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On Behalf of the Federal Public and Community Defenders

Before the United States Sentencing Commission
Public Hearing on Proposed Fraud Amendments

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My name is Hector Dopico, and I am a Supervisory Assistant Federal Public Defender in the Southern District of Florida (Miami). I would like to thank the Commission for holding this hearing and giving me the opportunity to testify on behalf of the Federal Public and Community Defenders regarding implementation of the proposed amendments for health care fraud involving Government health care programs, securities fraud, bank fraud, and frauds relating to financial institutions.

I. PROPOSED AMENDMENTS UNDER THE PATIENT PROTECTION ACT (PPA)

The Commission proposes (1) a multi-tiered enhancement for Federal health care offenses involving Government health care programs where the loss amounts exceed 1 million dollars; and (2) a special rule for calculating loss in “Federal health care offenses involving a Government health care program,” which provides that the “aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute prima facie evidence of the amount of the intended loss, *i.e.*, is evidence sufficient to establish the amount of the intended loss, if not rebutted.” The Commission also seeks comment on the appropriate definition of a “Government health care program,” including whether certain Federal or State programs or private health care programs should be included.

As a threshold matter, we strongly urge the Commission, in its unique role as an expert body, to take the necessary time and resources to implement fully the mandate of the directives in the PPA. While the PPA contains two specific directives regarding the calculation of loss in health care frauds involving Government health care programs and multi-tiered enhancements for losses more than \$1 million, which we understand the Commission intends to carry out this amendment cycle, the PPA contains other directives that the Commission should carefully consider before implementing those two provisions. In the very same section where it provided for multi-tiered enhancements, Congress directed the Commission to “if appropriate, otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.” Pub. L. No. 111-148, § 10606(a)(2)(C)(iv), 124 Stat. 1007. It then expressly directed the Commission to “account for any aggravating or mitigating circumstances that *might justify exceptions*, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment

of this Act, provide sentencing enhancements,” *id.* at § 10606(a)(3)(D)(emphasis added), and it instructed the Commission to “ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.” *Id.* at § 10606(a)(3)(F).

Given the complexity of the fraud guidelines, and the wide variety of circumstances involving frauds on Government health care programs, we believe that the Commission should undertake a comprehensive review of the fraud guideline in general and health care fraud offenses specifically. Nothing in the language of the PPA requires the Commission to act immediately. Indeed, by directing the Commission to consider possible exceptions to the tiered enhancements and intended loss directives, it clearly contemplated a more comprehensive review of the guidelines as they apply to health care fraud offenses. Because we believe that there are a number of mitigating circumstances that might justify exceptions to the tiered-enhancement and loss rules, we encourage the Commission to study the issue more thoroughly before promulgating amendments to §2B1.1 as they relate to health care fraud offenses involving Government health care programs.

If, however, the Commission decides to promulgate the tiered-enhancements and the intended loss rule this cycle, it should state in its Reason for Amendment that the Commission has insufficient empirical data to conclude that the current guidelines, including the multitude of enhancements for specific offense characteristics under USSG §2B1.1 and the provisions of Chapter 3, do not “reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement actions to prevent such fraud,” or showing that the guidelines do not otherwise provide severe enough penalties for persons convicted of health care offenses to “ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing.” Pub. L No. 111-148, § 10606(a)(3), 124 Stat. 1007. Under current law, defendants convicted of health care fraud, many of whom are first time, non-violent offenders, are sent to prison for lengthy periods of time. According to the Department of Justice, in FY 2010, its Medicare Strike Force prosecution teams obtained convictions for health care fraud against 240 defendants. Nearly two-thirds of those defendants (146) were sent to prison, “averaging more than 40 months of incarceration.”¹

In addition to providing for significant retributive periods of incarceration, existing law gives prosecutors powerful tools to deter fraud. Indeed, stepped-up law enforcement efforts have had “a significant deterrent effect” on the number of Medicare claims for durable medical equipment even under existing guidelines. *See, e.g., Reducing Fraud, Waste, and Abuse in Medicare, Hearing before the Subcomm. on Health and Subcomm. on Oversight of the H. Comm.*

