HEALTHCARE INEQUALITY & FRAUD PREVENTION: PATERNALISM JUSTIFIED TO ENABLE CHOICE

By

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Abstract

Under the newest health policy in the United States, *The Patient Protection & Affordable Care Act*, Medicaid expansions in consenting states enable low-income individuals to obtain health insurance. Part I provides an argument defending a positive duty to facilitate choice in health services. The section discusses the conflict in political theory on health inequity, and why an expansion of Medicaid is the most effective plan to improve the health status of America. Part II provides an argument to increase funding to government agencies responsible for prosecuting fraud, waste, and abuse in the healthcare sector. Every dollar of funding to healthcare fraud prevention yields an eightfold return, yet many argue for budget cuts to sustain other government programs. Well-funded agencies are necessary if the government wishes to recover the billions lost each year to criminal activity. One solution is a redirection of funds from wasteful sectors to more effective programs. Congress should choose to fund programs that produce better health and economic outcomes for the U.S. Paternalism is justified to enable choice in this sector by reducing healthcare inequality, improving health outcomes, and recovering funds typically forfeited to criminals.

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Introduction

In a speech given to the Medical Committee for Human Rights, Dr. Martin Luther King Jr. stated, "of all the forms of inequality, injustice in healthcare is the most shocking and inhumane." [1] Healthcare inequality is "the difference in health status or in the distribution of health determinants between different population groups." [2] This two-part thesis discusses the impact of health care inequality and defends policies seeking to resolve problems faced by the uninsured population of America. Additionally, the expansion of government agencies is defended in order to reduce fraud, waste, and abuse of tax monies. In this work, "expansion" will mean an increase in funds provided to a particular program or agency. Recommendations include a redirection of government funds to the most effective programs, instead of wasting billions on activities that yield little to no benefit.

In Part I, the cause of health care inequality in America is attributed to income inequality. While income inequality has increased rapidly in the last thirty years, this thesis does not discuss how to solve the root problem of income disparity in America. Rather, it focuses on the inequality of access to health services attributed primarily to cost. Given the implications of health care inequality, the government has a positive duty to expand state involvement in health care. Paternalism in health enables citizens to have more choice in health services and improve health outcomes. In the first section, the impact of income inequality on low-income demographics is discussed, focusing primarily on access to health services. The work of Robert Reich and Barbara Ehrenreich is employed to discuss income and how it creates a more complex inequality in the health care sector. In the second section, the work of Iris Marion Young and

[1] Moore, A., pp.1
[2] World Health Organization (WHO)

John Rawls is introduced. Young's conception of oppression is paired with Rawls' difference principle in order to present a positive duty for government action in funding health services. In the third section, the relationship between enabling choice and improved health outcomes encourages discussion of choice theorists. Sigal Ben-Porath and Matthew Zwolinski's opposing views of choice are discussed; arguments that either support government intervention or free-market solutions as the best theoretical model of health care in America. Section four focuses on the importance of the paradox of choice in relation to the healthcare sector. Drawing upon the work of Barry Schwartz and Derek Thompson, the section discusses how much choice society should have relative to how markets and governments contribute to providing health services. In the final section, a defense of paternalism as a method of enabling choice in the low-income population is presented. It is the purpose of this thesis, using both political theories and empirical data, to encourage compliance with a positive duty for the state to intervene in health services. Government action can enable choice and improve health outcomes. It is the role of government to do whatever it takes to protect American lives. Without the recent expansions in Medicaid, health services would not be accessible to many low-income citizens. A lack of access to health services leaves citizens vulnerable to making destructive choices to their health and, in turn, increases mortality rates. Policies geared toward government intervention through Medicaid expansion, like that of the *Patient Protection & Affordable Care Act (PPACA)*, are necessary to enable choice in health services.

After giving a normative argument for government intervention, the second half of the thesis focuses on provisions within the *PPACA* which have done the most to combat fraud in the sector. Part II outlines how the U.S. combats fraud, waste and abuse in the healthcare sector. The first section provides an analysis of a past policy and its effectiveness against healthcare fraud.

The second section addresses the implications of the *PPACA* and its role in both strengthening the policies of the past and providing a framework for future anti-fraud efforts. The third section delves deeper into the topics of healthcare fraud by identifying specific sectors at which fraud is commonplace. How the *PPACA* seeks to combat fraud in each of these sectors will be addressed. The fourth section reports on an interview conducted with a health care professional regarding fraud and billing practices in the sector. In the fifth section, opposition to the policy will be introduced and common arguments against the expansion of anti-fraud efforts are discussed. Section six provides an argument for why legislation such as the *PPACA* is necessary to advance anti-fraud efforts. The argument provides the most effective policy recommendations to combat ever-changing fraudulent techniques. As a way to reclaim the billions lost each year to health care fraud, increased government involvement in anti-fraud efforts is necessary. Recommendations include: increase funding for government agencies that prove to obtain returns on investment through the investigation and prosecution of fraudulent activity, increase collaboration and transparency between public and private sectors, increase scrutiny on all claims, and focus monitoring efforts on interest groups who profit from fraudulent activities. The conclusion summarizes and presents a plan to free up funding to increase the budget of public health programs. Such strategies may not require additional taxation if bi-partisan forces discuss a redirection of funding from less efficient sectors. By investing in programs that focus on yielding long-term benefits instead of on wasteful behaviors, better health and economic outcomes will result.

PART I

I - How is Health Care Inequality Created?

There are various dimensions to health care inequality. Some dimensions of inequality include geographical, physical, temporal, and sociocultural dimensions. However, the leading contributor to the development of health care inequality in America is the financial dimension. Most presidential administrations of the modern era have yet to combat income inequality directly, but rather choose to focus on small incremental change. Most recently, the Obama administration boasted during the 2008 and 2012 election cycles that income inequality would be on the executive agenda; however, it hasn't been dealt with in a lasting way. Many economists and academic theorists continue to discuss this growing problem. For example, Robert Reich, an economist and former Secretary of Labor in the Clinton administration, has chosen to focus his career on solving the problem of rapidly increasing inequality.[3] The data presented in Reich's documentary, *Inequality for All*, sheds light on how income inequality has affected both middle and lower-income Americans. Emmanuel Saez and Thomas Piketty, introduced in the film, are the first researchers to obtain International Revenue Service (IRS) tax data dating back to the imposition of the income tax of 1913. Seen in *Graph 1*, wages flatten dramatically in the late 1970's even though productivity continues to rise. [4] In addition to a flat wage rate, the share of annual national income that the middle and lower classes obtains continues to decline each year.

Due to income inequality, many individuals are either unable or unwilling to spend the amount required to pay for health services. If an individual cannot secure a steady job, for example, they are left with few options. Among these options include cutting back on spending.

[3] Reich, R.
[4] Saez, E. Piketty, T.

For many low-income citizens, not purchasing health insurance plans is necessary to obtain other goods for survival in the short-term. In Barbara Ehrenreich's work, *Nickel and Dimed*, she writes about her experience working as a minimum wage worker. In her social experiment, she worked various low-paying jobs to observe whether the minimum wage is enough to satisfy a living wage. A living wage is a "subsistence wage which provides the necessities and comforts essential to an acceptable standard of living." [5] For the sake of argument, assume livable wage is enough means to obtain shelter, clothing, food, utilities, and health care services. Ehrenreich had a difficult time making use of the little wage she earned. Even though she starts the experiment with money, she finds it difficult to maintain a living wage. She notes in her work, "if you have no money for health insurance – and the hearthside's niggardly plan kicks in only after three months – you go without routine care or prescription drugs and end up paying the price." [6] In her experiment, Ehrenreich has more present financial concerns to prioritize. Typically, short-term financial dilemmas take priority over obtaining healthcare insurance. Without subsidies to enable choice for low-income individuals, those who are in Ehrenreich's position continue to put off preventative and primary care for the sake of maintaining a budget or providing for family and dependents.

Ehrenreich's observations on the living wage still hold true today. As seen in the data provided in *Graph 2*, a national sample taken by the Center for Disease Control (CDC) displays polling data from individuals of different employment and insurance status. 40% of the "uninsured and unemployed" population is not likely to receive medical care because of the cost of such services. 35% of the "uninsured and employed" portion of the sample is not likely to receive care. These numbers are high compared to the mere 10% of individuals who are both

[5] Merriam-Webster Dictionary
[6] Ehrenreich, B. pp.27

employed and insured.[7] Data supports the assertion that a large portion of the populace is not receiving preventative care because of cost, while the most affluent obtain care as needed.

