

1-2000

The Effect of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on Health Care Fraud in Montana

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**THE EFFECT OF THE HEALTH INSURANCE
PORTABILITY AND ACCOUNTABILITY ACT OF
1996 (HIPAA) ON HEALTH CARE FRAUD IN
MONTANA**

A. Craig Eddy*

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I. INTRODUCTION

The United States Department of Justice has declared health care fraud the nation's number one white collar crime priority.¹ The rationale for this, originally expressed by Willie

1. See Kevin J. Darken, *Understanding the New Health Care Fraud Legislation*,

Sutton in reference to robbing banks and often quoted by white collar crime professor Pamela Bucy, is "because that's where the money is."² The delivery of health care will soon cost American citizens in excess of 1.4 trillion dollars annually, or approximately 15% of the gross national product.³ The General Accounting Office estimates that fraud and abuse accounts for 10% of these expenditures, or 140 billion dollars per year translating to 384 million dollars per day.⁴ The recovery of over 1.5 billion dollars in Medicare fraud by the federal government in the last three years⁵ and the fact that the state of Montana recouped 1.1 million dollars in Medicare/Medicaid fraud in 1998 supports this estimate and highlights the problem even in a rural state such as Montana.⁶

Health care fraud has existed since the dawn of medical care as unscrupulous physicians duped patients into paying for "snake oil" cures.⁷ However, early health care was not sufficiently lucrative to stimulate significant fraud schemes and most crimes by dishonest physicians were more direct in nature.⁸ In the early twentieth century this began to change. World War I stimulated a rapid advance in the science of medicine, post war industrialization improved access to

CRIM. JUST., Fall 1997, at 30, 30.

2. See, e.g., PAMELA H. BUCY ET AL., HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW § 1.01, at 1-3 (perm. ed. rev. vol. 1999); Pamela H. Bucy, *Crimes by Health Care Providers*, 1996 U. Ill. L. Rev. 589, 589 (1996); and PAMELA H. BUCY, WHITE COLLAR CRIME: CASES AND MATERIALS 758 (2nd ed. 1998).

3. See PROSPECTIVE PAYMENT ASSESSMENT COMMISSION REPORT AND RECOMMENDATIONS TO THE CONGRESS at 12 (March 1996) (predicted yearly expenditures for health care will exceed 1.4 trillion dollars by the year 2000).

4. See Alwyn Cassill, *Cop: Federal Fraud Police Yourself or We'll Get You*, AM. HOSP. ASSN. NEWS, Feb. 3, 1997, at 1. See also MALCOLM K. SPARROW, LICENSE TO STEAL: WHY FRAUD PLAGUES AMERICA'S HEALTH CARE SYSTEM 2 (1996). This figure is only an estimate by the Government Accounting Office and in reality has no basis in fact. Losses could be significantly higher or lower but until they are carefully measured, 10% seems the politically acceptable figure.

5. See Jack A. Rovner, *Health Care Fraud and Abuse Control After HIPAA*, 9 HEALTH LAW 17, 17 (1997) (citing 2 HEALTH CARE DAILY REP. 2 (Mar. 5, 1997)).

6. See interview with Leif Johnson, Assistant United States Attorney, in Missoula, Mont. (Apr. 2, 1999).

7. These early fraudfeasors concocted evil tasting mixtures of opium and alcohol which did little to cure patients but did render them both apathetic to their disease and addicted.

8. See PAMELA H. BUCY ET AL., HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW § 1.02, at 1-7 (perm. ed. rev. vol. 1999). Professor Bucy points out that in the early years, there was little money to be made in medicine and little demand for medical care. This forced physicians to have other jobs, some of which were criminal. For example, there is the case of a physician who moonlighted as a highwayman.

hospitals and the Great Depression stimulated the development of medical insurance.⁹ This resulted in an enormous influx of money into the health care system and set the stage for the modern health care fraud industry.

In 1996, amid reports of increasing Medicare and Medicaid fraud and abuse as well as increasing concern about the long-term financial viability of Medicare and Medicaid, Congress "caught health insurance reform fever and passed, with near unanimity, the Kassebaum-Kennedy Bill."¹⁰ This bill became known as the Health Insurance Portability and Accountability Act of 1996,¹¹ or HIPAA. HIPAA is an extraordinarily broad law which, in addition to its own provisions, amended the Employee Retirement Income Security Act of 1974, (ERISA),¹² the Public Health Service Act, (PHS),¹³ and the Internal Revenue Code.¹⁴ HIPAA was initially to function as a remedy for loss of private health insurance due to employment changes. However, a more broad interpretation ensued, and HIPAA became the first federal statute to regulate private health care and dramatically increase the government's ability power to prosecute and punish health care fraud.

This paper will explore the potential effects of the HIPAA on existing health care fraud law in Montana. In order to properly understand the impact of this new legislation, the reader must have a basic understanding of current health care law. Part II of this paper discusses the history and background of health care fraud and abuse law. Part III outlines the background and purposes of HIPAA. Part IV elaborates on Title II of HIPAA, the core of its anti-fraud provisions. Part V is a summary of interviews with the Medicaid Fraud Division of Montana's Department of Health and Human Services and the Deputy U.S. Attorney responsible for prosecuting Medicare fraud in Montana. Part VI is an analysis of a few cases that have been reported under HIPAA and Part VII speculates on the effects of

9. See Bucy, *supra* note 8, § 1.02, at 1-8.

10. See Jack A. Rovner, Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Accountability Act of 1996, 7 ANN. HEALTH L. 183, 183 (1997).

11. See Pub. L. No. 104-191, 110 Stat. 1936 (1996).

12. See 29 U.S.C. §§ 1001-1461 (1994 & Supp. III 1997); see, e.g., 29 U.S.C. § 1181 (1994).

13. See 42 U.S.C. §§ 201-299 (1994 & Supp. III 1997); see, e.g., 42 U.S.C. § 300gg-41 (1994).

14. See 26 U.S.C. §§ 1-9806 (1994 & Supp. III 1997); see, e.g., 26 U.S.C. § 9801 (1994).

HIPAA likely to evolve over the next few years. Part VIII offers a final critique of HIPAA's inadequacies.

II. THE HISTORY AND BACKGROUND OF HEALTH CARE FRAUD AND ABUSE LAW

Prior to World War I, most patients paid their medical bills personally and directly to their health care provider. In the agrarian, pre-industrialized United States, this was sometimes accomplished through barter of goods or services. However, as America industrialized and populations concentrated, the concept of health insurance developed both as a way to share the cost of injury and as a way to attract physicians to the expanding, but somewhat undesirable, West by guaranteeing them a livable income.

Early medical insurance consisted primarily of Blue Cross/Blue Shield and a few other private insurers which provided hospital and physician payments.¹⁵ This type of insurance primarily covered the working middle class and did offer some opportunity for fraud through charging for services not provided.¹⁶ However, this particular type of fraud was a civil matter litigated between the private third party insurers and the physician providers, a matter thought best handled by the state courts.

Health care fraud became a federal issue in 1965 when social concerns over inequitable distribution of health insurance prompted the government to expand its role in health care and create Medicaid and Medicare.¹⁷ Medicare was constructed following the Blue Cross/Blue Shield model with fee for service reimbursement by a third party payer mechanism. Part A of Medicare mimicked Blue Cross paying for hospitalization and Part B emulated Blue Shield paying for physician services. Within 30 years, Medicare and Medicaid were paying nearly half of all health care costs in the United States.¹⁸

15. See ROBERT CUNNINGHAM III & ROBERT CUNNINGHAM JR., *THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM* (1997) (describing the rise of Blue Cross in 1929 as a teacher's hospital insurance plan at Baylor University and the rise of Blue Shield shortly thereafter as a plan which started in the mining and lumber camps of the Pacific Northwest to pay physicians a guaranteed monthly fee in order to induce them to come to the camps).

16. See *id.*

17. See Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified at 42 U.S.C. §§ 401-33 (1994)).

18. See PROSPECTIVE PAYMENT ASSESSMENT COMM'N, REPORT AND RECOMMENDATION TO THE CONGRESS at 7 (June 1994).

A. *The Medicare and Medicaid Systems Encourage Fraud*

The fact that Medicare emulated the Blue Cross model is important for two reasons. First, it emphasizes the strength of the health care industry lobby in Washington, D.C. and second it set the stage for modern health care fraud. In the early 1960s, the primary alternative to Medicare and Medicaid was nationalization of the health care system. In 1965 the powerful lobbying efforts of the American Medical Association, American Hospital Association, American Pharmaceutical Association and others managed to forge a compromise between full nationalization and the existing privatized system by submitting to a marked increase in government control of the medical marketplace. This compromise made the government the primary insurer for a large segment of the population and thus a direct plaintiff in any civil fraud case.

Applying the Blue Cross model to Medicare and Medicaid set the stage for the escalation of health care fraud because the fee for service system of Blue Cross lacked anti-fraud mechanisms. Professor Bucy emphasizes this fact in her white collar crime treatise with eloquent simplicity when she states, "the way you pay people affects the way they cheat."¹⁹ She goes on to point out that from an anti-fraud perspective, the fee for service reimbursement provisions of Medicare and Medicaid are a disaster.²⁰ Under an unlimited fee for service arrangement, the more services a physician delivers, the more she gets paid from the deep pocket of the federal government.²¹ This encourages four types of fraud: 1) billing for services not provided; 2) billing for a service more expensive than that actually provided; 3) billing for unnecessary services; 4) paying kickbacks for referrals.²² The first three types of fraud are easy to accomplish and hard to detect²³ in a setting where legitimate services are provided in a confidential milieu at a high volume, the provision of services may be difficult to verify on subsequent

19. Bucy, *supra* note 8, § 1.03, at 1-21.

20. *See id.*

21. *See* James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. L. & MED. 205, 207-209 (1996).

