change. We have the opportunity to make this change as the United States moves toward health care reform. We should take advantage of this opportunity by examining and analyzing the potential for fraud in each of the reform options available.