Americans are feeling the effects of financial uncertainty. For those attempting to maintain a budget, cutting back health care expenditures or seeking alternative forms of care is ideal. As Ehrenreich states, "Gail […] ran out of money for estrogen pills. […] so she spends $9 a pop for pills to control the migraines she wouldn't have if her estrogen supplements were covered." [8] Public opinion polls report time and time again that cost and access are the most serious health care issues in the sector. Seen in *Figure 1*, 23% of Americans say they are concerned with the cost of health services most, followed by 16% concerned with access. [9] Cost and access to health services rank higher than obesity, cancer, diabetes, heart disease, smoking, AIDS, drug/alcohol abuse, and mental illness. Individuals who are living paycheck to paycheck are likely to put off the care they need to maintain acceptable health status. Workers who do not have employee benefits find it hard to gather the resources to insure themselves or their family without some form subsidy. Cost is the largest contributing factor in the inequality of access to health services; therefore, there is a direct correlation between income inequality and the inability of low-income individuals to access health services.

II - A Positive Duty to Protect American Lives

Given the realities of health care inequality, the government must take up an interest in bettering the health insurance status of Americans. In Iris Marion Young's work, *Justice and the Politics of Difference*, she discusses how exploitation, marginalization, cultural imperialism,

[7] Center for Disease Control (CDC), 2010
[8] Ehrenreich, B. pp.28
[9] Gallup, 2013

powerlessness, and violence play a role in how social constructs affect the citizenry. She calls these problems the "five faces of oppression." Her analysis of the worst forms of oppression, marginalization and powerlessness, connect well with the problems in the healthcare sector today. For Young, she refers to marginalization as "a growing underclass of people permanently confined to lives of social marginality, most of whom are racially marked." [10] In essence, the act of marginalization is constraining a group of people to a lower social standing in society. This process of exclusion is ever present in the health care sector. Those who cannot afford private health insurance are excluded from health services the affluent may utilize. Young declares that "marginalization is perhaps the most dangerous form of oppression; a whole category of people is expelled from useful participation in social life and thus potentially subjected to severe material deprivation and even extermination" [9]. Many who do not have access to preventative care will face extermination by a host of chronic diseases. Mortality attributed to preventable disease and lack of preventative care among the low-income population is significantly higher than those from middle to high-income populations. Predominately, these low-income populations are made up of black, Hispanic, and non-white citizens. [11] Young's focus on powerlessness is also applicable to the health care crisis. Low-income and marginalized populations are powerless in the pursuit of obtaining health services. They often feel that their views are not being represented and, as a result, do not see a point in voting. Marginalized individuals do not feel a need to participate in the democratic process; Young describes the powerless as individuals with "little or no work authority, express themselves awkwardly, especially in public or bureaucratic settings, and do not command respect." [12] In order to resolve

[10] Young, I.M., pp.53
[11] Sommers, BD. Baicker, K. Epstein, AM., 2013
[12] Young, I.M., pp.57

the problems that plague the marginalized and powerless populations, government intervention through expansion in access to health services is the ideal solution. However, in order to justify the expansion of health services to low-income demographics, one must prove the state has a duty to intervene.

In his work, *A Theory of Justice*, John Rawls argues the state must have a role in the advancement of the least well-off so long as inequality is present in society. A positive duty can be found in Rawls' second principle of justice, which holds "social and economic inequalities, for example inequalities of wealth and authority, are just only if they result in compensating benefits for everyone, and in particular for the least advantaged of society." [13] The "least advantaged in society" can be seen as identical to Young's description of the marginalized and powerless population; Rawls' "difference principle" allows for inequality if and only if the unequal distribution is beneficial to the least well-off. With respect to health services, unequal distribution is not benefitting the low-income demographics in society. Many do not have the financial means to pay for insurance. Low-income populations are far more likely to die from preventable diseases. A higher likelihood of pre-mature death is certainly not a benefit; the difference principle thus instills a positive duty in the state to ensure low-income populations have access to health services. In order to ensure this benefit, the government must come up with a plan to enable choice in health services among the citizenry. However, there is a debate among political theorists about how to enable choice effectively. Is a full governmental intervention in health care necessary to protect the choice of these marginalized and powerless populations? Is the free-market alone enough to provide choice? Does the answer lie in some mixed conception of government and free-market ideals? These questions are much easier to grasp with the help of

[13] Rawls, J., pp.14-15

political theorists who specialize in choice theory, and who have different understandings of what level of paternalism is necessary when applied to access of health services.

III - Enabling Choice: Paternalism vs. Free-Market Solutions

There are alternative views when it comes to enabling choice in society. Sigal Ben-Porath argues in her work, *Tough Choices: Structured Paternalism and the Landscape of Choice*, that some level of paternalism is justified to enable choice. She calls this form of government involvement "structured paternalism." She gives structured paternalism the working definition as "an attempt to improve the circumstances or well-being of others while keeping in mind their inferred needs, including the threshold conditions of civic equality and the expansion of opportunity." [14] Structured paternalism is a model to enable choice while also respecting the autonomy and liberty of the populace. This focus on choice "requires greater emphasis on the state's responsibility to provide equal standing, choice sets, and opportunities to choose for all members […] pursued through the regulation and opportunities and choices, or metaphorically, through cultivating a fruitful landscape of choice." [15] While not directly addressed in her work, the liberal egalitarian model for providing opportunity is applicable to the health care sector. Structured paternalism is likely to consider the choice landscape of health services for the low-income population. Medicaid expansion does what Ben-Porath considers is necessary to enable choice while avoiding what she calls "destructive choices."

Destructive choices are choices that cause irreversible harm to the individual. Ben-Porath argues structured paternalism is a way to prevent individuals from making these harmful decisions. She articulates, most importantly, that the state must "offer forms of support and

[14] Ben-Porath, S., pp.20
[15] Ben-Porath, S., pp.9

prevention in this sphere, to help individuals avoid destructive choices and thus support their well-being, a goal that can often be advanced by providing appropriate opportunities and choices, rather than by using punitive measures." [16] There are destructive choices anyone can make in their health status, but lower-income populations are more susceptible to making harmful choices. For example, choosing to not purchase health insurance and poor health habits are leading factors attributed to high mortality rates among these populations. [17] Therefore, choosing to not participate in accessing health services is a destructive choice to one's well-being. Under her idea of structured paternalism, it is necessary to accept an appropriate level of government intervention in health services to enable individuals within the society to improve their well-being. Porath asserts society should allow paternalism in policies that "recognize the reality of human abilities and limitations, and designs institutions and policies that enable society and the individuals within it to reach their goals and improve their overall well-being." [18] Conceptually, Ben-Porath must agree with the implementation of Medicaid expansion. Public expansion of health services does more than improve access to health services, but encourages individuals to take advantage of the new policy. Instead of being constrained by their income, citizens can now exercise choice in their health.

Policies such as the *PPACA*, which focus on providing choice in health services to low-income individuals, satisfy Ben-Porath's commitment to freedom and civic equality. Ben-Porath is seeking a form of paternalism that is "less coercive and more regulatory, allowing for policies that aim to inform individuals of available choice sets, expand the rates of options when needed […] increase their availability and the likelihood of individuals choosing the most productive

[16] Ben-Porath, S., pp.45
[17] Sommers, BD. Baicker, K. Epstein, AM., 2013
[18] Ben-Porath, S., pp.39

ones." [19] Medicaid expansion proves to affect the rate of mortality dramatically. The rollouts of the *PPACA* in the last half-decade appear to be improving the amount of the populace receiving preventative care. [20] The uninsured rate has gone down from 18.2% in third quarter 2013 to 13.4% in first quarter 2014. By January 2015, the rate had fallen to 12.9%, the lowest uninsured rate since fiscal 2008. [21] This drop in uninsured rate happened in quarters directly following the Medicaid expansion. As reported by the Agency for Healthcare Research and Quality (AHRQ), "for the first time in a decade, Americans reported fewer barriers to health care. Americans encountering difficulties fell to 26.1%, and most groups experienced improved access as a result of the *Affordable Care Act.*" [22] These results show a correlation between an expansion of health services and an increase in overall health and well-being among the populace. Empirical evidence supports the hypothesis which drives Ben-Porath's stance on structured paternalism and, in this case, a justified level of paternalism in health care. She notes at the conclusion of her work, "policies based on this closer connection can work toward a society where more individuals can exercise greater power over their lives and enjoy greater opportunities to improve their well-being and to express their preferences and identities". [23] Policies that utilize paternalism as a way to enable choice prove to improve health access among the citizenry, much like Medicaid expansion has proven to do time and time again. However, some theorists hold that the free-market is enough to regulate goods like health care.