22. *See* Pamela H. Bucy et al., *Fraud by Fright: White Collar Crime by Health Care Providers*, 67 N.C. L. REV. 855, 933 (1989).

23. *See, e.g.*, *United States v. Mekjian*, 505 F. 2d 1320 (5th Cir. 1975) (physician billed Medicare for compensable steroid joint injections to relieve joint pain when in reality he gave routine intramuscular vitamin injections).

examination, and patients often fail to remember the exact technical details of services rendered. Compounding this is the fact that Medicare is usually billed directly by the health care provider so the patient is unaware of the precise services billed. The scenario is further complicated by the subjective nature of the medical profession in which providers may not agree that a particular treatment is necessary. Kickbacks are likewise difficult to detect because they occur between a small number of interrelated providers and may easily be disguised as legitimate referrals.²⁴

As fraud in the Medicare/Medicaid system is a simple and lucrative crime to commit and is difficult and expensive to detect, the most important conclusion that follows is *health care fraud is unlikely to disappear without a major change in how health care is delivered*. Statutes like HIPAA are merely stop gap measures in an attempt to make the penalty for health care fraud exceed the gains of the fraudulent conduct. This penalty driven system, fortified by HIPAA, is no more likely to be effective in the health care field than it has been in the war on drugs.

B. Health Care Fraud is Proscribed by a Hybrid of Administrative, Civil and Criminal Law

An important issue in prosecuting white collar crime is determining when a particular behavior becomes criminal in nature. In most infractions, the more blameworthy the actor, the more likely the state is to intervene with criminal sanctions. In areas of white collar crime such as such as environmental crimes or money laundering, criminal prosecution is used because the magnitude and deterrent effects of criminal consequences exceed that of civil or administrative penalties.²⁵ However, this is less true in the area of fraud in general and health care fraud in particular.

Historically, about one third of health care fraud has been prosecuted by state governments and two thirds by the federal government.²⁶ Prosecutions may proceed administratively,

24. For example, a surgeon might maintain a sailboat in the Bahamas that he makes available to his "friends" who just happen to be the internists who refer patients to him.

25. See James M. Strock, *Environmental Criminal Enforcement Priorities for the 1990s*, 59 GEO. WASH. L. REV. 916, 922 (1991).

26. See Bucy, *supra* note 22, at 883.

civily, or criminally. Although Medicare and Medicaid statutes specifically prohibit health care fraud, most prosecutions have proceeded under the general fraud statutes.²⁷ The reason for this is unclear. There is considerable overlap between the specific Medicare/Medicaid fraud statutes and the tried and true general fraud statutes. Most likely, prosecutors prefer general fraud statutes because of their familiarity to investigators, courts and jurors, and because there is well established case law precedent interpreting these laws. In prosecuting health care fraud crimes, the state and federal government have four primary goals in mind: 1) protect the patients; 2) recover funds fraudulently obtained by unscrupulous providers; 3) deter repeat conduct by the offender; and 4) deter similar conduct by other offenders.²⁸

White collar crime scholars Albert Reiss and Albert Biderman state that in the area of fraud, a clear line dividing a civil from a criminal case based on defendant culpability or seriousness of the sanctions ultimately imposed is impossible to define.²⁹ The law of health care fraud exemplifies this dilemma. For any given behavior, there are usually three overlapping sets of causes of action and remedies from which to choose: 1) administrative actions and remedies which are generally not public unless appealed; 2) civil actions and sanctions which are a public proceeding with financial consequences often as dire as the criminal sanctions; and 3) criminal prosecution and punishment which includes incarceration as well as fines.

i. Administrative Causes of Action and Remedies

Administrative causes of action are subject to the rules promulgated by Health and Human Services and state Medicaid boards and change literally daily. These actions are subject to administrative due process as outlined by the Administrative Procedures Act³⁰ and are used primarily to bring individual providers into compliance with procedures in order to best monitor their claims for fraudulent activity. A lengthy discussion of administrative actions is beyond the scope of this paper.

Common administrative remedies in health care fraud

27. See Bucy, *supra* note 8, § 3.01, at 3-3.

28. See generally Bucy, *supra* note 22, Parts II and III, at 870-937.

29. See Bucy, *supra* note 8, § 1.04, at n.1.

30. See Administrative Procedures Act, 5 U.S.C. §§ 551-59 (1994 & Supp. IV 1998).

include actions to recover improperly obtained money, actions to exclude provider participation in Medicare and Medicaid programs and actions to revoke a provider's professional license.

In health care fraud, the decisions about choice of remedy are made at three levels: 1) the administrative agency responsible for the program defrauded; 2) the investigating unit responsible for developing the case; and 3) the prosecutor. The administrative agency caseworkers have wide discretion regarding the application of administrative sanctions or referral of the case for further investigation. Generally caseworkers give the provider the benefit of the doubt and simply recover the money unless the provider continues an illegal practice after a warning. If the administrative agency refers a case for investigation, the investigators also have discretion in deciding the outcome of the case. If, after further examination, the investigator feels there has been a misunderstanding between provider and caseworker, he can refer the case back to the agency. Alternatively, the investigator may refer the case to the prosecutor who then exercises wide discretion in whether to bring civil charges, criminal charges or both.³¹

ii. Civil Causes of Action and Sanctions

Civil action is usually sufficient to recapture fraudulently obtained funds and deter repeat conduct by the individual offender. Civil prosecution is reserved for those instances when administrative actions are ineffective in deterring repeat conduct or when the behavior is so blatant that it offends the sensibilities of the casework administrator.

Any fraudulent claim for Medicare or Medicaid gives the government a first party interest to prosecute the fraud civilly. The most commonly used civil cause of action is pursuant to the False Claims Act which is aimed at thwarting the "world's second oldest profession . . . stealing."³² Civil RICO³³ and money laundering³⁴ have also been commonly used.³⁵ The application of asset forfeiture to health care fraud through RICO and money laundering promoted federal and state interest in prosecuting

31. See discussion *infra* Parts II.B.(ii)-(iii).

32. Bucy, *supra* note 8, § 4.01, at n.1 (quoting Representative Bedell in the Cong. Rec. H6483 (daily ed. Sept. 9, 1986)).

33. See Racketeer Influenced and Corrupt Organization Act, 18 U.S.C. §§ 1961-68 (1994 & Supp. 1997).

34. See 18 U.S.C. § 1956 (1994 & Supp. III 1997).

35. See Bucy, *supra* note 8, § 4.01, at 4-3.

health care fraud civilly.

In a civil case, not only is the burden of proof for conviction lower, but sanctions can be more lucrative. Assets can be forfeited in the absence of a conviction and the burden of establishing the assets were procured legally falls to the defendant.³⁶ Any of the provider's assets used in connection with the alleged crime become subject to forfeiture including a home, office building, bank accounts, etc. These facts combine to make the pursuance of civil health care fraud an enticing prospect for the government. Other civil sanctions include damages for fraud based malpractice brought by patients, tort and breach of contract lawsuits by private insurance companies and statutory civil actions such as the False Claims Act.³⁷

iii. Criminal Prosecution and Punishment

Criminal prosecution for health care fraud requires proof beyond reasonable doubt. This level of proof is difficult to attain due to the complexity of the statutes, enormity of the paperwork involved and the strictness of the intent requirement. The prosecutor makes the decision to prosecute based on three major criteria: 1) the level of proof that the evidence supports (preponderance of evidence or beyond reasonable doubt); 2) the degree of intent; and 3) the severity of damage to patients and the program. Of these three criteria, sufficiency of evidence and severity of damage are usually obvious by the time the investigator hands the case to the prosecutor. Demonstration of the requisite intent is often the most complex discretionary decision the prosecutor faces.³⁸

Criminal prosecution is usually reserved for conduct that is injurious to individuals, particularly flagrant, or to deter similar conduct by other offenders. Federally, mail and wire fraud have been the most common charges prosecuted because nearly all health care fraud involves submission of claims either electronically or through the mail.³⁹ False claims, false statements, and conspiracy make up most of the rest of the charges although RICO,⁴⁰ money laundering, tax offenses, and

36. See generally PAMELA H. BUCY, WHITE COLLAR CRIME: CASES AND MATERIALS 328-417 (2d. 1998).

37. See False Claims Act, 31 U.S.C. §§ 3729-33 (1994).

38. See discussion *infra* Part C.

39. See discussion *infra* Part C.

40. Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§ 1961-68 (1994).

theft of government property have also been invoked.⁴¹ The state has traditionally employed state Medicaid fraud as its primary criminal charge, but controlled substance offenses, elder abuse crimes, larceny and conspiracy have also been applied.⁴² Criminal punishment may include fines, incarceration and the loss of privileges of citizenship that follow felony conviction.

Criminal health care fraud prosecutions have been significantly impacted by the Sentencing Reform Act of 1984.⁴³ These guidelines, enacted largely in response to drug and firearm offenses, have markedly reduced judicial discretion in dispensing justice in health law violations. The guidelines call for fines of up to twenty-five thousand dollars and five years imprisonment for *each offense*.⁴⁴ Since health care offenses often stem from an improper billing procedure that has been repeated for multiple patients, they are charged as multiple counts of the same offense.⁴⁵ In health care violations with a minimal scienter requirement, a competent and dedicated physician can be at risk for many years of imprisonment and fines out of any imaginable proportion to the alleged crime.⁴⁶

41. See Bucy, *supra* note 8, § 3.01, at 3-3 & 3-4. See also interview with Leif Johnson, Asst. U.S. Attorney, U.S. Attorney's Office, in Billings, Mont. (April 2, 1999).

