Testimony of

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Waste, Fraud, and Abuse in Government Health Care

April 5, 2011

Chairman Gowdy and members of the subcommittee, it is a pleasure to be present with you today to discuss waste, fraud, and abuse in government health care programs. I will focus on the two largest such programs, Medicare and Medicaid.

As it happens, the best available data on waste in the U.S. health care sector comes from the Medicare program. That body of research suggests that one third of Medicare spending offers no benefit to seniors whatsoever. Fraud is prevalent in both Medicare and Medicaid, and occurs not just at the hands of those who dispense or receive government subsidies, but also at the hands of elected and unelected officials in how they communicate the costs of those programs to the public. Abuse is most readily identifiable in Medicaid, where millions of Americans, who could obtain health or long-term care insurance on their own, instead opt to have taxpayers pay their medical and long-term care expenses, while states use various inappropriate schemes to maximize their pull-down of federal Medicaid dollars.

The acute problems of waste, fraud, and abuse in Medicare and Medicaid are not a consequence of fee-for-service payment or any other particular design feature; they are a consequence of *government*. All economic endeavors involve the risks of waste, fraud, and abuse. But these problems are endemic to government for the simple reason that government spends other people's money, and nobody spends other people's money as carefully as they spend their own. The only way to eliminate waste, fraud, and abuse in a governmental activity is to eliminate that activity.

This hearing is particularly timely given the budget blueprint that House Budget Committee chairman Paul Ryan (R-Wisc.) has introduced today. The Medicare and Medicaid

reforms in that proposal could dramatically reduce waste, fraud, and abuse in those programs. Expanding those proposals would do even more to combat waste, fraud, and abuse.

Wasteful Medicare Spending

Decades ago, researchers now affiliated with the Dartmouth Atlas stumbled across what may be the best method of detecting wasteful spending in an economic sector as complex as medicine. They noticed that patients in some areas consume a lot more medical care than patients in other areas — more office visits (to specialists in particular), more diagnostic tests, more procedures, more hospitalizations, *et cetera*. Dartmouth researchers began to question whether the patients who consume more care actually benefit from that additional care. They have therefore spent the past few decades measuring both geographic variation in medical consumption, as well as any benefits of that consumption for which they can find data. Do patients in high-spending areas start out sicker than patients in low-spending areas? Do they end up healthier? Are they more satisfied with their care? The Dartmouth researchers are scientists trying to capture the empirical reality of America's health care sector. They have been doing this for a long time, they are very good at it, and they consistently find that a lot of the medical care that Medicare purchases is wasteful. That is, it appears to provide zero value.[2]

That finding has drawn intense criticism, not least from health care providers in high-spending areas, whose efficacy and resource use it calls into question. Dartmouth researchers have tried to address those criticisms by approaching the issue from whatever angles the data will allow. It is possible, and many critics claim, that high-spending regions spend more because they treat sicker patients. The Dartmouth folks have therefore controlled for patients' health status, then measured whether patients in high-spending areas experienced better outcomes.[3] It is certain, as critics also note, that those controls are imperfect. Dartmouth researchers have therefore controlled for the ultimate outcome — death — by measuring geographic variation in Medicare enrollees' medical consumption in the last six months of life. That too is an imperfect strategy: it is possible that high-spending regions are doing things that keep some Medicare patients alive and out of that cohort. Dartmouth researchers have compared variations in spending to measures of quality other than health outcomes, including "process" measures that show whether doctors are following evidence-based treatment guidelines. To determine whether patient preferences are driving geographic variation, they have compared consumption patterns to surveys estimating patients' preferences for more- vs. less-aggressive treatment.

These various strategies consistently show that a large share of Medicare spending cannot be explained by patient characteristics, patient preferences, or better health outcomes. Indeed, Dartmouth researchers have even found that higher spending often correlates to lower-quality care.[4] These findings suggest that perhaps one-third of Medicare spending is not making patients any healthier or happier.[5]

These research strategies are not perfect, either individually or in the aggregate, because the data are imperfect and medicine is extraordinarily complex. Nevertheless, the central finding – that Medicare wastes a substantial portion of its nearly $500 billion annual budget – has held up to many different research strategies. Dartmouth researchers have produced a sizable and credible body of research that suggests as much as one third of Medicare spending is little more

than a wealth transfer from taxpayers and premium-payers to health care providers and medical suppliers.

