

Government Compliance Initiatives in Combating Fraud and Abuse in Federal Health Care Programs

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This paper examines the federal government's compliance initiatives in detecting and preventing fraud and abuse in federal health care programs. The Department of Justice estimates that Medicare, the largest federal medical insurance program for the elderly, is defrauded by nearly \$27 billion annually. The objective of this paper is to (1) provide an overview of common health care frauds, (2) discuss federal health care anti-fraud legislation, (3) describe the elements of a voluntary compliance program, and (4) explain Corporate Integrity Agreements (i.e., involuntary compliance programs) and their reporting requirements. The paper also identifies future research opportunities relating to health care compliance programs.

INTRODUCTION

Americans spend more than \$1 trillion on health care each year, and the government expects this amount to grow to about \$2.2 trillion annually by 2008 (U.S. Office of Management and Budget 2001). Each year, Medicare, the federal government's largest health insurance program, spends more than \$220 billion on nearly 40 million Americans 65 years of age and older and other Americans with disabilities (U.S. Department of Health and Human Services 2001). Between 2002 and 2006, federal spending on Medicare is expected to rise at an average annual rate of 5.4 percent, from \$226 billion to \$279 billion (U.S. Office of Management and Budget 2001). While the exact amount lost due to fraud is unknown, health insurance industry sources estimate that the loss could be as high as 10 percent of the nation's total annual health care expenditures (National Health Care Anti-Fraud Association 2001). According to the U.S. Department of Justice (DOJ), Medicare alone is defrauded by nearly \$27 billion annually (Danninger 2000).

Fraud is typically characterized as an intentional deception or misrepresentation made by an individual or entity in order to obtain an unwarranted benefit. Examples of health care fraud include: (a) billing for services not actually performed; (b) billing for more costly services