42. See Bucy, *supra* note 8, § 3.01, at 3-3 & 3-4. See also interview with Leif Johnson, Asst. U.S. Attorney, U.S. Attorney's Office, in Billings, Mont. (April 2, 1999); Interview with Joan Ashley, Director, Montana Medicaid Surveillance Utilization Review Service (SURS), in Helena, Mont. (Apr. 6, 1999).

43. See 18 U.S.C. §§ 3551-59 (1994 & Supp. IV 1998); 28 U.S.C. § 994 (1994). See also Federal Sentencing Guidelines Act of 1986, 28 U.S.C. §§ 1, 994 (1994).

44. See, e.g., 42 U.S.C. 1320a-7b (Supp. III 1997) (outlining penalties for willful and knowing violation of Medicare billing laws) (emphasis added).

45. See *e.g.* United States v. Krizek, 859 F. Supp. 5 (D.D.C. 1994). A physician whom the court described as "dedicated" and "competent" was charged with knowingly presenting a false claim, knowingly presenting a false record, conspiracy to defraud the government and unjust enrichment. The government requested treble actual damages of \$245,000 and penalties of \$10,000 for each of 8,002 allegedly false reimbursement claims. The government claimed that the physician billed for a 45-minute psychotherapy session instead of the proper 30-minute session. *Id.* at 6-11.

46. See *id.* Here, the physician was at risk for twenty-five years imprisonment and more than 80 million dollars in fines because his billing clerk, his wife and a non-physician, averaged the duration of the doctor's patient visits at sometimes 15 minutes and sometimes two hours. Admittedly, this practice was wrong, but it surely did not merit threats of jail time and permanent financial ruin.

*C. The Traditional Intent Requirement of
Health care Fraud*

In health care fraud, like many white collar crimes, the facts of a particular interaction are usually not at issue. There are patient charts, detailed accounts of tests and billing records which describe the conduct. More often, the issue of criminality turns on intent of the provider.

The definition of intent varies with the statute invoked to charge health care fraud. For example, the Criminal False Claims Act requires that the defendant submit a false claim "knowingly"⁴⁷ but the False Statement Act requires that the defendant "knowingly and willfully"⁴⁸ make a false statement. Courts dealing with health care fraud have held, in keeping with standard criminal jurisprudence, that the term "knowingly," does *not* require specific intent to commit a crime.⁴⁹ However, in some criminal cases, particularly those involving complex statutes, courts have interpreted knowingly in a liberal manner in favor of the criminally accused by compelling the prosecution to prove knowingly in each element of the crime.⁵⁰ An example of this requirement occurs in *Staples v. United States* in which the Court held the defendant must know not only that he possesses a firearm but also that it is an automatic weapon, each fact a separate element of the crime.⁵¹ The policy behind this interpretation is that a statutory crime carrying a substantial penalty is presumed to require a defendant to know the *facts* that make his conduct illegal.⁵²

An exemption to the general interpretation of knowingly is called the "public welfare exception." This exception, sometimes applied in environmental crimes, states that if the danger to the public is sufficiently great, strict liability may be applied to

47. See 18 U.S.C. § 287 (1994).

48. 18 U.S.C. § 1001 (1994) (emphasis added).

49. *United States v. Hopkins*, 53 F.3d 533, 537-41 (2d. Cir. 1995).

50. See *United States v. X-Citement Video, Inc.*, 513 U.S. 64, 68-74 (1994).

51. 511 U.S. 600, 619-20 (1994).

52. See *id.* See also *United States v. Weitzenhoff*, 1 F. 3d 1523, 1530 (9th Cir. 1993), amended & superseded on denial of reh'g by 35 F. 3d 1275, 1285-89 (9th Cir. 1994) and *United States v. Ahmad*, 101 F. 3d 386, 390-91 (5th Cir. 1996) (these two cases both quoted *United States v. Staples: Weitzenhoff* to affirm that a mistake of law is not an exception to the general rule that criminal behavior does not require specific intent and *Ahmad* to affirm that knowingly applies to all elements of a crime and a mistake of fact (believing gasoline discharge was actually water) does prevent criminal conviction).

certain individuals.⁵³ For example, in CERCLA,⁵⁴ an “owner” of property may be held responsible for pollution on that property even if he has no knowledge or control of that pollution.

In health care crimes, a court must balance the need to prevent fraud against the obligation to protect individuals from substantial punishment for inadvertent crimes.⁵⁵ A health care prosecutor might argue that the public welfare exception should apply and the legal system should place the onus of acquiring knowledge of fraudulent activity on the health care provider because the consequences of health care fraud to society are enormous and the provider is in the best position to monitor fraudulent activity. The defense could counter by pointing out that the complexity of the health care statutes makes interpretation by individual providers treacherous. Additionally, the severity of the penalties are such that it is unfair to impose them without clear notice to the defendant of his criminal behavior.⁵⁶

Whether a court would allow the public welfare exception remains an open question. However, since the public welfare exception has been ruled to be narrow and not applied to machine guns,⁵⁷ it is unlikely the United States Supreme Court would condone its application to any but the most egregious health care fraud. Its application would likely require physical patient risk as well as individual and government financial losses.

Adding the term “willfully” to a statute further complicates the intent definition. Early on, in *United States v. Greber*, the Third Circuit found that the term “willfully” did not mandate specific intent to commit a crime.⁵⁸ Rather, the defendant merely had to intend his actions and to carry out those actions willfully.⁵⁹ However, several years later the United States Supreme Court interpreted the terms “willfully” and the phrase

53. See, e.g., Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. § 9607 (1994 & Supp. III 1997).

54. See *id.* at §§ 9601-75 (1994 & Supp. III 1997).

55. See Andrea Tuwiner Vavonese, Comment, *The Medicare Anti-Kickback Provision of the Social Security Act—Is Ignorance of the Law an Excuse for Fraudulent and Abusive Use of the System?*, 45 CATH. U. L. REV. 943, 976 (1996).

56. See *supra* notes 45 and 46.

57. See *Staples v. United States*, 511 U.S. 600, 607-610 (1994).

58. 760 F.2d. 68, 71 (3d Cir. 1985) (finding that if the effect of a business practice was an inducement to refer patients, the Defendant violated the statute even if legitimate services were performed for fair market value).

59. See *id.*

“knowingly and willfully” to require specific intent to commit the crime in tax (*Cheek v. United States*)⁶⁰ and money laundering (*Ratzlaf v. United States*)⁶¹ cases. In 1995, the Ninth Circuit applied *Ratzlaf* and *Cheek* to health care fraud for the first time, holding in *Hanlester Network v. Shalala*⁶² that the element of intent required the defendants to know that their conduct was unlawful and to undertake that conduct with the specific intent to commit the crime.⁶³ This decision created quite a stir in the OIG’s office which vowed to “aggressively contest” the application of the *Hanlester* standard in other circuits.⁶⁴

Almost immediately, in *United States v. Neufeld*,⁶⁵ a district court in the Sixth Circuit disagreed with the Ninth Circuit. The *Neufeld* Court held that the language in the money laundering and tax statutes at issue in *Ratzlaf* and *Cheek* could be distinguished as more vague than the language in the Medicare anti-kickback statutes. It further held that the ambiguities of conduct addressed in *Ratzlaf* were sufficiently innocent compared to that of *Neufeld* in the Medicare setting and that the prior Supreme Court holding that willfulness requires specific intent need not apply in Medicare fraud.⁶⁶ In 1996, the Eighth Circuit also refused to follow *Hanlester* for similar reasons.⁶⁷ The Tenth Circuit has taken a somewhat intermediate stance in *United States v. Migliaccio*, holding that the complex regulations in health care fraud require the prosecution to prove that there is no reasonable interpretation of the rules which could render a defendant’s statements truthful.⁶⁸

The Supreme Court has so far declined to address the issue of “willfully” in the Medicare fraud context.⁶⁹ However, given its jurisprudence in *Ratzlaf* and *Cheek*, it is likely that the Court would apply the specific intent requirements it identified in

60. 498 U.S. 192, 202 (1991).

61. 510 U.S. 135, 149 (1994).

62. 51 F.3d 1390 (1995).

63. *See id.* at 1400.

64. *See Department of Justice Refuses to Ask for Supreme Court Review of Hanlester Anti-Kickback Case*, 7 BNA MEDICARE REP. NO. 6, Feb. 9, 1996, at 157.

65. 908 F. Supp. 491, 494-97 (S.D. Ohio 1995).

66. *See id.*

67. *See United States v. Jain*, 93 F.3d 436, 440-41 (8th Cir. 1996).

68. 34 F.3d 1517, 1524 (10th Cir. 1994).

69. *See Barbara Yuill, High Court Justices’ 1999-2000 Docket Currently Includes Six Health Law Cases*, 8 BNA HEALTH L. REP. NO. 6, Sept. 30, 1999, at 1573 (the United States Supreme Court has not yet addressed the *Hanlester* doctrine and has not seen fit to add it to this year’s docket).

those cases to health care fraud in all but the most egregious fact circumstances.