Moving Medicare from its current structure as an open-ended entitlement to a voucher system would help reduce wasteful health care spending by giving seniors an incentive to avoid low- and zero-value services. At present, Medicare enrollees have little incentive to avoid wasteful expenditures because they do not reap the savings. A well-designed voucher system, however, would give each Medicare enrollee a fixed sum of money with which they could purchase any private health insurance plan they choose. Enrollees who choose an economical plan could keep the savings in a health savings account and pass any balances on to their heirs. Chairman Ryan's proposal takes a large step in this direction, though I do see room for improvements.[6]

Skeptics may worry that seniors will make bad decisions with their vouchers, or that the voucher amounts may prove inadequate. They should consider what the Dartmouth Atlas implies for vouchers. As President Obama's Council of Economic Advisers put it, "nearly 30 percent of Medicare's costs could be saved without adverse health consequences."[7] In other words, vouchers would come with a huge built-in margin of safety: seniors could consume one-third less care without any harming their health. At the same time, vouchers would improve the quality of care for seniors by encouraging "accountable care organizations" and other innovations.[8]

Medicare & Medicaid Fraud

Medicare and Medicaid are rife with fraud and other types of improper payments. The Centers for Medicare and Medicaid Services estimates that Medicare made at least $48 billion in improper payments in 2010.[9] That figure does not include improper payments in Part D, which auditors believe is also highly susceptible to abuse.[10] Nevertheless, $48 billion amounts to more than 9 percent of total Medicare spending and nearly four times the combined profits of private health insurance companies.[11] CMS also estimates that the federal government alone made $22.5 billion in improper Medicaid payments in 2010, making the combined total of improper payments in the two programs somewhere north of $70 billion per year.[12] In one infamous case, a New York dentist once billed that state's Medicaid program for 991 procedures in a single day. In 2005, the *New York Times* reported that New York's Medicaid program "has become so huge, so complex and so lightly policed that it is easily exploited," and that "a chief state investigator of Medicaid fraud and abuse in New York City said he and his colleagues believed that at least 10 percent of state Medicaid dollars were spent on fraudulent claims, while 20 or 30 percent more were siphoned off by what they termed abuse, meaning unnecessary spending that might not be criminal."[13] Some experts estimate that improper payments are even more prevalent in these programs. Harvard University's Malcolm Sparrow estimates that improper payments account for 20 percent of spending in federal health care programs.[14] That suggests Medicare alone makes $100 billion in improper payments annually. The Government Accountability Office has for two decades designated both Medicare and Medicaid as posing a high risk for fraud.[15] Decades of congressional efforts to combat Medicare and Medicaid fraud have proven largely fruitless and even harmful to patients, as my colleague Prof. David Hyman explains in his satirical book *Medicare Meets Mephistopheles*, an excerpt from which I have attached as an appendix.[16]

Medicare fraud is not confined to the behavior of criminals and a few health care providers.[17] Elected and unelected officials, in both legislative and executive branches of the federal government, routinely defraud the American public by pretending that the so-called Medicare trust funds contain assets that may be used to pay future Medicare benefits.[18] As the Clinton administration explained in its 2000 budget submission, the "balances" in the Medicare and Social Security trust funds "do not consist of real economic assets that can be drawn down in the future to fund benefits…The existence of large trust fund balances, therefore, does not, by itself, have any impact on the Government's ability to pay benefits."[19] Congress and the White House, under the control of both parties, have also defrauded the American people by using budgetary gimmicks that hide the full cost of Medicare. These fraudulent gimmicks include the legislated reductions in Medicare payments to physicians under the Balanced Budget Act of 1997 and Part A providers under the Patient Protection and Affordable Care Act of 2010. Such spending reductions are so politically implausible that Congress routinely rescinds them. Yet their inclusion in statute makes Medicare appear less costly than it actually will prove to be in a 10-year budget window and beyond. This type of fraud has become so routine that the Congressional Budget Office attempts to correct for it by projecting future Medicare outlays based on current *policy* (assuming that Congress rescinds the spending reductions) as opposed to current *law* (which assumes the reductions will take effect).[20]