Matthew Zwolinski, in his work "Sweatshops, Choice, and Exploitation," focuses on whether capitalism in third world countries is exploitative or not. In his work he claims, "even if

[19] Ben-Porath, S., pp.45
[20] Sommers, BD. Baicker, K. Epstein, AM, 2013
[21] Gallup Poll, 2015.
[22] Agency for Healthcare Research Quality
[23] Ben-Porath, S., pp.150

the conditions of sweatshops are unfair, relative to their other alternatives, sweatshop labor is a very attractive option for workers in the developing world." [24] He attempts to prove that a coercion of poverty does not exist in the international labor market of sweatshops. To put his argument into perspective, he gives the example of Nokuthula Masango. Masango is a low wage earner who works in a South African sweatshop. Zwolinski asserts Masango has more choice in her labor options with capitalism than without it. Even if sweatshop workers are treated unfairly, they are given a better option via sweatshop labor than they would otherwise. Coercion of poverty does not exist because workers like Masango can still choose between their limited options; the worker is choosing to enter into that mutually beneficial contract over other prospects. Zwolinski purports that it can be assumed the worker will choose the best option for their well-being, even if their options are constrained.

Zwolinski's work is directly relatable to citizens obtaining health care. Zwolinski is likely to argue that the free market is more than enough to provide individuals with access to health services. If an individual feels as though health services are vital to their well-being, they have access to an abundance of health insurance plans on the free-market. Zwolinski's view of capitalism requires low-income individuals to prioritize their preferences; if a low-income individual wishes to obtain insurance, they should spend what income they have on those health services. Markets are efficient enough to provide services like health care at fair prices for those goods and services through voluntary trade. In essence, his stance defends a market justice framework of choice. Opposite to social and distributive justice, like Rawls and Ben-Porath focus on, market justice is a focus on efficiency and autonomy of individual choice. Under the market justice framework, health care is an economic good that can be accessed solely on an

[24] Zwolinski, M., Learn Liberty

individual's ability to pay. At the heart of this perspective is choice, or an individual's choice and responsibility to put their health before purchasing other goods. A very similar scenario that Masango has been placed in, citizens in the U.S. are constrained in their choice sets. There is no formal barrier prohibiting an individual from entering a mutually beneficial contract with an insurance company for such services. If the individual prefers to spend their money on other goods, so be it. Thus, under Zwolinski's view, enabling the government to limit the options of the free-market is unacceptable. A commitment to the market requires a rejection of the *PPACA* because the policy itself limits free-market choice. The policy forces citizens to either buy insurance or pay a fine. Zwolinski, who stresses the importance of mutually beneficial contracts, would detest such a law because it forces an individual to contract with the government.

IV - Paradox of Choice in Health Care Insurance

In The Paradox of Choice: Why More is Less, Barry Schwartz's thesis is that too much choice can be harmful to the consumer in any market. While Schwartz asserts in his work that autonomy and freedom of choice are necessary to our well-being, he admits "though modern Americans have more choice than any group of people ever has before, and thus, presumably, more freedom and autonomy, we don't seem to be benefiting from it psychologically." [25] He supposes that with so many options to choose from, individuals can no longer make choices effectively. In his Ted talk, he gives a real-world example of "choice paralysis" in action. A study on voluntary investment in retirement plans taken from Vanguard, a mutual fund company, shows this phenomenon quite well. Schwartz elaborates on the results of the study, "for every 10 mutual funds the employer offered, rate of participation went down two percent. You offer 50 funds – 10 percent fewer employees participate than if you only offer

[25] Schwartz, B., Chp. 5

five". [26] It is because so many funds are offered to the individuals that they decide to put off the decision further and further. Alternatively, those who were given fewer options were able to compare effectively and decide on a fund to invest in. Schwartz asserts that the more options there are, "the easier it is to regret anything at all that is disappointing about the option that you choose." [27] Too much choice can be detrimental to an individual's decision-making process, but what about in sectors where choice is severely constrained or not available at all?

Barry Schwartz's paradox of choice appears to be present within the private sector of health insurance, but only for those who can afford to purchase plans off the free-market. For those who are low-income, their choice sets are constrained so much that there are no options to begin with; thus, the paradox of choice does not exist for those who cannot afford insurance. Schwartz asserts "autonomy and freedom of choice are critical to our well-being, and the choice is critical to freedom and autonomy." [28] In this way, Schwartz agrees low-income individuals are not given the proper "freedom and autonomy" in their choice of health services. These concepts of freedom and autonomy are necessary for Schwartz's paradox of choice to hold. Without proper choice, low-income individuals do not experience this paradoxical phenomenon which is theorized to impact every decision on the free market.

Derek Thompson, in his article "More is More: Paradox a Choice a Myth," presents contrary empirical evidence against Schwartz's theory of choice as a paradox. The article implies that the paradox of choice is essentially a myth; the unlimited choice associated to the free-market behavior does not contribute to choice paralysis. Thompson offers the research of Benjamin Scheibehenne as a way to combat Schwartz's view of the paradox of choice. The study

[26] Schwartz, B., Ted Talk Transcript
[27] Schwartz, B., Ted Talk Transcript
[28] Schwartz, B., Chp. 5

concluded that "on the basis of the data on hand, we could not reliably identify sufficient conditions that explain when and why an increase in assortment size will decrease satisfaction, preference strength, or the motivation to choose". [29] Thompson asserts that Scheibehenne's research offers the conclusion that extra choices do not seem to have a significant enough impact on the decision-making of consumers. Additionally, Thompson presents a study by Daniel Mochon on "single-option aversion" as a way to explain why shoppers choose certain goods over others. Mochen suggests individuals will want as many options as possible in order to "heighten distinctions and make us more certain about our final choice […] choices reduce anxiety by making us feel like we've searched exhaustively -- and now we're ready to buy." [30] This single-option aversion can be related to the health care sector. In purchasing insurance in the free-market, individuals who can afford coverage will not want the government to step in and tell them which coverages or doctors they may or may not have. The *PPACA*, for example, limits the ability of many individuals to keep their primary physician and previous coverage; the policy initiates this change in order for more lower-income individuals to obtain access to health services.

V – Paternalism Enables Choice in Health Services

Robert Reich's passion for exposing income inequality and the significant wealth gap in America aids in understanding how complex forms of inequality, like that of healthcare, are created. Additionally, Barbara Ehrenreich's experiment reveals that health care inequality is the result of low wages and gaps in employment. For example, minimum wage workers are likely to put off seeking health care services in order to maintain their budget; CDC data is telling and supports Ehrenreich's theory that, without some form of government subsidy, low-income

[29] Scheibehenne, B., pp.421
[30] Thompson, D., pp. 1

individuals prefer not to spend money on preventative care. Rather, many of these workers prefer to put food on the table to survive in the short-term; this survival strategy trumps any incentive to invest in long-term health.

In order to justify paternalism to fix the problems presented by Reich and Ehrenreich, one must come up with a conception of justice which requires a positive duty for state intervention. With the help of Iris Marion Young and John Rawls, a positive duty for government expansion of health services is constructed. Low-income populations are both marginalized and powerless when it comes to obtaining access to health care. Without subsidized options, individuals who cannot afford health services will be placed into a group of lesser health status in society. Consequently, many individuals will feel powerless when faced with decisions regarding their well-being. For example, low-income individuals often feel their vote does not matter on a particular piece of legislation. This oppression requires government intervention, and Rawls has a solution to combat this health care inequality. Rawls' difference principle holds that inequality is acceptable so long as its consequences are beneficial to the least well-off. In the health care sector, inequality is not producing any beneficial results for the impoverished of society. Therefore, the government has a positive duty to model health care expansion in a way as to enable choice for the least advantaged in society. Realistically, this implies policy be enacted which allows for Medicaid expansion.

