STATEMENT OF

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BEFORE THE
UNITED STATES SENTENCING COMMISSION

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HEARING ON
PROPOSED AMENDMENTS TO THE FEDERAL
SENTENCING GUIDELINES

WASHINGTON, DC

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Madam Chair and Members of the Commission:

Thank you for the opportunity to appear before you today to discuss the Commission's proposals for guideline amendments in response to congressional directives in the recently enacted Patient Protection and Affordable Care Act. As U.S. Attorney in the District of Massachusetts and Chair of the Healthcare Fraud Working Group of the Attorney General's Advisory Committee, it is an honor to speak to you today on behalf of the Department of Justice and federal prosecutors nationwide.

Federal and state spending on Medicare and Medicaid exceeds $800 billion per year and is expected to double over the next 10 years. Various estimates indicate that tens of billions of dollars per year is lost to waste, fraud, or abuse. In addition to ensuring that affordable health insurance is available to millions of Americans and protecting them against potentially catastrophic medical expenses, the Patient Protection and Affordable Care Act supports the efforts of federal prosecutors to prevent and crack down on health care fraud, waste, and abuse. Meeting this challenge head-on remains a top priority of the Administration, and we are taking a strategic approach to combating the sophisticated white collar criminals who would steal from the health care till – regardless of whether they are providers, equipment suppliers, or corporate wrongdoers.

The Assistant United States Attorneys of the 93 United States Attorneys' Offices, in partnership with the trial attorneys of the Criminal Division of the Department, the special agents of the Federal Bureau of Investigation, and the men and women of the Department of Health and Human Services, are strategically targeting and prosecuting entities and individuals who steal from Medicare, Medicaid and other health care systems by billing for unnecessary or non-existent services. As a result of this inter-agency effort – which in part uses Strike Forces to quickly identify, investigate, and prosecute those who steal from our health care

systems – the government has recovered more than $4 billion in taxpayer dollars in Fiscal Year 2010 alone. And that $4 billion in stolen proceeds was returned to the Medicare Health Insurance Trust Fund, the U.S. Treasury, and others in FY 2010.

Despite those unprecedented results, there is a great deal more to be done in this area. Thus, we applaud the Commission today as it considers amendments to the federal sentencing guidelines that we believe fairly and appropriately implement and support the goals of the Affordable Care Act.

We support the Commission's response, in the newly proposed section 2B1.1(b)(8), to the Act's directive that the Commission, among other things, amend the federal sentencing guidelines to provide for a tiered sentencing enhancement based on the loss amount associated with an offense involving a "Government health care program." This provision, specifically mandated by the Act, is essential to combating health care fraud and reflects an appropriate measure of a health care fraud defendant's culpability.

Moreover, we support the Commission's response, through a new special rule in Application Note 3(F), to the Act's directive to amend the guidelines to provide that the aggregate dollar amount of fraudulent bills submitted to a

"Government health care program" shall constitute prima facie evidence of "intended loss" by the defendant.

We would like to propose two additional items for the Commission's consideration.

First, we recommend that the tiered enhancement proposed for losses "involving a Government health care program" at §2B1.1(b)(8) be expanded to apply not only to Government health care programs, but to losses to privately funded health care benefit programs as well. In this way, the reach of the federal sentencing guidelines would mirror the broader reach of the criminal statutes that are referenced to this guideline for sentencing purposes. We believe federal health care offenses involving privately funded health care benefit programs should also be subject to the proposed tiered enhancements where losses are more than $1 million, $7 million, and $20 million, respectively, in accordance with congressional direction that the Sentencing Commission review the federal sentencing guidelines applicable to persons convicted of any "Federal health care offense." These federal health care offenses include any violation of or conspiracy to violate 18 U.S.C. §§ 664, 1027, and 1954; 29 U.S.C. §§ 1111, 1131, and 1141, as well as other "Federal health care offenses" listed in 18 U.S.C. § 24(a) where

the victims are employee benefit plans subject to ERISA (the Employee Retirement Income Security Act of 1974) through which approximately 140 million Americans receive privately funded health care.