¹ Health and Human Services News Release, *Health care prevention and enforcement efforts recover record \$4 Billion Dollars; new Affordable Care Act tools will help fight fraud*, available at <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>.

on Ways and Means (June 15, 2010) (written statement of Edward N. Siskel, Associate Deputy Attorney General, U.S. Dep't of Justice).²

In short, no empirical evidence supports the need for higher sentences in health care fraud case involving Government health care programs and the Commission should so state in its Reason for Amendment. Courts should know that the increases were not the result of the Commission's expert research, but instead another example of "signal sending" by Congress. See USSC, *Fifteen Years of Guideline Sentencing: An Assessment of How Well the Federal Criminal Justice System is Achieving the Goals of Sentencing Reform* 56 (2004) (hereinafter *Fifteen Year Review*).

A. Special Rule on Calculating Loss for Health Care Fraud Involving Government Health Care Programs

We appreciate the Commission's efforts to ensure that the special rule on calculating loss in federal health care offenses involving Government health care programs is rebuttable. We encourage the Commission to do more, however, in ensuring that loss amounts are not inflated because of the rule.

The Commission should more fully incorporate into the application note existing case law on calculating intended loss. Consistent with the proposed amendment on calculating loss, most circuits hold that the amount billed is prima facie evidence of the amount of intended loss.³ Courts, however, also acknowledge that where a defendant presents evidence that he was "knowledgeable regarding the government's fee schedules and the differences between what is billed to Medicare and what is reimbursed, the loss calculation should be determined based on the paid amount. This loss amount more accurately reflects the loss a defendant intended to cause through his fraudulent scheme." *United States v. Semrau*, 2011 WL 9258, *4 (W.D. Tenn. 2011) (citing *United States v. Singh*, 390 F.3d 168, 193-94 (2d Cir. 2004) and *Miller*, 316 F.3d at 504)). We encourage the Commission to include such language in the new application note on calculating loss in cases involving Government health care programs.

² Available at <http://www.justice.gov/ola/testimony/111-2/06-15-10-siskel-reducing-fraud-waste-abuse-in-medicare.pdf>. And while the Department supported increased sentences for health care fraud offenses involving \$1 million or more in losses, no empirical evidence supported the need for such increases, particularly given the claimed deterrent effects of enforcement actions under existing law.

³ See, e.g., *United States v. Mikos*, 539 F.3d 706, 714 (7th Cir. 2008); *United States v. Miller*, 316 F.3d 495, 504-05 (4th Cir. 2003); *United States v. Serrano*, 234 Fed. App'x 685, 687 (9th Cir. 2007); *United States v. Cruz-Natal*, 150 Fed. App'x 961, 964 (11th Cir. 2005); *United States v. McLemore*, 200 Fed. App'x 342, 344 (5th Cir. 2006).

B. The Commission Should Amend the Guidelines to Account for Mitigating Circumstances that Justify an Exception to the Loss Calculation and Enhancement Rules.

The PPA directs the Commission to “account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal Sentencing Guidelines, as in effect on the date of enactment of this Act, provide sentencing enhancements,” and if appropriate, “otherwise amend the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal health care offenses involving Government health care programs.” Pub L. No. 111-148, § 10606(a)(3)(D), 124 Stat. 1007.

Health care fraud involves a variety of defendants, from major corporations and institutions, to doctors and nurses, to receptionists and secretaries, to “straw” or nominee owners⁴ and middlemen, to recruiters, and finally to purported beneficiaries who are often recruited at soup kitchens, senior centers and even skid row.⁵ Many of the “lower-level” defendants reap minimal financial benefit from their role in the offense and may have little or no knowledge of the scope of the fraudulent scheme. While the defendants who conceive and implement the scheme may receive millions of dollars in fraudulent payments, these smaller participants may realize only small sums of money for their efforts. A few examples demonstrate our point and how the current guidelines do not adequately account for mitigating circumstances.

