This week's Outside the Box is guaranteed to upset you. It is about Medicare fraud. Warning: it was written by a very conservative analyst and is "pro" the Ryan plan. I want you to read it not because I am trying to get you to support the Ryan plan but to get a handle on the size of Medicare and Medicaid fraud and just how easy it is to perpetrate.

There may well be better ways than the Ryan plan as advocated here, but something must be done. Want to cut spending by $1 trillion in ten years? Eliminate the fraud. If American Express can hold fraud to 0.3%, maybe we should outsource our Medicare fraud detection to them. I say that only slightly tongue in cheek.

This outraged me. I knew it was bad, but I had no idea… The piece is short, but it will strike a nerve, I bet. The link to the original is http://www.nationalreview.com/articles/271006/entitlement-bandits-michael-f-cannon?page=1.

Tomorrow morning I leave for New York and then on to Maine with my youngest son, Trey, for a few days of fishing, wine, and friends; and then I'm back for a night and off the next day to a consulting gig in Calgary. In and out and then home for a few weeks (I hope).

John Mauldin, Editor

Outside the Box

Entitlement Bandits

By Michael F. Cannon
Adapted from the July 4, 2011, issue of *National Review.*

The budget blueprint crafted by Paul Ryan, passed by the House of Representatives, and voted down by the Senate would essentially give Medicare enrollees a voucher to purchase private coverage, and would change the federal government's contribution to each state's Medicaid program from an unlimited "matching" grant to a fixed "block" grant. These reforms deserve to come back from defeat, because the only alternatives for saving Medicare or Medicaid would either dramatically raise tax rates or have the government ration care to the elderly and disabled. What may be less widely appreciated, however, is that the Ryan proposal is our only hope of reducing the crushing levels of fraud in Medicare and Medicaid.

The three most salient characteristics of Medicare and Medicaid fraud are: It's brazen, it's ubiquitous, and it's other people's money, so nobody cares.

Consider some of the fraud schemes discovered in recent years. In Brooklyn, a dentist billed taxpayers for nearly 1,000 procedures in a single day. A Houston doctor with a criminal record took her Medicare billings from zero to $11.6 million in one year; federal agents shut down her clinic but did not charge her with a crime. A high-school dropout, armed with only a laptop computer, submitted more than 140,000 bogus Medicare claims, collecting $105 million. A health plan settled a Medicaid-fraud case in Florida for $138 million. The giant hospital chain

Columbia/HCA paid $1.7 billion in fines and pled guilty to more than a dozen felonies related to bribing doctors to help it tap Medicare funds and exaggerating the amount of care delivered to Medicare patients. In New York, Medicaid spending on the human-growth hormone Serostim leapt from $7 million to $50 million in 2001; but it turned out that drug traffickers were getting the drug prescribed as a treatment for AIDS wasting syndrome, then selling it to bodybuilders. And a study of ten states uncovered $27 million in Medicare payments to dead patients.

These anecdotes barely scratch the surface. Judging by official estimates, Medicare and Medicaid lose at least $87 billion per year to fraudulent and otherwise improper payments, and about 10.5 percent of Medicare spending and 8.4 percent of Medicaid spending was improper in 2009. Fraud experts say the official numbers are too low. "Loss rates due to fraud and abuse could be 10 percent, or 20 percent, or even 30 percent in some segments," explained Malcolm Sparrow, a mathematician, Harvard professor, and former police inspector, in congressional testimony. "The overpayment-rate studies the government has relied on . . . have been sadly lacking in rigor, and have therefore produced comfortingly low and quite misleading estimates." In 2005, the *New York Times* reported that "James Mehmet, who retired in 2001 as chief state investigator of Medicaid fraud and abuse in New York City, said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal." And even these experts ignore other, perfectly legal ways of exploiting Medicare and Medicaid, such as when a senior hides and otherwise adjusts his finances so as to appear eligible for Medicaid, or when a state abuses the fact that the federal government matches state Medicaid outlays.

Government watchdogs are well aware of the problem. Every year since 1990, the U.S. Government Accountability Office has released a list of federal programs it considers at a high risk for fraud. Medicare appeared on the very first list and has remained there for 22 straight years. Medicaid assumed its perch eight years ago.

