

HEALTH CARE FRAUD AND ABUSE: A TALE OF BEHAVIOR INDUCED BY PAYMENT STRUCTURE

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ABSTRACT

The campaign to curtail “fraud and abuse” in the Medicare and Medicaid programs represents an attempt by regulators to evade more fundamental and difficult questions regarding cost and quality control. In the Medicare arena, tackling these larger questions will require dismantling the program’s fee-for-service structure and imposing on providers financial incentives to evaluate carefully health care costs and benefits.

IN his thorough and insightful paper,¹ David Hyman undertakes an examination of the existing federal system for fraud control in the Medicare and Medicaid programs. After offering an overview of current laws that govern fraud control, he discusses how well these laws fit with the economics of the medical marketplace and with the social norms of the various players in this marketplace. In these comments, I address what I take to be the major points of Hyman’s paper. Although I concur with many of these points, I believe that Hyman fails to focus sufficiently on structural features in the Medicare program that actually encourage undesirable billing practices. As a consequence, Hyman undersells one of the conclusions to be drawn from the fact (noted by Hyman himself) that much of what the government pursues under the rubric of fraud appears to fall short of intentionally deceitful behavior.² This conclusion is that federal regulators have used politically appealing health care fraud strategies to attempt cost and quality control simply because the government lacks effective mechanisms for addressing these problems directly. In addition, Hyman is, to my mind, overly pessimistic in his view that private-sector cost control techniques are unlikely to prove effective at changing physician norms that militate in favor of providing all care that has any marginal benefit. To the contrary, so long as such techniques

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¹ David A. Hyman, *Health Care Fraud and Abuse: Market Change, Social Norms, and the Trust “Reposed in the Workmen,”* in this issue, at 531.

² As Hyman points out, given the wide spectrum of conduct to which the terminology of fraud and abuse is applied, little normative weight should be attached to its use. *Id.* at 532 n.2.

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can actually be implemented,³ private-sector techniques that place the onus of financial overruns on physicians are quite likely to change their behavior. I conclude my comments by examining how the government, should it choose to maintain the current system of incentives that operates in Medicare, might address that relatively small amount of residual behavior that is true fraud.

I. PROBLEMS WITH THE MEDICARE FEE-FOR-SERVICE STRUCTURE

As Hyman notes, allegations of fraud often involve situations in which the normative weight to be attached to the action in question is unclear. He fails to emphasize, however, that in the Medicare arena, the very structure of the program encourages a spectrum of questionable and cost-increasing, but not necessarily deceitful, practices. Because Medicare (unlike virtually all other forms of health care delivery) remains largely a fee-for-service system that pays per unit of health service provided,⁴ providers have an incentive to maximize these units of service.⁵ Providers may, for example, increase service volume simply by unbundling the services for which they file claims.⁶ In addition, they are likely to find a medical need for providing a service in situations where federal regulators may subsequently find no such medical need. Because “medical necessity,” the concept that triggers Medicare coverage,⁷ is notoriously slippery in its contours,⁸ both the regulators and the providers may have a plausible argument. The regulator may believe that the level of benefit achieved for a given cost is insufficient to classify the service as medically necessary, while the provider may believe otherwise.

³ As discussed further below, see text at note 14 *infra*, various features of contract and tort law may thwart attempts to implement cost-conscious health care delivery.

⁴ Currently, almost 85 percent of Medicare beneficiaries are in fee-for-service Medicare. That percentage is likely to remain high for the foreseeable future, given the current trend toward health plan withdrawal from the managed care component of Medicare. See Medicare and Medicaid HMO Enrollment Growth Has Slowed Significantly in the Past Year, Managed Medicare & Medicaid, November 20, 2000, available at 2000 WL 9420045.

⁵ See Timothy Stoltzfus Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash against Fraud and Abuse Enforcement*, 51 Ala. L. Rev. 239, 250 (1999) (noting that Medicare is still fundamentally a fee-for-service system that pays providers for “delivering distinct units of health care services.”).

⁶ *Id.* at 252.