III. THE BACKGROUND AND PURPOSES OF HIPAA

Shortly after his inauguration, President Bill Clinton announced that health care reform was a top priority of his administration⁷⁰ and promptly appointed his wife to accomplish this goal. Unfortunately, the Clinton's Health Security Act⁷¹ was couched in terms of "comprehensive federalization" which the 1994 Republican Congress, the American Medical Association, and the American Hospital Association rapidly labeled "socialization of medicine" and thwarted. After the flaming death of their Health Security Act, the Clintons were able to keep public discontent with health insurance alive by emphasizing the barrier of prior existing illness to continuous health insurance when changing jobs. Interestingly, the Clintons accomplished this using the storytelling technique conceived by critical legal theorists in the 1970s.⁷² Critical legal theory was executed brilliantly by Ruth Bader Ginsburg to sway the Supreme Court to a position against gender discrimination when she was director of the American Civil Liberties Union Women's Rights Project.⁷³ Using the same strategy that

70. See Jeffrey H. Birnbaum & Michael K. Frisby, *Clinton Pledges That Crime and Welfare Issues Will Get Near Equal Billing With Health Care*, WALL ST. J., Jan. 24, 1994, at A16.

71. See H.R. 3600, 103d Cong. (1993).

72. A detailed discussion of critical legal theory and its progeny critical race theory and critical gender theory is beyond the scope of this paper. In general, critical legal theorists deconstruct the central ideas of modern legal thought using a variety of argument styles. One technique, employed predominantly by critical race and gender theorists, is telling real life stories which emphasize the absurdity of the outcome of traditional jurisprudence. Classic examples of this style are found in Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes in FEMINIST LEGAL THEORY: READINGS IN LAW AND GENDER* 404 (Katharine T. Bartlett et al. eds., 1991) and in Regina Austin, *Sapphire Bound! in CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT* 426 (Kimberle Crenshaw et al. eds. 1996). If the reader is interested in a more general exposure to critical legal theory, see *THE POLITICS OF LAW* (David Kairys ed., rev. ed. 1990). In particular, see Robert W. Gordon, *New Developments in Legal Theory*, in *id.* at 413. See also James Boyle, *The Politics of Reason: Critical Legal Theory and Local Social Thought*, 133 U. PA. L. REV. 685 (1985); Note, *'Round and 'Round the Bramble Bush: From Legal Realism to Critical Legal Scholarship*, 95 HARV. L. REV. 1669 (1982); and Roberto Mangabeira Unger, *The Critical Legal Studies Movement*, 96 HARV. L. REV. 563 (1983).

73. See David Cole, *Strategies of Difference: Litigating for Women's Rights in a Man's World*, 2 LAW & INEQ. J. 33, 53-58 (1984). This paper offers an in-depth analysis of Ginsburg's use of incidents of discrimination against males to educate the United States Supreme Court about the evils inherent in any type of gender discrimination,

Ginsburg argued to the Supreme Court, the Clintons and their democratic political machine convinced congress that the health care system needed reformation by telling stories that resonated with the conservative majority; stories of hardworking white middle class folks who suffered bankruptcy, untreated illness and even premature death through lack of health care insurance.⁷⁴ This inflamed Congress sufficiently to pass the Kassebaum-Kennedy Bill nearly unanimously and in September of 1996, Clinton signed it into law.⁷⁵ HIPAA contains approximately one third of the reforms originally proposed by the Clintons in their Health Security Act couched in less aggressive terms.⁷⁶ The broad purpose of HIPAA is stated in the Act itself and provides that HIPAA is:

[a]n Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.⁷⁷

Thus HIPAA, a statute that was originally billed primarily as a remedy for loss of private health insurance due to employment changes, became the first federal statute to regulate private health care and markedly increased the government's power to prosecute health care fraud. On the first anniversary of its passage, Donna E. Shalala, Secretary of Health and Human Services announced:

This anniversary marks the enactment of landmark legislation that has given millions of working people the comfort of knowing that if they change jobs, they need not lose their health insurance. This is an important step that demonstrates our commitment to improve access to high quality health care for all Americans. This

supporting her arguments concerning discrimination against women. See also Ruth Ginsburg, *Gender and the Constitution*, 44 U. CIN. L. REV. 1 (1975) and Ruth Ginsburg, *Sex and Unequal Protection: Men and Women as Victims*, 11 J. FAM. L. 347 (1971) for her own specific examples.

74. See, e.g., Rick Wartzman, *Advertising War Over Health Reform Heats Up, With Confused Americans Caught in Crossfire*, WALL ST. J., July 15, 1994, at A14; Hilary Stout, *Insurers' Harry and Louise Campaign Returns to TV to Cut Up Health Plan*, WALL ST. J., June 21, 1994, at A24; and Michael Wines & Robert Pear, *President Finds Benefits in Defeat on Health Care*, N.Y. TIMES, July 30, 1996, at A4.

75. See Rovner, *supra* note 10, at 183.

76. See *Health Hippo: HIPAA Page* (visited Feb. 5, 2000) <<http://hippo.findlaw.com/hipaa.htm>>.

77. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, 1936.

legislation provides that a woman with a sick child can move from one group plan to another without a lapse in health insurance, and without paying more than other employees for that coverage. And it gives small businesses access to health insurance programs to provide their employees with the coverage they need and deserve. In addition to providing health care portability, this legislation created a stable source of funding for fraud control activities, and is giving us new resources to attack fraudulent health care providers, and develop new management tools and techniques. Funded by these critical resources, today I was pleased to award more than \$2.25 million in grants for new programs that will strengthen our ongoing fraud efforts.⁷⁸

Contrary to these accolades the circuitous conception and birth of HIPAA has rendered it disjointed and prompted scholars to criticize it as “somewhat schizophrenic.”⁷⁹ HIPAA is divided into five separate sections with little tying them together. Title I addresses health care access, portability and renewability; Title II deals with health care fraud; Title III creates medical savings accounts and speaks to long term medical care, consumer protection and organ transplantation efforts; Title IV regulates private group health insurance plans; and Title V amends the Tax Code in the area of revenue offsets. This paper will focus on the Title II health care fraud provisions.

IV. TITLE II OF HIPAA

Title II of HIPAA is the substance of the government’s attack on health care fraud. It outlines four approaches to controlling fraud and abuse: 1) education; 2) broadening the definition of health care fraud; 3) enhancement of health care fraud enforcement; and 4) expansion of penalties for health care fraud.

A. Provisions to Educate Providers, Payers and the Public About Health Care Fraud

One of the theories regarding the prevalence of health care fraud is that the rules are so complex that providers simply cannot determine whether or not a given practice is permitted. To address this problem, drafters of HIPAA decided to educate

78. See *Health Hippo: HIPAA Page* (visited Feb. 5, 2000) <<http://hippo.findlaw.com/hipaa.html>> (quoting Donna Shalala’s comments when HIPAA was signed into law).

79. Katherine Benesch, *Health Care Fraud Criminalization Growing*, 7 N.J. LAW. 1422 (1998).

all parties involved in health care transactions. Underlying this approach was the hope that it would not only clarify fraudulent behavior to the providers but also convert payers and recipients into a network of fraud surveillance.

i. Office of the Inspector General Advisory Opinions

Provisions forbidding kickbacks and self-referrals have been some of the most complex areas of health care law. Amid federal anti-kickback statutes,⁸⁰ the Stark Amendments,⁸¹ and antitrust law, business arrangements between hospitals, physicians, laboratories, surgical centers and other health care agencies have become minefields of potential criminal liability. HIPAA authorized the Office of the Inspector General (OIG) to issue advisory opinions regarding the legality of specific transactions between February 21, 1997 and August 21, 2000.⁸² These opinions are limited to the parties to a transaction and the following four questions: 1) whether a transaction constitutes prohibited remuneration; 2) whether a transaction complies with exceptions or safe harbors; 3) whether a transaction constitutes an inducement to limit services to beneficiaries; and 4) whether a transaction is grounds for civil or criminal sanctions. The OIG must issue a requested opinion within sixty days and that opinion is binding on the OIG and the parties but may not be used as precedent by other parties. The requesting party must pay all costs as well as a request fee of \$250.

OIG opinions have been requested in much lower numbers than anticipated.⁸³ One reason for this is that all information submitted to the OIG becomes public information and many providers opt to pay their own lawyers to research the questions and retain their privacy. Another reason may be controversy regarding whether the Department of Justice and Internal

80. See 42 U.S.C. § 1320a-7b(b) (Supp. III 1997).

81. Pub. L. No. 101-239 took effect in 1992 and is known as the Stark I Amendment. It specifically prohibits referral of Medicare patients to medical laboratories in which a physician has an ownership interest and requires reporting of ownership information and referral arrangements. Pub. L. No. 103-66 took effect in 1993 and is known as the Stark II amendment. It broadened the coverage of Stark I to include Medicaid patients and prohibited ten other categories of referrals in addition to medical laboratories.

82. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 205(b)(6), 110 Stat. 1936, 2002 (codified at 42 U.S.C. § 1320a-7d(b)(6) (Supp III 1997)).

83. See Rovner, *supra* note 5, at 18.

Revenue Service are bound by OIG opinions.⁸⁴

ii. Safe Harbors and Special Fraud Alerts

The federal anti-kickback statute already contained six statutory exceptions known as “safe harbor” rules which exempted certain remunerative practices from prosecution.⁸⁵ For example, *Greber* interpreted the antikickback provisions of the Medicare Act quite narrowly.⁸⁶ However, the Department of Health and Human Services (HHS), by administrative rule, defined as legal certain hospital/physician business relationships which would not have survived a *Greber* standard of review.⁸⁷ Examples of these practices include leasing of office space, equipment rental, or even direct payments to physicians. These practices will clearly tend to induce referrals. However, if they are constructed in strict compliance with the standards outlined by HHS, they will survive scrutiny.