The proposals advanced by Chairman Ryan would reduce fraud in both Medicare and Medicaid. Medicare fraud would decline because fraud would become easier to police. At present, Medicare makes more than 1 billion separate payments per year to "700,000 physicians, 6,000 hospitals and thousands of other providers and suppliers."[21] Converting Medicare to a voucher system would reduce the number of financial transactions Medicare performs to one per senior, which would dramatically reduce opportunities for fraud while increasing Medicare's ability to detect it. It would also be easier to detect and prosecute providers or insurers who attempt to defraud seniors. Under a voucher system, fraudsters would be cheating seniors out of the senior's own money, rather than the governments, which would make seniors more active partners in policing fraud.

Chairman Ryan's proposals would reduce Medicaid fraud by replacing the system of matching grants that Congress uses to fund state Medicaid programs with a system of block grants. At the margin, states pay for 43 percent of the cost of their Medicaid programs, while the federal government pays 57 percent. States therefore care about fraud less than half as much as they should, because the federal government bears most of the cost of Medicaid fraud. Under a system of block grants, states would bear 100 percent of the cost of fraud, and would therefore have a much greater incentive to detect and eliminate it.

Medicaid Abuse

As a means-tested program funded partly by open-ended federal matching grants, Medicaid is subject to abuse both by enrollees and by states. It is an abuse of the Medicaid program when individuals could obtain coverage on their own, but instead enroll in Medicaid so that taxpayers will cover their medical or long-term care expenses. For example, the *New York Times* recently reported, "Dr. Kim A. Hardey, an obstetrician-gynecologist in Lafayette, [La.,]

said…many of his patients have jobs with private insurance but switch to Medicaid when they become pregnant, avoiding premiums, deductibles and co-payments."[22] Medicaid has spawned a cottage industry of elder-law attorneys who offer to hide or shelter the assets of well-to-do seniors so that they will look poor on paper and thereby qualify to have Medicaid pay their long-term care expenses.[23] Such "crowd-out" of private coverage is a well-documented phenomenon in the economics literature.[24]