Having established a positive duty for expansion of health services, the question remains to what extent is government intervention necessary to enable choice for the citizenry. Sigal Ben-Porath's view of government intervention aids in constructing a view for justified paternalism in the health care sector as a way to enable choice. Due to income inequality, choice sets of low-income demographics are constrained in a way that only leads to destructive choices. This line of

thinking combats Zwolinski's focus on the free-market being ideal as a provider of choice. For example, a working mother of three will likely put off preventative care in order to feed her family. The choice to provide necessary sustenance is not much of a choice at all. It is a decision which was made under a constrained set of options, and in any scenario the woman is left with only destructive choices. The decision to choose health insurance coverage over groceries will lead to unacceptable consequences in the short term; her family goes hungry. Her decision to choose food over health insurance will lead to disastrous consequences in her future health status; she will be susceptible to a host of chronic diseases, most of which are preventable with proper access to health services. In fact, her options are so constrained that the phenomenon of the paradox of choice does not apply to her. Schwartz will argue the woman is not being given full autonomy and freedom. Therefore, enabling choice via Medicaid expansion is justified so long as the government is proving to make progress in enhancing the well-being of the populace while inequality is present.

It is important to identify policies which fit this conception's limitations. Medicaid expansion must therefore prove to enable choice. Harvard researchers decided to identify whether or not Medicaid expansion leads to these beneficial consequences for society. More specifically, they set out to identify a trend between Medicaid expansion and an impact on mortality rates. Their hypothesis was that "Medicaid expansions would reduce mortality, rates of uninsured and cost-related barriers to care and would improve self-reported health, particularly among minority and lower-income populations." [31] The data from the study establishes a strong case to support their hypothesis. The net change in mortality rates after the expansion is significant. The decline is 19.6 deaths per 100,000 deaths, or a relative reduction of 6.1%. For

[31] Sommers, BD. Baicker, K., Epstein, AM., 2013

those in the "high poverty" population, there was a decline of 22.2 deaths per 100,000 deaths, or just over a 7% decline. Similarly, those in the non-white population group had a net change of -41 deaths per 100,000, or a 12% reduction in mortality rate. [32] Seen in *Graph 3*, the states which implemented the expansion saw a steady decrease in mortality rate over the five year period after the expansion. Not only was mortality affected, but also a reduction in financial strain on low-income individuals who are seeking health services. In Oregon, for example, "coverage led to a reduction in financial strain from medical costs, according to a number of self-reported measures. In particular, catastrophic expenditures, defined as out-of-pocket medical expenses exceeding 30% of income, were nearly eliminated." [33] Low-income individuals and minority populations are living longer with less financial strain, so enabling their choice sets for health services appears to benefit society substantially both in health and economic outcomes.

The researchers conclude "state Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health." [34] The reduction begs the question of why the Medicaid expansions, such as the *PPACA*, get so much criticism. Empirically, it cannot be denied that Medicaid continues to advance the welfare of the community and enable health care options that would otherwise not be available to low-income individuals. Government expansion in health care is the sole reason low-income individuals are able to avoid destructive choices in their health. For these demographics, government involvement in health care guarantees choice in health services the free-market cannot. The long term benefits of providing the populace with access to health care services insures better public health in the next generation, as well as succeeds in furthering

[32] Sommers, BD. Baicker, K. Epstein, AM., 2013
[33] Baicker, K. Taubman, S.
[34] Sommers, BD. Baicker, K. Epstein, AM, 2013

choice within society. Therefore, the government has a positive duty to enact policies which provide more choice to demographics that are marginalized and powerless in the face of the free-market.

PART II

The United States spends more than $2 trillion dollars annually on health care. An estimated 3% of this total is lost to health care fraud; losses that accumulate to over $65 billion dollars a year. In the fiscal year 2013, the IRS recovered just over 4.3 billion dollars in judgments and settlements. [35] Even though federal efforts have increased, current enforcement is not enough to combat fraudulent activity in the sector. Healthcare fraud is an indicator of increasing healthcare costs for consumers in the United States; therefore, the issue needs to be addressed more directly in the coming years. In PART II, the impact of the *PPACA* on health care fraud efforts is evaluated. Proposed recommendations to enhance institutions and pre-existing policies which aim to combat such criminal activity are discussed and defended.

I - A History of Anti-Fraud Policy

The historical context must be established to address the *PPACA*'s impact properly upon anti-fraud efforts in the healthcare sector. There is a growing concern regarding the effectiveness of the reform in the coming years. In this section, those policies that have been altered or enhanced as a result of the *PPACA* will be discussed. In the following section, the most impactful provisions will be evaluated in more detail.

False Claims Act – 1863

The False Claims Act (FCA), also known as the "Lincoln Law," is a law enacted in 1863. It is one of the first instances of a *qui-tam* provision in American policy, which allows for persons not affiliated with the government directly to file lawsuits or civil action on behalf of the federal government. [36] Commonly, such an action is referred to as "whistleblowing."

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[35] U.S. Department of Health and Human Services (HHS)
[36] U.S. Department of Justice

Whistleblowing was first observed in the case of *Franklin v. Parke-Davis*, where off-label marketing of the drug Neurontin was submitted to Medicaid. The case settled for over $430 million and landed two felony convictions. The outcome of the case set precedent for future anti-fraud cases, and forced Pfizer to create an employee fraud prevention program. [37] Since *Franklin v Parke-Davis* the government has landed a number of high paying settlements from fraudulent activities like that of the off-labeling. This case settlement set precedent for several off-labeling suits over the next decade. There have been a number of settlements with pharmaceutical companies; the most recent of cases dealt with GlaxoSmith Kline LLC, and ended in $3 billion worth of fines. [38] As a result of this provision the government can recover billions of dollars, but there is a severe reliance upon whistleblowers to initiate justice. With respect to all types of fraudulent action, fraud in the healthcare sector amounts for 40% of the total collected. [39] In a sector which has seen an increase in fraud since the FCA's inception, recovery and prosecutions should be a primary concern in the fight against healthcare fraud.

Under the *PPACA* there appears a number of changes to the FCA to incentivize whistleblowing as well as increase penalties for fraudulent offenses. The first of which was the alteration of the "Public Disclosure Bar." This allows the federal government the power of final word on whether a court can dismiss a case on the basis of public disclosure. The language articulates: "the court shall dismiss an action unless opposed by the Government, if substantially the same allegations or transaction alleged in the action or claim were publicly disclosed." [40] The *PPACA* also initiated what is called an "Original Source Requirement." The requirements for being considered an original source include: "direct and independent knowledge of the

[37] Greene LLP
[38] Sifferlin, A.
[39] Helmer Jr, J.B.
[40] *Patient Protection & Affordable Care Act*, (U.S.C. 3730(e)(4)(A)

information on which the allegations are based […] knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions." [41]

Anti-Kickback Statute – 1972

The Anti-Kickback Statute was enacted in 1972 through the Social Security Amendments of 1972 as a way to protect federal health care programs from abuse and corruption. The statute prohibits the "exchange of anything of value, in an effort to induce (or reward) the referral of federal health care program business." [42] The most important case involving the Anti-Kickback Statute was that of *United States v. Gerber.* This case was a landmark in the area of healthcare fraud because it opened the door to future prosecutions. The court implemented what they call a "one-purpose" test. A one purpose test is "if one purpose of the payment was to induce future referrals, the Medicare statute has been violated." [43] The test set precedent for future cases to be decided on this basis of judgement, bringing the complex issue of intent to the forefront of the law.

The statute is known to be very broad in application among the types of transactions it presides over. Thus, before the *PPACA,* there were looming questions surrounding what is seen as "intent" in the violator's action. The *PPACA* did much in the way of specifying the policy's ambiguities surrounding intent; the new policy specifies the violator need not realize he or she is committing the fraudulent activity. The intent to commit a violation of the Anti-Kickback Statute is no longer a factor to be considered when executing the law and prosecuting offenders. Rather, all that matters is that a violation took place. The government must prove the wrongdoing; the

[41] *Patient Protection & Affordable Care Act,* (U.S.C. 3730(e)(4)(B)
[42] American Health Lawyers Association (AHLA)
[43] *United States v. Greber*, 760 F.2d 68, 69

burden of proof is on the state. The amendment on the part of the *PPACA* has allowed ambiguity to be cleared away and facilitates for a more effective conviction process. [44]

Physician Self-Referral Law ("Stark" Law) – 1989

The "Stark" Law is also important in the discussion of anti-healthcare fraud provisions. Formally called the Physician Self-Referral Law, the provision seen under Section 1877 of the Social Security Act prohibits physicians from making referrals for health services paid by Medicare to another entity that is directly or financially tied to the physician. For example, if a doctor makes a referral payable by Medicare to a third party in which the doctor sees a financial gain, it is a violation of the Stark Law. [45] The law also prohibits that third party from presenting such claims for the illegal referral. Additionally, the law establishes and allows the Secretary to regulate and provide exceptions for those relationships that do not appear to be a risk for fraud, waste, and abuse.