HIPAA authorized one additional exception for risk sharing between managed care organizations and providers.⁸⁸ Also, HIPAA authorized the OIG to develop and publish safe harbor rules to guide various health care providers in their business dealings.⁸⁹ Additionally, the OIG is required to annually solicit proposals from the public (including health care providers) for modifying existing safe harbor rules or establishing new ones.⁹⁰ In considering a safe harbor, HIPAA lists ten factors the OIG must evaluate including patient access to health care, freedom of patient choice of provider, provider incentives to order goods or make referrals, competition, quality of care delivered, and program cost.⁹¹ The OIG uses standard notice and comment rulemaking procedures to comply with these mandates.

Special fraud alerts are the opposite of safe harbors and provide notice to the public and health care providers of

84. See Darken, *supra* note 1, at 32.

85. See 42 U.S.C. § 1320a-7b(b) (Supp. III 1997).

86. See *United States v. Greber*, 760 F.2d 68, 71 (3rd Cir. 1985).

87. See Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35,952 (1991)(codified at 42 C.F.R. pt. 1001).

88. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 216(b), 110 Stat. 1936, 2007 (codified at 42 U.S.C. § 1320a-7(b) note).

89. See *id.* § 205(a), 110 Stat. at 2000 (codified at 42 U.S.C. § 1320a-7d(a) (Supp. III 1997)).

90. See *id.* § 205(a), 110 Stat. at 2001 (codified at 42 U.S.C. § 1320a-7d(a) (Supp. III 1997)).

91. See *id.*

practices that constitute fraud per se, much like the “per se rules” of anti-trust law.⁹² The most recent example of a significant special fraud alert is the OIG’s advisory bulletin on gainsharing issued in July, 1999.⁹³ This document effectively prohibited any form of patient care related gainsharing, a practice which had up until that time been widely used to align the financial incentives of hospitals and their staff physicians.⁹⁴

Like safe harbors, these alerts can be issued by the OIG of its own accord or can be requested by any member of the public.⁹⁵ HIPAA requires the OIG to use the same factors and the notice and comment rulemaking procedure for fraud alerts as it does for safe harbor provisions.⁹⁶

iii. Explanation of Medicare Benefits

HIPAA requires that every Medicare patient receive an Explanations of Medicare Benefits (EOMB) for every Medicare covered item or service. EOMBs have turned out to be a fertile source for patient reporting of possible fraudulent billing practices.⁹⁷ This process has encouraged patients to review the benefits they have received and provides a convenient mechanism and financial incentive for reporting discrepancies.⁹⁸

iv. National Data Bank

HIPAA mandates that HHS establish a national data bank that records information about providers who commit fraud and abuse.⁹⁹ The data required includes not only the entity committing the fraudulent act but the officers and owners of the

92. *See id.* § 205(c), 110 Stat. at 2003 (codified at 42 U.S.C. § 1320a-7d(c) (Supp. III 1997)).

93. OIG Special Advisory Bulletin on Gainsharing Arrangements and CMPs for Hospital Payments to Physicians to Reduce or Limit Services to Beneficiaries, 64 Fed. Reg. 37,985, 37,987 (1999).

94. In response to the OIG’s ruling, one Dallas law firm complained that it had over a hundred (now illegal) gainsharing arrangements in place for its clients. *See Katherine E. Harris & Barbara Yuill, Gainsharing: IG Bulletin Strikes Down Gainsharing, Says CMP Law Bans Incentives To Curb Care*, 8 BNA HEALTH L. REP. 1133 (July 15, 1999).

95. *See id.*

96. *See id.*

97. *See Health Insurance Portability and Accountability Act of 1996*, Pub. L. No. 104-191, § 203(a), 110 Stat. 1936, 1998.

98. *See id.*

99. *See id.* § 221(a), 110 Stat. at 2009 (codified at 42 U.S.C. § 1320a-7e(a) (Supp. III 1997)).

entity, any affiliate entities, the nature of the acts and any injury stemming from the acts.¹⁰⁰ Only final adverse actions are reportable, but these include any final adverse administrative, civil or criminal action and any licensure revocation.¹⁰¹ Malpractice claims or settlements are not reported to the fraud data bank but are reported to a separate data bank, the National Practitioner Data Bank created by the Health Care Quality Improvement Act of 1986.¹⁰²

B. Provisions to Extend the Definition of Health Care Fraud

HIPAA defined “health care fraud” as an independent federal crime protecting federal, state and, for the first time, private health care plans.¹⁰³ The criminal section of Title II of HIPAA creates five new federal crimes.¹⁰⁴ In addition, HIPAA expanded the existing money laundering, asset forfeiture and fraud injunction statutes to cover “federal health care offenses” and defined that term very broadly to include virtually any illegal act touching any health benefit program, public or private.¹⁰⁵

i. Specific New Federal Crimes

HIPAA defines four new felonies and a misdemeanor.¹⁰⁶ The felonies significantly broaden the definition of the health care offenses by removing specific limitations present in other federal criminal statutes.¹⁰⁷ Section 242(a) of HIPAA makes health care fraud generally a crime. It prohibits *knowingly and willfully* executing or attempting to execute a scheme to defraud any health care benefit program or to fraudulently obtain money or property from such programs in connection with the delivery of or payment for health care benefits, items, or services.¹⁰⁸ This

100. *See id.* § 221(b), 110 Stat. at 2009 (codified at 42 U.S.C. § 1320a-7e(b) (Supp. III 1997)).

101. *See id.*

102. *See id.*; *See also* 42 U.S.C. § 11101-11152 (1994).

103. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 241-47; 249, 110 Stat. 1936, 2016-21.

104. *See id.*

105. *See* 18 U.S.C. § 24 (Supp. III 1997); 18 U.S.C. § 1956 (Supp. III 1997); 18 U.S.C. § 982 (Supp. III 1997); and 18 U.S.C. § 1345 (Supp. III 1997).

106. *See* Health Insurance Portability and Accountability Act of 1996 §§ 241-47, 249, 110 Stat. at 2016-21.

107. *See* Bucy, *supra* note 8, § 3.01, at 3-3.

108. *See* Health Insurance Portability and Accountability Act of 1996 § 242, 110

offense is patterned after the bank fraud statute.¹⁰⁹ Under this new offense however, federal prosecutors may indict an entire health care fraud scheme including entities, individuals, managers, and co-conspirators, without first tying it to traditional conspiracy or mail fraud or wire fraud statutes.¹¹⁰ This simplifies the charging and conviction of complex health care fraud because it reduces the number of elements a prosecutor must prove to make her case. Additionally, HIPAA allows prosecution of fraudulent intrastate electronic billings to private insurers, which could not have been prosecuted under the wire fraud statutes.¹¹¹

Section 243(a) of HIPAA makes theft or embezzlement in connection with health care a federal crime.¹¹² No person or entity may *knowingly and willfully* embezzle, steal, intentionally misapply, or otherwise convert *any* of the money, property, premiums, or other assets of a health care benefit program. There is no statutory minimum amount, so federal prosecutors may now charge thefts or embezzlements which do not meet the previously existing jurisdictional requirements of \$5,000 or more from an entity receiving more than \$10,000 of federal funds per year.¹¹³ This statute law also allows federal prosecutions of embezzlements from private health insurance plans.¹¹⁴

False statements relating to health care matters are made a federal crime by section 244(a) of HIPAA.¹¹⁵ This includes both false statements to the government which could be prosecuted under the existing statute¹¹⁶ and false statements made to private insurers which could not be prosecuted. This statute also contains the *knowingly and willfully* scienter requirement and specifically prohibits falsifying, concealing, or covering up a material fact by any trick, scheme, or device; making any materially false, fictitious, or fraudulent statements or

Stat. at 2016 (codified at 18 U.S.C. § 1347 (Supp. III 1997)).

109. See 18 U.S.C. § 1344; See also Darken, *supra* note 1, at 31.

110. See Health Insurance Portability and Accountability Act § 242, 110 Stat. at 2016.

111. See *id.*

112. See *id.* § 243(a), 110 Stat. at 2019 (codified at 18 U.S.C. § 669 (Supp. III 1997)).

113. See 18 U.S.C. § 666 (1994).

114. See Health Insurance Portability and Accountability Act of 1996 § 243, 110 Stat. at 2017.

115. See *id.* § 244(a), 110 Stat. at 2017 (codified at 18 U.S.C. § 1035 (Supp. III 1997)).

116. See 18 U.S.C. § 1001 (Supp. III 1997).

representations; or making or using any materially false document, knowing it contains any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services.¹¹⁷

It is now a crime, pursuant to section 245(a) of HIPAA, to *willfully* attempt to or actually obstruct, prevent, mislead, or delay, the communication of information or records relating to a violation of a federal health care offense to a criminal investigator.¹¹⁸ Section 245(b) defines the term “criminal investigator” broadly as “any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.”¹¹⁹ This new statute is much broader than the existing statutes because it does not contain the “by means of bribery” and “official proceedings” limitations.¹²⁰

Penalties for these felony offenses include fines which vary according to the damage to the particular federal program and a maximum prison sentence of five to ten years.¹²¹ If the violation results in serious bodily injury, the maximum sentence rises to 20 years, and if it results in death, the maximum sentence is life imprisonment.¹²²

The new HIPAA misdemeanor is aimed primarily at recipients of Medicare and Medicaid benefits. Section 217 of HIPAA prohibits purposefully disposing of assets, *including by any transfer in trust*, in order to qualify an individual for Medicaid.¹²³ This provision has created some confusion amongst estate planners who attempt to protect estate assets through trusts at the end of life.¹²⁴ In Montana, this has also been a difficult hurdle for asset (land) rich but cash poor ranch families when they are faced with a sick child or other catastrophic

117. See Health Insurance Portability and Accountability Act of 1996 § 244, 110 Stat. at 2017-18.

118. See *id.* § 245, 110 Stat. at 2018 (codified at 18 U.S.C. § 1518 (Supp III 1997)).

119. See Health Insurance Portability and Accountability Act of 1996 § 245(b), 110 Stat. at 2018.

120. See, e.g., 18 U.S.C. § 1510 (1994) and 18 U.S.C. § 1512 (1994).

121. See Health Insurance Portability and Accountability Act of 1996 §§ 242(a)(2), 243(a)(2), 245(a), 110 Stat. at 2016-18.

