

## Preface

In 2003, Congress approved, and the President signed, the new prescription drug benefit for the Medicare program. Effective in 2006, the drug benefit is expected to increase Medicare program costs by hundreds of billions of dollars over the next decade. This expansion of the Medicare program marks the single greatest expansion of federal health care benefits in a generation.

When my coauthor Carol Lam and I completed the main volume of this book in 2001, we observed (in Chapter 1, Section II), that while the total population of Medicare program beneficiaries had grown in the 16 years between 1980 and 1996 from 28.5 million to 38 million, the number of individuals older than 80 grew from 5.49 million to 8.5 million. We predicted that if that “same trend persists through 2010, the percent of Medicare program beneficiaries older than age 80 will exceed 25 percent.” Our point was this: that the program costs would continue to grow, and, as the population of the United States aged, the growth rate itself would increase. We surmised that, as the nation’s population continued to age and the numbers of the truly elderly expanded, the availability of money to steal would continue to entice cheating. In short, we believed that the health care fraud problem would not go away and that investigative and prosecutive resources—simply to keep pace with the growth in program expenditures—would also have to grow. Or risk falling behind.

While the beneficiary population has grown, the numbers of the truly elderly have increased more significantly. By 2002, the Medicare enrollment had grown to 40.7 million, an increase in eight years of less than 10 percent.<sup>1</sup> However, the number of beneficiaries older than 85 increased to 5.2 million people.<sup>2</sup> In short, the number of Medicare program beneficiaries in 2002 over the age of 85 almost equaled the number of program beneficiaries over the age of 80 in 1980.

Thus, by 2002, the number of “old” elderly—those program beneficiaries expected to need the most health care—continued to expand as a percentage of the Medicare program. At the same time, the growth of that part of the program designed to control costs—Medicare + Choice—languished. We noted (in Chapter 3, Section V) that “[i]n 1995, 15 percent of total Medicare expenditures were to managed care plans.” By 2000, however, more than 87 percent

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<sup>1</sup><http://www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg30.pdf>.

<sup>2</sup><http://www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg29.pdf>.

of all program expenditures were fee for service.<sup>3</sup> That proportion will decrease as Medicare begins, in 2006, to pay for outpatient prescription drugs.<sup>4</sup>

Where will this leave the nation's health care system, as regards its susceptibility to fraud, and the continued need for fraud enforcement efforts? Unfortunately, it is my opinion that the system is just as prone to fraud today as it was a decade ago. Although health care fraud enforcement spending increased slightly between 1998 and 2002 as a percent of program dollars, in absolute dollar terms, very little is spent on health care fraud enforcement. In 1998, Medicare program expenditures totaled \$252 billion;<sup>5</sup> by 2002, expenditures had grown to \$385 billion.<sup>6</sup> In 2002, Medicaid program expenditures by the federal government exceeded \$240 billion.<sup>7</sup> Overall, health care sector spending alone accounted for \$1.4 trillion, or 14 percent of the gross domestic product.<sup>8</sup>

In 1998, just \$119 million was spent on federal health care enforcement activities.<sup>9</sup> In 2002, the last full year for which numbers are available, the Secretary of Health and Human Services reported that \$209 million was spent on health care fraud enforcement activities.<sup>10</sup> Put in dollar terms, each dollar spent on health care fraud enforcement has to watch out for billing fraud and kickback activities for \$1,842 in Medicare program benefits. Not to mention \$1,148 in Medicaid spending. Or \$3,708 in non-federal health care spending. So, while enforcement efforts have yielded some impressive results, the nation spends a pittance to police the health care system.

This Supplement covers all OIG advisory opinions, cases, statutes, and federal regulations through December 2003. There was, in 2003, considerable growth in the law interpreting the health care fraud statute, 18 U.S.C. §1347, which was enacted in 1996 as a part of the Health Insurance Portability and Accountability Act. The number of advisory opinions now exceeds 100. 2004 and 2005 promise to be watershed years in health care fraud enforcement, as CMS moves to implement the prescription drug benefit. Those years may also see changes in the sentencing of health care fraud providers. Although not covered in this Supplement, the reader should note the pending U.S. Supreme Court review of the constitutionality of the federal sentencing guidelines (the application of the guidelines in health care fraud cases is reviewed at length in Chapter 13). By the time the 2004 Supplement is published, it can be anticipated that the Supreme Court will have ruled on the guidelines' constitutionality.

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<sup>3</sup><http://www.cms.hhs.gov/charts/series/sec3-b1-9.pdf>.

<sup>4</sup>See also <http://www.cms.hhs.gov/researchers/pubs/datacompendium/2002/02pg6.pdf>.

<sup>5</sup><http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf>.

<sup>6</sup><http://www.cms.hhs.gov/charts/series/sec3-b1-9.pdf>.

<sup>7</sup><http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf>.

<sup>8</sup><http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf>, at 28.

<sup>9</sup><http://oig.hhs.gov/reading/hcfac/HCFAC%20Annual%20Report%20FY%201999.htm#c>.

<sup>10</sup><http://oig.hhs.gov/publications/docs/hcfac/HCFAC%20Annual%20Report%20FY%202002.htm#3>.