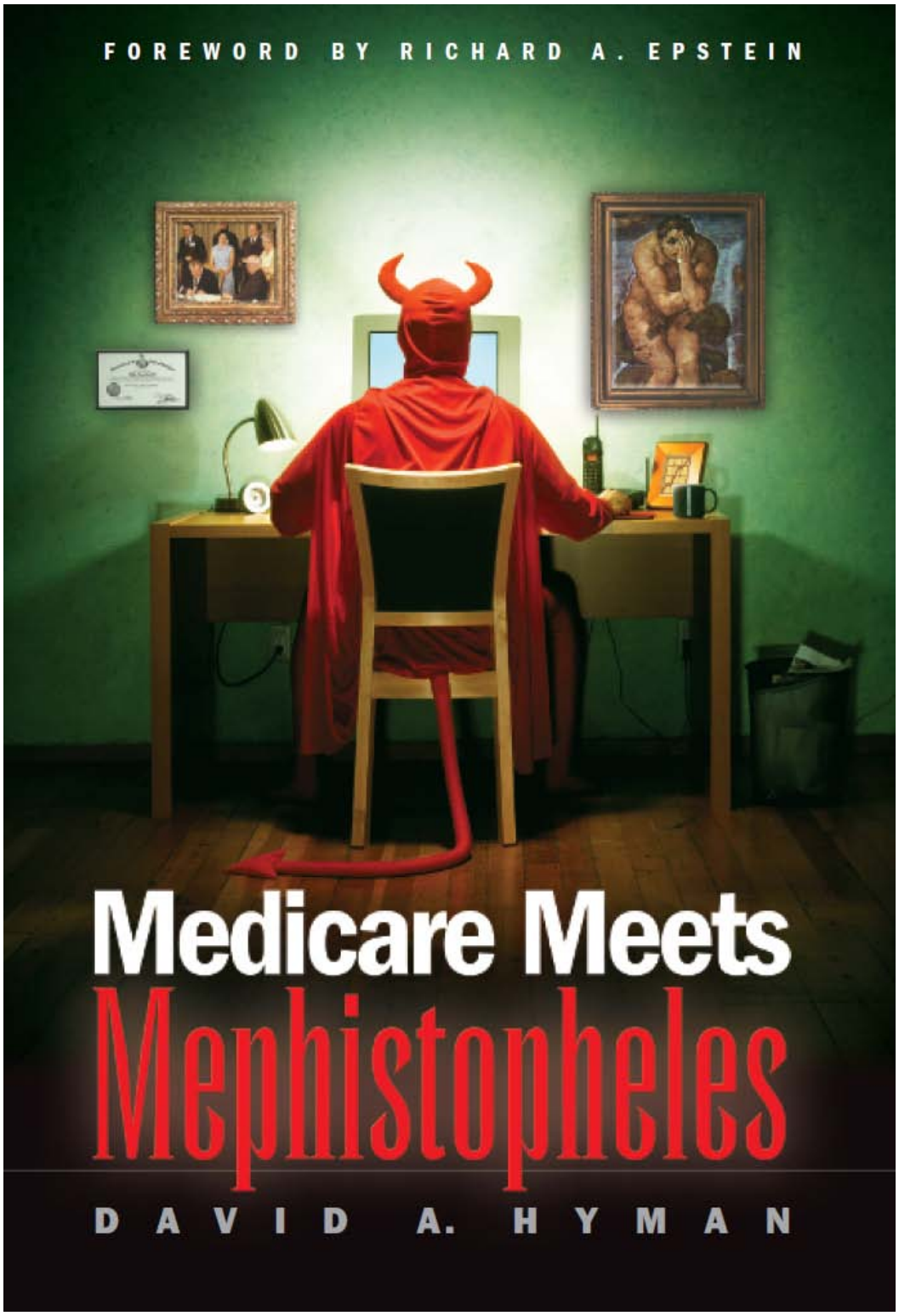
The federal government finances its share of Medicaid through a system of matching grants. The federal government will match each $1 a state spends on its Medicaid program with at least $1 and as much as $4 of federal funds. A matching-grant system creates an enormous incentive for states to *appear* to be allocating additional funds to their Medicaid programs, even if they are not. In 2007, the Government Accountability Office wrote, "GAO has reported for more than a decade on varied financing arrangements that inappropriately increase federal Medicaid matching payments. In reports issued from 1994 through 2005, GAO found that some states had received federal matching funds by paying certain government providers, such as county operated nursing homes, amounts that greatly exceeded established Medicaid rates. States would then bill CMS for the federal share of the payment. However, these large payments were often temporary, since some states required the providers to return most or all of the amount. States used the federal matching funds obtained in making these payments as they wished. Such financing arrangements had significant fiscal implications for the federal government and states. The exact amount of additional federal Medicaid funds generated through these arrangements is unknown, but was in the billions of dollars…[S]uch financing arrangements effectively increase the federal Medicaid share above what is established by law…They shift costs inappropriately from the states to the federal government, and take funding intended for covered Medicaid costs from providers, who do not under these arrangements retain the full payments."[25] In 2005, GAO reported that a cottage industry had emerged to help states abuse Medicaid's matching-grant system; the agency found that 34 states "are using consultants on a contingency-fee basis to maximize federal Medicaid reimbursements."[26]

Chairman Ryan's proposal to block-grant Medicaid would reduce both types of Medicaid abuse. Block grants would encourage states to reduce enrollments by non-needy residents because states would have bear 100 percent of the marginal cost of such abuse, rather than 50 percent or less. In addition, under a system of block grants there would be no policy levers that states could pull to increase their federal Medicaid funds.

Conclusion

I thank the committee for your attention, and I look forward to your questions.

