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February 23, 2011

Honorable Patti B. Saris
Chair
United States Sentencing Commission
One Columbus Circle, N.E.
Suite 2-500, South Lobby
Washington, DC 2002-8002

Re: Supplemental Written Testimony on Proposed Fraud Amendments

Dear Judge Saris:

I am writing to follow up on some questions that arose during my testimony before the Commission on February 16, 2011.

The Definition of "Government health care program" Should Be Limited to Medicare, Medicaid, and CHIP.

My written testimony set forth a limited definition of "government health care program," which defenders believe remains true to the language of the directive and the other provisions of the Patient Protection and Affordable Care Act. When questioned about how the term "Government health care program" should be defined, I indicated that prosecutors were certainly free to bring to the court's attention any losses to private insurers.

With that answer, I did not intend to make it appear that I was abandoning the position stated in my written testimony. I was simply acknowledging that under the current guidelines, losses to Medicare, other government programs, and private insurers are added together for purposes of determining the amount of loss under USSG §2B1.1(b). *See, e.g.*, *United States v. Hoffman-Vaile*, 568 F.3d 1335, 1344 (11th Cir. 2009) (losses sustained by private insurance companies and patients considered as part of relevant conduct in Medicare fraud scheme). Under the new proposed tiered enhancement for health care fraud offenses involving Government health care programs, only the loss amount for the fraud involving

a Government health care program should trigger the multi-tiered enhancement. If the Commission were to provide for a more inclusive enhancement, it would be contrary to the plain language of the directive, which speaks only to Government health care programs.

Another question focused on whether excluding private insurers from the loss calculation for purpose of the multi-tiered enhancement and special loss calculation rule would complicate the measure of loss. My answer, which spoke generally to the complicated nature of calculating loss in fraud cases, did not fully address the question. While I have not personally handled a case that involved insurers other than Medicare, my colleagues have handled many. Based upon defender experience in these cases, it would not complicate the process any further to separate out losses involving specified Government health care programs from other insurers. Loss amounts are already separated for purposes of restitution. In all health care fraud cases, the Mandatory Victim and Restitution Act requires the court to calculate the amount of the actual loss suffered by *each* victim and order payment accordingly. 18 U.S.C. § 3663A©. Thus, as a matter of course, probation officers and the court must determine the loss suffered by each separate insurer and enter an order of restitution that separates out the losses. To do this, the fraudulent bills for each insurer must be identified and the amount paid out as a result of the fraud must be calculated. The amount due to each insurer is not aggregated. An example from a presentence report in a health care fraud cases shows how the billed amount and paid amounts can be disaggregated:

MEDICAL INSURER	BILLED AMOUNT	PAID AMOUNT
Blue Cross Blue Shield - Georgia	$3,329,175.00	$2,450,363.85
Blue Cross Blue Shield - Tennessee	$54,102.12	$29,240.76
CIGNA	$239,360.00	$151,781.76
United Health Group	$66,880.00	$17,449.48
Blue Cross Blue Shield - Illinois	$392,480.00	$326,843.28
TRICARE	$10,120.00	$5,665.20
AETNA	$87,120.00	$46,746.56
TOTAL:	**$4,179,237.12**	**$3,028,090.89**

Another case example showing how a court separates out loss amounts is *United States v. Osuju*, 2011 WL 195552 (4th Cir. Jan 21, 2011). The government's brief on appeal described the process as follows:

> In this case, Defendants Varnado and Osuji, with their co-conspirators, submitted approximately fraudulent [sic] 313 claims requesting $2,312,702.44 as reimbursement for motorized wheelchairs with dates of service between August 2, 2003 and November 21, 2003. This number represented the intended loss amount. Medicare paid $1,259,455.80 based on these claims, and private pay insurers paid an

additional $30,541.06.

* * *

> The court also found the exact amount which Medicare and private pay insurers lost, making these restitution amounts part of the judgments. While Medicare paid $1,259,455.80 based on the false and fraudulent claims, the restitution amount owed to Medicare accounted for recoupments, meaning Medicare was owed $1,192,982.30 in restitution, as was reflected on the judgment. The judgment also noted that BCBS of Texas was due $4,232.52, Aetna due $571.53, and BCBS of Alabama due $10,470.18 in restitution.
>
> *United States v. Osuji*, 2009 WL 4927189 (4th Cir. Dec/ 21, 2009) (Brief for the United States).

Similar examples abound. *See United States v. Hunt*, 2007 WL 4451913, *22 (6th Cir. Aug. 20, 2007) (First Final Brief of Appellant Hunt) (court designated restitution amounts payable to Cigna and BC/BS.); *United States v. Rosin*, 263 Fed. Appx. 16, 23 n.1 (11th Cir. 2008) (ordering separate restitution amounts for Medicare and Aetna, a private insurer).

Because probation and the court must disaggregate the amount of loss for each insurer, it would not further complicate the process by disaggregating those losses for purposes of determining the extent of the enhancement under the new multi-tiered enhancement for Government health care programs.

The Invited Downward Departure in USSG §2B1.1 is of Limited Use.

A question was posed about the use of application note 19© in §2B1.1, which states that a downward departure may be warranted in "cases in which the offense level determined under this guideline substantially overstate the seriousness of the offense." This provision, however, has not historically been used to acknowledge a defendant's lesser culpability in a scheme to defraud. Some courts view it as embodying the "economic reality" principle, which allows correction of the disparity between the actual loss and intended loss in cases where the defendant has "devise[d] an ambitious scheme obviously doomed to fail and which causes little or no academic loss." *See generally United States v. Jordan*, 544 F.3d 656, 672 (6th Cir. 2008); *see also United States v. Parris*, 573 F. Supp. 2d 744, 750 (E.D.N.Y. 2008) (departure approved only "where an intended loss calculated under the Guidelines was 'almost certain not to occur.'). Other courts view "lack of personal profit" as not ordinarily a ground for departure. *See United States v. Broderson*, 67 F.3d 452, 459 (2d Cir. 1995). In light of this case law, cases where courts apply the departure because the loss amounts the defendant's culpability are few and far between and limited to a small number of courts. *See United States v. Desmond*, 2008 WL 686779, *2 (N.D. Ill. 2008) (granting departure

to defendant who played limited role in fraud); *United States v. Forchette*, 220 F. Supp. 2d 914, 929 (E.D. Wis. 2002) (granting departure where defendant did not devise scheme, did not steal or draft checks, his gain was disproportionate to loss, and he was unaware of nature and scope of scheme).

If the Commission intends for that departure language to also cover those situations where the amount of intended loss overstates the defendant's culpability, then it should amend the application note to make that clear.

Thank you again for the opportunity to appear before the Commission and share the views of the Federal Public and Community Defenders on the proposed health care fraud amendments.

Very truly yours,

Hector Dopico
Supervisory Assistant Federal Public Defender

cc: William B. Carr, Jr., Vice Chair
Ketanji B. Jackson, Vice Chair
Hon. Ricardo H. Hinojosa, Commissioner
Hon. Beryl A. Howell, Commissioner
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Isaac Fulwood, Jr., Commissioner Ex Officio
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