- Jose Montes is a nominee owner of a medical supply company that billed Medicare \$4 million.⁶ Mr. Montes received only \$10,000 for agreeing to be the nominee owner. The intended loss amount was calculated at \$3.2 million, and the actual amount paid by Medicare was \$2 million. The court denied Mr. Montes a minor role adjustment.

⁴ A “nominee owner” is one recruited and paid by the true owner to be the owner of record of a company, open bank accounts, submit bills, and cash checks in order to disguise the true owner. *See Combating Health Care Fraud, Hearing Before the Subcomm. on Labor, Health and Human Services, Education and Related Agencies of the H. Comm. on Appropriations 2* (March 4, 2010) (written statement of Omar Perez, Special Agent, Office of Inspector General, U.S. Dep’t of Health and Human Services), available at <http://oig.hhs.gov/testimony/docs/2010/3-4-10PerezHAppropsSub.pdf>. Typically, a nominee owner is paid \$10,000 to \$20,000 for his or her role. *Id.* at 4.

⁵ *See generally Criminal Enforcement Against Medicare and Medicaid Fraud, Hearing Before the House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security 4* (March 4, 2010) (written statement of Timothy Menke, Deputy Inspector General for Investigations, Office of the Inspector General, Department of Health & Human Services), available at <http://judiciary.house.gov/hearings/pdf/Menke100304.pdf>.

⁶ *United States v. Jose Montes*, No. 09-20330 (S.D. Fla. 2009).

- Sandra Mateos was a nurse at a clinic that defrauded Medicare by submitting bills for unnecessary treatments of a drug used to treat HIV patients.⁷ The masterminds of the scheme enlisted the help of two brothers to set up clinics that would bill Medicare for services. The brothers recruited Mateos to work as an infusionist and to pay kickbacks to patients to receive unnecessary treatments. Over the course of just five months, the clinic billed Medicare for about \$11 million. Medicare paid more than \$8 million of those claims. The brothers received sixty percent of the profits and the masterminds split the remainder. Mateos was paid approximately \$500 per week (about \$10,000 over the course of the fraud). At sentencing, the district court held Mateos accountable for the entire intended loss (more than \$9 million), sentencing her to 7 years imprisonment.⁸ The masterminds of the scheme were initially sentenced to 30 months and 70 months imprisonment. The court later reduced their sentences to 24 months based on the government's Rule 35(b) motion.
- Over the course of 16 months, Genna Yates was a patient recruiter, who recruited approximately 117 Medicare beneficiaries to obtain unnecessary medical services at two medical clinics.⁹ The leaders of the scheme would pay Yates \$100-150 per patient. Yates would keep half that amount and pay half to the patient. The clinics then fraudulently billed Medicare approximately \$840,565 in services rendered to those patients. Medicare paid approximately \$630,506 in claims. Yates, however, made no more than \$8,000 to \$12,000 dollars for her role in the scheme. Because the loss amount was based on the amount of intended loss, however, Yates's guideline range was calculated at 24 – 30 months imprisonment even though she was a first-time offender.

We here propose a number of ways in which the Commission could carve out appropriate exceptions to the loss rules and the multi-tiered enhancements for health care fraud offenses involving Government health care programs.

Apply the multi-tiered enhancements only to those defendants with aggravating roles. Congress plainly wanted to provide longer periods of imprisonment for persons convicted of health care fraud offenses involving Government health care programs, apparently believing that stiffer penalties would assist law enforcement efforts to prevent such fraud. Any meaningful

⁷ *United States v. Sandra Mateos*, 623 F.3d 1350 (11th Cir. 2010).

⁸ A doctor involved in the scheme was sentenced to 30 years imprisonment.

⁹ *United States v. Genna Yates*, No. 09-CR-20579 (E.D. Mich. 2010); see also Office of Public Affairs, Dep't of Justice, *Clinic Owners and Patient Recruiters Plead Guilty In Detroit-area Diagnostic Testing Fraud Scheme* (Oct. 27, 2010), available at www.justice.gov/opa/pr/2010/October/10-crm-1210.html.

prevention effort, including one based upon the unsupported view that severe punishments deter,¹⁰ should be aimed at those who plan and organize fraudulent schemes rather than on easily replaced lower-level offenders.

