Stop Taking Advantage Of Medicare/Medicaid

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The article addresses the existing inequalities that result from profit-driven operations in the Medicare and Medicaid systems. The author has explored how the political class, policymakers, and healthcare providers contribute to the challenges faced by Medicare and Medicaid and outlines some of the solutions available. In conclusion, the article maintains that the system should stop the fraud and profiteering of Medicare and Medicaid if the goal of ensuring that the aging population and low-income groups get better services at affordable rates is to be achieved.

Medicaid provides critical healthcare insurance to Americans who would otherwise go uninsured; most people have problems with Medicaid because of its complex requirements. Currently, some companies are overcharging the medical industry through Medicaid and getting away with such charges due to the complex nature of the programs. Such fraud causes loss to the system while the taxpayers bear the burden. The current system allows private organizations to take advantage of low-income and vulnerable populations, which is not right.

The government has seen the continued rise in the cost of Medicaid, with some critics blaming the rising costs on immigration and low-income groups, and some even suggesting getting rid of the program altogether. However, the real issue is the lack of government action on fraud, inadequate oversight of the system, and financial exploitation by healthcare providers and pharmaceutical companies. (Centers for Medicare & Medicaid Services, 2024)

Medicare is also another program that is susceptible to fraud. Healthcare providers can be paid for services that are not provided. Patients may receive unnecessary services or treatments because providers want to increase billing. Companies can sell expensive equipment that patients do not need, while individuals may use stolen information to make false claims.

Fraud damages patients as well as the government. False information may be placed in a medical record, affecting future care. Patients may receive procedures with unnecessary risks. When funds are lost through fraud, fewer resources remain for legitimate services.

Healthcare Costs

Healthcare costs in the United States are high compared with many other developed countries. The reasons include medicine prices, administrative expenses, specialist care, technology, hospital charges, and chronic disease.

Medicare and Medicaid must pay for services in a complex market where providers have different prices and incentives. The government may have limited negotiating power for some products. Administrative systems are also complicated because federal and state governments, private insurers, hospitals, and contractors all participate.

High costs do not always mean high-quality care. Some services may be repeated because providers do not share information. Patients may receive treatment in emergency departments because they lack access to primary care. Preventable disease and poor management of chronic conditions also increase spending.

Private Contractors

The government uses private companies to administer parts of Medicare and Medicaid. Contractors process claims, manage plans, provide equipment, and perform other services. Private participation can provide expertise and efficiency, but it also creates opportunities for profit and conflicts of interest.

Companies may reduce services to lower costs or receive higher payments by documenting patients as more seriously ill. Oversight is necessary to ensure that public money is used for patient care rather than excessive administrative expenses or profit.

Medicare Advantage

Medicare Advantage allows private insurance companies to provide Medicare benefits. Supporters argue that the plans offer additional benefits and coordinated care. Beneficiaries may receive dental, vision, or wellness services not included in traditional Medicare.

Critics raise concerns about payment methods, limited provider networks, prior authorization, and marketing. Plans may receive higher payments when members are classified as having more health conditions. Accurate risk adjustment is important to prevent overpayment.

Patients should receive clear information regarding costs, provider access, and restrictions. Advertising should not create confusion about whether a plan is government-operated or privately managed.

Prescription Drugs

Prescription drug costs are a significant burden for patients and public programs. Pharmaceutical companies invest in research, but prices may remain high even after development costs have been recovered.

Generic medicines and biosimilars can reduce costs, but competition may be delayed by patents, legal strategies, or agreements between companies. Medicare's ability to negotiate drug prices has been limited historically, although recent laws have expanded negotiation for selected medicines.

Patients sometimes skip doses or avoid filling prescriptions because of cost. This can worsen health and lead to more expensive hospital treatment. Policies should ensure that essential medicines are affordable while supporting genuine innovation.

Provider Payment

Traditional payment systems often reimburse providers for each service. This fee-for-service approach can encourage a higher volume of tests and procedures, even when additional care does not improve outcomes.