There were some important changes to the Stark Law with the initiation of the *PPACA*. Now providers and physicians can submit what is called a "Self-Referral Disclosure Protocol" (SRDP); this allows providers and suppliers to self-disclose all potential violations to the government. As a result, if any violations did occur the Secretary of HHS has authority to reduce the charges weighed against the individual provider. The provision appears to be an incentive to those who have committed fraud and knew it, but who wish to avoid paying violation fees in full. [46]

[44] *United States v. Greber*
[45] Center for Medicare & Medicaid Services (CMS)
[46] Centers for Medicare & Medicaid Services (CMS)

Civil Monetary Penalties – 1989

The Civil Monetary Penalties Law was enacted in 1989 as a means to address civil penalties. This law allows substantial civil monetary penalties to be enforced for the aforementioned violations. These violations include:

> "(1) knowingly presenting or causing to be presented, a claim for services not provided as claimed or which is otherwise false or fraudulent in any way; (2) knowingly giving or causing to be given false or misleading information reasonably expected to influence the decision to discharge a patient; (3) offering or giving remuneration to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services; (4) arranging for reimbursable services with an entity which is excluded from participation from a federal health care program; (5) knowingly or willfully soliciting or receiving remuneration for a referral of a federal health care program beneficiary; or (6) using a payment intended for a federal health care program beneficiary for another use" [47]

Under the *PPACA*, more oversight was granted under the Civil Monetary Penalties Law. The OIG can now incorporate new CMP authorities and organize regulations regarding the clarity of the violations and penalties outlined in the law. [48]

[47] American Health Lawyers Association, Civil Monetary Penalties Law. 42 U.S.C. § 1320a-7a.
[48] United States Federal Registry

Health Insurance Portability and Accountability Act– 1996

The Health Insurance Portability and Accountability Act (HIPAA) was put into place in 1996 in order to fund a reinvigorated Health Care Fraud and Abuse Program to combat waste and abuse within both federal and private health insurance systems. With HIPAA came a number of changes; it was the first bill of its kind to limit an employer's ability to exclude coverage for pre-existing conditions. The bill prohibits discrimination against employees based on various health factors they may have including but not limited to prior medical conditions or inherent genetic qualities. The Act also assures that citizens can have and renew individual healthcare insurance policies, as well as allows for group healthcare plans. [49]

Since its inception, there have been two primary changes. The first is titled Health Information Technology for Economic and Clinical Health Act (HITECH) which seeks to strengthen HIPAA rules for electronic transmission of health information as well as increase enforcement. The second, the *PPACA*, expands this focus on electronic security and simplification. The *PPACA* implements what is known as a Health Plan Identifier as well as a universal standard for electronic fund transfers. Additionally, the *PPACA* increased its penalties for non-compliance with the new operating rules. [50]

II - Anti-Fraud Provisions of the *PPACA*

The Patient Protection and Affordable Care Act, often referred to as "Obamacare" by popular culture, was enacted in 2010. With the policy came a number of changes to existing structures that seek to combat Medicare, Medicaid, and private insurance fraud in the healthcare sector. The *PPACA* strengthened preventative measures with respect to the previous fraud

[49] U.S. Department of Health & Human Services
[50] U.S. Department of Health & Human Services

prevention model in an effort to become more proactive on a federal level. The *PPACA* seeks to provide more funding to prevent fraud, assess and enhance screening techniques, to establish larger penalties, and enhance data sharing capabilities.

The most important aspect of the anti-fraud policy of the *PPACA*, increased public funding towards fraud prevention, allow for substantial upgrades to an already-existing framework. The policy allows for an additional $350 million dollars to be funneled annually into the Health Care Fraud and Abuse Control Account (HCFACA) to employ a larger pool or government workers who work to combat fraud. Such funding is provided for a ten-year period, at the conclusion of which (2020) the policy is to be evaluated and revised.

> "ADDITIONAL FUNDING – (i) For fiscal year 2011, $95,000,000; (ii) For fiscal year 2012, $55,000,000; (iii) For each of fiscal years 2013 and 2014, $30,000,000; (iv) For each of fiscal years 2015 and 2015, $20,000,000. ALLOCATION.—The funds appropriated under this paragraph shall be allocated in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended." [51]

The Centers for Medicare and Medicaid Services (CMS) of the United States is also dramatically affected under the new policy. Under the *PPACA*, CMS is encouraged to visit providers, increase oversight, and conduct far more thorough background checks. The *PPACA* requires providers to submit themselves to a screening before enrollment. This screening requires

[51] *Patient Protection & Affordable Care Act*, pp. 945

a provider to submit all past associations with suppliers and other providers. If there appears to be a connection between a provider and another delinquent entity, the government will require a much more in-depth screening process. States "agree to conduct background checks under the nationwide program on a statewide basis; and iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify" (658) [27].

The *PPACA* has placed more control with the government to control providers who are high-risk. Along with screening, background checks include fingerprinting of providers who are considered high-risk for fraudulent activity. The policy allows the government to require surety bonds when Medicare-funded claims and services are provided, thus adding a layer of protection to the public funding. Each provider is required to have a National Provider Identity (NIP) which is shown on every document whether it be a claim or application. Additionally, U.S. Department of Health and Human Services (HHS) has the right to deny enrollment of any provider if it believes to prevent or combat fraud. The HHS has a right to suspend Medicare and Medicaid payments to providers if the activity is suspect or if there is an investigation open. The *PPACA* also sets a cap on claim filings. This limit on claims requires the provider to file a claim to the CMS within 12 months of providing the service. The newest penalties connected to the *PPACA* allow for the government to recapture money lost as well as impose more stringent penalties for offenders. The Office of Inspector General (OIG) is given authority under the policy to impose much stronger fines against fraudulent providers or suppliers. For example, for each false claim or statement submitted to the government, a $50,000 fine will be introduced. If the OIG catches a provider for overpayment, and who does not submit this overpayment to the government, the fine is again $50,000 or up to three times the amount of claim.

> "In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including if applicable, a final determination on an appeal) is made." [52]

There are new penalties established under the *PPACA* which aim to combat those who falsify data on claims or hinder an investigation relating to Medicare or Medicaid fraud. In addition to fines, jail time has also been strongly affected under the *PPACA*. The policy allows for 20-50% increase in a given sentence if the crime involves over $1,000,000. Additionally, the Department of Justice is given much more authority in the search and investigation of facilities where wrongdoing may likely be apparent. For example, a provider taking advantage of the elderly by filing fraudulent claims in a nursing home facility will be less likely to succeed due to such enforcement. Therefore, the provisions and overall focus of anti-fraud policy in the *PPACA* appears to do much more for criminal deterrence. [53]

One of the more substantial effects of the *PPACA* is in the area of data sharing. The policy significantly expands the ability to share data across a number of federal networks. The integrated data repository (IDR) of the CMS is expanded under the *PPACA*. It allows the

[52] *Patient Protection & Affordable Care Act*, pp. 736.
[53] *Patient Protection & Affordable Care Act*

Department of Defense, Social Security Disability Insurance, Medicare, Medicaid, Veterans Administration, and the Indian Health Service to pool their claims data into one system. The Secretary shall:

> "establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services […] IN GENERAL– The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse […] INDIVIDUALS DESCRIBED—The following individuals are described in this clause: (I) The Commissioner of Social Security. (II) The Secretary of Veterans Affairs. (III) The Secretary of Defense. (IV) The Director of Indian Health Service." [54]

The DOJ has much more investigative authority under the access of such a system. Therefore, better data sharing allows for agents and government officials to identify and prosecute criminals far easier than the previous system.

[54] *Patient Protection & Affordable Care Act*. pp. 693.

III – A Deeper Look: PPACA Fraud Provisions by Sector

There are many types of fraud in healthcare. The *PPACA* affects each sector of healthcare differently and seeks to strengthen regulation and oversight in all areas. Some of the most prevalent sectors where fraud takes place include Durable Medical Equipment (DME), home health, hospice, and nursing home fraud. [55]

Durable Medical Equipment (DME) pertains to any and all medical equipment that is prescribed by a doctor and that is reusable. Commonplace DME includes: walkers, wheelchairs, scooters, oxygen equipment, prosthetics, and hospital beds. "In 2009, Medicare spent more than $10 billion on durable medical equipment. More than half of that was improperly spent – meaning the equipment was unnecessary or the bill was wrong." [56] Sometimes providers will market their DME as free of charge with their services, but at the same time bill Medicare for the cost. Many times doctors prescribe DME that is not needed and may even bill equipment on duplicate orders to generate even more profit out of a broken system.