⁷ Medicare covers the cost of services deemed “reasonable and necessary for the prevention of illness.” 42 U.S.C. § 1395y(a)(1)(B).

⁸ Through the 1980s and early 1990s, many courts found that the term “medical necessity” could not be used even to exclude experimental treatments of questionable efficacy. See Mark A. Hall & Gerard F. Anderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. Pa. L. Rev. 1637, 1647–57 (1992). More recently, some private insurers appear to have applied the term in a manner that includes considerations of cost-effectiveness. See Sara J. Singer & Linda A. Bergthold, *Prospects for Improved Decision Making about Medical Necessity*, *Health Aff.*, January–February 2001, at 202. It is unclear, however, how these plans implement cost-benefit trade-offs; indeed, many of the plans do not mention cost-effectiveness criteria in the materials they provide enrollees.

In addition to providing incentives for increased service volume, the Medicare system provides incentives for increased service intensity. Because the amount of Medicare payment is proportional to the complexity of the service provided, providers have incentives to provide more complex, and thus more remunerative, services. Regulators may subsequently determine that these complex services are not medically necessary. Furthermore, where a service could, at least arguably, fall on the line between a more remunerative billing code—known in the Medicare regime as a “diagnostic related group,” or “DRG”—and a less remunerative DRG, the provider is likely to bill for the more remunerative DRG.

Toward the end of his paper, Hyman analogizes the regulatory challenge of identifying fraud in the Medicare and Medicaid programs to that faced by the U.S. Customs Service in finding contraband smugglers among the hundreds of millions of individuals who cross U.S. borders each year. In both cases, the number of transactions that must be monitored is large, and only a small percentage of these transactions involve intentional deceit. In the context of the Medicare program, however, the analogy actually understates the problem. While the determination of whether a service is medically necessary is often a judgment call subject to second-guessing by regulators *ex post*, the determination of an imported good’s contraband status is, under the applicable law and regulations, relatively straightforward. Moreover, in contrast to the Medicare regime, customs law does not itself encourage questionable behavior.⁹ A more precise analogy would be to a program in which the government paid individuals for each item that they brought across the border. Although some of these items would be forbidden by a vague law that prevented the import of items that were (for example) “contrary to the public interest,” this prohibition would be defined with precision only after the fact, in some small percentage of cases in which it was enforced. When it was enforced, however, the punishment would be draconian. The predictable effect of such a program would be similar to what has happened in the context of Medicare—risk seekers would test the limits of a vague law, and those who were risk averse might be chilled from engaging in desirable behavior. Moreover, because most of those regulated by the program would find its application arbitrary and capricious, the program would foster resentment and distrust.

II. USING FRAUD LAW TO PURSUE COST AND QUALITY GOALS

The primary goal of any health care delivery program is to provide low-cost, high-quality care. Fee-for-service programs such as Medicare perform poorly with respect to cost and not particularly well with respect to quality. Because Hyman does not focus on Medicare’s fee-for-service structure, he

⁹ To be sure, contraband smugglers are rewarded for their efforts in the marketplace.

does not squarely ask why regulators are focusing on fraud rather than Medicare's more fundamental structural problem. Hyman does hint at both the question and the answer by noting that "eliminating 'waste, fraud, and abuse' in governmental programs is a subject on which there is universal agreement. Politicians denounce them, newspapers editorialize against them, and no interest group argues in their favor."¹⁰ But he does not take the next step of saying that the shibboleth of fraud and abuse was introduced in the political arena largely because more direct efforts at cost control, such as enrolling all seniors in some form of managed care, were seen as politically untenable. In contrast with its view of managed care, the public views fraud enforcement efforts in an extremely positive light. In fact, public opinion surveys suggest that overwhelming majorities of people think that the Medicare cost problem could be solved by vigorous policing of fraud.¹¹ Once an aggressive fraud control regime was in place, it was only natural that fraud regulators would attempt to expand their jurisdiction beyond cost control, to the important question of health care quality. Such jurisdiction expansion was particularly easy given the current regulatory vacuum on quality issues, at least at the federal level.¹² Thus we see the various ill-conceived attempts, described so well by Hyman, to regulate quality through the lens of fraud.