The problem with using loss amounts as a proxy for culpability is that it results in severe punishments for lower-level offenders, who may be held accountable under the loss rules for amounts over \$1 million, but who do not set-up the scheme, exercise little decision-making authority, and reap a much smaller share of the profits of the crime than those who organized or planned the scheme.

To better accomplish what Congress set out to do in the PPA, the Commission should carve out an exception for the multi-tiered enhancement, pursuant to its authority under Pub. L. No. 111-148, § 10606(a)(3)(D), 124 Stat. 1007. Similar to the super-aggravating role enhancements in USSG §2D1.1(b)(14), the Commission should limit application of the new proposed enhancement as follows:

If the defendant receives an adjustment under §3B1.1 (Aggravating Role), and if the defendant was convicted of a Federal health care offense involving a Government health care program and the loss under subsection (b)(1) was (A) more than \$1,000,000 increase by 2 levels; (B) more than 7,000,000 increase by 3 levels; or (C) more than \$20,000,000 increase by 4 levels.

Modify USSG §3B1.2. Our prior proposals that the Commission delete the word “substantially” from the commentary to §3B1.2 would help clarify that low-level defendants should receive a role adjustment.¹¹ The Commission should also add an application note, which clarifies that nominee owners of fraudulent companies and other low-level defendants who receive little remuneration from the fraud are eligible for a minor or minimal role adjustment regardless of the amount of loss involved in the fraud. *See United States v. Escoto*, 377 Fed. App’x. 867 (11th Cir. 2010) (court declined to give nominee owner role adjustment because of amount of loss); *United States v. Lugo*, 393 Fed. App’x. 598, 599 (11th Cir. 2010) (amount of loss cited as a reason for not giving mitigating role adjustment to nominee owner).

Clarify operation of the relevant conduct rules. Existing confusion about the appropriate scope of “relevant conduct” adds to our concern with changes to the health care fraud guidelines. Health care fraud offenses often involve conspiracies with numerous agreements. One co-conspirator may know nothing about other co-conspirator agreements or the scope of the overall operations. We have commented in the past on the need to clarify the

¹⁰ See, e.g., Andrew von Hirsch et al., *Criminal Deterrence and Sentence Severity: An Analysis of Recent Research* (1999); Michael Tonry, *Purposes and Functions of Sentencing*, 34 Crime and Justice 28-29 (2006).

¹¹ Letter from Marjorie A. Meyers, Chair, Federal Defender Guideline Committee to Hon. William K. Sessions, III, Chair, United States Sentencing Comm’n, at 20 (Aug. 18, 2010).

application of §1B1.3 (a)(1)(B), governing cases of jointly undertaken activity, so that it is clear that relevant conduct covers only reasonably foreseeable activity within the scope of the defendant's agreement.¹² With the directive for amount-driven changes to the health care fraud guidelines, the need to clarify and limit the scope of “relevant conduct” is heightened.

A case example demonstrates the need for clarification in the relevant conduct rules. Ricardo Aguera, like several of his family members, operated a company that provided durable medical equipment (“DME”) to Medicare beneficiaries.¹³ His company obtained prescriptions for aerosol medications for these beneficiaries, many of whom were using respiratory devices. A couple who operated two pharmacies, which were able to submit Medicare claims for aerosol prescriptions, paid kickbacks to Mr. Aguera in exchange for him referring the prescriptions to them. Fifty other DME owners were involved in a far-reaching scheme set up by the couple. Although Mr. Aguera’s company billed \$1.7 million in claims, the court held him responsible for the \$17 million in claims generated by all fifty businesses. The government argued that Mr. Aguera saw the names of the other business in a logbook he signed when he received his money from the masterminds of the scheme – the couple who owned the pharmacy. Based on that evidence, the government claimed, and the court found, that the activities of the other businesses were reasonably foreseeable to Mr. Aguera. The court imposed a sentence of 121 months. In an all too common cruel twist, the masterminds of the scheme received lighter sentences than Mr. Aguera because of the cooperation they provided against the fifty owners they directed.