How can there possibly be so much fraud in Medicare and Medicaid that even the "comfortingly low" estimates have ten zeros? How can this much fraud persist decade after decade? How can it be that no one has even tried to measure the problem accurately, much less take it seriously? The answers are in the nature of the beast. Medicare and Medicaid, the two great pillars of Pres. Lyndon Johnson's "Great Society" agenda, are monuments to the left-wing ideals of coerced charity and centralized economic planning. The staggering levels of fraud in these programs can be explained by the fact that the politicians, bureaucrats, patients, and health-care providers who administer and participate in them are spending other people's money — and nobody spends other people's money as carefully as he spends his own. What's more, Medicare and Medicaid are spending other people's money in vast quantities. Medicare, for example, is the largest purchaser of medical goods and services in the world. It will spend $572 billion in 2011. Each year, it pays 1.2 billion claims to 1.2 million health-care providers on behalf of 47 million enrollees.

For providers, Medicare is like an ATM: So long as they punch in the right numbers, out comes the cash. To get an idea of the potential for fraud, imagine 1.2 million providers punching 1,000 codes each into their own personal ATMs. Now imagine trying to monitor all those ATMs.

For example, if a medical-equipment supplier punches in a code for a power wheelchair, how can the government be sure the company didn't actually provide a manual wheelchair and pocket the difference? About $400 million of the aforementioned fines paid by Columbia/HCA hospitals were for a similar practice, known as "upcoding."

And how does the government know that providers are withdrawing no more than the law allows? Medicaid sets the prices it pays for prescription drugs based on the "average wholesale price." But as the Congressional Budget Office has explained, the average wholesale price "is based on information provided by the manufacturers. Like the sticker price on a car, it is a price that few purchasers actually pay." Pharmaceutical companies often inflate the average wholesale price so they can charge Medicaid more. Teva Pharmaceuticals recently paid $27 million to settle allegations that it had overcharged Florida's Medicaid program by inflating its average wholesale prices, and the Department of Justice has accused Wyeth of doing the same. Merck recently settled a similar case.

Most ominously, how does the government know that people punching numbers into the ATMs are health-care providers at all? In his testimony, Malcolm Sparrow explained how a hypothetical criminal can make a quick million: "In order to bill Medicare, Billy doesn't need to see any patients. He only needs a computer, some billing software to help match diagnoses to procedures, and some lists. He buys on the black market lists of Medicare or Medicaid patient IDs." With this information in hand, Billy strides right up to the ATM, or several at a time, and starts punching in numbers. "The rule for criminals is simple: If you want to steal from Medicare, or Medicaid, or any other health-care-insurance program, learn to bill your lies correctly. Then, for the most part, your claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all." These schemes are sophisticated, so Billy might hire people within Medicare and at his bank to help him avoid detection.
Last year, the feds indicted 44 members of an Armenian crime syndicate for operating a sprawling Medicare-fraud scheme. The syndicate had set up 118 phony clinics and billed Medicare for $35 million. They transferred at least some of their booty overseas. Who knows what LBJ's Great Society is funding?

And there are other forms of fraud. An entire cottage industry of elder-law attorneys has emerged, for instance, to help well-to-do seniors appear poor on paper so that Medicaid will pay their nursing-home bills. Medicaid even encourages the elderly to get sham divorces for the same reason. It's all perfectly legal. It's still fraud.

Medicaid's matching-grant system also invites fraud. When a high-income state such as New York spends an additional dollar on its Medicaid program, it receives a matching dollar from the federal government — that is, from taxpayers in other states. Low-income states can receive as much as $3 for every additional dollar they devote to Medicaid, and without limit. If they're clever, states can get this money without putting any of their own on the line. In a "provider tax" scam, a state passes a law to increase Medicaid payments to hospitals, which triggers matching money from the federal government. Yet in the very same law, the state increases taxes on hospitals. If the tax recoups the state's original outlay, the state has obtained new federal Medicaid funds at no cost. If the tax recoups more than the original outlay, the state can use federal Medicaid dollars to pay for bridges to nowhere. As Vermont began preparations for its

Obamacare-sanctioned single-payer system this year, it used a provider-tax scam to bilk taxpayers in other states out of $5.2 million. In his book *Stop Paying the Crooks*, consultant Jim Frogue chronicles more than half a dozen ways that states game Medicaid's matching-grant system to defraud the federal government.