Appendix


FOREWORD BY RICHARD A. EPSTEIN
Medicare Meets
Mephistopheles
DAVID A. HYMAN

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Difficile est saturam non scribere
(It is hard not to write satire.)
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Medicare has resulted in extraordinary wealth for providers—not quite, as Samuel Johnson once put it, "beyond the dreams of avarice,"[3] but close. Yet, the whole point of avarice is that more than most is never quite enough, and providers ceaselessly agitate for increases in Medicare payments. As a concentrated special interest, providers have had considerable success in extracting ever-increasing sums from the federal fisc—in many instances convincing Congress to specify payment rates well in excess of those that would prevail in a free market.[4] As one former CMS administrator put it, "There are plenty of $400 toilet seats in the Medicare program because Medicare cannot deliver services to its beneficiaries without providers and because providers are major sources of campaign contributions in every congressional district in the nation."[5] Consistent with our larger goals, and as outlined in chapter 2, Medicare's compensation arrangements pay providers based on their inputs (procedures performed or time spent) and not their outputs (high-quality care actually delivered)—with predictable results on the quality and cost of care.[6]

Congress initially failed to appreciate how avarice would affect the Medicare program. When Medicare was enacted in 1965, a single provision prohibited making false statements to secure reimbursement. Matters did not remain in this pristine form for long, as the Medicare honeypot quickly attracted the more feloniously inclined members of the profession. In relatively short order, there developed a complicated interlocking array of health care-specific civil, criminal, and administrative anti-fraud laws and regulations enacted by the states and the federal government, along with multiple levels of investigative and enforcement agencies.[7] The following sidebar provides some background on how

Medicare Fraud and Abuse Laws: A Primer

Although a wide range of laws are potentially implicated by health care fraud, the three most significant provisions (anti-kickback, Stark, and false claims) are briefly outlined below.

Anti-Kickback

The anti-kickback statute was first enacted in 1972, and explicitly prohibited "kickbacks, bribes, or rebates" in connection with items or services for which payment could be made under Medicare.[8] For example, specialists and medical labs were prohibited from paying a general practitioner for sending business their way. No specific intent was required, and violation was a misdemeanor. The anti-kickback statute was substantially broadened in 1977 to include the solicitation or receipt of *any* remuneration, whether direct or indirect, overtly or covertly, in cash or in kind, in connection with items or services for which payment could be made under Medicare. Violation of the statute became a felony, subject to a maximum fine of $25,000 and imprisonment for up to five years. Various statutory and regulatory exceptions were created. Criminal prosecutions under the anti-kickback law have been relatively rare, and prosecutors have generally focused on the most egregious violations. Thus, the anti-kickback law provides fraud enforcers with a tool of tremendous power, but it is a tool that has, to date, received relatively limited use.

Self-Referral (Stark Amendments)

In 1989, Congress passed a limited prohibition on "self-referral" as part of a larger budget reconciliation act.[9] This provision, which was inserted at the insistence of Rep. Fortney (Pete) Stark, by whose name it is commonly known (Stark I), prohibits physicians from referring Medicare patients to a clinical laboratory in which they hold a financial interest, and prohibits the clinical laboratory from billing for services performed as a result of such referrals. In 1993, Congress passed Stark II, which prohibits physicians from referring Medicare patients to 10 additional categories of providers in which the referring physician or a family member has a financial interest and prohibits those providers from billing for services performed as a result of such referrals. Because Representative Stark wanted to cover every conceivable permutation imaginable, the definition of "financial interest" broadly encompasses both compensation arrangements and ownership and investment interests. The Stark Amendments contain a significant number of complicated exceptions and limitations, which variously apply to all financial relationships, compensation arrangements, and ownership and investment interests.

The Stark Amendments operate as a strict liability offense, so a physician doesn't need to be aware of the law or intend to break it for a violation to occur. Violation of the Stark Amendments is punishable by being thrown out of the Medicare program and civil penalties of up to $15,000 plus twice the amount claimed for each service that a person knows (or should have known) should not have been claimed. Although HHS has issued some regulations inter-

preting the scope of the Stark Amendments, the process has been exceedingly difficult and time-consuming. Enforcement has also been rare.

