

various points in time. The fact that this novel H1N1 influenza A virus has become a pandemic virus expands the previous definition of the term.

The 1918 influenza virus and its progeny, and the human immunity developed in response to them, have for nearly a century evolved in an elaborate dance; the partners have remained linked and in step, even as each strives to take the lead. This complex interplay between rapid viral evolution and virally driven changes in human population immunity has created a “pandemic era” lasting for 91 years and counting. There is little evidence that this era is about to come to an end.

If there is good news, it is that successive pandemics and pan-

demic-like events generally appear to be decreasing in severity over time. This diminution is surely due in part to advances in medicine and public health, but it may also reflect viral evolutionary “choices” that favor optimal transmissibility with minimal pathogenicity — a virus that kills its hosts or sends them to bed is not optimally transmissible. Although we must be prepared to deal with the possibility of a new and clinically severe influenza pandemic caused by an entirely new virus, we must also understand in greater depth, and continue to explore, the determinants and dynamics of the pandemic era in which we live.

No potential conflict of interest relevant to this article was reported.

This article (10.1056/NEJMp0904819) was published on June 29, 2009, at NEJM.org.

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Finding Money for Health Care Reform — Rooting Out Waste, Fraud, and Abuse

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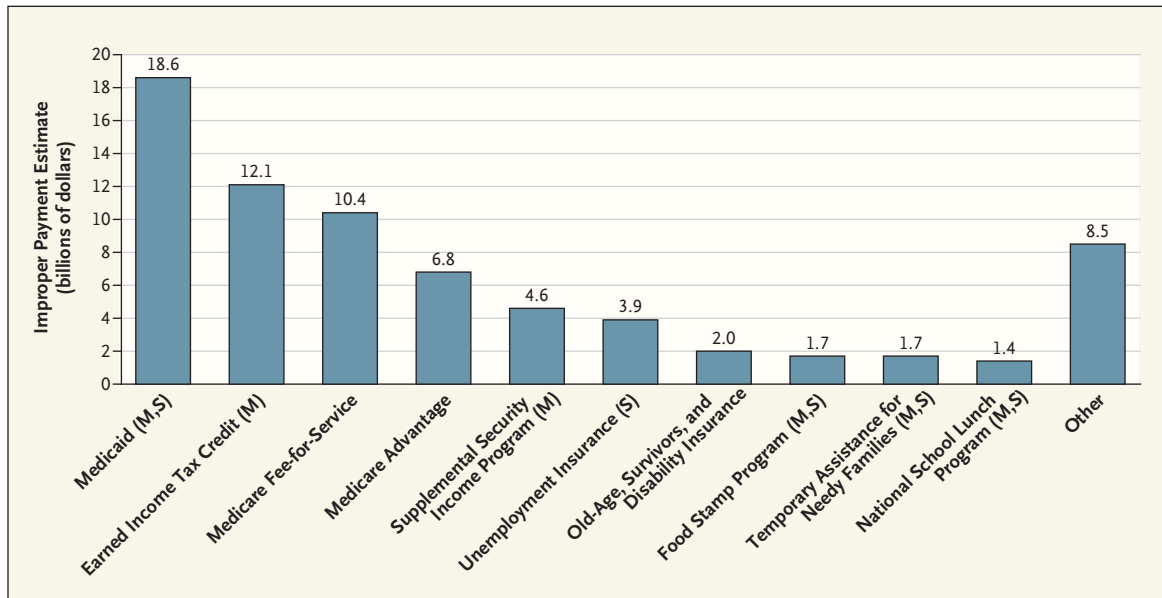
In their quest to enact health care reform legislation, Democrats’ major challenge is securing the money to pay for greatly expanded insurance coverage and more government regulation in the face of strong Republican opposition and an unsettled private sector. President Barack Obama has emphasized time and again, recently in a letter to Senators Max Baucus (D-MT) and Edward Kennedy (D-MA), that “health care reform must not add to our deficits over the next 10 years — it must be at least deficit neutral and put America on a path to reducing the deficit over time.” As the administration and its congressional allies pursue revenue sources to pay the estimated costs of near-

universal coverage (\$1.2 trillion over a decade), one potential source that Obama has emphasized is an acceleration of government efforts to pursue waste, fraud, and abuse that sap the health care system of billions of dollars every year.

The National Health Care Anti-Fraud Association, an organization of about 100 private insurers and public agencies, estimates that some \$60 billion (about 3% of total annual health care spending) is lost to fraud every year, but that figure is considered conservative. In 2008, government-wide “improper payments” cost the U.S. Treasury \$72 billion, or about 4% of total outlays for the related programs.¹ Of that amount, 50% took the form of reimburse-

ments to providers, medical suppliers, and other Medicare and Medicaid vendors. Medicaid had an estimated improper-payment rate of 10.5%, or \$18.6 billion, for the federal share of Medicaid expenditures — the highest rate of any federal program.

Improper payments have been a “long standing, widespread, and significant problem” for the federal government,¹ but Congress has not always been willing to appropriate the monies that the executive branch seeks for antifraud activities. In 4 of the past 5 years, Congress rejected Bush administration requests to provide an additional \$579 million to combat health care fraud on the grounds that doing so would reduce budgets for curing cancer



Estimated Amounts of Improper Payments during Fiscal Year 2008, According to Program.