Since 1986, the GAO has published at least 158 reports about Medicare and Medicaid fraud, and there have been similar reports by the HHS inspector general and other government agencies. In 1993, Attorney General Janet Reno declared health-care fraud America's No. 2 crime problem, after violent crime. Since then, Congress has enacted 194 pages of statutes to combat fraud in these programs, and countless pages of regulations.

Yet federal and state anti-fraud efforts remain uniformly lame. Medicare does almost nothing to detect or fight fraud until the fraudulent payments are already out the door, a strategy experts deride as "pay and chase." Even then, Medicare reviews fewer than 5 percent of all claims filed. Congress doesn't integrate Medicare's myriad databases, which might help prevent fraud, nor does it regularly review the efficacy of most of the anti-fraud spending it authorizes. Many of the abuses noted above, such as those of the Brooklyn dentist, were discovered not by the government but by curious reporters poking through Medicaid records. The amateurs at the *New York Times* found "numerous indications of [Medicaid] fraud and abuse that the state had never looked into," but "only a thin, overburdened security force standing between [New York's] enormous program and the unending attempts to steal from it.

The federal government's approach to fraud is sometimes so inept as to be counterproductive. Sparrow testified that a defect in the strategy of Billy, our hypothetical criminal, is that he doesn't know which providers and patients on his stolen lists are "dead, deported, or incarcerated." But Medicare's anti-fraud protocols help him solve this problem. When Medicare catches those claims, it sends Billy a notice that they have been rejected. "From Billy's viewpoint," Sparrow explained, "life could not be better. Medicare helps him 'scrub' his lists, making his fake billing scam more robust and less detectable over time; and meanwhile Medicare pays all his other claims without blinking an eye or becoming the least bit suspicious."

Efforts to prevent fraud typically fail because they impose costs on legitimate beneficiaries and providers, who, as voters and campaign donors respectively, have immense sway over politicians. At a recent congressional hearing, the Department of Health and Human Services' deputy inspector general, Gerald T. Roy, recommended that Congress beef up efforts to prevent illegitimate providers and suppliers from enrolling in Medicare. But even if Congress took Roy's advice, it would rescind the new requirements in a heartbeat when legitimate doctors — who are already threatening to leave Medicare over its low payment rates — threatened to bolt because of the additional administrative costs (paperwork, site visits, etc.).

Politicians routinely subvert anti-fraud measures to protect their constituents. When the federal government began poking around a Buffalo school district that billed Medicaid for speech therapy for 4,434 kids, the *New York Times* reported, "the Justice Department suspended its civil inquiry after complaints from Senator Charles E. Schumer, Democrat of New York, and other politicians." Medicare officials, no doubt expressing a sentiment shared by members of

Congress, admit they avoid aggressive anti-fraud measures that might reduce access to treatment for seniors.

It's not just the politicians. The Legal Aid Society is pushing back against a federal lawsuit charging that New York City overbilled Medicaid. Even conservatives fight anti-fraud measures, albeit in the name of preventing frivolous litigation, when they oppose expanding whistle-blower lawsuits, where private citizens who help the government win a case get to keep some of the penalty.

Sparrow argued that when Medicare receives "obviously implausible claims," such as from a dead doctor, "the system should bite back. . . . A proper fraud response would do whatever was necessary to rip open and expose the business practices that produce such fictitious claims. Relevant methods include surveillance, arrest, or dawn raids." Also: "All other claims from the same source should immediately be put on hold."

Some of the implausible claims will be honest mistakes, such as when a clerk mistakenly punches the wrong patient number into the ATM. And sometimes the SWAT team will get the address wrong, or will take action that looks like overkill, as when the Department of Education raided a California home because it suspected one of the occupants of financial-aid fraud. How many times would federal agents have to march a handcuffed doctor past a stunned waiting room full of Medicare enrollees before Congress prohibited those measures?