By contrast, the private sector has taken a somewhat different approach to cost control. Managed care organizations often have fairly elaborate utilization review mechanisms to deny coverage for care either prospectively, concurrently, or retroactively. Although this ongoing utilization review may appear to be a more expensive form of deterrence than imposing high sanctions *ex post* in a small, arbitrarily selected, number of cases, it may ultimately prove less expensive. After all, the arbitrary sanctions-based approach has very costly collateral consequences in terms of fostering resentment and distrust in the regulated population.

Unfortunately, the survey evidence marshalled by Hyman indicates that, even in the private sector, so long as cost containment is implemented through administrative rules, physicians may attempt to game the system so as to evade cost control measures.¹³ Thus it should come as no surprise that private managed care organizations have had their own difficulties in controlling health care cost escalation. In order to control such escalation, insurance companies must make cost-benefit trade-offs with respect to technology. Just

¹⁰ Hyman, *supra* note 1, at 533.

¹¹ Jill Bernstein & Rosemary Stevens, *Public Opinion, Knowledge, and Medicare Reform*, 18 *Health Aff.*, January–February 1999, at 185 (summarizing surveys in which 87 percent of respondents said that eliminating waste, fraud, and abuse would eliminate Medicare's funding problems).

¹² For the most part, health care quality is regulated through the imperfect mechanisms of state tort law.

¹³ Hyman, *supra* note 1, at 541–43.

as various principles of our contract and tort law make it difficult for insurers to make such trade-offs,¹⁴ so too does gaming.

So if fraud control efforts by the government are an unfortunate response to Medicare's fee-for-service structure, and private-sector approaches that rely on administrative rules also have limitations, is there any method that will be effective? Hyman's paper stops short of addressing this issue, although he does suggest that physician norms that interpret fidelity to the patient as requiring no consideration of cost are going to be very difficult to change.

III. CHANGING PHYSICIAN BEHAVIOR: THE ROLE OF FINANCIAL INCENTIVES

With respect to the possibility of changing physician behavior, I am not as pessimistic as Hyman. Although physician norms are no doubt quite robust, there is reason to believe that physician behavior is not impervious to change. First of all, the major study of actual physician behavior cited by Hyman, an analysis by Matthew Wynia and colleagues recently published in the *Journal of the American Medical Association*,¹⁵ indicates that gaming is practiced by a minority of physicians. Only 39 percent of physicians in the anonymous survey reported using even one deceptive tactic (for example, exaggerating the severity of illness or changing the billing diagnosis) in order to secure for patients coverage that the physicians perceived as necessary. Thus when the professional norm of fidelity comes into conflict with more general norms of truthfulness, many physicians defer to the norm of truthfulness. Moreover, there does not appear to be an affirmative norm in favor of gaming. Rather, gaming may be accepted if it is necessary to implement the fidelity norm. Finally, although the Wynia survey included physicians who worked under some level of financial incentive to practice conservatively and found that these physicians were as likely to engage in gaming as anyone else,¹⁶ the survey did not ask whether the specific gaming practices in which those physicians engaged directly affected their annual income. Direct financial incentives not to engage in gaming behavior should reduce such behavior dramatically. Because gaming is practiced reluctantly in the first instance, the "demand curve" for such behavior is likely to be quite elastic.

Admittedly, the demand curve for cost-increasing behavior that does not

¹⁴ For discussions of how contract law makes it difficult for insurance companies to restrict coverage on the basis of cost-benefit trade-offs, see, for example, Clark Havighurst, *Health Care Choices* 21–22 (1995); Arti K. Rai, *Rationing through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 *Ind. L. J.* 1015, 1046–47 (1997). For discussions of how the unitary standard of care complicates efforts to deliver health care in a cost-conscious manner, see, for example, Patricia M. Danzon, *Tort Liability: A Minefield for Managed Care?* 26 *J. Legal Stud.* 491 (1997); Rai, *supra*, at 1047.