122. See *id.*

123. See Health Insurance Portability and Accountability Act of 1996 § 217, 110 Stat. at 2008-09 (codified at 42 U.S.C. § 1320a-7b(a)(6) (Supp. III 1997)).

124. Rovner, *supra* note 5, at 20.

illness.¹²⁵

ii. Alterations in Existing Law

In addition to creating new laws, HIPAA also expands existing health care law. Specifically, HIPAA expands the definition of a kickback and materially alters the money laundering,¹²⁶ asset forfeiture,¹²⁷ and injunctive relief statutes,¹²⁸ to cover “federal health care offenses.” First, Section 241 of HIPAA redefined the term “federal health care offense” broadly to include a criminal conspiracy to violate or a violation of any new health care fraud statute¹²⁹ or any of the existing applicable federal offenses if the violation involves a health care program.¹³⁰ Next, Section 246 of HIPAA expanded the scope of “specified unlawful activity” when including any act or activity constituting an offense involving a federal health care offense as a predicate act for a money laundering violation.¹³¹ Then, Section 249 amended the criminal forfeiture statute with a new section containing mandatory forfeiture language, which states that a court “*shall* order a person [convicted of a federal health care offense] to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.”¹³² Lastly, Section 247 broadened the fraud injunction statute authorizing the government to file a civil action to enjoin the commission or imminent commission of a federal health care offense and to freeze the assets of persons disposing of property obtained as a

125. Personal experience of the author in his cardiovascular surgical practice.

126. See Health Insurance Portability and Accountability Act of 1996 § 246, 110 Stat. at 2018.

127. See *id.* § 249, 110 Stat. at 2020.

128. See *id.* § 247, 110 Stat. at 2018 (codified at 18 U.S.C. § 1345 (a)(1) (Supp. III 1997)).

129. See Health Insurance Portability and Accountability Act of 1996 § 241, 110 Stat. at 2016 (codified at 18 U.S.C. § 24(a)(1) (Supp. III 1997)).

130. See *id.* § 241, 110 Stat. at 2016 (codified at 18 U.S.C. § 24 (a)(2) (Supp III 1997)) to include false claims (18 U.S.C. § 287 (1994)); conspiracy (18 U.S.C. § 371 (1994)); theft or embezzlement of employee benefit plans (18 U.S.C. § 664 (1994)); theft or bribery from programs receiving federal funds (18 U.S.C. § 666 (1994)); false statements (18 U.S.C. § 1001 (1994)); false statements in ERISA documents (18 U.S.C. § 1027 (1994)); mail fraud (18 U.S.C. § 1341(1994)); wire fraud (18 U.S.C. § 1343 (1994)); and ERISA bribery (18 U.S.C. § 1954 (1994)).

131. See Health Insurance Portability and Accountability Act of 1996 § 246, 110 Stat. at 2018 (codified at 18 U.S.C. § 1956 (c)(7) (Supp. III 1997)).

132. See *id.* § 249, 110 Stat. at 2020 (codified at 42 U.S.C. § 1320a-7b(a)(6) (Supp. III 1997)) (emphasis added).

result of a federal health care offense.¹³³

A subtle, but potentially one of the most profound, change HIPAA made was to the anti-kickback statute. The anti-kickback statute prohibits *knowingly and willfully* soliciting, receiving, offering, or paying any “remuneration” in return for, or to induce, the furnishing or purchase of services or goods under the Medicare or Medicaid programs.¹³⁴ There has been a significant amount of controversy over whether waiving a co-payment or deductible constituted remuneration to induce patients to use a particular provider. Section 231 of HIPAA clarifies this controversy by specifically stating that waving a co-payment is a kickback unless it is done for a documented financial need or failure to collect it after reasonable efforts.¹³⁵ Further, Section 204 extends it to all federal health care programs except the Federal Employee Health Benefit Program.¹³⁶ There has also been confusion about how to apply the anti-kickback rules to managed care. As discussed *supra*, Section 216 of HIPAA provides a safe harbor for remuneration between individuals and managed care organizations as long as the risk of non-payment is shared.¹³⁷

A common practice among physicians has been to routinely waive deductibles and co-payments for patients with financial hardship. However, co-payments and deductibles are considered to be a part of the system of preventing overuse of Medicare and

133. See *id.* § 247, 110 Stat. at 2018(codified at 18 U.S.C. § 1345 (Supp. III 1997)).

134. See 42 U.S.C. § 1320a-7b(b) (Supp. III 1997)(emphasis added).

135. See Health Insurance Portability and Accountability Act of 1996 § 231(h), 110 Stat. at 2014 (codified at 42 U.S.C. § 1320a-7a(i)(6) (Supp. III 1997)).

136. See *id.* § 204, 110 Stat. at 2000 (codified at 42 U.S.C. § 1320 a-7(b),(f)(Supp. III 1997)). This statute references 42 U.S.C. § 1320a-7(f) which defines Federal Health Plan as “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 or Title 5).” Here, the FEHBO is specifically excepted from coverage. The reason for this exception is unclear. Professor Joan Krause at Loyola University has postulated the following two possibilities: one is that the nature of the programs is different from “federal health care programs” in general: it is merely an employee benefit plan, not a publicly-supported health plan for a “vulnerable” population. Two, it’s run through a completely different part of the government than HHS (OMB), and is treated as more of a pure government contracting program. Personal communication with Joan Krause, Professor, Loyola University, in Chicago, Ill. (Feb. 7, 2000).

137. See Health Insurance Portability and Accountability Act of 1996 § 216, 110 Stat. at 2007(codified at 42 U.S.C. § 1320a-7(b) (Supp. III 1997)). Capitation is the predominant example of this type of arrangement. A physician accepts a specific yearly fee to care for a patient which is lowered to induce an increase in volume. As long as the physician shares the risk of financial loss if the patient requires more care than the fee pays for, this arrangement is defined as acceptable under HIPAA.

Medicaid services by those very patients. Therefore, HIPAA attempted to distinguish between permissible and impermissible waivers of coinsurance and deductibles.¹³⁸ As defined by HIPAA, remuneration now includes the *routine* waiver, or partial waiver, of coinsurance and deductible amounts and the transfer of items or services for free or for less than fair market value.¹³⁹ However, HIPAA has added a safe harbor to allow a certain amount of largess on the part of health care providers. As long as the waiver is not offered as part of any advertisement or solicitation, the provider does not *routinely* make such waivers, the waiver was made after the provider determined in good faith that the patient was in financial need or the provider failed to collect the coinsurance or deductible after making reasonable collection efforts, the waiver is considered permissible.¹⁴⁰

C. Provisions to Increase Enforcement Resources

The underpinning of an effective statute is sufficient resources to provide enforcement. Both branches of law enforcement, investigation and prosecution, agree that thus far the most important effect of HIPAA has been the infusion of significant funds into enforcement.¹⁴¹ As the amount of money at risk for fraudulent conversion in health care has grown, increasingly coordinated and sophisticated schemes have been developed to divert those funds. Likewise, identification of perpetrators requires increasing sophistication and expense. The Medicare Integrity Program has also had a significant impact on the early identification of fraudulent activity.¹⁴² In the future, three other provisions are likely to have significant effect on law enforcement: 1) authorization of investigative subpoenas; 2) the encouragement of *qui tam* actions; and 3) and the creation of networking programs between private, state and federal fraud control divisions.

138. See Health Insurance Portability and Accountability Act of 1996 § 231(h), 110 Stat. at 2014.

139. See *id.* (codified at 42 U.S.C. § 1320a-7a(i)(6) (Supp. III 1997)).

140. See *id.*

141. Interview with Jimmy Weg, Director, and Shane Shaw, Lead Investigator, Montana State Medicaid Fraud Investigation Unit, in Helena, Mont. (Apr. 6, 1999).