Add an application note that mitigates the effects of the intended loss rule.

Application notes should provide examples and directions that ensure that loss amounts are not inflated and properly reflect a defendant’s level of culpability. We recommend that the Commission expressly state that the amount of money received by an individual defendant because of his participation in the fraudulent scheme indicates the role the defendant played in the scheme and the defendant’s overall level of culpability (*i.e.*, less money received, less culpable as a general rule). In such cases, the application note should state that if intended loss greatly overstates the defendant’s culpability then the base offense level should be based on the actual loss or the defendant’s gain.

Another case example shows the dramatic difference between the so-called intended loss, the actual loss, and the defendant’s personal gain.

- Reinel Pulido was a nominee owner of a DME company, Soroa Medical.¹⁴ The company submitted over \$15.6 million in fraudulent claims, but was only

¹² See, e.g., Letter from Marjorie A. Meyers, Chair, Federal Defender Guideline Committee to Hon. William K. Sessions, III, Chair, United States Sentencing Comm’n (July 1, 2010).

¹³ *United States v. Richard Aguera*, No. 06-20609 (S.D. Fla. 2007).

¹⁴ *United States v. Reinel Pulido*, No. 07-20921 (S.D. Fla. 2008).

reimbursed \$1,565,410. Pulido admitted being recruited to place his name on all the documents related to Soroa Medical. He was paid approximately \$50,000 for becoming the nominee owner.

Add a “safety-valve” for low-level fraud offenders. Just as Congress and the Commission crafted the safety valve to mitigate the harsh effects of using drug quantity as the measure of culpability in drug cases, *Fifteen Year Review, supra*, at 51, the Commission could amend the guidelines to better account for the mitigating factors present in fraud cases. Such a “safety-valve” could apply to low-level defendants who disclose to the government the names of the true owners and other participants of the scheme in exchange for a reduction in their offense level. The language of such a safety-valve could track the provisions of USSG §5C1.2(a)(5).

Without appropriate guideline adjustments for low-level offenders in these cases, the resulting guideline sentences will be unjust and unfair, will violate 18 U.S.C. § 3553(a), and will decrease confidence in the criminal justice system and the guidelines. If the Commission were to promulgate guidelines that treat all defendants the same, based on intended loss without providing for mitigating circumstances it will create “unwarranted *similarities*” among dissimilarly situated individuals. *See Gall v. United States*, 552 U.S. 38, 55-56 (2008). As the foregoing discussion of case-related examples reveals, individuals convicted of health care fraud offenses range from low-income women who act as patient recruiters, to recent immigrants who are recruited to act as nominee owners, to low-level clinic personnel who reap minimal financial benefit, and to fraudsters. Lengthy prison sentences for all of these individuals are unnecessary to accomplish the purposes of sentencing and undermine respect for the criminal justice system.

C. The Tiered Enhancements and Special Loss Calculation Rules Should be Limited to the Narrow Government Health Care Programs Targeted By Congress.

The Commission requests comment on how “Government health care program” should be defined. We encourage the Commission to read the phrase “Government health care program” in pari materia with other provisions of the PPA, which are designed to prevent fraud, waste, and abuse in Medicare, Medicaid, and the Children’s Health Insurance Program (“CHIP”).

The phrase “Government health care program” is nowhere defined in the PPA. Nor is it defined elsewhere in the U.S. Code or regulations. It is clear, however, that when Congress limited the directives in sections 10606(a)(2)(B) and (C) to “Government health care programs,” it had in mind a particular subset of health care programs. Because subtitle E of the PPA indicates that Congress was especially concerned with fraud in three key Government health care programs – Medicare, Medicaid, and CHIP – we encourage the Commission to define “Government health care program” by reference to those three programs.

