



THE COMMITTEE ON ENERGY AND COMMERCE

MEMORANDUM

February 25, 2013

To: Health Subcommittee

From: Energy and Commerce Committee Majority Staff

Re: Hearing entitled “Fostering Innovation to Fight Waste, Fraud and Abuse in Health Care”

On Wednesday, February 27, 2013, at 10:15 a.m., in 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled “Fostering Innovation to Fight Waste, Fraud and Abuse in Health Care.” The following memorandum provides background on the hearing witnesses and the issue of waste, fraud and abuse in health care.

I. WITNESSES¹

Panel I

Peter Budetti
Deputy Administrator and Director, Center for Program Integrity
Centers for Medicare and Medicaid Services

Kathleen M. King
Director, Health Care
Government Accountability Office

Carolyn L. Yocom
Director, Health Care
Government Accountability Office

Panel II

Darrell Langlois
Vice President, Compliance, Privacy and Fraud
Blue Cross and Blue Shield of Louisiana

Tom M. Greene
Greene LLP

¹ Additional witnesses may be added.

II. WASTE, FRAUD AND ABUSE IN HEALTH CARE

Waste, fraud and abuse in our nation's health care system is a tremendous problem, especially in the Medicare and Medicaid programs. The Government Accountability Office (GAO) has consistently designated Medicare and Medicaid as high-risk programs, "in part due to their susceptibility to improper payments," which GAO defines as payments made in error due to causes like submission of duplicate claims or fraud, waste, and abuse.² According the GAO, for Fiscal Year (FY) 2011, the estimated improper payments reached approximately \$65 billion.

The February 2013 GAO High-Risk Report highlighted a 2012 financial report from the U.S. Department of Health and Human Services (HHS) which estimated "a national improper payment rate for Medicaid of 7.1 percent (with the federal share estimated at \$19.2 Billion)," enough to fund the entire federal share of most Medicaid programs.³ While improper payment rates have decreased since 2009, GAO recommended, "more federal oversight of Medicaid's fiscal and program integrity." In its recommendations, GAO noted, among other things, that the Centers for Medicare and Medicaid Services (CMS) data systems do not provide complete, reliable and timely data to support agency oversight and program integrity efforts.⁴

The CMS estimate of improper payments, which relies on random samples of claims data, is widely thought to understate the true size of the problem. In an April 2012 study, former CMS Administrator Donald M. Berwick and RAND Corporation analyst Andrew D. Hackbarth estimated that fraud and abuse added as much as \$98 billion to Medicare and Medicaid spending in 2011— more than \$30 billion over CMS estimates for that same year.⁵ A study from the Institute of Medicine estimated health care fraud at \$75 billion a year and found that about 30 percent of total U.S. health spending in 2009 -- roughly \$750 billion -- was wasted on unnecessary services, excessive administrative costs, fraud and other problems.⁶

New requirements in the Patient Protection and Affordable Care Act (PPACA) have raised concerns about patterns of fraud, waste and abuse in Federal entitlement programs migrating to the commercial insurance market. For example, section 1001 of PPACA, known as the medical loss ratio requirement (MLR), mandates that health plans spend 80 to 85 percent of premium revenue on "reimbursements for clinical services" and "activities that improve health care quality" beginning in 2011. On December 1, 2010, HHS issued regulations defining approved activities that improve health care quality or fall within the department's definition of clinical services. Activities that fall outside of approved activities are categorized as administrative expenses and therefore penalized by the MLR regulations. According to the regulations, many investments in fraud prevention, provider quality review, care coordination, network management and expansion are not approved activities and thus are discouraged. This

² Government Accountability Office (GAO). [Available online.](#)

³ GAO, High-Risk Series: An Update. Available online at <http://www.gao.gov/products/GAO-13-283>

⁴ <http://www.gao.gov/assets/660/652163.txt>

⁵ Donald M. Berwick, MD, MPP; Andrew D. Hackbarth, MPhil, "Eliminating Waste in US Health Care," JAMA. 2012; 307(14):1513-1516. doi:10.1001/jama.2012.362, available at: <http://jama.jamanetwork.com/article.aspx?articleid=1148376>.

⁶ Best Care at Lower Cost: The Path to Continuously Learning Health Care in America Mark Smith, Robert Saunders, Leigh Stuckhardt, J. Michael McGinnis, Editors; Committee on the Learning Health Care System in America; Institute of Medicine.

likely will lead to an increase in fraudulent payments made by commercial payers and, ultimately, could raise premiums.

III. Staff Contacts

Should you have any questions regarding this hearing, please contact Paul Edattel, Monica Popp or Robert Horne at (202) 225-2927.