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HEALTH CARE FRAUD: ALL PUBLIC AND PRIVATE PAYERS NEED FEDERAL CRIMINAL ANTI-FRAUD PROTECTIONS

ELEVENTH REPORT

BY THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

AUGUST 2, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
Washington, DC, August 2, 1996.

Hon. NEWT GINGRICH,
Speaker of the House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: By direction of the Committee on Government Reform and Oversight, I submit herewith the committee's eleventh report to the 104th Congress.

WILLIAM F. CLINGER, Jr.,
Chairman.

CONTENTS

		Page
I.	Summary	1
II.	Background	2
III.	Findings	7
IV.	Recommendations	12

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104TH CONGRESS, 2nd Session | HOUSE OF REPRESENTATIVES | REPORT 104–747

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AUGUST 2, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. CLINGER, from the Committee on Government Reform and Oversight, submitted the following

ELEVENTH REPORT

On July 25, 1996, the Committee on Government Reform and Oversight approved and adopted a report entitled "Health Care Fraud: All Public and Private Payers Need Federal Criminal Anti-Fraud Protections." The chairman was directed to transmit a copy to the Speaker of the House.

I. SUMMARY

Health care fraud, by some estimates a $100 billion problem, does not stay within the jurisdictional boundaries that divide Federal, State and local health care finance and law enforcement. Sophisticated patterns of fraud and abuse have been detected operating simultaneously against private insurers as well as Federal and State health programs. These scams victimize patients and payers across multiple States, even nationally.

Faced with increasing health care costs, and the growing price of health care fraud, Congress and Federal policymakers are aware of the need for a more coordinated, unified approach to anti-fraud enforcement.[1] One essential element of that approach is the availability of Federal criminal health care offenses to prosecute frauds against any and all payers victimized by the same scheme.

Current Federal enforcement tools are inefficient and inadequate against increasingly sophisticated patterns of fraud and abuse. Health care fraud cases, prosecuted mainly under mail and wire

[1] *Fraud and Abuse in Medicare and Medicaid: Stronger Enforcement and Better Management Could Save Billions,* Eighth Report of the Committee on Government Reform and Oversight, June 27, 1996, pp. 7–10.

fraud statutes, money laundering and false claims laws, are complex, costly and time-consuming.

Scarce enforcement resources are wasted when Federal enforcement efforts to protect Medicare and Medicaid only result in "fraud shifting" to private payers. In that event, the general public continues to pay the price for health care fraud in the form of higher insurance premiums and higher costs for Government health programs.

Support for creation of Federal health care fraud crimes is both longstanding and bipartisan. The previous and current administration endorsed making health care fraud a Federal crime. Legislation in both the 103d and 104th Congress has enjoyed bipartisan sponsorship and support.

Findings in brief

1. Health care fraud schemes steal billions of dollars from public and private payers each year.
2. The Department of Justice (DOJ) needs stronger and more direct statutory authority to deter fraud and abuse against public and private health care plans.
3. Scarce enforcement resources are wasted in pursuit of the same fraudulent scheme against public and private health care plans in multiple jurisdictions.

Recommendation

1. Congress should enact legislation to make health care frauds against all public and private payers Federal criminal offenses.

II. BACKGROUND

Total health care spending in the United States reached $1 trillion[2] in FY 95. Medicare and Medicaid programs together represent one-third of all U.S. health care spending. The remaining $664.5 billion of health care spending are generated by States and private health care payers.

Federal outlays to Medicare in FY 95 were $159.8 billion[3] while Federal and State outlays to Medicaid were $156.2 billion.[4] Other Federal health care programs such as Civilian Health and Medical Program of the United States (CHAMPUS) and Federal Employee Health Benefit Plan (FEHBP) cost the Federal Government $3.3 billion and $16.2 billion[5] respectively in FY 95.

According to the General Accounting Office (GAO), 10% of every health care dollar spent in this Nation is lost to fraudulent and wasteful provider claims.[6] Applying this estimate to all health care spending means that more than $100 billion, or over $274 million a day, was lost to fraud and abuse in FY 95.