Under the *PPACA*, DME fraud is approached thoroughly in an attempt to regain regulative authority and reduce fraudulent billing. The *PPACA* requires a physician or physician assistant to have a face-to-face with the patient before issuing any form of certification for DME. The provision ensures the patient meet with a medical professional and agrees with the decision before the equipment order is billed to Medicare. The physician must also be a registered Medicare eligible doctor and must go through all the proper registration channels the federal government has put forward. The HHS has authority in these matters, and can deny DME providers as they see fit to reduce healthcare abuse, fraud, and waste.

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[55] U.S. Department of Justice
[56] Senior Medicare Patrol (SMP)

> "The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary." [57]

Home healthcare is another sector in which fraud is prevalent, and in which the *PPACA* seeks to improve oversight. Again, the policy requires physicians with Medicare patients to be enrolled and approved as a Medicare doctor. The face-to-face rule also applies, except for it additionally requires the meeting to take place at least 90 days before the start of the in-home care. If either of the conditions is violated, there will be more aggressive penalties. As noted in the policy, if an individual or firm:

> "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services." [58]

[57] *Patient Protection & Affordable Care Act*, Sec. 6406
[58] *Patient Protection & Affordable Care Act*, Sec, 6408

The *PPACA* also addresses the hospice sector, an easily manipulatable sector for criminals. In addition to the face-to-face meetings, the government now requires an 180 day re-certification visit as well as certified documentation that such a visit had taken place. Nursing homes are another sector where fraud is prevalent. Before the *PPACA*, there was not a focus on ethics or compliance by nursing home staff. The policy requires Skilled Nursing Facilities (SNFs) report information to the government on their workers and associated members of the staff providing the care. "The functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers." [59] Oversight is increased substantially for the DOJ and allows for enhanced detection strategies for background checks. Improving the effectiveness of background checks is one of the primary focuses under this policy, and especially for detecting fraud in nursing homes given the vulnerability of the elderly. Due to increased oversight, the DOJ can monitor and prosecute wrongdoing in the sector easier than before the adoption of the *PPACA*.

IV - Field Interviews

To further grasp the underline concepts of fraud in billing practices, I sat down with Jessica Pitts, the program director for medical insurance billing and coding at Brookline College in Tucson. An integral part of the Brookline program, Pitts instructs medical insurance billing, coding, and allied health classes at the Tucson campus. Below is a transcript of our discussion from November, 2014.

[59] *Patient Protection & Affordable Care Act*, Section 684.

What do you believe is the most common form of criminal activity in the health care sector? What is the hardest to detect or guard against?

"I believe that fraud and abuse are the most common form of criminal acts in the healthcare sector. As an instructor in the medical billing and coding, I have discussed many types of fraud that happens. Examples are as follows:

1. Billing for services not rendered.

2. Upcoding of services. A patient comes in for an annual checkup, and the claim that is submitted is for a surgery.

3. Upcoding of items. Similar to upcoding of services, but involving the use of medical equipment. An example is billing Medicare for a power-assisted wheelchair while only giving the patient a manual wheelchair.

4. Duplicate claims. In this case, a provider does not submit exactly the same bill but changes some small portion, like the date in order to charge Medicare twice for the same service rendered. Rather than a single claim being filed twice, the same service is billed two times in an attempt to be paid twice.

5. Unbundling. Bills for a particular service are submitted in piecemeal, that appear to be staggered out over time. These services would normally cost less when bundled together, but by manipulating the claim, a higher charge is billed to Medicare resulting in a higher pay out to the party committing the fraud.

6. Excessive services. Occurs when Medicare is billed for something greater than what the level of actual care requires. This can include medical related equipment as well as services.

7. Unnecessary services. Unlike excessive services, this fraudulent scheme occurs when claims are filed for care that in no way applies to the condition of a patient, such as an echocardiogram billed for a patient with a sprained wrist.

8. Kickbacks. Kickbacks are rewards such as cash, jewelry, free vacations, corporate sponsored retreats, or other lavish gifts used to entice medical professionals into using specific medical services. This could be a small cash kickback for the use of an MRI when not required, or a lavish doctor/patient retreat that is funded by a pharmaceutical company to entice the prescription and use of a particular drug" (Pitts, 2014).

Could you walk me through the process that occurs at a high level from the time a claim gets submitted to the step where it gets paid?

"I focused on the three 'P's' in my classroom. Patient, Providers, Payers. The first step is when the patient hands over her insurance card and fills out a demographic form at the time of arrival in the office or hospital. The demographic information form includes: patient name, date of birth, address, Social Security or driver's license number, the name of the policyholder, and any additional information about the policyholder if the policyholder is someone other than the patient. At this time, the patient also presents a government-issued photo ID so that you can verify that she is the insured member. If a patient uses someone else's insurance coverage is fraud. So is submitting a claim that misrepresents an encounter. All providers are responsible for verifying the patient's identity, and they can be held liable for fraud committed in their office.

The second step is after the initial paperwork is complete, the patient's encounter with the service provider or physician occurs, followed by the provider documenting the billable services. The third step is the coder abstracts the billable codes, based on the physician documentation.

The fourth step is the coding goes to the biller who enters the information into the appropriate claim form in the billing software.

After the biller enters the coding information into the software, the software sends the claim either directly to the payer or to a clearinghouse, which sends the claim to the appropriate payer for reimbursement. If everything goes according to plan, and all the moving parts of the billing and coding process work as they should, your claim gets paid, and no follow-up is necessary. Of course, things may not go as planned, and the claim will get hung up somewhere — often for missing or incomplete information — or it may be denied. If either of these happens, the biller has to follow up to discover the problem and then resolve it" (Pitts, 2014).

Have you heard of any recent cases in Tucson that resulted in federal action or a large lawsuit?

"Yes, the Heart Hospital. The hospital was charged with HIPPA violations and had to close down. The hospital merged with St. Mary's Hospital." (Pitts, 2014).

Under the Affordable Care Act, was the idea to expand federal enforcement and funding for anti-fraud efforts a good decision? Do you believe anti-fraud efforts should be increased, i.e. more funding for programs that seek to root out this criminal activity?

"I believe that fraud can happen in any situation. I believe that more enforcement always help and more regulations in the office and hospital setting. Funding can always help with criminal activity, but guidelines should be accessed and follow up. Education! Education is the best way to go!" (Pitts, 2014).

In general, do you find healthcare professionals more in favor of or opposed to the Affordable Care Act (2010)?

"I believe a majority health professionals are in favor of the new policy. Many see that the *PPACA* is very hard to keep track of with the paperwork. Billing has to be done in a separate way from the usual routine. Also, keeping track of patients that do not have current residency. Some individuals feel that individuals should help get the proper healthcare to help in the preventive methods of disease transmission. So, when it comes to billing, it is a lot harder to manage" (Pitts, 2014).

If you could put one policy or program related to the healthcare sector in place tomorrow, what would you do and why?

"Community Health Programs to inform people of prevention and health risk that is in the healthcare field. I believe the more education that is provided, the better the outcome" (Pitts, 2014).

In the conversation above, we discuss the prevalence of various forms of billing fraud. The most common forms, billing for services not rendered and up-coding for services actually rendered, appear to be the hardest to track down and prosecute. A cut in funding to the DOJ and HHS will make stopping these practices incredibly difficult. As Pitts recommended, "I believe that fraud can happen in any situation. I believe that more enforcement always help and more regulations in the office and hospital setting. Funding can always help with criminal activity but guidelines should be accessed and followed up. Education! Education! Is the best way to go" (Pitts, 2014).

V - Common Criticisms of Anti-Fraud Efforts under the *PPACA*

Common criticisms of anti-fraud efforts include a generalized argument appealing to less government enforcement and less taxation; another asserts spending cuts on Health and Human Services (HHS), Office of Inspector General (OIG), and the Department of Justice (DOJ) are necessary in order to enrich other government programs. Some common programs individuals believe should receive more attention include education, border enforcement, military, or even Medicaid/Medicare funding itself. Many simply believe it is an unjustified expenditure that the tax-payer must take on. In this section, I respond to these criticisms by arguing that the investment of Medicaid/Medicare must be protected. These agencies are necessary in order to rectify the increasing instances of fraud, waste, and abuse in the healthcare sector. Funding for anti-fraud efforts save tax-payers in the long run, preventing and deterring criminals from making unethical decisions in their billing practices.