False Claims

The False Claims Act was a Civil War–era statute, enacted in response to anecdotes of procurement fraud against the Union Army.[10] The original statute included both civil and criminal sanctions, which were subsequently separated into distinct statutory provisions. The FCA creates a cause of action against individuals or entities who knowingly present a false claim to the government. No specific intent to defraud is required; it is sufficient if the defendant acted with "deliberate ignorance" or in "reckless disregard" of the falsity of the statement. Sloppy billing practices, such as failing to review claims carefully before they are submitted, will satisfy this standard. If it can be shown that a representative sample of claims is false, the court will generalize the results to all filed claims. Because of these considerations, an FCA case is much easier to investigate and prosecute than a comparable criminal case.

An FCA claim may be brought by the federal government or private plaintiffs. If a private plaintiff brings the case, the government can elect to take it over or allow the plaintiff to pursue it on his own. Private plaintiffs who sue under the FCA are known as *qui tam* relators and are entitled to a share of the eventual recovery—with the relative share affected by whether the government takes over the case. Historically, the vast majority of the cases that the government does not join have foundered.

The FCA specifies that violators are liable for a statutory penalty of $5,500 to $11,000 per claim, in addition to three times the amount of damages sustained by the government because of the false claim. Because most health care providers typically submit a large number of modest claims, this structure means that statutory penalties generally dwarf actual damages, and quickly rise to staggering levels—as much as $1.1 million for every 100 false claims, irrespective of the dollar value of the false claims. In one case, a provider accused of receiving an overpayment of $245,392 was sued for statutory penalties of $81 million.[11] The stakes in these cases are so large that most defendants are under extreme pressure to settle, and quickly do so. Indeed, virtually all of the precedents involve (generally unsuccessful) motions to dismiss. Thus, the allegations of plaintiffs are almost never tested at trial—a pattern that, I am pleased to report, creates substantial opportunities for mischief on the part of those bringing FCA claims.

These fraud and abuse provisions create a self-reinforcing dynamic that redounds to our benefit. The vast sums of money spent by Medicare create the demand for laws to restrain the avarice of providers. Provider avarice triggers a search for ways around those laws, which, in turn, results in the broadening of those laws. As the laws are broadened, they discourage organizational innovation and market entry and catch more innocent providers. This, in turn, triggers a backlash against the law and widespread violation thereof. Plus, lawyers get rich off each step. What more could we ask for?

the fraud control program works. Although Medicare's fraud control program was well intended, we have, through a variety of skillful measures, successfully redirected it to encourage our larger goals.

First, we ensured that the reach of the fraud statutes would exceed their (functionally defensible) grasp by criminalizing conduct well beyond that which was necessary to protect the program. Indeed, we even criminalized conduct that results in benefits to patients without fiscal harm to the program. That created overwhelming incentives for otherwise law-abiding lawyers and providers to simply ignore the law. Not surprisingly, the same "speakeasy" norms that we observed during Prohibition developed. Professor James Blumstein describes the issue nicely:

> In the current environment it is a truism that the fraud and abuse law is being violated routinely but that those violations are acknowledged as not threatening the public interest. Indeed, they further the public interest and are needed to improve the functioning of the health care marketplace. . . . In sum, the modern American health care industry is akin to a speakeasy—conduct that is illegal is rampant and countenanced by law enforcement officials because the law is so out of sync with the conventional norms and realities of the marketplace and because respected leaders of the industry are performing tasks that, while illegal, are desirable in improving the functioning of the market.[12]

There were predictable consequences when this speakeasy norm came into conflict with the norms of fraud control personnel. For example, in one well-known case, the government charged Columbia/HCA with Medicare fraud, asserting that its use of two sets of cost reports indicated it was intending to break the

law—even though most companies in the health care business were reported to use two sets of cost reports.[13] In another high-profile case, the government obtained a settlement of $111 million from National Health Labs, even though the U.S. attorney reportedly conceded that there wasn't a health lawyer in the United States that would have advised his clients against the practices in question.[14] The following sidebar provides details on another notorious case that demonstrates how these anti-fraud statutes serve our larger goals.