The need to confront waste, fraud and abuse in the Nation's health care plans more aggressively is recognized by both Democrats and Republicans. Previous Congresses and previous adminis-

[2] "National Health Care Expenditures," Health Affairs, Project Hope, p. 1.
[3] Historical Tables, Budget of the United States Government, fiscal year 1997, p. 59.
[4] Congressional Budget Office (CBO), 3/96 "Baseline Report: Medicaid."
[5] Appendix, Budget of the United States, fiscal year 1997, p. 923.
[6] GAO Report: "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse," GAO/HRD–92–69, 5/7/92, p. 1.

trations have supported the adoption of more effective criminal sanctions against those who defraud health care payers.

In a May 1992 report produced for the Subcommittee on Human Resources and Intergovernmental Relations, the General Accounting Office (GAO) found "that vulnerabilities within the health insurance system allow unscrupulous health care providers, including practitioners and medical equipment suppliers, to cheat health insurance companies and programs out of billions of dollars annually."[7] GAO reports, "Health care fraud has expanded beyond single health care provider frauds to organized activity affecting health care programs *in both the Government and private insurance sectors*."[8] [Emphasis added]

The report stated "profiteers are able to stay ahead of those who pay claims because of a variety of factors. These include (1) independent operations of the various health insurers that limit collaborative efforts to confront fraudulent providers . . . Further, efforts to combat the problems by one insurer can be largely negated when fraudulent or abusive providers move their operations to other insurers."[9]

In discussing the nature and prevalence of fraud and abuse of health care plans, the May 1992 GAO report stated, "Instances of fraud and abuse can be found involving all segments of the health care industry in every geographic area of the country . . ."[10] In addition, GAO found "schemes can be quickly replicated throughout the health care system."[11]

The Bush administration made five specific proposals to combat health care fraud. On January 13, 1993, the Secretary of the Department of Health and Human Services (HHS), the Attorney General and the Director of the Office of Management and Budget (OMB) announced the recommendations of a task force commissioned to examine the problem of health care fraud and abuse.[12] The recommendations included:

- Extending to all public and private payers the current Medicare and Medicaid prohibition on kickbacks.
- Expanding the current Medicare ban on payment for self-referrals for clinical lab tests to additional services where the physician does not directly render service and where abuses have been found.
- Strengthening the Medicare and Medicaid civil monetary penalty statutes and the quality of care sanctions to deter abuses.
- Prohibiting the routine waiver of Medicare Part B (physician and outpatient services) coinsurance.
- Establishing databases of all final adverse actions and certain active fraud investigations against health care practitioners, with appropriate safeguards for privacy and access.

In the announcement, OMB Director Richard Darman emphasized, "More must be done to combat health care fraud and waste.

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[7] Ibid.
[8] Ibid., p. 2.
[9] Ibid., p. 1.
[10] Ibid., p. 2.
[11] Ibid., p. 3.
[12] "Administration Announces Task Force Recommendations to Combat Health Care Fraud and Abuse," HHS/OMB/DOJ press release, January 13, 1993 (in subcommittee files).

Every percent of health care expenses lost to fraud and abuse annually costs honest Americans $9 billion per year." [13]

The Clinton administration, in its FY 1994 Health Care Fraud Report, called for an "all-payer" approach to health care fraud control and for the creation of criminal health care fraud offenses. Acknowledging the scope and variety of health care fraud, the report stated, "Everyone pays the price for health care fraud: beneficiaries of Government health care insurance such as Medicare and Medicaid pay more for medical services and equipment; consumers of private health insurance pay higher premiums; and taxpayers pay more to cover health care expenditures." [14]

In the 103d Congress, discussions included the widespread nature of health care fraud. Before the House Committee on Judiciary's Subcommittee on Crime and Criminal Justice on February 4, 1993, GAO reported all payers are vulnerable to fraud and abuse.

Janet Shikles, Director of Health Financing and Policy Issues, testified "Criminal prosecution and civil pursuit of fraud is expensive, slow and has been shown to have little chance of recovering financial losses. Moreover, private insurers are largely without access to the administrative remedies of the public payers, such as the ability to exclude providers convicted of health care fraud from billing the public programs." [15]

Efforts to determine how both public and private health care plans could be better protected from fraud resulted in the release on July 7, 1994 of a staff report by Senator William Cohen (R–ME), ranking member of the Senate Special Committee on Aging.

