uninsured often receive health care—some of which they pay for out of pocket, and some of which is provided without compensation. (Hence the complaints about our “free rider” dilemma, which has been overblown.) Relying on the 2005 Medical Expenditure Panel Survey, the O’Neills examined selected medical services (including routine checkups, Pap smears, PSA tests, mammograms, and more) received by nonelderly adults (aged 18 to 64). They established that “the uninsured receive about 50 to 60 percent of the amount of services received by those who are insured.”

But what about Americans’ relatively low life expectancy at birth? Surely that reflects profound flaws in the U.S. health-care model? On closer inspection, no. In a recent blog post, my NR colleague Jonah Goldberg cited the work of health economists Robert Ohsfeldt of Texas A&M and John Schneider of Oxford Outcomes (a consultancy). In their 2006 book, The Business of Health, Ohsfeldt and Schneider demonstrate that America’s adult population was clinically obese; meanwhile, the obesity rates in the U.K., France, and Japan were 23 percent, 9.4 percent, and 3.2 percent, respectively. One need not endorse nanny-state solutions to acknowledge that the U.S. has a weight problem. Obamacare won’t solve it.

Here’s another reason we should not expect the landmark bill to yield major health gains: A hefty chunk of the newly insured under Obamacare—anywhere from 15 million to 18 million people, according to projections—will rely primarily on Medicaid for their insurance. Unfortunately, the fact that Medicaid reimburses participating providers at low rates has made it increasingly difficult for recipients to find doctors. In a 2008 survey, only 40.2 percent of physicians told the Center for Studying Health System Change that they were accepting all new Medicaid patients, and more than a quarter (28.2 percent) said they weren’t taking any. It can be even harder for Medicaid patients to locate dentists.

And yet this is the program that will soon be flooded with a massive wave of new enrollees. Dr. Edward Miller, dean and CEO of Johns Hopkins Medicine, has written that “without an understanding by policy makers of what a large Medicaid expansion actually means, and without delivery-system reform and adequate risk-adjusted reimbursement,” Obamacare “will have catastrophic effects on those of us who provide society’s health-care safety-net.”

If the overarching goal of health-care reform were to improve health outcomes, we would not be steering millions of Americans into a program that has consistently shortchanged both patients and providers.

Oklahoma senator and medical doctor Tom Coburn often tells the story of Guillermo Denis Gonzalez, a convicted killer who, while out of prison between murders, posed as a supplier of medical products and submitted more than half a million dollars in false Medicare claims. But Gonzalez was just one of the thousands who bilk taxpayers for billions of dollars annually.

While statistics on fraud are somewhat hard to come by, the available numbers are truly frightening. A 2009 Government Accountability Office study found that 10.5 percent of Medicare payments in fiscal year 2008 were improper. And a Thompson Reuters study in October of 2009 found there to be somewhere between $600 and $850 billion annually in health-care waste, which includes fraud but also inefficiency and medical errors. Nationwide estimates of fraud alone tend to place it in the $60–100 billion range.

Part of the reason for all of this waste is the way the government processes payments. It is under pressure to pay bills quickly so that providers and suppliers don’t opt out of the system, and payments are investigated only if the Centers for Medicare and Medicaid Services (CMS) or the Office of Inspector General (OIG) later discovers or is informed about some impropriety. By that point, the cash is hard to recover.

During its effort to pass its health-care bill, the Obama administration pressed the issue of waste, fraud, and abuse over and over. As the president described the problem in a speech in Missouri, “The health-care system has billions of dollars that should go to patient care, and they’re lost each and every year to fraud and abuse and massive subsidies that line the pockets of insurance-company executives.”

Calling All Con Artists . . .

The president’s new entitlement will prove a fount of fraud

BY TEVI TROY

If the overarching goal of health-care reform were to improve health outcomes, we would not be steering millions of Americans into a program that has consistently shortchanged both patients and providers.
But when it comes to Obamacare’s solutions, there isn’t much “there” there. The new law achieves much of its “waste, fraud, and abuse” savings not by cutting actual waste, fraud, and abuse, but by scaling back the Medicare Advantage program. By spending a trillion taxpayer dollars in the current system, and specifically by putting 16 million more people on Medicaid, it actually increases the number of opportunities for fraud. And it does not take the bipartisan anti-fraud steps that President Obama appeared to embrace leading up to and following the February health-care summit.

To be fair, the legislation does have a number of useful fraud provisions, including the allocation of $250 million over the next decade to the Health Care Fraud and Abuse Control Fund. This fund will be used to streamline prepayment reviews, the better to detect fraud, and to implement a new 90-day review period that will allow the HHS to withhold payment from high-risk suppliers more easily.

