Causes and Challenges of Healthcare Fraud in the US

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Abstract

Healthcare fraud has become a major source of concern in the United States. This research discusses Healthcare fraud in the United States with a primary focus on identifying the influences that cause this type of fraud and the many challenges that exist in combatting this issue. Emphasis on the impact of Enterprise Risk Management (ERM) in the healthcare industry is also discussed. The research also covers the fraud triangle, which sheds light on the many challenges in detecting and preventing fraud in the healthcare industry. Included is also a discussion of the Committee of Sponsored Organizations of the Treadway Commission (COSO), the organization responsible for the development of different frameworks that lead the direction and regulation of ERM.

Keywords: Healthcare, Fraud, ERM, Pressure, COSO

Introduction

Fraud occurs all the time, affecting different types of industries and organizations, especially in the United States. Healthcare fraud is a specific type of fraud that has escalated into a problem that affects many citizens. The United States government and its private sector bodies have been and continue to work to combat this type of fraud. In 1996, the Health Insurance Portability and Accountability Act (HIPPA) was passed by congress. With this Act came the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC). This program is under the direction of the Attorney General and the Department of Health and Human Services (DHHS). In 2012, the DHHS and the Department of Justice (DoJ) were able to recover $4.9 billion related to fraud, thanks to the HCFAC's preventions and enforcement efforts (Nordqvist). This amount seems significant, however, when compared to the total estimated amount of healthcare fraud, it is a small accomplishment. According to the FBI, their organization and other government agencies have spent $80 billion of taxpayer's money on exposing and investigating healthcare fraud ("Health Care Fraud"). The Office of the Inspector General, US Department of Health and Human Services, states that during the 2012 fiscal year, the federal government was able to negotiate more than $3.0 billion on health care fraud judgments and also deposited $4.2 billion with the department of treasury and other federal agencies administering health care programs. These are all results of President Barack Obama making the elimination of fraud, waste, and abuse a top priority in his administration (Nordqvist, Christian). Healthcare fraud is a problem that the average person should be aware of. For this to occur; the problem has to be forcefully investigated and exposed. Understanding how and why healthcare fraud is committed will help investigators in their pursuit of reducing and eliminating it.

Complexity and Risks

The Healthcare industry, like many other organizations, faces high levels risks in the everyday business environment. This is so because the industry employs hundreds of thousands of individuals who are interacting with millions of people every day. Of the many activities they're involved in on a day to day basis, the two main activities are testing and billing. Testing and billing are the two areas, besides the actual complications of a person's health that involve the most risk, specifically fraud risk.

If management is able to focus in on the high risk areas and determine which of these areas can be easily managed, they can reduce the amount of risk and lower the total amount of fraud being committed. Due to the complex environment of the healthcare industry and the difficulty in defining areas of most risk, ERM has been established to help stop fraud risk. Although ERM varies in size and type, it is very effective in organizations and plays a significant role in the healthcare industry. There are few different influences that have caused an increase in ERM in the healthcare field. These influences include: an increase in government regulations such as HIPPA. Due to the fact that there is great attention focused on patient safety, expectation, satisfaction, and advances in technology, all have caused an increase in costs which leaves greater room for fraud to occur ("Making the Transition to Enterprise Risk Management"). The growth of healthcare fraud is costing billions of U.S. Dollars, with a majority of that amount shouldered by taxpayers. Since it affects the average American, it is also their responsibility to become more knowledgeable of this serious problem. It is a prevalent issue in today's society, and if the average person becomes aware of how and why it occurs, just maybe some will be willing to assist in the fight against healthcare fraud.