The report found current criminal and civil statutes inadequate to effectively sanction and deter health care fraud. The report states "the lack of a specific Federal health care fraud criminal statute, inadequate tools available to prosecutors, and weak sanctions have significantly hampered law enforcement's efforts to combat health care fraud. Inordinate time and resources are lost in pursuing these cases *under indirect Federal statutes*. [Emphasis added] Often even when law enforcement shuts down a fraudulent scheme, the same players resurface and continue their fraud in another part of the health care system." [16] The report recommended:

- Making all health care fraud and abuse a violation of Federal law.
- Establishing a data base available to all program administrators, private insurers and law enforcement groups which will identify persons or providers who have been found guilty of fraud.
- Establishing standard penalties for fraud which, for a first time offender, require mandatory exclusion from the programs for a specified period of time as well as assessment of civil monetary penalties.
- Strengthening certification standards and procedures for providers.

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[13] Ibid.

[14] DOJ report: "Department of Justice Health Care Fraud Report, Fiscal Year 1994" p. 3.

[15] GAO Testimony: "Health Insurance: Legal and Resources Constraints Complicate Efforts to Curb Fraud and Abuse," GAO/T–HRD–93–3, 2/4/93, p. 1–2.

[16] "Gaming the Health Care System: Investigative Staff Report," Senator William Cohen, ranking member, Senate Special Committee of Aging, July 7, 1994, p. 3.

• Enhancing provider responsibility and accountability for electronic media claims.

• Requiring contractors to utilize automated computer screening of provider claims.

• Making HCFA's pricing of medical equipment and services more current, competitive and market sensitive in its reimbursement of provider claims.

• Improving anti-kickback laws.

In the 103d Congress, hearings and legislation dealing with the deterrence, detection and prosection of health care fraud enjoyed bipartisan support.

The Subcommittee on Human Resources and Intergovernmental Relations (HRIR), chaired by Representative Edolphus Towns (D–NY), held three hearings on waste, fraud and abuse in Medicare and Medicaid. Two hearings focused on Medicaid fraud and prescription drug diversion.

As a result of the hearings, the subcommittee recommended that HCFA develop a strategy to address drug diversion, including designation of unit within HCFA to provide assistance to State Medicaid agencies.

It is estimated prescription drug diversion schemes cost the Medicaid program billions of dollars. New York State alone estimates that it loses $150 million a year to fraudulent prescription drug operations.[17]

Legislative proposals to strengthen health care anti-fraud efforts was also offered by both Democrats and Republicans. On July 27, 1994, the HRIR Subcommittee marked up Section 5401 of H.R. 3600, the Health Security Act. Subcommittee Chairman Towns' substitute amendment to Section 5401 directed the Secretary of HHS and the Attorney General to establish a program to "prevent, detect and control health care fraud and abuse."[18] The substitute amendment, supported by Representative Steven Schiff (R–NM), the ranking member of the subcommittee, was adopted and incorporated into H.R. 3600.

Representative Bob Michel (R–IL), Republican Leader, introduced H.R. 3080, the Affordable Health Care Now Act of 1993. As the Republican counterproposal to H.R. 3600, H.R. 3080 established an all-payer anti-fraud and abuse program. This included creating the criminal offense of health care fraud, extending the application of criminal penalties under Section 1128B of the Social Security Act to private health care plans, extending penalties for health care fraud and broadening the application of the mail fraud statute.

In the 104th Congress, the subcommittee, chaired by Representative Christopher Shays, (R–CT) held eight hearings which considered waste, fraud and abuse in health care programs:

1. HRIR Subcommittee hearing on Department of Health and Human Services, March 1, 1995.

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[17] *Waste in Human Service Programs: Other Perspectives: Oversight Hearing Before the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Reform and Oversight,* HRIR hearing of 5/23/95. (Testimony of Doug Kennedy, New York Post investigative reporter) (original transcript p. 82, in subcommittee files).

[18] Activities of the House Committee on Government Operations, Report 103–884, 1/2/95, p. 218 & p. 294.

2. HRIR Subcommittee follow-up hearing on Department of Health and Human Services, March 22, 1995.

3. HRIR Subcommittee hearing on Waste in Human Service Programs, May 23, 1995.

4. HRIR Subcommittee hearing on Keeping Fraudulent Providers Out of Medicare and Medicaid, June 15, 1995.

5. HRIR Subcommittee hearing on H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995 and H.R. 1850, the Health Care Fraud and Abuse Act of 1995, September 28, 1995.