But when Obama says his health-care reform will save $900 billion in “waste, fraud, and abuse,” he’s defining his terms rather loosely—using them to mean, among other things, Medicare Advantage subsidies. These were created by President Bush and the GOP Congress as part of the prescription-drug legislation, and were designed to give Medicare recipients the option of receiving more services in exchange for higher payments, with the federal government picking up part of the tab.

They gave President Obama a rather fat target in his hunt for savings. The health-care law cuts about $130 billion in Medicare Advantage spending over ten years by freezing payments at 2010 levels and working to bring them in line with the payments disbursed through traditional Medicare plans. But while Medicare Advantage subsidies are expensive, and their merits a matter of debate, they’re used to provide legitimate services. It is therefore disingenuous to lump them in with “waste, fraud, and abuse.”

Pursuing fraud as traditionally understood would actually have been helpful to the president in his quest for a deficit-neutral bill; the savings to be had dwarf what is available in the form of Medicare Advantage cuts. According to Malcolm Sparrow of Harvard, author of License to Steal, the aforementioned $60–100 billion estimates are only guesses, based on an assumption that approximately 10 percent of Medicare expenditures are fraudulent. This is already a far higher rate of fraud than the private sector’s, which is typically less than 1 percent, but Sparrow thinks the actual figure for Medicare could be in the 20–30 percent range.

Relative to the enormous scale of the problem, the bill’s estimated savings are quite meager. The biggest saver among the provisions is Section 3310, “Reducing Wasteful Dispensing of Outpatient Prescription Drugs in Long-Term Care Facilities,” which would save $5.7 billion over ten years, per the Congressional Budget Office (CBO). Next-biggest is Section 6402, “Enhanced Medicare and Medicaid Program Integrity Provisions,” which would save $2.9 billion. None of the other provisions would save more than $0.9 billion, including the new reconciliation bill, which was passed as the supposed fulfillment of Obama’s anti-fraud pledge.

These provisions will help at the margins—and CBO is typically skeptical of anti-fraud efforts’ ability to save money, so its estimates might be low. But the best way to eliminate fraud is to move away from our current third-party-payer system. When a third party—such as the government or an insurance company—picks up the bill, doctor and patient have little incentive to avoid excessive or inappropriate costs. When the patient pays out of pocket, by contrast, he takes careful note of the expenses he bears, with the consequence that the market becomes more efficient. Moving away from third-party payments would therefore not only reduce waste and fraud, but drive down the cost of legitimate services. Perversely, Obama’s health-care reform further entrenches the third-party system.

If the president had been serious about eliminating fraud, he might have pushed for a number of remedies even within the context of the third-party-payer system. One of the best would be to use biometrics to verify the identities of recipients at the front ends of transactions. Companies such as Florida-based Bioclalm offer the technology needed to do this—they scan fingerprints and convert them to numerical IDs. The health-care law does direct the secretary of health and human services to look at “data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine,” which would allow the use of prepayment technologies. But permission does not ensure CMS will actually use this method.

Another fix has been suggested by Senator Coburn, in a memorable exchange with President Obama at the health summit. He called for the use of secret shoppers to investigate health-care providers who participate in Medicare. Obama said in a subsequent address that he was receptive to this “interesting suggestion,” but it did not make the final package.

Coburn predicted that package would fail to reduce fraud by even 1 percent. So when the bill returned to the Senate, he offered an amendment calling for the inclusion of the nine Republican anti-fraud provisions that, although omitted from the legislation, President Obama had endorsed in a February 22 “framework” document. These included creating a database of all previous Medicare-related sanctions; giving background checks to, and then registering, agencies that handle Medicare billing; and holding Medicare contractors liable for submitting claims from excluded providers. But the Coburn amendment failed in the Senate.

Obama’s failure to push for anti-fraud measures is unfortunate, given that there appears to be bipartisan openness to addressing fraud. As the Center for Health Transformation’s Jim Frogue noted after testifying before the House Judiciary Committee, he received “no pushback from any members of the committee” when suggesting a very aggressive series of fixes to the fraud problem.

His list was long and comprehensive. He advocated adding a perjury penalty for those who make false statements in their applications to become Medicare suppliers; using private-sector standards to determine the market-appropriate number of suppliers in a given area (which could reduce the number of suppliers, and thus potential scammers); and reducing the number of appeals available to suppliers. He also recommended outsourcing the auditing of Medicare data and paying the auditors based on how much fraud they uncover.

All of these efforts remain viable, and should be a part of any future effort to undo the damage the Democrats have done. Ultimately, however, only the repeal of Obamacare—and a decisive move away from third-party payment—will solve the problem that the president has just exacerbated.