Staff cuts to federal agencies such as Health and Human Services (HHS) and the Office of the Inspector General (OIG) are not the solution to the problem of health care fraud. In fact, federal spending cuts aimed at reducing staff will only make the fraudulent activity more prevalent in the future. According to the HHS, for every dollar spent on healthcare fraud enforcement, about $8 is returned via settlements in and out of courts. Gary Cantrell, the deputy inspector general at HHS, notes "with fewer agents we investigate fewer cases, and with fewer cases we're likely to have fewer convictions, few civil settlements, which will likely translate into less recoveries […] the problem is certainly growing…yet our resources are declining." [60] There are a number of sectors where increased government spending could have a massive impact, but no other government organization is close to recovering an eightfold return. It

[60] Magan, D., pp.1

becomes a question of short-term benefits versus long-term investment. Should the government cut spending across the board, reducing the efficiency of an already understaffed department, in order to promote short term benefits in other sectors? Alternatively, should the government invest in enforcement and future returns, as a way to both deter criminals from engaging in fraudulent activity and seek returns much larger than the original investment? Much like the many examples of fraud outlined in the previous section, these questions may be answered by looking at specific case outcomes. Lawrence Duran, who owned American Therapeutic, was sentenced to fifty years in prison for a Medicaid scam amounting to $205 million. Duran had to pay close to $87 million in restitution in addition to his prison sentence. Returns from this case came close to over 5 billion dollars and resulted in over 1,500 individuals charged with fraudulent behavior. [61] These results were produced solely by the Medicare Fraud Strike Force, a coalition of the HHS and the Department of Justice funded by the programs which the *PPACA* champions. Due to this case and many others, Cantrell argues enhanced government enforcement in this type of fraud has already made a significant impact on deterrence. Apart from the eightfold return that has been made by the HHS, Cantrell asserts this funding for government enforcement is needed for criminal deterrence. As he notes, "we saw this scheme (Duran), and others like it in south Florida and Louisiana […] largely as a result of law-enforcement efforts, we saw significant reductions of Medicare outlays." [62] Deterrence is effective, as other community health centers reduced their overall billings to Medicare after the incident with Duran unfolded. So in addition to the empirical weight of the eightfold returns, criminal deterrence produced from actions taken from the HHS, OIG, and DOJ have effectively reduced fraud and kept health organizations more honest about their billing practices. Such results cannot be

[61] *United States Department of Justice*. Office of Public Affairs.
[62] Magan, D., pp.2

produced if spending cuts and anti-fraud provisions under the *PPACA* are reversed or restructured in the coming decade. As Cantrell notes, "last year (2012), we closed over 1,200 complaints because of lack of resources […] that number's going to be pretty high this year as well, likely to exceed 1,000." [63] When the government is spending nearly half a trillion dollars on Medicare, and close to $400 billion on Medicaid, there must be anti-fraud programs and funding set in stone to ensure the integrity of the programs hold.

VI - Policy Recommendations

In an ever-changing landscape of fraud, adjustments in policy should target maximizing the effectiveness of taxpayer dollars. In order to reclaim even a fraction of the $65 billion lost each year, provisions must be adjusted in a more progressive and outcome-oriented way. First, transparency between the private and public sector should be of focus in order to ensure claims are legitimate. Second, resources should be funneled to the Center for Medicare and Medicaid Services in order to enhance their predictive modeling technology. Government agencies such as the DOJ and HHS should increase the frequency of screenings on high-risk health providers as a way to deter criminal activity in the sector. Funds provided via the *PPACA* which allow for these efforts must continue. In many ways, this administration has already done more than any other in the advancement of anti-fraud efforts.

> "This Administration has made a firm commitment to rein in fraud and wasteful spending, and with the Affordable Care Act, we have more tools than ever before to implement important and strategic changes. CMS thanks the Congress for providing us with these new authorities and

[63] Magan, D., pp.2

> resources, and looks forward to working with you in the future as we continue to make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources" [64]

Overturning the *PPACA*, including the annual $350 million of funding dedicated to anti-fraud efforts, hinders the efforts of government agencies pursuing criminal activity. Not only should these policies continue to be active, they should be enhanced as to increase returns in the future and protect the nation's investment in the Medicaid and Medicare programs. As noted by Sparrow in a subcommittee hearing on health care fraud:

> "From year to year the Office of the Inspector General (DHHS) reports return ratios per dollar spent in the region of 17 to 1. Sometimes higher. One view is that these handsome returns reveal a highly efficient operation. But any economist would tell you, conversely, that this shows the levels of investments in control are nowhere near optimal. Economists would say that one ought to keep adding controls until the marginal returns get much closer to one-to-one. Returns of the order of 20 to 1 indicate a reservoir of fraud available, and considerable ease in skimming off the more obvious cases. If you're standing in a lake, it does not take much effort to scoop up a bucket of water and hold it up for everyone to see." [65]

Return on investment is, in most recent estimates, eightfold. $350 million annually does not do this problem justice when there is an "ocean" of fraudulent activity in the healthcare

[64] Budetti, P., pp.1
[65] Sparrow, M.K., pp. 5

sector. With increased prosecution and oversight, criminal activity in the sector will decrease and taxpayer money will be protected in the long-term as more and more of the $65 billion is reclaimed annually. In addition to enhancing anti-fraud funding, increased incentives under the *qui-tam* provision appear a necessary change to encourage whistle-blowers to speak out about criminal activities by their firm or employer. As the law is currently established, the qui tam provision provides "liability for triple damages and a penalty from $5,500 to $11,000 per claim for anyone who knowingly submits or causes the submission of a false or fraudulent claim to the United States." [66] While there are incentives to whistle-blow, they do not yet appear to be substantial enough for individuals to sacrifice their career and future earning potential based purely out of ethical concerns. No matter how strongly an individual disagrees with fraudulent practices in the health care sector, they are likely to put ethical concerns on the backburner and rather focus on earning potential; financial security and career fulfilment are likely to take precedent in a working professional's life. A more effective *qui-tam* provision should focus on insuring concealment of identity and more financial incentive. Instead of the current provision that guarantees a fixed reward to those who whistle-blow, a percentage should be implemented into the *qui tam* provision so as to incentivize further their cooperation with the federal government. A change in the provision will encourage workers and professionals in the sector to call out any wrongdoings within their firms and keep health organizations accountable.

Further, it seems necessary to reform spending in this country to reap the most public good from the investment of taxpayer dollars. Fighting inequality and criminal enforcement in the health care sector have proven to protect proactively the public good. The most recent Medicaid expansions enable choice in minority demographics, giving low-income individuals

[66] Fox Rothschild LLP.

the ability to purchase affordable insurance options. With respect to anti-fraud efforts and the agencies responsible for creating task forces, an eightfold return for every additional dollar spent is a sound investment of taxpayer money. While these successful programs are proven to be fruitful, both in health and economic outcomes, the U.S. continues spend on sectors that are neither efficient nor necessary. For example, the United States spends more on defense than any other country in the world. It can be observed in *Graph 4* that America spends more on defense than the next seven highest spending countries combined. [67] While the U.S. has commitments toward defense spending across the globe, the sheer size of this defense budget is bound to cause problems back home regarding the future of entitlement programs. As noted in the President's FY 2016 Budget Submission for discretionary spending, defense expenditures will on average increase $7.2 billion a year until it hits $570 billion in FY 2020. [68] Billions of dollars are being thrown away for marginal levels of improvement to the defense and well-being of the nation's security. If these increases are redirected to public health programs and anti-fraud efforts, it will result in the improved health status of Americans and more funding recovered from criminal activity.