6. HRIR and Government Management, Information, and Technology Subcommittee joint hearing on the Oversight and Review of Medicare's Transaction and Information Systems, November 16, 1995.

7. HRIR Subcommittee hearing on Screening Medicare Claims for Medical Necessity on February 8, 1996.

8. HRIR and GMIT Subcommittee joint hearing on H.R. 3224, the Health Care Fraud and Abuse Prevention Act of 1996, H.R. 1850, the Health Care Fraud and Abuse Act of 1995 and H.R. 2480, Inspector General for Medicare and Medicaid, May 2, 1996.

Representative Schiff introduced H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995, along with Representatives Shays, Clinger (R–PA), Towns and Schumer (D–NY), on September 13, 1995.

Title I required the Inpectors General of the Departments of Health and Human Services (HHS), Defense, Labor, Veterans Affairs, the Office of Personnel Management and the U.S. Attorney General to establish a joint program to prevent, detect and control health care fraud which includes State agencies and local law enforcement; required Federal enforcement authorities to coordinate their efforts more effectively; and established a control account, funded by fines and damages, to help defray Federal and State costs of prevention and detection of fraud and abuse.

Provisions of H.R. 1850, introduced by HRIR ranking member Representative Towns, were very similar to those of Title I of H.R. 2326. However, H.R. 1850 did not include the Attorney General as part of the health care fraud control program. At the September 28, 1995 hearing, there was a consensus that the addition of the Attorney General strengthened the proposed coordination effort, adding a direct link to criminal enforcement.

Title II established health care fraud as a crime for public and private payers, defined health care fraud to include theft, embezzlement, false statements, bribery, graft, illegal, remunerations, and obstruction of criminal investigations of health care fraud, established civil penalties for health care fraud and established investigative demand procedures.

Title III provided for new tools for the HHS Inspector General (IG) to better combat Medicare and Medicaid fraud and abuse.

Major portions of Title II of H.R. 2326 were included in the Medicare Preservation Act which was passed by the House on October 19, 1995.

On March 29, 1996, Representatives Schiff and Shays introduced H.R. 3224, an updated version of H.R. 2326. Again, most of Title

II was included in H.R. 3103, the Health Care Availability and Affordability Act. H.R. 3103 was passed by the House on March 28, 1996.

On June 11, 1996, Senators Bob Graham (D–FL) and Max Bacchus (D–MT) introduced S. 1858 to provide for improved coordination communication and enforcement related to health care waste, fraud and abuse. S. 1858 would establish health care fraud as a crime, define false statement, theft, embezzlement, money laundering and obstruction of investigations as health care offenses, establish forfeitures for health care offenses, provide for injunctive relief and grand jury disclosure.

III. FINDINGS

1. Health care fraud schemes steal billions of dollars from public and private payers each year

Hearing testimony and supporting documents point to an increasing awareness on the part of policy analysts, Federal law enforcement officials and health insurers that public and private payers share the same vulnerability to abusive practices and fraud.

In the June 15, 1995 HRIR hearing, William Mahon, executive director of the National Health Care Anti-Fraud Association (NHCAA), testified, "By its nature, the amount lost to any ongoing fraud can never be quantified to the exact dollar and thus must be estimated in an educated context. In that context, NHCAA estimates the loss to outright fraud at between 3% and perhaps as much as 10% of what we spend as a nation on health care each year." [19]

Mr. Mahon enumerated what he viewed as the stark realities of health care fraud: "One is that almost never do fraudulent providers defraud one payer at a time. The only smart way to commit health care fraud is to spread your activity among enough payers, so that you remain relatively inconspicuous with each one for longest possible time." [20]

Mr. Mahon continued, "The second truism of the subject is that almost never do fraudulent providers defraud either the private or the public sector exclusively. If they do it to Medicare, to Medicaid, to CHAMPUS [Civilian Health and Medical Plan of the United States] they do it to employers health insurance, to Blue Cross and Blue Shield, and to Aetna and all the other private payers." [21]

He also reported "that multiple-target, private-public fraud can be addressed most effectively through concerted private-public efforts . . ." [22]

Gerald Stern, Special Counsel on Health Care Fraud for the DOJ, agreed, stating, "Perpetrators of health care fraud will seek to prey on any health care system the market produces or Congress

