say $50 million of that is being skimmed off fraudulently every day.

Medicaid, the program covering the destitute, is also riddled with problems. It serves 39 million people and the bill exceeds $141 billion annually.

Investigators have found fraud in all segments of the health care system, from physicians and hospitals to nursing-home operators, providers of patient transportation and laboratory and clinic operators.

Probes by federal and state agencies have uncovered a large array of misdeeds: the government was billed for services that were never provided, orders for goods and services were forged, and services that were not medically necessary or even useful were provided. There were also overcharging and improper referrals, and even payoffs for providing the names of new health maintenance organization (HMO) enrollees (see sidebar).

Why are Medicare and Medicaid such easy marks? Government watchdogs such as the General Accounting Office say they are ripe for abuse because they are fragmented, poorly supervised and awash in public money. Much of that money is within reach of practitioners and entrepreneurs who have little accountability and can order goods and services as they see fit; their clients, on the other hand, have no incentive to care about costs, all of which are paid by a distant third party.

My friend Carmine, a gentle but streetwise 80-year-old cancer outpatient who requires frequent treatment in community clinics and doctors' offices, only has to call a Medicare-approved van service to be transported to his facility of need. For that he pays a $3 fee (plus tip) and the van service bills Medicare for the remainder.

Carmine thinks this is so wonderful he uses it to go to the bank, grocery store, or even to the airport (a $25 trip) when he is going to visit his family in New Jersey. For him the $3 user fee is a pretty good deal, and the van driver doesn't care whether he heads for the radiation clinic or the airport. And Medicare will pay.

Dr. Robert MacMillan, president of Insurance Claims Management Systems, provides claims management and managed-care services for Canadian and other foreign health insurance firms that cover travellers in North America. From his Florida office he deals with many American hospitals, doctors, labs, managers and suppliers across the American health care system.

MacMillan, a past president of the Ontario Medical Association and former executive director of OHIP, says health care fraud in Canada pales in comparison to that south of the border. He says Canada's disciplinary colleges have demanded a higher level of accountability and have stricter

Fraud cases range from the sublime to the ridiculous

American investigators didn't have to look far to find examples of Medicare and Medicaid fraud.

Consider the van service that, over 16 months, billed Medicare $62 000 for ambulance trips to transport one beneficiary 240 times. Nobody noticed.

Medicare was also charged rates as high as $600 per hour for physical and speech therapy services rendered by therapists earning $20 an hour. Elderly residents of a nursing home were occasionally invited to coffee meetings to greet newcomers. When one of the resident's sons examined billing statements for his mother, he found that the nursing home had been billing Medicare for group-therapy sessions for everyone attending the coffee klatches. Nobody but the son noticed.

Dr. Barry Feldman, a podiatrist and middleman for a medical-equipment company, was convicted of soliciting Medicare referrals and then giving each patient a lymphedema pump, regardless of need. Medicare paid the $4800 bill that came with each pump.

One psychiatrist billed Medicare for an average of 26 sessions, 45–50 minutes each, per day. They had not been provided.

Then there were Robert and Margie Mills, owners of ABC Home Health Care (America's largest privately held home health-services company), who charged Medicare $84 341 for gourmet popcorn for parties and "conferences," $27 930 for ABC umbrellas, and over $1 million for liquor, lease payments for their son's BMW, maid services and utility fees for their personal ocean-front condo. In all, ABC was charged with submitting $14 million in improper billings. At the end of 1994, ABC's revenues from Medicare totalled almost $616 million for the year and accounted for 95% of the company's business. Robert Mills was subsequently convicted of Medicare fraud, mail fraud, money laundering, conspiracy and witness tampering; his wife was found guilty of making false statements.

Even mainstream hospitals have been targeted by federal investigators. Investigators say that more than 4600 hospitals have illegally billed Medicare separately for outpatient services that should have been covered by inpatient reimbursements. That's double billing, and the government says it intends to recover at least $125 million from the errant hospitals under a settlement plan that cuts their penalties in return for cooperation.