U.S. Congress Joint Economic Committee hearing

Protecting Patients and Taxpayers: Combating Healthcare Fraud and Leakage to Strengthen Program Integrity

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Chairman Schweikert, Ranking Member Hassan, and members of the committee,

Thank you for inviting me to present my thoughts on reducing fraud, waste, and abuse in health insurance programs before this Joint Economic Committee hearing today.

Americans rely on health insurance to give them affordable access to essential medical care. But the cost of coverage keeps increasing in large part due to the ease with which programs can be billed for unintended purposes.

My testimony begins by describing how payment by third parties, such as insurers and the government, makes healthcare susceptible to fraud, waste, and abuse. It discusses how the administration of claims by private insurers can help mitigate these problems; but notes that this also creates new challenges of overpayment and improper enrollment. Such problems are exacerbated by the incentive states have to claim Medicaid matching funds – and the absence of any upper limit on their ability to do so.

Payments to providers

The challenge of healthcare fraud, waste, and abuse has grown enormously over the past century. This is largely because the cost of medical services is increasingly borne by insurers and the government, rather than by those who decide which services are to be purchased and from whom. From 1929 to 2023, the proportion of health-care spending paid out of pocket by patients has declined steadily from 80% to 11%.[1]

Even narrowly defined, healthcare fraud is a major problem. In 2025, enforcement actions by the Department of Health and Human Services Office of Inspector General (HHS-OIG) took down $15 billion in healthcare fraud.[2] This represents only the tip of the iceberg of the program integrity challenge. The U.S. Government Accountability Office (GAO) estimated that Medicare and Medicaid made improper payments of $94 billion in 2025.[3]

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[1] https://www.ssa.gov/policy/docs/ssb/v24n11/v24n11p3.pdf; https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data
[2] https://oig.hhs.gov/documents/sar/11445/Fall_2025_SAR--508.pdf
[3] https://www.gao.gov/assets/gao-26-108694.pdf

That figure includes some legitimate healthcare expenses, which were improperly documented. But it may also underestimate the true level of fraud, as it does not represent an exhaustive assessment of potential sources of improper payments. (For example, such assessments count only whether state payments to Medicaid Managed Care Organizations were consistent with demographic records; not whether those payments may have been inflated for other reasons).[4]

The magnitude of the healthcare program integrity challenge varies from service to service, and from payer to payer. Healthcare costs are unlikely to be inappropriately inflated when the necessary course of treatment is objectively well-defined, where service providers are well-established, where the appropriate provision of services is easy to monitor, and where payers have the incentive and ability to forestall unnecessary expenses.

But this is often not the case. Although Medicare pays for inpatient hospitalizations according to patient diagnoses, providers of outpatient treatment are typically reimbursed for whatever services they deliver to patients. This provides substantial freedom and flexibility for clinicians to treat patients as they see fit; but it makes it easier for unscrupulous providers to bill for services which may not be strictly necessary. Often it allows them to needlessly prescribe costlier treatment alternatives. In some cases, it makes it possible for fraudsters to bill for services which were never delivered at all.

Claiming reimbursement (either from insurers or the government) for care that was never delivered is illegal and may result in imprisonment or the loss of a license to practice medicine. Such fraud is rare in the case of hospitalizations, where patients would be likely to push back against cost-sharing for services they did not receive, multiple independent providers are typically involved, there is extensive documentation, and revenues largely accrue to large long-established non-profit institutions.

But fraud is much more widespread for durable medical devices, home health services, and increasingly for telehealth. In these instances, small fly-by-night firms can be set up and disappear quickly, making a quick profit by billing for many simple services in isolation. When the government pays the entirety of the bill (as is typically the case with Medicaid), there may be no one with the knowledge and direct interest to push back against improper claims. This is particularly problematic for Medicaid, which increasingly pays for loosely defined "personal care". A reporter recently found 80 companies based in a single abandoned building, which billed Medicaid more than $73 million for home health services.[5]

The traditional Medicare benefit is highly susceptible to fraud and improper payments, because the program reimburses any licensed provider that accepts the program's terms of

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[4] https://www.gao.gov/assets/gao-25-107770.pdf#page=4

[5] https://www.dailywire.com/news/inside-ohios-home-health-empire-7-buildings-288-medicaid-companies-250-million

payment, rather than limiting reimbursement to established networks of providers deemed to offer the best quality and value for money.

The Centers for Medicare & Medicaid Services (CMS) undertakes little scrutiny of the medical necessity of fee-for-service Medicare claims submitted by medical providers. To combat fraud, it relies on a "pay and chase" approach. But a 2016 report noted that it manually reviewed less than 0.3% of claims to identify and correct improper payments.[6] Even when these are identified, CMS must often struggle through litigation to recover funds.