VII - Implications & Conclusion

The importance of paternalism in the healthcare sector has made itself known through the failures of the free-market. Before the most recent Medicaid expansions, Americans struggled to afford insurance, and, as a result, have taken less interest in obtaining health services to combat many of preventative diseases which plague low-income and minority demographics. *The Patient Protection and Affordable Care Act* has done much to enable choice in health services

[67] Peter G. Peterson Foundation
[68] United States Department of Defense. President's Budget Submission FY 2016

for these demographics, as well as improve the manpower of government agencies responsible for recovering taxpayer monies which fund such programs through anti-fraud strike teams. So much so that an eightfold return on investment has become the norm. However, the government could do more in order to maximize the health and economic outcomes of America. The potential benefits that come from redirecting funds to these programs are being lost to programs that yield a lower marginal return on investment. Redirecting funds from the defense budget will only serve to improve outcomes for the nation. The question lies in how much of a redirection is necessary to gain peak efficiency, a question that can be answered by health care economists and Congress.

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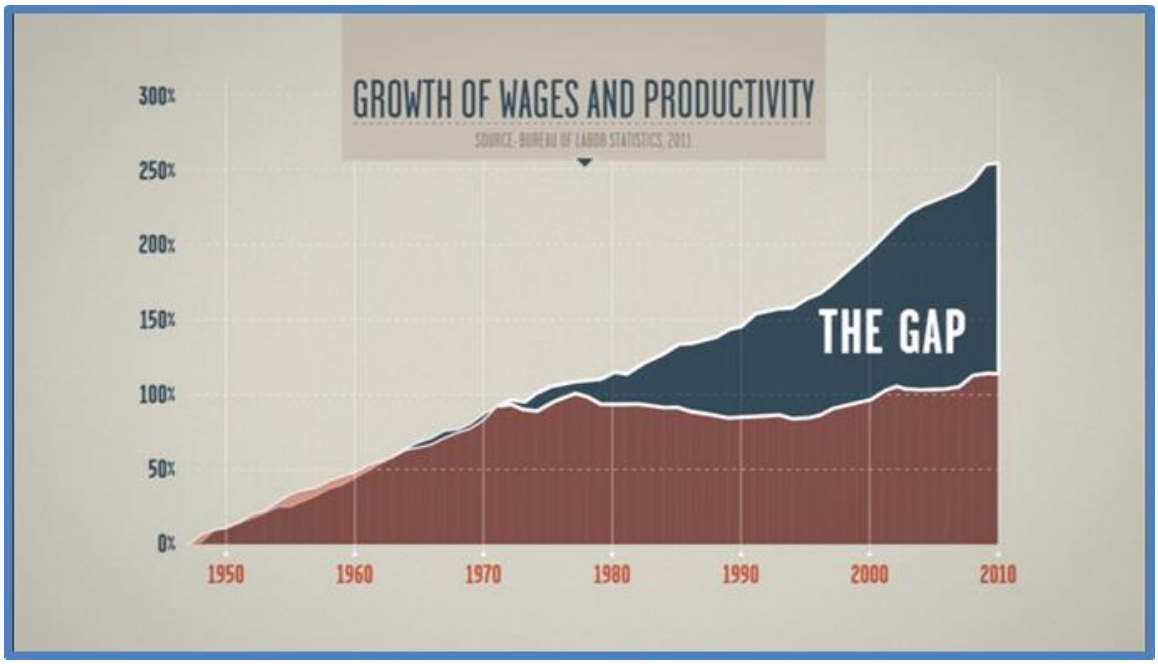
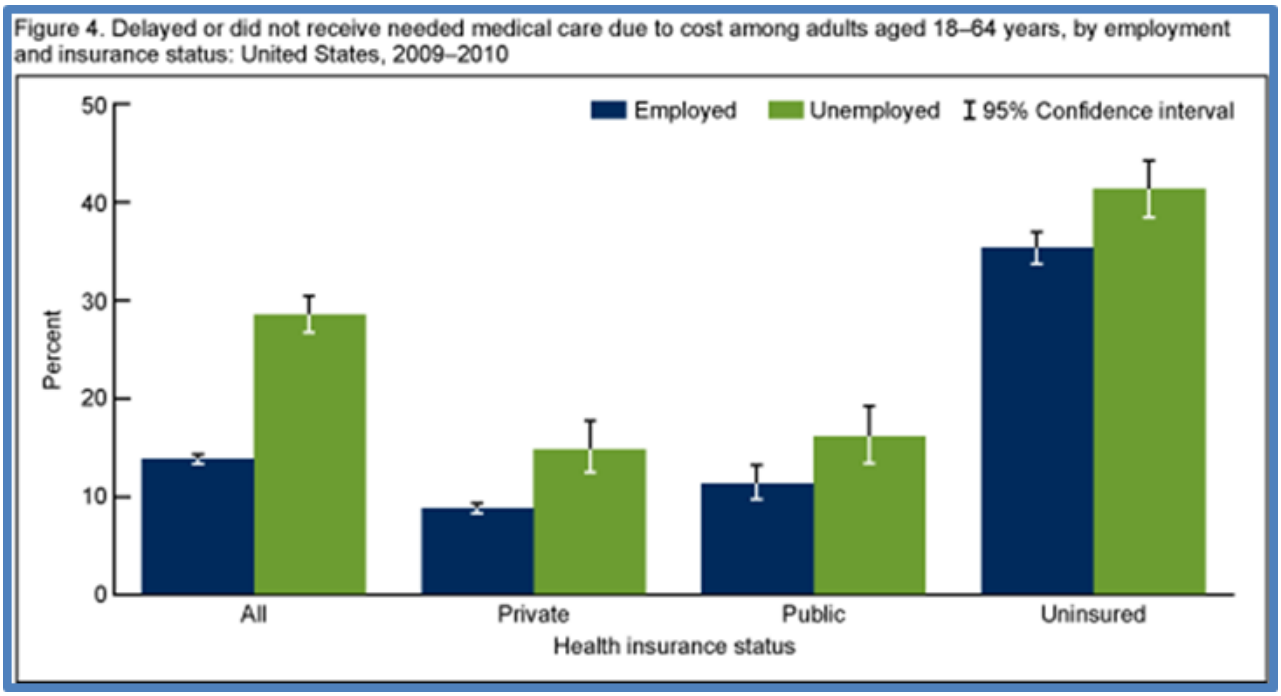
Graphs & Figures

Graph 1: Growth of Wages & Productivity Stagnant



Graph 2: CDC Data on Employment &. Uninsured



Graph 3: Harvard Study on Medicaid Expansion & Mortality Rate

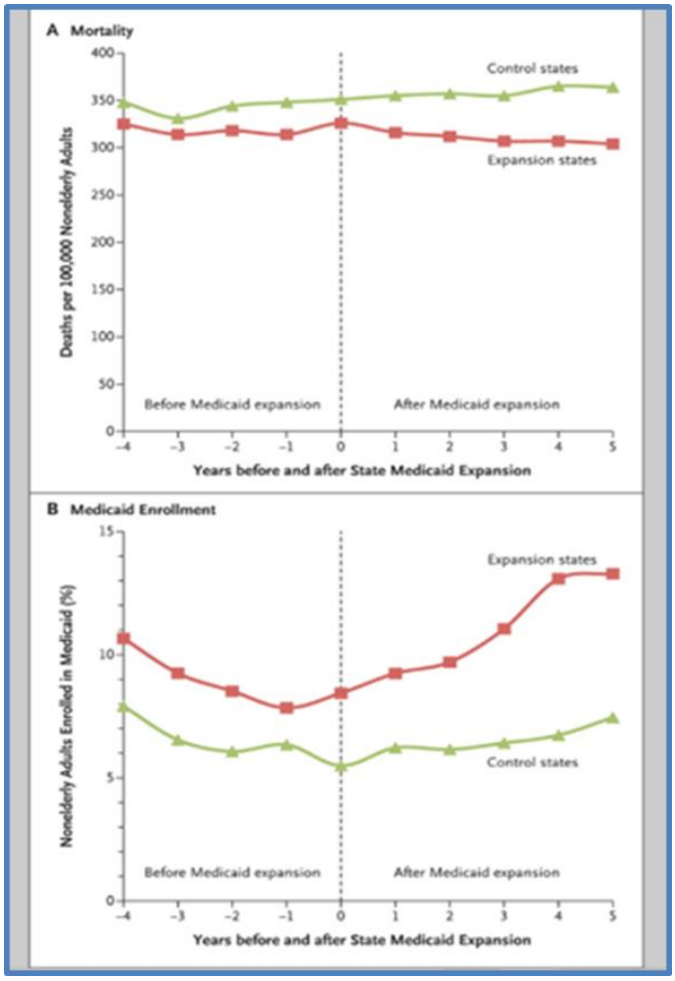


Figure 1: The Cost of and Access to Healthcare