There are many innocent Americans who are being cheated when visiting different medical facilities or when they are getting medications. Their lack of education in understanding different medical information facilitates the occurrence of medical fraud. The people who are being taken advantage of are usually ignorant to the fact that wrongful actions are taking place. However, this cannot always be controlled. Reason being, the actions are being perpetrated by professionals in the healthcare industry taking advantage of innocent people who lack knowledge in these areas. These professionals and doctors may either document procedures that were not performed or order procedures that are not necessary. There are countless possible ways of committing fraud and if professionals want to commit it, they can. Another factor that drives healthcare fraud is the issue of tough economic times. When the economy experiences tough times, people tend to act irrationally and make choices they would not normally consider. This falls within the "pressure" section of the fraud triangle.

The Fraud Triangle

To better comprehend fraud, it is imperative to understand the fraud triangle. Healthcare fraud is not the only type of fraud that affects people worldwide on a daily basis. Included are identity theft, tax fraud, or general scandalous money making schemes that all fall under the "Fraud Triangle". As mentioned previously, one of the three angles of the fraud triangle is "pressure", which results in irrational behavior of individuals when they face tough times. The other two angles, "opportunity" and "rationalization", also play important roles in impacting healthcare fraud.

One reason individuals commit fraud is because they are under some form of pressure. This pressure is either internal or external. Internal pressure can arise from family issues or pressure to succeed in one's career. External factors, for example, can be a struggling economy. Regarding pressure, Cressey (1973), states that "an individual has some financial problem that he is unable to solve through legitimate means." Financial problems can put pressure on individuals to seek opportunities to commit fraud. In the Healthcare industry, these professionals are constantly under pressure to make money for their employers and their families. An employer requiring a certain quota to be met every period or trying to maintain a professional's lifestyle are a couple examples of situations that increase pressure that in turn could lead to fraud. Whatever the reason, many professionals in the healthcare industry fall victim to this pressure.

Opportunity is another part of the fraud triangle, and is the stage where people have access to commit fraud. The Association of the Certified Fraud Examiners states that this is the place where "a person must see some way he/she is in a position of trust to solve their financial problem with a low perceived risk of getting caught" (Cressey, 1973). If someone in the healthcare industry is truly contemplating committing healthcare fraud, they will most likely consider and weigh out all their options. They have obviously been under immense pressure, which potentially leads the individual to seeking ways they can find some extra cash or take advantage of a system. Certain healthcare professionals such as doctors may have ability to request patients to have extensive tests that are unnecessary. The doctor may gain benefits from this by having their patients have certain procedures, or the hospital could benefit from invoicing large sums of cash for procedures not done. When this occurs, patients may not know what they have been charged for and pay the charges anyway. This ignorance by patients has given the healthcare professional the opportunity to commit healthcare fraud. If there is pressure to generate extra revenue and there is an opportunity, the first two stages are complete.

The third stage of the triangle is rationalization. This stage is the last step which occurs just before a person actually commits fraud. The ACFE states that this is the stage where "a fraudster must justify the crime to himself in a way that makes it an acceptable or justifiable act" (Cressey, 1973). In all fraud situations, this last stage is incredibly important especially in healthcare fraud. In healthcare fraud, there are people who rationalize the reasons for the fraud they are about to, or have committed. They may not perceive their actions as fraudulent behavior, but the rationalization stage still occurs. For example, a doctor could state that all the tests were completely necessary, just "incase" something was missed and that these extra tests could potentially find the real cause of illness. But if the patient came in with a stuffy nose and ear ache, a CAT scan may not necessarily be appropriate, but a set of antibiotics could be. Once the first two stages of the fraud triangle have occurred, the third stage is not far behind.

Challenges and Education

Since healthcare fraud is so prevalent, it must be controlled and eventually stopped. However, combating this type of fraud faces many challenges. One of the major challenges in combating healthcare fraud is the lack of knowledge by the general public on this specific issue. The average American does not know what to look for in detecting this type of fraud. If education is provided in this area of fraud, it should lead to increased enforcement of rules in the medical environment and establish adequate punishment of the guilty parties. Educating the population who seek medical attention would hopefully assist them in paying closer attention whenever they are billed for healthcare costs. While the FBI has been doing its part in combating this fraud, it needs the assistance of all involved. As previously stated, the FBI has recovered 4.9 billion dollars. This is the most ever recovered in one year and is still increasing. From 2008 to 20011 the FBI recovered 14.9 billion dollars, and average of 3.73 billion dollars per year. Prior to that, from 2004 to 2007, the FBI recovered 6.7 billion dollars, with an average amount of 1.68 billion per year (Nordqvist).