[19] *Keeping Fraudulent Providers out of Medicare and Medicaid: Oversight Hearing Before the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Reform and Oversight,* hearing of 6/15/95, p. 84.
[20] Ibid.
[21] Ibid., p. 81.
[22] Ibid., p. 85.

adopts. Where there is money, unscrupulous providers simply shape schemes to fit the particular form of reimbursement."[23]

A February 1994 GAO Report, "Medicaid: A Program Highly Vulnerable to Fraud," found Medicaid is ". . . highly vulnerable to fraud because of its size, structure, target coverage."[24] GAO reports show that medical professionals or businesses that engage in fraudulent and abusive practices have targeted both Medicaid and Medicare resulting in unnecessary expenditures by both programs *as well as by private health care insurers*. (Emphasis added)

In addition, Sarah Jagger, GAO's Director of Health Financing and Policy, reported during the March 22, 1995 oversight hearing on the Department of Health and Human Service (HHS) the opportunities for fraud and abuse exist because each program provides incentives to submit claims for services that are not needed, not provided, or overpriced.[25]

A January 13, 1993 joint HHS/DOJ/OMB announcement reported "there is no reason to believe that the overutilization risk attributable to kickbacks does not apply to private payers. Most kickback schemes involve federal programs and private payers as well . . . Some kickback schemes start by avoiding Medicare and Medicaid business until after referral patterns are established."[26] Administration officials noted this type of scheme would no longer be available to evade liability under the proposed all-payer anti-kickback statute.

The Cohen staff report states, "Our investigation found that scams such as these are perpetrated against both public and private health plans, and that health care fraud schemes have become more complex and sophisticated, often involving regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices . . ."[27]

Recent high profile prosecutions of health care fraud cases demonstrate that these schemes target public and private payers simultaneously.

National Medical Enterprise (NME) operated psychiatric hospitals and substance abuse facilities nationally. NME plead guilty to bribing doctors and other referral sources to refer patients for admission to NME facilities. It was also alleged NME paid for referrals of patients, improperly waived Medicare co-payments for patients and then claimed reimbursement from Medicare for these waived amounts as bad debts, engaged in other billing fraud, and billed for services not rendered and for treatment that was not reasonable or necessary.

In June 1994 NME signed a criminal plea and civil and administrative settlement with DOJ to pay $379 million in criminal fines, civil damages and penalties to the Federal Government and several

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[23] Ibid., p. 56.

[24] GAO Report: "Medicaid: A Program Highly Vulnerable to Fraud," GAO/T–HEHS–94–106, 2/25/94, p. 1.

[25] *Agency Oversight Hearing on HHS: The Mission of HHS: Oversight Hearing Before the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Reform and Oversight,* hearing of 3/22/95. (Prepared written statement of Sarah Jagger, Director of Health Financing and Policy, General Accounting Office,) p. 87.

[26] See *Supra* note 12 p. 2.

[27] See *Supra* note 16 p. 2.

States for kickbacks and fraud at NME in more than 30 States.[28] This included a payment to several States of a total of $16.3 million for harm caused the State-funded portion of Medicaid and other State health programs.

In addition to this plea arrangement, NME has been the subject of several civil suits by private payers who were also defrauded. In the first stage of settlements, NME agreed to pay $125 million to Aetna Life Insurance, Metropolitan Life Insurance and CIGNA.[29] Subsequent settlements included 13 other companies which recouped $90 million.

Another well-known health care fraud case, the so-called "Rolling Labs" case, involved a billion dollar medical insurance scheme. A chain of mobile diagnostic testing services and clinics in the Los Angeles area performed medically unnecessary tests on unsuspecting patients after promising free preventive diagnostic tests. Bills for these medically unnecessary tests were submitted to public and private health care plans. After a 5-year investigation of this scheme by multiple Federal and State agencies, two defendants were convicted of mail and wire fraud, conspiracy, money laundering and racketeering.[30]

Other examples of health care fraud cases include:

- In 1991, one of New Hampshire's largest employers, the Sturm, Ruger Co., canceled its employees' prescription drug benefit after costs of the benefit increased so dramatically as to force the company to raise the employee co-payment from $3 to $20. It was later discovered that a Newport, NH pharmacist had defrauded that and other prescription plans, as well as the State Medicaid program, for a total of $373,278 between April 1989 and July 1991.
- On April 18, 1995, a Bridgeport, CT Federal grand jury returned an indictment for wire fraud against an individual who participated in a scheme to defraud CIGNA and its subsidiary for submitting false claims.
- On May 24, 1995, an FBI initiative was announced which targeted staged automobile accidents and related casualty and health insurance fraud. It resulted in arrests and indictments in 31 States.
- On May 25, 1995, the U.S. Attorneys offices in Columbus, OH and Charleston, SC and the Federal Trade Commission announced a coordinated attack on telemarketing health care fraud schemes filing several actions against companies in Ohio and South Carolina with deceptive practices in selling medical equipment.

2. The Department of Justice (DOJ) needs stronger and more direct statutory authority to deter fraud and abuse against public and private health care plans

Current criminal and civil statutes are inadequate to effectively sanction and deter health care fraud. According to the Cohen staff report, "Federal prosecutors now use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act,

[28] See *Supra* note 19 p. 52.
[29] Business Week, "Put the Head in the Bed and Keep it There," October 19, 1993.
[30] See *Supra* note 19 p. 52.

false statement statutes and money laundering statutes to prosecute health care fraud. Our investigation found that the lack of a specific Federal health care fraud criminal statute, inadequate tools available to prosecutors, and weak sanctions have significantly hampered law enforcement's efforts to combat health care fraud." [31]

Reinforcing that finding, the DOJ's Stern testified regarding a fraud scheme perpetrated against Medicare and other health care payers that took many months to prosecute under mail and wire fraud laws: "In San Diego, an ophthalmologist had been billing Medicare and other health care plans more than $80 million for medically unnecessary cataract and eyelid surgery. Last March, after a multimonth jury trial, he was convicted of 132 counts of false claims, mail fraud, and money laundering." [32]

He continued, "On some days, he saw more than 150 patients. On other days, he performed 35 to 45 surgeries, with each patient receiving six separate surgical procedures, unrelated to medical need. In 1992, after a search warrant was executed, Medicare suspended all payments to the physician. While he was awaiting trial, the State of California revoked his medical license. The U.S. Attorney General's office obtained a court order repatriating $7.5 million, which he shipped offshore." [33]

In his testimony on June 15, Mr. Mahon supported specific initiatives to give prosecutors additional tools in the fight against health care fraud. He suggested "following the so-called 'all-payer' approach, featured in virtually all of the legislative proposals on health care fraud, many of them bipartisan, set forth since 1992—the essence of which is:

- to create a Federal crime of health care fraud, encompassing actions against private and public third-party payers.
- to make illegal in dealings with private and other government payers what today is illegal only in dealings with the Medicare and Medicaid programs.
- to effectively bar providers guilty of fraud from dealings with any health insurance plan, private or public.
- to coordinate the activities of Federal and State law enforcement agencies and to provide for their coordination of activity with private payers." [34]

In his September 28, 1995 testimony, Mr. Mahon reemphasized the importance of the "all-payer" approach:

> In NHCAA's June 15 testimony, we urged the Subcommittee to consider that the most effectively way to protect the public interest in addressing fraud against the nation's health care payment systems is through a so-called "all-payer" approach, recognizing (1) that the public impact of health care fraud extends far beyond its effect on the Medicare, Medicaid and other government programs and (2) that any effective new anti-fraud effort must be tailored to certain realities of the crime, specifically:

[31] See *Supra* note 16 p. 3.
[32] See *Supra* note 19 p. 85.
[33] Ibid., p. 50.
[34] Ibid., p. 85.

• that private sector health care expenditures exceed those of government health insurance programs, representing 57% and 43% respectively, of the nation's total health care outlays.

• that in most cases, dishonest providers who defraud government programs also defraud private health insurers, and vice-versa.

• that the typical health care fraud scheme is aimed a multiple private and public payers simultaneously.

• that any deficiencies in current law notwithstanding, it already is far more dangerous for dishonest providers to defraud Medicare and Medicaid than to steal from private payers.