¹⁵ Matthew K. Wynia *et al.*, *Physician Manipulation of Reimbursement Rules for Patients: Between a Rock and a Hard Place*, 283 *JAMA* 1858 (2000).

¹⁶ *Id.* at 1863.

require deception, and hence is governed more squarely by the traditional fidelity norm, may be less elastic. Financial incentives can do more, however, than shift individuals from one point to another on the demand curve for a particular behavior. They can also, at least in the long term, change the slope of the demand curve. In other words, financial incentives can slowly lead to norm change. As an example of norm change through financial incentives in a field related to health care, consider the changes that have occurred in the last 20 years in academic biomedical research. Prior to 1980, university researchers competed with each other in the traditional currency of academia—publications, citations, and prizes. They did not compete via patents.¹⁷ In 1980, Congress determined that although this no-patenting norm may have been efficient from the standpoint of the university research community, it imposed negative externalities on the economy as the whole. If research was not patented, private companies would not invest in the development necessary to translate the research into a commercial product.¹⁸ In passing technology transfer legislation that sought to encourage patenting of publicly funded research, Congress was attentive to the idea that norm change might require financial incentives. Thus Congress made certain that efforts to seek patents would be in the financial self-interest of universities and of individual researchers.¹⁹ Among scientists, the initial reaction to this legislative change was dismay; there was no immediate rush to patent discoveries. By contrast, widespread patenting is now an accepted part of academic science.²⁰ Similarly, because of the pervasiveness of physician financial incentives in the marketplace, we may be seeing some preliminary evidence of norm change. Although physician codes of ethics (which codify, and reflect, more informal norms) generally stop short of explicitly encouraging physicians to allocate resources across patients, some ethics codes do note that cost is a consideration that physicians should take into account.²¹

In addition, from the standpoint of institutional accuracy, financial incentives that encourage physicians to incorporate cost considerations have greater promise than does administrative review. Administrative review removes decision-making authority from the party that is likely to know best how to make cost-benefit trade-offs given the complexities of a particular case—the treating physician. I am hardly the first analyst to make this point. Mark Hall's thorough comparative institutional study of cost control mechanisms

¹⁷ See Arti K. Rai, *Regulating Scientific Research: Intellectual Property Rights and the Norms of Science*, 94 *Nw. L. Rev.* 77, 92–94 (1999).

¹⁸ *Id.* at 95–96.

¹⁹ *Id.* at 98.

²⁰ *Id.* at 109.

²¹ See Gail B. Agrawal, *Resuscitating Professionalism: Self Regulation in the Medical Marketplace*, 66 *Mo. L. Rev.* 341 (2001).

in health care favors financial incentives over administrative review.²² Administrative mechanisms of cost control may also push physicians into quasi-lawyerly advocacy roles for which they are ill suited.²³

Of course, reliance on financial incentives to change physician behavior may have untoward effects in terms of the quality of care provided. In areas of treatment that are irreducibly resource intensive, quality is positively correlated with cost. As expenditures go down, so too does quality. With respect to quality, however, the relative “stickiness” of norms is likely to have some positive effects. Norms may constrain the extent to which physicians are willing to practice below a certain minimum level of resource use. More generally, norms may help to ensure that when decisions not to provide particular services are made, they are made in cases where the marginal benefits of those services are relatively small. The ultimate goal with respect to norm change in health care should be not to eliminate traditional norms of fidelity to the patient but, rather, to infuse them with a concern for cost.²⁴

IV. SHORT-TERM REFORM

The ideal response, then, to concerns about fraud that are at bottom concerns about cost control would be to shift both Medicare and Medicaid to a managed care structure that relied on physician financial incentives. Because Medicare is likely to remain a fee-for-service system for the foreseeable future, however, we need to contemplate second-best responses. In a world where fee-for-service Medicare dominates, what role should we assign to fraud prosecution? The answer to that question is not altogether clear. However, because fraud prosecution is a very blunt—and even destructive—tool for addressing cost and quality concerns, prosecutions should probably be limited to intentional deceitful behavior (for example, situations in which institutions bill for services that were never provided).