Subtitle E, titled “Medicare, Medicaid, and CHIP Program Integrity Provisions,” contains extensive directives to executive agencies, which are focused on strengthening the regulatory process to prevent and detect fraud. For example, section 6401 of the PPA directs the Secretary of the Department of Health and Human Services in consultation with the Inspector General of that department, to promulgate regulations governing the screening of providers who participate in the Medicare, Medicaid, and CHIP programs. Pub. L. No. 111-148, § 6401, 124 Stat. 747. It also amends 42 U.S.C. § 1395(c)(c) to require providers under those programs to establish compliance programs. Another provision of section 6401 requires Medicare to share with state agencies charged with administering Medicaid and CHIP programs information about providers who have been terminated from the Medicare program.

Section 6402(a) of the PPA established “Enhanced Medicare and Medicaid Program Integrity Provisions.” That section directs HHS to set up a data sharing and matching program “for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII [Medicare] and XIX [Medicaid].” It also contains new provisions that give authority to the Inspector General of the Department of Health and Human Services to obtain information for “purposes of protecting the integrity of the programs under titles XVIII and XIX.” And, it provides HHS the authority to impose administrative penalties on Medicare, Medicaid, and CHIP beneficiaries who knowingly participate in a Federal health care offense.”

Defining the term “Government health care program” by reference to Medicare, Medicaid, and CHIP is also consistent with the Administration’s efforts to combat health care fraud. In 2009, the Administration created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to “prevent waste, fraud and abuse in the Medicare and Medicaid programs.”¹⁵ More recently, DOJ, working with HSS has expanded its Medicare Fraud Strike Force teams, which focus on “‘hot spots’ of unexplained high billing” in the Medicare program.¹⁶ The Government has focused other efforts on Medicare Fraud, setting up such independent websites at www.stopmedicarefraud.gov, and [ww.smpresource.org](http://www.smpresource.org), and launching programs designed to help prevent, detect, and report health care fraud involving Medicare and Medicaid fraud.

Given provisions of the PPA that target fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs, as well as the Administration’s enforcement efforts targeted at

¹⁵ Dep’t of Justice Press Release, *Health Care Fraud Prevention and Enforcement Efforts Recover \$4 Billion: New Affordable Care Act Tolls Will Help Fight Fraud*, available at <http://www.justice.gov/opa/pr/2011/January/11-asg-094.html>.

¹⁶ Dep’t of Justice Press Release, *Associate Attorney General Tom Perelli Speaks at the Department of Justice – Health and Human Services Health Care Fraud Press Conference*, available at <http://www.justice.gov/iso/opa/asg/speeches/2011/asg-speech-110124.html>; *see also* Jerry Markon, *Justice Department Charges 94 People with Health-Care Fraud*, *The Wash. Post*, July 16, 2010.

those programs, any amendment to the guidelines that increases sentences for “Government health care programs” should focus on those three programs, and no more.

In any event, the term Government health care program should not include state health care programs or private insurers. First, the ordinary meaning of “Government” with a capital “G” refers to federal programs. Webster’s Third New International Dictionary 982 (2002). Second, if Congress wanted to provide greater enhancements for all insurers, it could have merely directed the Commission to provide increases for “any defendant convicted of a Federal health care offense” rather than “any defendant convicted of a Federal health care offense involving a Government health care program.” That it did not shows that it wanted persons who defraud Government health care programs punished more severely than others. Congress could reasonably conclude that the enormous effects that Medicare and Medicaid fraud have on the public treasury warrant such enhancements. In addition, the Medicare and Medicaid programs constitute the largest single purchaser of health care in the United States, making it a prime target for fraud and abuse.¹⁷

Focusing the enhancements on the major federal Government health care programs is also no different from the myriad circumstances where Congress and the Commission have imposed greater liability when a federal interest is at stake. *See, e.g.*, USSG §2J1.4 (impersonating a federal officer, agent, or employee); 2J1.9 (payment to witnesses in federal proceedings); 2K2.5(b)(A) (providing for 2-level enhancement for possession of a firearm or dangerous weapon in a federal court facility); 3A1.2, comment, n.3 (providing for upward departure for exceptionally high-level officials “due to the potential disruption of the governmental function).