The desire to cut out wasteful and inappropriate expenses has been a major motivation for the development of Medicare Advantage. This program pays private insurers to procure healthcare for Medicare beneficiaries – giving them an incentive to eliminate needless expenses. Private insurers typically incur greater administrative costs to ascertain the medical necessity of healthcare expenditures before they are incurred – a process known as "prior authorization."

Prior authorization helps eliminate payment for services that are not medically necessary, or for which fraudulent reimbursement claims are filed. It also reduces the cost of prescriptions, referrals, and diagnostic tests.[7]

But prior authorization also imposes costs. An AMA survey found that physicians and their staff spend 13 hours per week completing prior-authorization requests.[8] In 2023, 27 percent of medical providers reported that it took more than five days for them to receive approval for treatment.[9] Such delays can impede timely access to treatment.[10] It may also lead to inappropriate denials of care, due to human error during the processing of claims.[11] Prior authorization also requires oversight, to ensure that insurers don't use it to refuse to pay for necessary medical care.[12]

Payments to insurers

But, while delegating responsibility for payment to private insurers helps reduce one type of improper payment, it also creates a new challenge: that payments to insurers themselves might become unduly inflated.

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[6] https://edit.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2016-Medicare-FFS-Report-Congress.pdf
[7] https://www.city-journal.org/article/health-care-insurance-costs-prior-authorization
[8] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[9] https://academic.oup.com/healthaffairsscholar/article/2/9/qxae096/7727862
[10] https://pmc.ncbi.nlm.nih.gov/articles/PMC10927330; https://pmc.ncbi.nlm.nih.gov/articles/PMC6396925
[11] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
[12] https://www.city-journal.org/article/health-care-insurance-costs-prior-authorization

Medicare Advantage (MA) has generated real accomplishments: plans have reduced the cost of procuring medical care, enhanced the benefit package, and improved health outcomes for beneficiaries.[13] But the savings they have generated have typically not been passed on to taxpayers.

In 2025, the federal government paid Medicare Advantage plans an average of $15,126 per beneficiary, adjusted for enrollees' expected health-care needs.[14] This has led to plans being increasingly extensive in documenting their enrollees' medical diagnoses, in order to obtain higher payments – including for ill-defined conditions for which claims are hard to challenge.

The Medicare Payment Advisory Commission (MedPAC) notes that the imperfect categorization of medical needs means that the program currently "overpays for beneficiaries who have very low costs and underpays for beneficiaries who have very high costs."[15] Medicare Advantage plans are therefore eager to offer costly supplemental benefits (worth $2,520 per beneficiary in 2024) that are disproportionately attractive to healthy enrollees.[16]

Since the Bipartisan Budget Act of 2018, plans can offer Special Supplemental Benefits to pay for groceries, utilities, education, sporting, and social activities which might yield incidental benefits to health.[17] This pretext has proven to be fanciful. Purchasing new golf clubs for Medicare beneficiaries does not reduce their risk of costly hospitalizations, while paying for their ski passes may actually increase it. But doing so will encourage the relatively healthy among them to enroll in plans.[18]

Because of these "coding and selection" effects, MedPAC estimates that overpayments to MA plans have increased the cost of the Medicare program by $84 billion in 2024.[19]

Medicaid has also increasingly employed private insurers to administer its benefits. From 1992 to 2022, the proportion of Medicaid beneficiaries enrolled in comprehensive managed care increased from 9% to 77%.

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[13] https://manhattan.institute/article/enhancing-medicare-advantage
[14] https://www.cms.gov/oact/tr/2026#page=170
[15] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/congressional-testimony/testimony-improving-care-for-beneficiaries-with-chronic-conditions-senate-finance-.pdf#page=12
[16] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf#page=18
[17] https://www.cms.gov/medicare/health-plans/healthplansgeninfo/downloads/supplemental_benefits_chronically_ill_hpms_042419.pdf
[18] https://www.city-journal.org/article/health-care-medicare-advantage-benefits-perks-insurers
[19] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf#page=23

But Medicaid Managed Care (MMC) is exempt from many of the market forces which hold Medicare Advantage accountable. States largely tell insurers what benefits they must cover and often specify how much insurers must pay for services. They hand pick carriers as contractors, typically without competitive bidding over rates. The government provides all of the funding and bears the bulk of the risk associated with the program. Oversight of access to providers is weak.[20]

Due to actuarial soundness requirements, which oblige states' payments to MMC plans to exceed their costs, Medicaid insurers have little incentive to reduce their costs by policing improper payments to medical providers. A recent HHS-OIG study found that 10% of MMC plans, covering 1.6 million enrollees in 13 states, did not flag a single provider for potential fraud, waste, or abuse in 2022.[21]