Medicare Fraud and Abuse: A Case Study

Consider the case of Dr. Swaran Jain, a psychologist who was convicted under the anti-kickback laws of soliciting and receiving remuneration from a psychiatric hospital for referring patients for admission. The patients actually required hospitalization; the facility was as good as or better than any of the alternatives and provided proper care to each of the patients; and there was no evidence that any patient suffered tangible harm or that the government suffered any adverse fiscal consequences. After a jury convicted Dr. Jain, the court of appeals affirmed the conviction, notwithstanding its observation that "all of the evidence suggests that Dr. Jain intended to provide and did provide his patients with the highest quality psychological services." Yet, he is now a convicted felon for conduct that should be unobjectionable on economic, health policy, and ethical grounds.[15]

The self-referral provisions are subject to similar criticisms, although they compound the problem with their

ambitious but highly indeterminate attempt to address any conceivable arrangement between physicians and 10 categories of ancillary services providers. When this indeterminacy is coupled with strict liability, the deleterious consequences of the fraud control regime become even clearer. The self-referral provisions certainly provide little help in differentiating fraudulent and abusive conduct from conduct that is harmless or beneficial to program beneficiaries. Indeed, when the American Health Lawyer's Public Interest Colloquium met to discuss the Medicare fraud and abuse laws, the diverse group of representatives of government, providers, academics, and other involved parties overwhelmingly believed the self-referral provisions were neither effective nor efficient.[16]

Second, we whipped up a frenzy among the public about health care fraud and created the widespread belief that fraud and abuse are pervasive. In fact, no one knows how common fraud and abuse are, but 72 percent of the American public believes that Medicare would have no financial problems if fraud and abuse were eliminated.[17] This perception is utterly uninformed by any connection with reality, but it serves our purposes nonetheless. Over time, Americans will begin to doubt the good faith and reputation for fair dealing that has hitherto prevailed among health care providers. This demoralization will ultimately redound to our benefit—as it has done in other areas.

Finally, the anti-kickback statute helped to embarrass the hospital industry, whose reputation for good deeds (principally providing charity care to those unable to pay) had become a serious

problem for us. Hospitals had reasonably interpreted the anti-kickback law as prohibiting them from offering discounts to uninsured and indigent patients because offering selective discounts induces referral—a no-no under this statute. Since hospital "list prices" (which no one ever pays) are staggeringly high, those least able to pay are faced with huge bills, consistent with Medicare regulations requiring reasonable efforts to collect unpaid bills. Various hospitals, both nonprofit and for-profit, then decided to use collection agencies to hound those patients unmercifully. Several hospitals (including Yale–New Haven Hospital) had their debtors arrested as a way of encouraging payment—shades of Dickens!

As if things weren't demonic enough, the lawyers got involved. The Yale Law School students sued Yale–New Haven Hospital on behalf of individuals who had received treatment and were the target of aggressive debt collection for unpaid bills. The Attorney General of Connecticut filed a similar lawsuit. Then, more than 50 health systems across the country were named as defendants in class-action lawsuits led by a well-known plaintiffs' attorney from the tobacco litigation—alleging hospitals had engaged in "price gouging" of the uninsured.[18] Other lawsuits were filed by other lawyers against both not-for-profit and for-profit hospitals, alleging similar concerns. Although many of these lawsuits are objectively frivolous, it's a good day for us anytime we have doctors, lawyers, and hospital administrators at one another's throats.

[1] The Cato Institute is a nonpartisan, nonprofit, tax-exempt educational foundation organized under Section 501(c) 3 of the Internal Revenue Code. The mission of the Cato Institute is to increase the understanding of public policies based on the principles of individual liberty, limited government, free markets, and peace. In order to maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 82 percent of its funding from individuals, 10 percent from foundations, 1 percent from corporations, and the remainder the sale of publications. Cato's fiscal-year 2009 revenues were over $20 million. Cato has approximately 105 full-time employees, 75 adjunct scholars, and 23 fellows, plus interns.