In that context, we noted, any legislative efforts that focuses solely on increasing enforcement activities and the legal penalties related to fraud against government health insurance programs—without addressing the private sector side of the fraud equation—is likely to result in a "fraud-shifting" analogous to the familiar cost-shifting phenomenon. That is, rather than risk even more severe penalties by defrauding the government, dishonest providers will follow the safer path of intensifying their fraudulent billing activity against private payers.[35]

3. Scarce enforcement resources are wasted in pursuit of the same fraudulent scheme against public and private health care plans in multiple jurisdictions

During the June 15, 1995 hearing, Representative Towns said he "was very concerned about, even when we try and go after fraud and abuse, it seems we waste manpower and womanpower hours with various agencies stumbling over each other."[36] A more coordinated, unified enforcement approach to health care fraud, including the availability of Federal criminal health care offenses to prosecute frauds against any and all payers victimized, would address the problem.

Sarah Jaggar, Director of GAO's Health Financing Division, in the March 1995 hearing said that ". . . numerous jurisdictions have responsibility over Medicaid fraud and abuse matters. It is not unusual for a prescription drug fraud case [for example] to involve five or more State, local and Federal agencies in its investigation, prosecution and resolution."[37]

In her testimony before the House Committee on Judiciary's Subcommittee on Crime and Criminal Justice on February 4, 1993, Ms. Shikles raised the issue of the dollar threshold fraud cases usually need to reach before prosecutors will consider committing scarce resources. She reported that "investigative and prosecutorial resources and priorities vary by jurisdiction, often constraining state and Federal prosecutors from pursuing health care cases involving

[35] *H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995 and H.R. 1850, the Health Care Fraud and Abuse Act of 1995,* HRIR Subcommittee hearing of 9/28/95, (prepared written statement of William Mahon, executive director, NHCAA, p. 1).

[36] See *Supra* note 19 p. 3.

[37] See *Supra* note 25 p. 84.

relatively small dollar amounts. In several jurisdictions, for example, Federal prosecutors told us that they generally accept only criminal health care cases that are clear-cut and involve $100,000 or more . . ."[38]

IV. Recommendation

1. Congress should enact legislation to make health care fraud against public and private payers a Federal criminal offense

In his opening statement on June 15, 1995, HRIR ranking member Representative Towns asked, "Are there changes that must be made to current criminal and civil statutes to improve their effectiveness in sanctioning and deterring health care fraud?"[39]

The answer to Representative Towns' question was yes.

Gerald Stern testified that DOJ "endorses efforts to strengthen criminal, civil and administrative remedies for health care fraud, which will give prosecutors new tools in their efforts to stop health care fraud, punish its perpetrators and recover funds for the Government and other victims. These provisions create a general health care fraud offense prohibiting schemes to defraud health plans or persons in connection with the delivery of or payment for health care, establishment of a criminal and civil bar on kickbacks in any Federal health care program, authorizing administrative subpoenas in health care cases, and permitting use of grand jury material by civil health care prosecutors. Such measures would give us additional critical tools to combat this scourge on our nation's health care plans."[40]

NHCAA's William Mahon stressed "in trying to address Medicare and Medicaid fraud, Congress and law enforcement have an obligation and an opportunity to do it most effectively by addressing both sides of the equation. My outspoken comment, if you will, is that if Congress feels it has addressed Medicare-Medicaid fraud, but does not go beyond that into private payer fraud, it is shortchanging the taxpayers, shortchanging all the people who pay for private health insurance in this country."[41]

In a September 21, 1995 letter to the subcommittee, Martin Corry, director of Federal Affairs for the American Association of Retired Persons (AARP) concluded, "Creating a new criminal code provision that specifically addresses health care fraud, establishing a health care fraud and abuse control program, and creating a health care fraud and abuse control account are all measures that should significantly assist authorities in investigating and prosecuting fraudulent providers."[42]

Following the September 28, 1995 HRIR hearing, Thomas Schatz, president of Citizens Against Government Waste, wrote to Ways and Means Committee Chairman Bill Archer (R–TX) urging adoption of tough measures to eliminate waste, fraud and abuse in health care programs. "The information uncovered by the [CAGW]

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[38] See *Supra* note 15 p. 2.
[39] See *Supra* note 19 p. 4.
[40] Ibid., p. 56.
[41] Ibid., p. 82.
[42] Letter of September 21, 1995 to Representative Christopher Shays, chairman, Subcommittee on Human Resources and Intergovernmental Relations, from Martin Corry, director, Federal affairs, American Association of Retired Persons (in subcommittee files).

report and our research, and the testimony before the subcommittee today," Schatz said, "show that the problems in Medicare are indicative of the problems in health care in general."[43]

Making health care fraud against public and private payers a Federal criminal offense will end prosecutors' reliance on antiquated criminal statutes. Prosecutors should not have to jump through evidentiary hoops to develop mail or wire fraud cases when the real crime is health care fraud. Scarce resources should be focused on indicting and convicting those who knowingly and willfully defraud public and private health care plans.