The flow of Medicaid funds through MMC plans is itself very obscure. A 2021 federal investigation found that only eight states provided complete and accurate data on the utilization of medical services, on which they base Medicaid payments to MMC plans.[22] A GAO audit found that CMS failed to detect real problems in quality and access to managed long-term care benefits and lacked the information or strategy needed for effective oversight.[23]

Furthermore, paying private insurers up-front fees for each enrollee sits uneasily with the task of accurately policing eligibility, which is more challenging for means-tested benefits than for Medicare. A 2018 OIG audit of California's Medicaid program discovered that more than half of Medicaid plan enrollees surveyed were either ineligible for benefits or enrolled without appropriate proof of eligibility.[24] In 2024, CMS estimated that Medicaid plans likely obtained $14 billion per year in payments to cover 3 million Americans who were also covered by Exchange plans or Medicaid in another state.[25]

A similar problem of improper enrollment afflicts the Exchange established by the Affordable Care Act. In 2025, 92% of enrollees obtained federally subsidized coverage.[26] This created an enormous opportunity for fraud. Some insurance brokers systematically misreported enrollees' incomes to inflate subsidies, bribed homeless people to sign up, or enrolled others without their knowledge or consent.[27]

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[20] https://manhattan.institute/article/reining-in-medicaid-managed-care
[21] https://oig.hhs.gov/documents/evaluation/10912/OEI-03-22-00410.pdf
[22] https://oig.hhs.gov/oei/reports/OEI-02-19-00180.pdf
[23] https://www.gao.gov/products/gao-21-49
[24] https://oig.hhs.gov/oas/reports/region9/91702002.pdf
[25] https://www.cms.gov/newsroom/press-releases/cms-finds-2-8-million-americans-potentially-enrolled-two-or-more-medicaid-aca-exchange-plans
[26] https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files
[27] https://www.city-journal.org/article/obamacare-subsidies-fraud-florida-insurers

Enforcement is loose. A GAO investigation found that CMS approved subsidized Exchange plans for nearly all fictitious applicants it submitted, even though they failed to provide the requested documentation of identity, citizenship, and reported income.[28] In 2024, the federal government received over 200,000 complaints from people who found themselves signed up or switched to other Exchange plans without their permission.[29] In one case, last year, the Department of Justice charged a South Florida insurance broker with conspiracy to defraud the United States by deceptively marketing plans to claim nearly $162 million in Exchange subsidies.[30]

Under the Inflation Reduction Act of 2022, enrollees declaring incomes less than 150% of the Federal Poverty Level were eligible for Exchange plans entirely paid for by the federal government. In 2025, 782,118 residents of Florida's Miami-Dade County who enrolled in Exchange plans declared incomes below this threshold to claim free plans. This was remarkable, given that Miami-Dade County has only 669,115 residents with incomes that low, according to the Census Bureau – and only 19% of them reported being enrolled in Exchange plans.[31]

Fraudulent behavior by insurers and brokers is likely not entirely to blame for this discrepancy. In many cases, enrollees may have underreported their own incomes to qualify for larger subsidies. One study found the "bunching" of reported taxable income below the Medicaid eligibility cut-off, concentrated among the self-employed, without any associated change in labor supply.[32] A similar 2021 study found bunching of reported incomes below the cut-off in eligibility for Exchange subsidies, concentrated among those who purchased plans.[33]

Payments to states

The magnitude of fraud, waste, and abuse in healthcare entitlement programs owes much to the fact that states are often responsible for policing improper payments.

States have fewer resources with which to police improper Medicaid payments than the federal government does when directly administering Medicare, and less incentive to do so because the bulk of savings would go to a different level of government. Medicaid allows states to claim up to $9 in federal funding for every $1 they spend on services covered by the program, without any upper limit. In 2024, New York received more revenue from

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[28] https://www.gao.gov/products/gao-26-108811
[29] https://www.wsj.com/health/healthcare/social-media-ads-health-insurance-scams-37d1ecfa
[30] https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care
[31] https://www.city-journal.org/article/obamacare-subsidies-fraud-florida-insurers
[32] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3161753
[33] https://www.sciencedirect.com/science/article/pii/S0167629620310420

federal Medicaid matching funds ($56 billion) than it did from the state's personal income tax ($54 billion).[34]

In fact, states have an incentive to maximize Medicaid funding and habitually conspire with the healthcare industry to artificially inflate the program's expenses. California obtained $19 billion in federal funding by taxing insurers it used to cover Medicaid patients—claiming that this represented an increase in the program's costs.[35] All 50 states impose taxes on hospitals to increase the cost of Medicaid services for which they can claim federal matching funds – subsequently compensating providers for participating in the scam.[36]