142. Interview with Joan Ashley, Director, Medicaid Surveillance Utilization Review Service (SURS) in Helena, Mont. (Apr. 6, 1999).

i. Increased Funding

Section 201(b) of HIPAA establishes the Health Care Fraud and Abuse Control Account within the Federal Hospital Insurance Trust Fund.¹⁴³ A total of \$661 million was appropriated for HIPAA in 1997 increasing to \$1.2 Billion by 2003.¹⁴⁴ About two thirds of this money was directed to the Medicare Integrity Program discussed below.¹⁴⁵ The Departments of Health and Human Services (HHS) and Justice were authorized seventeen percent of this money to fund public and private coordination of enforcement.¹⁴⁶ Seven percent of this money was earmarked for the FBI to fund its involvement in health care fraud and abuse enforcement¹⁴⁷ and ten percent of these funds are reserved for the OIG in its anti-fraud activities within Medicare and Medicaid.¹⁴⁸

In addition to these appropriated funds, all fines, penalties and forfeitures collected as a result of criminal and civil health fraud proceedings and recoveries involving health care items or services made under the False Claims Act are deposited into the Health Care Fraud and Abuse Control Account¹⁴⁹ and split among the agencies that acted to recover the funds.

ii. Medicare Integrity Program

Section 202 of HIPAA authorizes the Medicare Integrity Program.¹⁵⁰ This program authorizes HHS to contract with private organizations to review and audit provider activities within the Medicare program.¹⁵¹ HHS has used private contractors to examine provider utilization activities, audit Medicare cost reports, recover payments improperly made, and

143. See Health Insurance Portability and Accountability Act of 1996 § 201(b), 110 Stat. at 1992 (codified at 42 U.S.C. § 1395i (Supp. III 1997)).

144. See *id.* § 201 (b)(3), 110 Stat. at 1994-96 .

145. See *id.* § 201(b)(4), 110 Stat. at 1995-96.

146. See *id.* § 201(b)(3), 110 Stat. at 1994-95; See also Colleen M. Faddick, *Health Care Fraud and Abuse: New Weapons, New Penalties, and New Fears for Providers Created by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")*, 6 ANN. HEALTH L. 77, 88 (1997).

147. See *supra* note 146.

148. See *supra* note 146.

149. See Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 201(b)(2)(c), 110 Stat. 1936, 1993-94.

150. See *id.* § 202(a), 110 Stat. at 1996 (codified at 42 U.S.C. § 1395ddd(a) (Supp. III 1997)).

151. See *id.* § 202(b), 110 Stat. at 1997 (codified at 42 U.S.C. § 1395ddd(b) (Supp. III 1997)).

educate providers, beneficiaries and payers.¹⁵² This has become a very lucrative business. Organizations eligible for such contracts must have the demonstrated capability to conduct the reviews and audits, and must comply with federal procurement conflict of interest standards.¹⁵³ The organizations must also agree to cooperate with OIG, the Department of Justice and other government law enforcement agencies in the investigation and deterrence of health care fraud and abuse.¹⁵⁴ HHS can establish additional qualifications as deemed appropriate but must use competitive procedures to select new contractors.¹⁵⁵

iii. Investigative Subpoenas

Investigative subpoenas are authorized by Section 248 of HIPAA.¹⁵⁶ This tool has markedly simplified the task of Medicare/Medicaid fraud investigators. These are administrative subpoenas and do not require a grand jury for issuance. The Department of Justice is authorized to issue subpoenas in connection with examination into health fraud crimes.¹⁵⁷ These subpoenas can require the production of records and other documents and the testimony of their custodians.¹⁵⁸ Persons who comply with these subpoenas in good faith are immune from federal and state civil liability.¹⁵⁹ Health information about an individual brought to light by an investigative subpoena may not be used or disclosed in any proceeding, unless the proceeding arises out of and is directly related to receipt of health care services, items, payments, a fraudulent claim related to health of that individual, or the government's receipt of court authorization upon a showing of good cause.¹⁶⁰

152. Interview with Joan Ashley, Director, Medicaid Surveillance Utilization Review Service (SURS), in Missoula, Mont. (Apr. 6, 1999).

153. See Health Insurance Portability and Accountability Act § 202(c), 110 Stat. at 1997 (codified at 42 U.S.C. § 1395ddd(c) (Supp III 1997)).

154. See *id.*

155. See Health Insurance Portability and Accountability Act of 1996 § 202(c)(4), (d), 110 Stat. at 1997-98 (codified at 42 U.S.C. § 1395ddd(c)(4)-(d) (Supp III 1997)).

156. See *id.* § 248, 110 Stat. at 2018-20 (codified at 18 U.S.C. § 3486 (Supp III 1997)).

157. See *id.*

158. See *id.* § 248, 110 Stat. at 2018-20 (codified at 18 U.S.C. § 3486(a) (Supp. III 1997)).

159. See *id.* (codified at 18 U.S.C. § 3486(d) (Supp. III 1997)).

160. See *id.* (codified at 18 U.S.C. § 3486(e) (Supp. III 1997)).

iv. *Qui Tam Actions*

HIPAA does not specifically address qui tam actions.¹⁶¹ Qui tam in health care fraud is authorized by the 1986 amendments to the False Claims Act.¹⁶² HIPAA does however encourage more individual participation in the enforcement of Medicare/Medicaid fraud. Further, the increased penalties HIPAA introduces makes qui tam actions potentially more lucrative. These factors have combined to produce a dramatic increase in health care qui tam cases. In fact, the predominant target of qui tam actions recently shifted from defense contractors to health care providers and the plaintiff's qui tam bar is growing rapidly.¹⁶³

v. *Coordination of Private and Public Enforcement Activities*

Section 201(a) of HIPAA directs the OIG and the Department of Justice to implement programs that coordinate federal, state, local and private activities to combat health care fraud and abuse.¹⁶⁴ The programs are intended to facilitate intergovernmental investigations, audits and inspections of health care delivery and payments.¹⁶⁵ They are further designed to coordinate and enforce criminal, civil and administrative fraud and abuse controls.¹⁶⁶

The OIG has issued guidelines for coordinating public and private health care fraud and abuse controls.¹⁶⁷ These guidelines encourage private health plans and government enforcement agencies to exchange data that may assist plans in effective fraud and abuse controls and address quality of care problems.¹⁶⁸ They also encourage the government and private plans to exchange information about ongoing investigations and

161. See generally, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

162. See False Claims Amendment Act of 1986, Pub. L. No. 99-562, 100 Stat. 3153. "The Committee's overall intent in amending the *qui tam* section of the False Claims Act is to encourage more private enforcement suits." S. Rep. No. 99-345, at 23-24 (1986), reprinted in 1986 U.S.C.C.A.N. 5266, 5288-89.

163. See Kaz Kikkawa, *Medicare Fraud and Abuse and Qui Tam: The Dynamic Duo or the Odd Couple*, 8 HEALTH MATRIX 83, 93-95 (1998).

164. Health Insurance Portability and Accountability Act of 1996 § 201(a), 110 Stat. at 1992-93 (codified at 42 U.S.C. § 1320 a-7(c) (Supp. II 1996 & Supp. III 1997)).

165. See *id.*

166. See *id.*

167. See Rovner, *supra* note 5, at 21 n. 25.

168. See Rovner, *supra* note 5, at 21 n. 25.

enforcement. Each government agency and each health plan should designate "information coordinators" to facilitate these information exchanges. The guidelines provide for confidential treatment of patient information supplied to government agencies by health plans and gives immunity to health plans for providing information to OIG or the Department of Justice unless they knowingly supply false information.¹⁶⁹

D. Provisions to Expand the Penalties for Health Care Fraud

A significant part of HIPAA follows the federal government's "get tough" attitude toward health care fraud by increasing penalties for conviction. Exclusion from Medicare and Medicaid is the death knell for most health care providers.¹⁷⁰ Mandatory exclusion can be likened to the mandatory sentencing guidelines. Sections 211(a) and 211(b) outline the mandatory program exclusions.¹⁷¹ HHS must now exclude from Medicare and Medicaid participation all persons and organizations convicted of any felony federal health care offense as well as for felony conviction relating to controlled substances.¹⁷² These bases for mandatory program exclusion are added to those for criminal convictions related to the delivery of health care items or services funded by Medicare or Medicaid, and to criminal convictions for patient neglect or abuse.¹⁷³ The minimum period of mandatory program exclusion is 5 years.¹⁷⁴

Exclusion for misdemeanor health care fraud convictions is permissive.¹⁷⁵ The misdemeanor federal crime, newly created by HIPAA, gives federal prosecutors a bargaining chip in plea arrangements. If charges can be reduced to a misdemeanor with restitution, a fraudfeasor may be induced to testify against a more culpable co-defendant in exchange for a sentencing

169. See Rovner, *supra* note 5, at 21 n. 25.

170. See Siddiqi v. United States, 98 F.3d 1427 (2d Cir. 1996). In this case, an oncologist's conviction for Medicare fraud over a \$640.88 billing dispute was overturned. Yet, the fallout of the case resulted in him losing a \$825,000/year practice and the interest on \$150,000 for a five year period. Additionally, he was reduced to working for \$85,000 per year at a Veterans Hospital.

171. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 211, 110 Stat. 1936, 2003-04 (codified at 42 U.S.C. § 1320a-7(Supp II 1996 & Supp. III 1997)).

172. See *id.* §§ 211(a)(1) and (b)(1), 110 Stat. at 2003-04 (codified at 42 U.S.C. § 1320a-7 (Supp II 1996 & Supp. III 1997)).