[2] To access this body of research, see the Dartmouth Atlas of Health Care, http://www.dartmouthatlas.org/. For an overview of the research on unwarranted geographic variation in medical spending, see John E. Wennberg, *Tracking Medicine* (New York, NY: Oxford University Press, 2010), http://gonzo.dartmouth.edu/.

[3] Elliott S. Fisher et al., "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138, no. 4 (February 18, 2003): 288–98.

[4] Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* (April 7, 2004): 192.

[5] Elliott S. Fisher, "Expert Voices: More Care Is Not Better Care," National Institute for Health Care Management, no. 7, January 2005, http:// www.nihcm.org/~nihcmor/pdf/ExpertV7.pdf.

[6] See Michael F. Cannon and Chris Edwards, "Medicare Reforms," DownsizingGovernment.org (Cato Institute), September 2010, http://www.downsizinggovernment.org/hhs/medicare-reforms.

[7]Office of the President, Council of Economic Advisors, *An Economic Case for Health Care Reform*, (Washington DC: June 2009), p. 13, http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf.

[8] See generally, Michael F. Cannon, "Ryan Budget: A Huge Opportunity To Improve Health Care," *KaiserHealthNews.org*, April 4, 2011, http://www.kaiserhealthnews.org/Columns/2011/April/040411cannon.aspx .

[9] U.S. Government Accountability Office, *Medicare and Medicaid Fraud, Waste and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payment*s, GAO-11-409T, (Washington D.C.: March 9,2011) p. 3, http://www.gao.gov/new.items/d11409t.pdf.

[10] Nathan Vardi, "Rx for Fraud," *Forbes*, June 20, 2005, p. 124. See also U.S. Government Accountability Office, *Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited*, GAO-08-760, July 2008.

[11] Jeffrey H. Anderson, "Medicare Loses Nearly Four Times as Much Money as Health Insurers Make," *The Weekly Standard* (blog), March 3, 2011, http://www.weeklystandard.com/blogs/medicare-loses-nearly-four-times-much-money-health-insurers-make_552860.html.

[12] U.S. Government Accountability Office, *Medicare and Medicaid Fraud, Waste and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payment*s, GAO-11-409T, (Washington D.C.: March 9,2011), http://www.gao.gov/new.items/d11409t.pdf.

[13] Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," *New York Times*, July 18, 2005, p. A1, http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?pagewanted=all.

[14] Malcolm Sparrow, "Criminal Prosecution as a Deterrent to Health Care Fraud," Testimony before the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs, May 20, 2009.

[15] See U.S. Government Accountability Office, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011), http://www.gao.gov/highrisk/risks/insurance/medicare_program.php.

[16] See David A. Hyman, *Medicare Meets Mephistopheles* (Washington: Cato Institute, 2006). Readers should note that *Medicare Meets Mephistopheles* is a satire in the tradition of C.S. Lewis' *The Screwtape Letters*. Its device is that it is written in the voice of a junior demon who is reporting to Satan on the success of Medicare as a recruitment tool that promotes all Seven Deadly Sins. I highly recommend it.

[17] For more information on how Medicare fraudsters cheat taxpayers, see F. Cannon and Chris Edwards, "Medicare Reforms," DownsizingGovernment.org (Cato Institute), September 2010, http://www.downsizinggovernment.org/hhs/medicare-reforms.

[18] See, for example, WhiteHouse.gov, "Health Insurance Reform Reality Check: Frequently Asked Questions About Health Insurance Reform," http://www.whitehouse.gov/realitycheck/faq#s1. ("As you know, the Medicare Trust fund is projected to run out of money in about 8 years. Health insurance reform would extend the life of the fund for additional years—through at least 2022—and give it greater stability and security.")

[19] U.S. Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2000* (Washington: Government Printing Office, 2000), p. 337, http://www.gpoaccess.gov/usbudget/fy00/pdf/spec.pdf.

[20] See, for example, U.S. Congressional Budget Office, *The Long-Term Budget Outlook*, June 2010 (revised August 2010), pp. 1-23, http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf.

[21] U.S. Centers for Medicare & Medicaid Services, "Fact Sheet: HCFA Management Reforms," Press Release, May 1, 2000, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=379.

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