Third, the Commission should not be concerned with creating complexity in a guideline that focuses on losses involving certain specific programs. As a practical matter, the overwhelming majority of these schemes involve Medicare and Medicaid. The Centers for Medicare and Medicaid Services at HHS maintain an extensive data base of Medicare, Medicaid, and CHIP claims.¹⁸ In those schemes that involve other insurers, the court, with the help of insurers, case agents, and probation officers, uses spreadsheets and other data management systems to trace the amount of loss to specified programs. Such analysis assists the court in determining loss amounts and in fashioning restitution orders.

¹⁷ *See A Closer Look: The Inspectors General Address Waste, Fraud, and Abuse in Federal Mandatory Programs, Hearing Before the H. Comm. on the Budget, 108th Cong. 82 (July 9, 2003) (statement of Dara Corrigan, Acting Principal Deputy Inspector Gen., Dep’t of Health and Human Servs.).*

¹⁸ *See generally* Centers for Medicare and Medicaid Services: *Research, Statistics, Data & Systems*, available at <http://www.cms.gov/home/rsds.asp>.

II. PROPOSED AMENDMENTS UNDER THE DODD-FRANK ACT

The Commission also asks how it should respond to the directives in the Dodd-Frank Wall Street Reform and Protection Act, Pub. L. No. 111-203, 124 Stat. 1376 (Dodd-Frank Act) regarding securities fraud, bank fraud, and other frauds relating to financial institutions. Those directives require the Commission to amend the guidelines only after “review” and only “if appropriate.” Pub. L. No. 111-203, § 1079A(1)(1)(A), 124 Stat. 2078. Recognizing that the guidelines contain a multitude of enhancements that apply to securities fraud and frauds related to financial institutions, the Commission is considering conducting a more comprehensive multi-year review of §2B1.1 and related guidelines.

The Defenders agree with the Commission’s observation that a comprehensive multi-year review of the fraud guidelines is in order. We encourage the Commission to undertake such a review rather than amend the guidelines or commentary this year. We are not alone in our view that the fraud guidelines need to be revisited. Just recently, the former Commissioner and General Counsel John Steer, along with Alan Ellis and Mark Allenbaugh, published an article outlining many of the flaws in the fraud guidelines and concluding that the Commission needs to undertake a “substantive reevaluation of the role of loss in calculating guideline sentences for economic offenses, and indeed, section 2B1.1 overall.” Alan Ellis, John R. Steer, and Mark H. Allenbaugh, *At a “Loss” for Justice: Federal Sentencing for Economic Offenses*, 25 WTR Crim. Just. 34, 35 (Winter 2011).¹⁹

During our regional hearing testimony, we offered several comments about operation of the fraud guideline, USSG §2B1.1, and how it can easily produce sentences that are greater than necessary to satisfy the purposes of sentencing. *See generally* Statement of Alan Dubois & Nicole Kaplan Before the U.S. Sentencing Comm’n, Atlanta, GA, at 30 (Feb 10, 2009); Statement of Jason D. Hawkins Before the U.S. Sentencing Comm’n, Austin, TX, at 22 (Nov 19, 2009); Statement of Nicholas T. Drees Before the U.S. Sentencing Comm’n, Denver, CO, at 16 (Oct 21, 2009). First, it “place[s] undue weight on the amount of loss involved in the fraud,” which in many cases “is a kind of accident” and thus “a relatively weak indicator of the moral seriousness of the offense or the need for deterrence.”²⁰ Because loss often is not the best indicator of culpability, a guideline driven by loss treats different offenders the same. Second, §2B1.1 imposes cumulative enhancements for many closely related factors, which can make the

¹⁹ *See also* Frank O. Bowman III, *Sentencing High-Loss Corporate Insider Frauds After Booker*, 20 Fed. Sent’g Rep. 167, 169 (Feb. 2008); James E. Felman, *Change in Federal Criminal Justice: Views from the Defense and Policy Advocacy Communities: The Need to Reform the Federal Sentencing Guidelines for High-Loss Economic Crimes*, 23 Fed. Sent’g. Rep. 138 (2010).