Currently, private insurers are often frustrated by prosecutors' unwillingness or inability to take on cases that, while significant to the insurer, fall short of certain dollar thresholds. In an all payer environment, enforcement resources can be focused on significant, high cost fraud schemes if losses to both public and private payers can be aggregated to reach dollar thresholds considered worthy of prosecution.

Congress has examined this critical issue of combating fraud and abuse in public and private health care plans since 1992. The problem has been clearly defined through congressional hearings, testimony and audits. Bipartisan legislation providing for a refined tool to attack this problem has made its way through committees to the floor of the House and has been passed by Congress.

The most recent legislative initiative passed by the House, the Health Care Availability and Affordability Act of 1996, H.R. 3103, carefully defines health care fraud offenses. It establishes health care fraud as a Federal felony for both public and private payers.

Under H.R. 3103, a person is guilty of health care fraud who "having devised or intending to devise a scheme or artifice, commits or attempts to commit an act in furtherance of or for the purpose of executing such scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program . . ."[44] A health care benefit program is "any public or private plan or contract under which any medical benefit, item or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract."[45]

The bill also authorizes forfeitures, injunctive relief, and investigative demand procedures.

Like H.R. 3103, any final legislation should require proof of a knowing and willful pattern of behavior for the application of these health care offenses by prosecutors. This would assure honest mistakes by health care providers would not result in criminal conviction or imprisonment.

"All payer" provisions should also carefully limit or exclude illegal remuneration, bribery or graft as health care offenses. While applicable to fee for service arrangements like Medicare, these of-

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[43] Letter of September 28, 1995 to Representative Bill Archer, chairman, House Committee on Ways and Means, from Thomas A. Schatz, president, Citizens Against Government Waste (in subcommittee files).

[44] H.R. 3103, the Health Care Accessibility and Affordability Act of 1996.

[45] Ibid.

fenses would have, at best, an uncertain impact on managed care programs. Strengthened anti-fraud provisions, particularly those aimed at intentional overutilization, need not, and should not be in conflict with legitimate managed care arrangements.

Nor should expanded Federal criminal health care offenses[46] interfere with the practice of medicine or the use of alternative procedures or therapies permissible under applicable State and Federal laws.

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[46] Regarding the permissible scope of federalization of criminal activity, see, memorandum of July 18, 1996 to the Subcommittee on Human Resources and Intergovernmental Relations from Charles Doyle, senior specialist, American Public Law, American Law Division, Congressional Research Service, U.S. Library of Congress (in subcommittee files). The U.S. Constitution vests Congress with the authority to "regulate commerce . . . among the several States," U.S. Const. Art. I, sec. 8, cl. 3, and to enact legislation "necessary and proper" to implement that authority, U.S. Const. Art. I, sec. 8, cl. 18. Congress may proscribe the use of the facilities of interstate commerce to accomplish health care fraud, *United States* v. *Lopez,* 115 S.Ct. 1624, 1629 (1995) ("Congress may regulate the use of the channels of interstate commerce"). Congress may also enact legislation to protect those "directly engaged in the production, distribution, or acquisition of goods and services in interstate commerce," *United States* v. *Robertson,* 115 S.Ct. 1732, 1733 (1995). Moreover, should Congress determine on the basis of its studies and evidence presented to it that health care fraud has a substantial impact upon some aspect of interstate commerce, the commerce clause empowers it to outlaw such misconduct, *United States* v. *Lopez,* 115 S.Ct. at 1629 ("Congress' commerce authority includes the power to regulate those activities having a substantial relation to interstate commerce.") Based upon evidence of interstate attributes of health care fraud comparable to that upon which it based the Controlled Substances Act and the Access Act, *Lopez* and the subsequent lower court cases indicate it may prescribe health care fraud under its commerce clause powers.