In some cases, states have simply captured federal overpayments for healthcare services to inflate their own general revenues.[37] New Hampshire used revenue from supplemental payments to fund its judicial system, highway program, and other general expenditures, as the state overpaid for care in return for "donations" to the state budget.[38]

When Congress capped the average rates at which states could receive reimbursement for hospital services, states responded by concentrating overpayments at favored (typically state-owned) facilities.[39] New York was able to generate a $15 billion windfall from the federal government over 20 years by getting its Medicaid program to pay $5,000 per day for individuals with developmental disabilities at state institutions.[40]

When hospitals serving disproportionately poor communities were exempt from payment caps, claims for supplemental payments at those facilities surged from $0.5 billion to $19 billion within two years, as this trick caught on and states rushed to take advantage.[41] Such payments were eventually limited by Congress, though with existing overpayments grandfathered—entrenching a windfall for states that had most abused the system.

Overpayments for Medicaid services allow states to indirectly claim federal resources to fund expenditures beyond the permitted scope of the program. Though federal law prohibits states from extending Medicaid benefits to even recent *legal* immigrants,

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[34] https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; https://www.tax.ny.gov/research/collections/fy_collections_stat_report/2023-2024-annual-statistical-reports.htm

[35] https://www.wsj.com/opinion/how-california-uses-medicaid-to-rip-you-off-healthcare-92502183

[36] https://crsreports.congress.gov/product/pdf/RS/RS22843; https://www.empirecenter.org/publications/hochul-hides-the-specifics-of-a-multibillion-dollar-tax

[37] https://pmc.ncbi.nlm.nih.gov/articles/PMC2140049/pdf/nihms34918.pdf

[38] https://www.kff.org/wp-content/uploads/2013/05/mrbfinancing.pdf

[39] https://www.gao.gov/products/gao-15-322

[40] https://www.govinfo.gov/content/pkg/CRPT-113hrpt11/html/CRPT-113hrpt11.htm

[41] Donald J. Boyd, "Medicaid Devolution: A Fiscal Perspective," in Medicaid and Devolution: A View from the States, ed. Frank J. Thompson and John J. DiIulio (Washington, DC: Brookings Institution Press, 2005), 62.

states use supplemental payments for public hospitals to finance medical care for millions of illegal immigrants.[42]

Various states claim federal Medicaid funds under waiver to finance welfare benefits from housing to food under the pretext that doing so yields incidental health benefits.[43] In Minnesota, such practices recently became a scandal which received national attention. CMS found the state's Housing Stabilization Services program "riddled with fraud," as spending surged from $3 million in 2020 to over $100 million in 2024.[44]

Since 2016, payments to healthcare providers distributed indirectly through Medicaid Managed Care organizations have been exempt from caps on fees for which states can claim federal matching funds[45]. By routing payment for Medicaid services through private insurers, states can greatly inflate the funding they obtain from Washington.[46] CMS estimates that the exemption of managed-care plans from limits on Medicaid payments for services will account for $145 billion in Medicaid spending this year alone.[47]

Inflated volumes are even harder to police than inflated fees. Medicaid fraud often goes unpunished. The federal government can, in theory, withhold matching funds from states that claim payments to which they are not entitled, but it lacks the manpower to scrutinize millions of claims and can exercise only loose oversight.

The enormous complexity of the Medicaid program—which involves many thousands of providers across 50 states receiving reimbursement through complex payment schemes under a vast array of different eligibility rules—makes abuse very difficult to identify and the overall efficiency of the program nearly impossible to assess. The federal government lacks timely, accurate, and complete data needed for oversight, or the political autonomy to sanction states that fail to comply.[48]

If a state seeks to inflate its federal Medicaid revenues by developing an elaborate scheme to hide kickbacks for hospitals through a web of formal reimbursement, indirect payments, tax preferences, managed-care rules, and favorable regulatory provisions, it is nearly impossible for the federal government to prevent it.

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[42] https://www.city-journal.org/article/medicaids-dark-money
[43] https://manhattan.institute/article/the-overblown-social-determinants-of-health
[44] https://www.cbsnews.com/minnesota/news/housing-stabilization-program-end-minnesota-house-bill/ ; https://apnews.com/article/trump-immigration-fraud-somalis-minnesota-walz-omar-64bfe699cc409f3f1ff6aa49b9210996
[45] https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-2-Oversight-of-Managed-Care-Directed-Payments-1.pdf#page=8
[46] https://manhattan.institute/article/reining-in-medicaid-managed-care
[47] https://www.cms.gov/newsroom/press-releases/cms-issues-guidance-strengthen-oversight-medicaid-state-directed-payments
[48] https://www.gao.gov/assets/gao-15-322.pdf