For Medicaid, the reported improper-payment estimate of \$18.6 billion represents the federal share. M denotes eligibility based on income (means), and S state administered. The name of the Food Stamp Program was recently changed to the Supplemental Nutrition Assistance Program. Data are from the Government Accountability Office.

and combating obesity.² Virtually no academic researchers study health care–related fraud activities, largely because — as Malcolm Sparrow, a Harvard professor of the practice of public management, testified recently — it “falls awkwardly between the traditional disciplines of health economics, health policy, crime control policy, anomaly detection and pattern recognition.”³

In 2002, Congress did enact the Improper Payments Information Act to make these payments more visible by requiring executive-branch agencies to report on estimated amounts improperly paid and actions taken to reduce them. Most of the improper payments in 2008 were accounted for by 10 programs, including Medicare and Medicaid (see graph). But, according to Kerry Weems, who was acting administrator of the Centers for Medicare and Medicaid Services (CMS) at the end of the Bush administration, “the total

amount of Medicare fraud is unknown.”² In a recent statement to the Senate Finance Committee, Lewis Morris, chief counsel of the Office of Inspector General, Department of Health and Human Services (DHHS), said, “Although we cannot measure the full extent of health care fraud in Medicare and Medicaid, everywhere we look we continue to find fraud in these programs.”

The administration has not set out a grand strategy for accelerating the pursuit of waste, fraud, and abuse, but Obama has repeatedly emphasized its importance — usually in the context of his determination to slow the growth of health care expenditures. On May 11, for example, he told health care system stakeholders that “by curbing waste, fraud, and abuse and . . . taking a host of other cost-saving steps, we can save billions of dollars, while delivering better care to the American people.”

The most visible step the administration has taken thus far was to announce plans to create an interagency Health Care Fraud Prevention and Enforcement Action Team to combat abuses in Medicare. At a May 20 news conference, Attorney General Eric Holder and Secretary of Health and Human Services Kathleen Sebelius said, “With this announcement, we raise the stakes on health care fraud by launching a new effort with increased tools, resources and a sustained focus by senior-level leadership.” They also announced the addition of new teams to the Medicare Fraud Strike Force to step up fraud investigations in Detroit and Houston. The first two such teams, focused on Miami and Los Angeles, have secured convictions in fraud cases that involve durable medical equipment and infusion clinics.

Though Congress’s health care reform proposals remain works

in progress, the Senate Finance Committee and the Senate Committee on Health, Education, Labor, and Pensions (HELP) plan to incorporate provisions for strengthening antifraud activities. In April, the Finance Committee set out a range of options for doing so, including more rigorous screening of providers who apply to participate in Medicare, through “submission of fingerprints, investigation of criminal background, licensure checks, unannounced site visits, and multi-state database inquiries.” Another option would increase and stabilize funding of antifraud activities conducted by the CMS.

Senator Charles Grassley of Iowa, the ranking Republican on the Finance Committee and a major antifraud crusader, also wants to include provisions requiring greater disclosure of industry payments to physicians. Meanwhile, a recent briefing paper of the HELP Committee, which “has responsibility for oversight of private health insurance,” said that the committee seeks “to advance the rooting out of fraud and abuse in the private sector and to link better private and public sector efforts.”

In 2008, the federal government allocated \$1.13 billion for program-integrity activities and enforcement of laws against health care fraud largely targeted at Medicare and Medicaid. To place this amount in perspective, Weems estimated that “Medicare spends less than one fifth of 1% [of its budget] on anti-fraud measures — a small fraction of what private [health] plans invest in

their efforts to build a network of honest providers.”² In its 2010 budget, the administration requested an additional \$311 million over 2 years for activities to fight health care fraud.

In the past, legislators have failed to appropriate sufficient funds to combat waste, fraud, and abuse in Medicare and Medicaid. According to Weems, “there is not enough money [for the CMS] to be able to even pay the bills in a reasonable way. The agency feels vulnerable . . . especially on the fraud issue. . . . Right now, we way, way, way under-spend for fraud and abuse.”³ Weems said a major reason for the shortfall is that the CMS derives its administrative budget from the same appropriation subcommittees as the National Institutes of Health and the Centers for Disease Control and Prevention, and “the political interests of legislators are far better served by increasing the budgets” of those agencies “or protecting one of their threatened hospitals or nursing homes.”

One of the developments of concern to federal officials charged with fighting fraud is the recent increase of organized crime in the health care sector. As the DHHS’s Morris testified recently, “Health care fraud is attractive to organized crime because the penalties are lower than those for other . . . offenses . . . there are low barriers to entry . . . schemes are easily replicated . . . and there is a perception of a low risk of detection.”⁵

As the government steps up efforts to fight health care fraud,

it will recognize that most participants in the medical economy are law-abiding people and organizations. But it is also the case that in our freewheeling society driven by capitalism, there is a strong distaste in many quarters for overzealous investigators. Nevertheless, as Democrats work to enact reform and, in the process, substantially increase tax revenues as a percentage of health care expenditures, they will be expected to become better stewards of the public’s vast and growing investment in health care.

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This article (10.1056/NEJMp0904854) was published on June 10, 2009, at NEJM.org.

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