One mechanism for limiting prosecution to raw fraud would be to alter the behavior of fraud control personnel (and, to a lesser extent, of program supervisors). How this behavior might be altered depends, at least to some extent, on an interesting theoretical question raised by Hyman’s paper. This is the question of precisely what type of behavior can constitute a norm. Hyman characterizes as “norm” behavior the attitudes not only of physicians²⁵

²² See generally Mark A. Hall, *Making Medical Spending Decisions* (1997). This does not mean that direct financial incentives need be the only mechanism available. To the extent that a plan based on administrative review is financially viable, a patient who is uncomfortable with having her physician operate under such incentives should have the option of a plan based on administrative review. See generally Rai, *supra* note 14, at 1035–38 (discussing giving patients choices between plans based on administrative review and plans based on financial incentives).

²³ See William M. Sage, *Physicians as Advocates*, 35 *Hous. L. Rev.* 1529 (1999).

²⁴ See generally Agrawal, *supra* note 21.

²⁵ Hyman, *supra* note 1, at 541–44.

but also of program supervisors (for example, Health Care Finance Administration supervisors),²⁶ of fraud regulators (for example, the Office of the Inspector General and the Department of Justice),²⁷ and even of the public.²⁸ It is worth asking how much of this behavior can be distinguished from ordinary, financially self-interested behavior. To the extent that it cannot, it is not clear whether this behavior truly constitutes a norm in the prescriptive sense of the word—that is, behavior in which actors think they “should” engage, as contrasted with behavior in which they do engage.²⁹ Moreover, as a practical matter, ordinary self-interested behavior can probably be changed more readily than prescriptive norm behavior. Indeed, the former type of behavior could presumably be changed very quickly and decisively by changing the relevant financial incentive structure.

With respect to physician behavior, a prescriptive norm probably does exist. By contrast, public approval of physician behavior that seeks to evade coverage limitations appears to represent strictly financially self-interested behavior—that is, consumers want to receive services whether or not they have paid an insurance premium sufficient to justify receipt of those services. The behavior of federal regulators may fall somewhere in the middle. Fraud control personnel obviously have a career interest, and hence something of a financial interest, in bringing fraud cases, particularly if the fraud cases are likely to result in large verdicts or settlements. Program administrators, by contrast, have a career/financial interest in having the programs that they supervise run smoothly and may thus be reluctant to question provider submissions. The extent to which the interests of fraud regulators and program administrators have become internalized such that they feel they “should” act in particular ways (and would act in those ways even where the behavior entailed some financial cost) is not clear. However, to the extent that these interests have not been internalized psychologically and are simply a reflection of ordinary self-interest, changing the structure of career and financial rewards might change behavior very quickly. For example, if the ease with which fraud prosecutions could be brought, or the size of the associated verdicts or settlements, were diminished, the eagerness of fraud control personnel to bring fraud cases would probably diminish. On a related note, if program supervisors were given financial incentives to engage in routine review of claims, they would probably be less eager to accommodate blindly the interests of providers. By changing the incentives of fraud prosecutors

²⁶ *Id.* at 544–45.

²⁷ *Id.* at 545–46.

²⁸ *Id.* at 546–47.

²⁹ See, for example, Robert D. Cooter, *Decentralized Law for a Complex Economy: The Structural Approach to Adjudicating the New Law Merchant*, 144 U. Pa. L. Rev. 1643, 1656–67 (1996) (arguing that a norm is not simply observed behavior but, rather, behavior in which people engage out of a sense of obligation).

and program administrators, we may thus be able to move to a regime that relies less on fraud prosecution and more on the ordinary review of claims.

V. CONCLUSION

In sum, Hyman has authored a masterly discussion of our health care fraud control regime. Although I have some objections to his views on norms, my principal objection is that he does not explicitly state the conclusion to which his paper leads—that health care fraud control is largely a catchphrase that is being used to divert attention from the much more difficult task of allocating health care resources in a manner that is sensitive to both cost and quality.