²⁰ *United States v. Emmenegger*, 329 F.Supp. 2d 416, 427-28 (S.D.N.Y. 2004).

recommended sentence in a run- of- the- mill case as much as life.²¹ Approximately forty specific offense characteristics replicate or overlap with the loss concept, with one another, and with further upward adjustments under Chapter 3.²² This exemplifies “factor creep,” where “more and more adjustments are added” and “it is increasingly difficult to ensure that the interactions among them, and their cumulative effect, properly track offense seriousness.”²³

As to the Commission’s specific request for comment about whether the guidelines adequately account for “the potential and actual harm to the public and the financial markets” from securities fraud, bank fraud, mortgage fraud and other frauds related to financial institutions, we believe they do. Indeed, feedback from the judiciary indicates that the guidelines for major frauds are too high. As one commentator put it:

[S]ince *Booker*, virtually every judge faced with a top-level corporate fraud defendant in a very large fraud has concluded that sentences called for by the Guidelines were too high. This near unanimity suggests that the judiciary sees a consistent disjunction between the sentences prescribed by the Guidelines [in corporate fraud cases] and the fundamental requirement of Section 3553(a) that judges impose sentences ‘sufficient, but not greater than necessary’ to comply with its objectives.²⁴

In short, none of the available evidence suggests that the fraud guidelines produce sentences that are too low to satisfy the purposes of sentencing. In the absence of such evidence,

²¹ Constitution Project’s Sentencing Initiative, *Recommendations for Federal Criminal Sentencing in a Post-Booker World* 9-10 (July 11, 2006); *United States v. Lauersen*, 362 F.3d 160, 164-65 (2d Cir. 2004); *United States v. Parris*, 573 F.Supp. 2d 744 (E.D.N.Y. 2008); *United States v. Adelson*, 441 F.Supp. 2d 506 (S.D.N.Y. 2006).

²² To give just one example, USSG §2B1.1(b)(9)(C) provides for a 2-level increase if the offense “otherwise involved sophisticated means”; §2B1.1(b)(10) calls for a 2-level increase if the offense involved “the possession or use of,” among other things, “device-making equipment.” Courts apply both enhancements based on the same conduct. *See, e.g., United States v. Abulyan*, 380 Fed. App’x. 409, 411-412 (5th Cir. 2010) (credit card swiper). Other enhancements, like “sophisticated means,” are overbroad and apply in uncomplicated fraud schemes. *See, e.g., United States v. Conner*, 537 F.3d 480, 492 (5th Cir. 2008) (use of fake identification across multiple states to obtain goods that were sold on eBay); *United States v. Jackson*, 346 F.3d 22, 25-26 (2d Cir. 2003) (use of hotels and courier services to take delivery of fraudulently obtained goods, use of prepaid phone cards to prevent tracking of activities, and manipulations of victims’ credit lines and billing addresses justified enhancement).

²³ *Fifteen Year Review*, *supra*, at 137, citing Barry Ruback & Jonathan Wroblewski, *The Federal Sentencing Guidelines: Psychological and Policy Reasons for Simplification*, 7 Psychol. Pub. Pol’y & L. 739, 742 (2001) (Complexity of Guidelines has created a “façade of precision” which “undermines the goals of sentencing.”).

²⁴ Bowman, *supra* note 19, at 169.

the Commission should proceed with great caution and carefully review the guidelines before adding additional aggravating enhancements or inviting upward departures.

III. CONCLUSION

We would be happy to discuss with the Commission any modifications to the guidelines that would advance the purposes of sentencing under 18 U.S.C. § 3553(a). We urge the Commission to undertake a comprehensive review of the fraud guidelines before adding to the complexity of USSG §2B1.1.