Gradually over the past nine years the FBI has been recovering money lost to healthcare fraud at an increasing rate. Unfortunately, the FBI cannot eliminate healthcare fraud on its own. Fortunately, the fraud examiners are being certified and auditors are becoming better equipped to find fraud and notify the correct authoritative bodies. As a result, punishments can be handed out and examples can be set to discourage others from committing healthcare fraud. However, some of the general public believe it is too costly to detect healthcare fraud and would rather just accept the amount of fraud as a loss in the process of doing everyday business. While, there are clear factors such as education and enforcement that can help eliminate fraud, if there is no effort to do so; fraud will continue to be an ever increasing problem (Sparrow).

Committee of Sponsored Organizations (COSO)

In 1985 the Committee of Sponsoring Organizations of the Treadway Commission (COSO), a joint effort of five different divisions, came up with the main objective of providing guidance in developing frameworks for different organizations. The five divisions that make up COSO include the Institute of Internal Auditors (IIA), the American Accounting Associations (AAA), the American Institute of Certified Public Accounting (AICPA), Financial Executives International (FEI), and the Institute of Management Accounts (IMA) (COSO-ThoughtLeadership in ERM). These five organizations developed and also keep evolving the concept of ERM. ERM addresses the different risks that are associated with the overall productivity of an organization and how to manage those risks in order for the enterprise to operate as efficiently as possible and with little fraud.

Enterprise Risk Management

ERM is defined as "a process, effected by an entity's board of directors, management and other personnel, applied in strategy setting and across the enterprise, designed to identify potential events that may affect the entity, and manage risk to be within its risk appetite, to provide reasonable assurance regarding the achievement of entity objectives ("ERM- Integrated Framework"). Within the definition of ERM are three underlying concepts that need to be addressed individually in order for it to be effective. First, ERM is a continuing process that an entity as a whole must follow. An organization may have different departments that affect different levels of the business, but regardless of how tasks are separated within the business entity, they must come together as a whole for proper functioning of ERM. Second, people at every level of the organization are affected by ERM. Although management is the main contributor to the effectiveness of risk management, it must be implemented by everyone within the organization in order for it to be successful. If any part of the entity is not adhering to ERM protocols, it will negatively impact other parts of the entity's operations.

Third, ERM identifies possible events and manages risks. Management strategically recognizes certain events will affect the business process and also identifies the risks that could potentially cause those events to occur. There are many negative aspects to a business which may cause it to potentially fail. However, it is management's duty to properly identify the risks in order to protect the business processes ("ERM- Integrated Framework").

The healthcare industry is a complex industry that has many inherent issues and risks that management must address. Employee training, insurance fraud, patient security and privacy, medication, and the value of patient care are just a few of the many concerns in the healthcare environment. These prevalent issues make ERM the perfect plan for management to implement in order to gain control over their organizations processes. ERM will also help managers accomplish objectives and goals set in their business plan, improve the internal controls within the organization, assist in the effective reporting of the business and other laws and regulations, reduce the amount of risks and prevent losses due to fraud or error, help protect their employees from legal situations, guarantee the safety and overall experience of patients, and help the entity as a whole to become more effective in their operations (Brannan).

Conclusion

The issue of healthcare fraud has become a widespread problem in the United States over the past few years. Enterprise Risk Management can help reduce this type of fraud, but without proper implementation by everyone involved, there will be little success. In addition to ERM, people must understand why this type of fraud is committed. Once people are aware that pressure, opportunity, and rationalization are the main causes of fraud they can become more educated in ways to prevent it. With the combination of implementation, understandability, awareness, and education; Healthcare fraud can be stopped in the United States.

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