Health care offenders often use the *same fraudulent billing scheme* to defraud government programs and private sector health benefit programs *simultaneously*.[1] As currently proposed, limiting the application of §2B1.1(b)(8) to health care offenses involving a Government health care program and the calculation of loss amount to "bills submitted to [a] Government health care program" (as directed under Application Note 3(F)(viii)) – particularly in cases where the majority of the loss amount was actually attributable to the private health insurance program – could, in practice, require the separation of government and

[1]*See United States.v Hardiman*, (S.D. Ill.)(plea Oct. 19, 2010) (guilty plea to more than $2 million in fraudulent claims to Medicare, Medicaid, Blue Cross, Blue Shield, and several union welfare funds); *United States v. Froelich*, 7 CR 62-1 (N.D.Ill.) (sentencing June 26, 2009)(fraudulent billing scheme sentencing documents reflect restitution for more than $2 million in losses to private insurers, collectively bargained plans, and employer-sponsored plans); *United States v. Sohka*, (D.N.J.) (sentencing Oct. 15, 2008) (sentencing for $2.5 million in fraudulent billing for services and medical treatment not performed).

private losses for guidelines purposes and would result in sentencing guideline ranges applicable to offenses involving private sector programs that are significantly lower than the guideline ranges applicable to offenses involving government programs, despite no meaningful difference in the defendant's culpability. We believe that failure to broaden the ambit of the proposed loss-related amendments will only result in greater sentencing disparities and unnecessary legal battles regarding whether the Commission intended the courts to treat public and private health care programs so differently. [2]

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[2]In the event that the Commission does not broaden the applicability of the loss-related proposals to include all privately funded health care programs, federal prosecutors favor inclusion of the following classes of health care programs within the coverage of the new enhancements: (A) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code), including but not limited to the Medicare and Medicaid programs; (B) any State health care program, as defined in 42 U.S.C. § 1320a-7(h); (C) any group health plan as defined in 29 U.S.C. § 1191b; (D) any multiple employer welfare arrangement subject to 29 U.S.C. § 1002(40); or (E) any insurer as defined at 18 U.S.C. § 1033(f)(2).

Moreover, large losses suffered by privately funded programs – such as employee health benefit plans or private insurers or associations – are likely to have a substantial negative impact on those programs, the individuals covered by such programs, *and the health care industry as a whole*, resulting in increases in the costs and premiums charged by private sector programs.[3] As I alluded to earlier, the goal of the Act was not only to ensure the availability of health care to American citizens, but to ensure that available health care *remains affordable* – in part, by eliminating waste and graft. As our Nation is recovering from economic crisis, we must be mindful in the health care context that we must protect not only the *public* fisc, but take smart measures to reduce the ways that sophisticated criminals similarly steal from private programs, cheating and ushering higher health care costs upon citizens. We urge the Commission to consider our proposal which will dispense with the need for defining "Government health care program and will promote deterrence in the private, as well as government, health care context.

[3]*See United States v. Graf*, 610 F.3d 1148 (9th Cir. 2010) (conviction of operator of privately funded health care insurance whose organizations sold coverage to more than 20,000 employees and failed to pay more than $20 million in medical claims).

Second, we propose that the guidelines be amended with respect to their application to health care offenses involving so-called "stand-alone kickback cases" under 42 U.S.C. § 1320a-7b(b). Presently, USSG §2B4.1 is the guideline that applies to such offenses, and the loss enhancement contained therein is either the kickback amount or "the value of the improper benefit to be conferred." The latter is defined by reference to §2C1.1, Note 3, which states that "'the benefit received or to be received' means the net value of such benefit[,]" not gross revenue. Generally, courts have used the gross revenue or billing amount only when the government was able to prove corruption of medical judgment, such as prescribing unnecessary procedures, or some other form of fraud. As a consequence, in kickback cases, the government has been limited to using the value of the kickback that was paid, resulting in low-level applicable guideline ranges (including frequent probationary sentences) that do not adequately reflect the nature of the offense and the true culpability of the defendant.

We urge the Commission to amend the guidelines so that, even absent fraud, §2B1.1 applies to the sentencing of kickback cases and, with respect to such offenses, the loss is defined expressly as the amount of the submitted claims that are influenced by the kickbacks.

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In closing, I would like to thank the Commission, again, for this opportunity to share the views of the Department of Justice and for its continued commitment to the development of fair sentencing policy.