Value-based payment attempts to link reimbursement to quality, coordination, and patient outcomes. However, quality measures can be difficult to design and may create administrative burden. Providers serving complex or disadvantaged populations should not be punished for factors beyond their control.

Fraud Detection

Technology can help identify unusual billing patterns. Data analysis may reveal providers who submit unusually high numbers of claims, use impossible combinations of services, or bill for patients in distant locations.

Algorithms should support rather than replace investigation. A statistical pattern does not automatically prove fraud, and legitimate providers should have an opportunity to explain unusual circumstances. Investigations must protect due process while acting quickly to prevent continuing losses.

Whistleblowers

Employees and contractors may discover fraud through their work. Whistleblower laws can allow individuals to report false claims and sometimes receive a portion of recovered funds.

Whistleblowers may face retaliation, job loss, and legal pressure. Organizations should create internal reporting systems, protect confidentiality, and investigate concerns independently. However, internal systems should not prevent employees from reporting to government authorities.

Patient Education

Patients can help detect fraud by reviewing Medicare Summary Notices and benefit statements. They should report services they did not receive and protect identification numbers from unauthorized use.

Education must be accessible to older adults, people with disabilities, and individuals with limited English proficiency. Scam calls and misleading advertisements frequently target vulnerable populations.

Medicaid Eligibility

Medicaid eligibility varies by state and may depend on income, age, disability, pregnancy, family status, and other factors. Complex enrollment procedures can prevent eligible people from receiving coverage.

Frequent eligibility reviews may cause people to lose coverage because of paperwork even when they remain qualified. Interruptions in coverage can disrupt treatment and increase emergency care.

Simplifying applications, using available income data, and providing assistance can improve access while maintaining program integrity.

Health Inequality

Medicare and Medicaid serve populations with significant health needs. Older adults may have multiple chronic conditions, while Medicaid beneficiaries may face poverty, unstable housing, food insecurity, and limited transportation.

Healthcare programs alone cannot eliminate these problems. Coordination with housing, nutrition, disability, and social services can improve outcomes. However, social programs should not be used as a reason to deny necessary medical care.

Political Debate

Medicare and Medicaid are frequently debated according to political ideology. Some policymakers emphasize government responsibility and universal access, while others emphasize private markets, state control, and reduced spending.

Constructive debate should use accurate information regarding beneficiaries, costs, fraud, and outcomes. Describing all recipients as dependent or all providers as dishonest prevents practical reform.

Ethics

Public healthcare programs involve ethical principles of justice, beneficence, and stewardship. Justice requires fair access to care. Beneficence requires policies that improve patient well-being. Stewardship requires responsible use of limited public resources.

Fraud violates all three principles because it diverts resources from patients, increases costs, and damages trust. At the same time, aggressive cost reduction can also be unethical if it denies beneficial treatment or creates unreasonable barriers.

Reform Options

The government should strengthen audits, data sharing, and enforcement against fraudulent providers. Penalties should be sufficient to discourage misconduct, and individuals responsible for intentional fraud should be held accountable rather than treating fines as a business expense.

Payment systems should reward effective care and prevention without creating incentives to avoid high-risk patients. Drug price negotiation and competition can reduce medication costs. Administrative procedures should be simplified to reduce waste and improve patient access.

Private plans and contractors should disclose financial information, ownership, quality, denials, and complaints. Patients need understandable comparisons between options.

Investment in primary care, home-based services, mental health, and chronic disease management can reduce avoidable hospitalization. Programs should also support caregivers who provide unpaid assistance to older adults and people with disabilities.

Conclusion

Medicare and Medicaid are essential programs that provide healthcare to older adults, people with disabilities, children, families, and low-income individuals. Their complexity and large budgets create opportunities for fraud and excessive profit, but these problems do not justify abandoning the programs.

Effective reform should target misconduct, reduce unnecessary administrative costs, negotiate fair prices, and improve coordination. Patients should be protected from both financial exploitation and denial of necessary care. Public money must be used according to the purpose for which it was collected: providing accessible and effective healthcare to eligible people. (U.S. Department of Health and Human Services Office of Inspector General, n.d.) (Medicare Payment Advisory Commission, 2025)

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