"It seems extraordinary," Sparrow said, that the HHS Office of Inspector General recommends "weak and inadequate response[s] . . . to false claims and fake billings" and that Medicare "fail[s] . . . to properly distinguish between the imperatives of process management and the imperatives of crime control." Extraordinary? How could it be any other way? Anti-fraud efforts will always be inadequate when politicians spend other people's money. Apologists for Medicare and Medicaid will retort that fraud against private health plans is prevalent as well, but this only drives home the point: Since employers purchase health insurance for 90 percent of insured non-elderly Americans, workers care less about health-care fraud, and have a lower tolerance for anti-fraud measures, than they would if they paid the fraud-laden premiums themselves.

The fact that Medicare and Medicaid spend other people's money is why the number of fraud investigators in New York's Medicaid program can fall by 50 percent even as spending on the program more than triples. That is why, as Sparrow explained in an interview with The Nation, "The stories are legion of people getting a Medicare explanation of benefits statement saying, 'We've paid for this operation you had in Colorado,' when those people have never been in Colorado. And when you complain [to Medicare] about it, nobody seems to care." The Ryan plan offers the only serious hope of reducing fraud in Medicare and Medicaid. Its Medicare reforms, especially if they were expanded later, would make it easier for the federal government to police the program, and its Medicaid reforms would increase each state's incentive to curb fraud.

To see how the Ryan plan would reduce Medicare fraud, imagine that the proposal really were what its critics claim it is: a full-blown voucher program, with each enrollee receiving a chunk of

cash to spend on medical care, apply toward health-insurance premiums, or save for the future. Instead of processing 1.2 billion claims, Medicare would hand out just 50 million vouchers, with sick and low-income enrollees receiving larger ones. The number of transactions Medicare would have to monitor each year would fall by more than 1 billion.

Social Security offers reason to believe that a program engaging in fewer (and more uniform) transactions could dramatically reduce fraud and other improper payments. As a Medicare-voucher program would, Social Security adjusts the checks it sends to enrollees according to such variables as lifetime earnings and disability status. The Social Security Administration estimates that overpayments account for just 0.37 percent of Social Security spending. Overpayments are higher in the Supplemental Security Income (SSI) program (8.4 percent), a much smaller, means-tested program also administered by the Social Security Administration. But total overpayments across both programs still come to less than 1 percent of outlays.

In reality, the Ryan "voucher" is much closer to the current Medicare Advantage program, through which one in four Medicare enrollees selects a private health plan and the government makes risk-adjusted payments directly to insurers. Skeptics will rightly note that, judging by the official improper-payment rates, Medicare Advantage (14.1 percent) is in the same ballpark as traditional Medicare (10.5 percent). Therefore, the Ryan plan should be seen not as a solution to Medicare fraud in itself, but as a step toward a vastly simplified, Social Security–like program in which the task of policing fraud is less daunting.

The Ryan plan would also vastly increase the states' incentive to curb Medicaid fraud. Just as a state that increases funding for Medicaid gets matching federal funds, a state that reduces Medicaid fraud gets to keep only (at most) half of the money saved. As much as 75 percent of recovered funds revert back to the federal government. In a report for the left-wing Center for American Progress, former Obama adviser Marsha Simon noted that "states are required to repay the federal share . . . of any payment errors identified, even if the money is never collected." The fact that Albany splits New York's 50 percent share of the spending with municipal governments may explain why the Empire State is such a hot spot for fraud: No level of government is responsible for a large enough share of the cost to do anything about it. The result is that states' fraud-prevention efforts are only a tiny fraction of what Washington spends to fight Medicare fraud.

Ryan would replace Medicaid's federal matching grants with a system of block grants. Under a block-grant system, states would keep 100 percent of the money they saved by eliminating fraud. In many states, the incentive to prevent fraud would quadruple or more. Block grants performed beautifully when Congress used them to reform welfare in 1996. They can do so again.

The Ryan plan would not reduce Medicare and Medicaid fraud to tolerable levels, but neither would any plan that retains a role for government in providing medical care to the elderly and disabled. What the Ryan plan would do is reduce how much the fraudsters — many of whom sport congressional lapel pins — fleece the American taxpayer. And that is no small thing.

— Michael F. Cannon is director of health-policy studies at the Cato Institute and co-author of *Healthy Competition: What's Holding Back Health Care and How to Free It.* This article is adapted from the one that appeared in the July 4, 2011, issue of *National Review.*