173. See *id.*

174. See 42 U.S.C. § 1320a-7 (Supp. II 1996 & Supp. III 1997).

175. See *id.* § 1320a-7(b) (Supp. II 1996 & Supp. III 1997).

recommendation that does not include Medicaid/Medicare exclusion. The maximum period of permissive exclusion is three years.¹⁷⁶

Sections 213 and 214 of HIPAA increase the liability of owners and managers of sanctioned health care organizations.¹⁷⁷ Individuals who own or control sanctioned organizations and who *know or should know* of the sanctionable offenses are subject to permissive program exclusion.¹⁷⁸ A sanctioned organization is one that is convicted of any felony or misdemeanor federal health care offense.¹⁷⁹ Officers and managers of sanctioned organizations are subject to permissive program exclusion, regardless of their degree of actual knowledge.¹⁸⁰

HIPAA creates specific penalties to deal with Health Maintenance Organizations (HMO) which try to make a profit by restricting services provided to patients or excluding eligible patients in Section 215.¹⁸¹ A HMO that fails to comply with its Medicare contracts is subject to fines ranging from \$10,000 per week until the compliance deficiency is corrected, to \$25,000 per deficiency that adversely affects its beneficiaries.¹⁸² If the deficiency involves improper beneficiary exclusion or expulsion, the fines increase to \$100,000 per determination and \$15,000 for each individual improperly denied enrollment.¹⁸³

Lastly, in Sections 231 and 232, HIPAA increases monetary penalties for civil fraud and abuse from \$2,000 to \$10,000 per count and from double to treble the amount of improper or excess reimbursement claimed.¹⁸⁴ The imposition of civil monetary penalties is extended to include not just Medicare and Medicaid but every federal health plan, except the Federal

176. *See id.* § 1320a-7(c) (Supp. II 1996 & Supp. III 1997).

177. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 213, 214, 110 Stat. 1936, 2005 (amending 42 U.S.C. § 1320 a-7(b) (Supp. II 1996)); 42 U.S.C. § 1320c-5(b)(Supp. II 1996)).

178. *See* 42 U.S.C. § 1320a-7(b)(15)(A)(i) (Supp. III 1997).

179. *See id.* § 1320a-7(b)(15)(B) (Supp. III 1997).

180. *See id.* § 213, 110 Stat. at 2005 (codified at 42 U.S.C. § 1320a-7(b)(15)(A)(ii) (Supp. III 1997)).

181. *See id.* § 215, 110 Stat. at 2005 (codified at 42 U.S.C. 1395mm (1994 & Supp. II 1996 & Supp. III 1997)).

182. *See id.* § 215, 110 Stat. at 2005-07 (codified at 42 U.S.C. 1395 mm(i)(6)(c) (Supp. III 1997)).

183. *See* 42 U.S.C. § 1395mm (1994).

184. *See* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 231, 232, 110 Stat. 1936, 2012-15 (codified at 42 U.S.C. § 1320a-7a (Supp. II 1996 & Supp III 1997)).

Employee Health Benefit Program.¹⁸⁵ Individuals who have been excluded from program participation, but remain owners, officers or managers of a participating organization and know or should know of sanctionable conduct by that organization, may be personally liable for civil monetary penalties.¹⁸⁶ The level of culpability for imposition of civil monetary penalties requires only that the sanctionable conduct be undertaken *knowingly* and clearly states that no specific intent to defraud is required.¹⁸⁷

E. Other Important Provisions

In addition to the provisions listed *supra*, HIPAA authorizes two miscellaneous provisions that may have a significant impact on health care fraud: incentives for efficiency suggestions and bounties for whistleblowers. In the first provision, HIPAA actively solicits efficiency suggestions in Section 203(c).¹⁸⁸ These suggestions are submitted directly to HHS and may trigger a financial award to individuals whose suggestions HHS adopts.¹⁸⁹

The second important provision is the “whistleblower” provision in Section 203(b) of HIPAA.¹⁹⁰ HHS is authorized to pay awards to individuals who report Medicare fraud and abuse.¹⁹¹ Reports that result in collection of at least one hundred dollars *may*, at the discretion of the Secretary of HHS, be rewarded with a portion of the amount collected.¹⁹² In implementing this program, HHS is directed to adopt procedures that will minimize any reports of frivolous or irrelevant information.¹⁹³ The whistleblower provision has already had a significant effect on the way investigations are

185. *See id.*; *See also supra* note 136.

186. *See* Health Insurance Portability and Accountability Act of 1996 §§ 231, 232, 110 Stat. at 2012-15 (codified at 42 U.S.C. § 1320a-7a (Supp. II & Supp III 1997)).

187. *See id.*

188. *See id.* § 203(c), 110 Stat. at 1999 (codified at 42 U.S.C. § 1395b-5 (Supp. III 1997)).

189. *See id.* § 203, 110 Stat. at 1998-99 (codified at 42 U.S.C. § 1395b-5 (Supp. III 1997)).

190. *See* Health Insurance Portability and Accountability Act of 1996 § 203(b), 110 Stat. at 1999 (codified at 42 U.S.C. § 1395b-5 (Supp. III 1997)).

191. *See id.* § 203, 110 Stat. at 1998-99 (codified at 42 U.S.C. 1395b-5 (Supp. III 1997)).

192. *See id.* § 203(b)(2), 110 Stat. at 1999 (codified at 42 U.S.C. 1395b-5 (Supp. III 1997)).

193. *See id.* § 203(b)(1), 110 Stat. at 1999 (codified at 42 U.S.C. 1395b-5 (Supp. III 1997)).

initiated and conducted.¹⁹⁴

V. HOW HIPAA IS CURRENTLY AFFECTING MONTANA

The effects of HIPAA on the State of Montana can be summed up in a single word: money. To date, no health care fraud case has been specifically charged using the HIPAA statutes. The primary effect of HIPAA has been to infuse financial support into the Medicare/Medicaid fraud investigation and prosecution systems and to encourage cooperation between the federal and state governments in addressing the fraud epidemic. The following four sections report the field research the author completed in researching this paper.

A. *Initial Reporting of Medicaid Fraud in Montana*

The author interviewed Joan Ashley, director of the Medicaid Surveillance Utilization Review Service (SURS) in Montana.¹⁹⁵ This administrative division of Health and Human Services is required by Medicaid and funded seventy-five percent by the federal government and twenty-five percent by the state. Its mission is to monitor health care expenditures, seek out overpayments and identify potential fraudulent billing.

SURS obtains its information from three sources: 1) statistical analysis of claims; 2) direct queries of Medicaid recipients; and 3) whistleblowers. The statistical analysis is accomplished by an Atlanta based company, Consultech. This company has a contract with the federal government to process Medicaid data in search of fraud. All Medicaid claims are submitted to Consultech which employs sophisticated computer modeling to identify billing patterns which are aberrant based on parameters set in consultation the federal Medicaid office and with SURS in Montana.¹⁹⁶ Direct queries are accomplished

194. See, e.g., David R. Olmos, *Health Care's New Breed of Whistle-Blower*, L.A. TIMES, Feb. 17, 1998, at A1. (Dr. Jim Montagano, a surgeon, initiated a false claims lawsuit where the federal government recovered a 12.6 million dollar settlement and paid Mangano and his lawyer a 2.3 million dollar share).

195. Interview with Joan Ashley, Director, Medicaid Surveillance Utilization Review Service (SURS), in Helena, Mont. (Apr. 6, 1999). The information discussed *infra* in Part V. A. regarding the initial reporting of Medicaid fraud in Montana was gained from this interview.

196. This type of modeling is called exception based identification. It uses parameters such as number of services per unit population, numbers of recipients per provider, number of visits per recipient, etc., and compares these to national standards and local usage patterns. If an exception is identified, SURS then investigates further.

by EOMB forms.¹⁹⁷ The Montana SURS sends out three hundred EOMB forms per month to Medicaid recipients asking for verification of services performed. Lastly, SURS maintains a telephone "hotline" for whistleblowers. Informants using this line have included patients, physicians and office personnel.

Once SURS identifies an aberrant pattern of billing, it requests documentation¹⁹⁸ of the services billed from the provider. If the provider can supply adequate documentation, no further action is taken except to warn the provider its practices may not comport with national standards and ask that provider to review its practices. If the provider cannot supply documentation, SURS exercises considerable discretion in deciding whether there is potential fraud or simple mistake. If the SURS caseworker feels there is a mistake, she will ask the provider to repay the "overpayment" and change its billing practice. The case worker has the discretion to allow up to ninety days to repay without interest and a year to repay with interest accruing only after ninety days. SURS also has administrative authority to impose sanctions¹⁹⁹ such as restricting providers to pre-approval or removing them altogether from the approved Medicaid provider list. Any sanctions imposed by Medicaid are reported to Medicare. If the provider disputes the caseworker's interpretation of a regulation or imposition of a sanction, it is entitled to administrative due process.²⁰⁰ If the caseworker suspects fraudulent intent, she refers the case to the fraud investigation unit. The statute of limitations is eight years but SURS rarely looks back farther than 3 years at a billing pattern.

The SURS communicates frequently with the fraud unit and meets formally once a month to discuss open cases in both agencies. Currently SURS has approximately 270 open cases. The majority of these cases involve suppliers of durable medical

197. See *supra* notes 97-98 and accompanying text.

198. The documentation depends on the service provided. In direct patient care from physicians, it consists of office notes, in durable medical equipment it consists of a "certificate of medical need" signed by a physician, from pharmacists, it is a copy of the prescription, etc.

199. See MONT. ADMIN R. 46-12-401 (1989).

200. The first step is a telephone hearing with the caseworker, the director of SURS, and anyone else the provider wishes. Next, there is a hearing before an administrative law judge where experts may testify. Finally, there may be an appeal to district court and ultimately to the Montana Supreme Court. There have been several appeals to district court but none to the Montana Supreme Court.

equipment, medical supply retailers and home health care agencies. SURS has excluded only nine physicians in the last three years. Physicians and other direct health care providers tend to comply quickly because a significant amount of their practices depend on Medicare and Medicaid. Also, physician transgressions are more difficult to detect and prosecute due to the intimacy of the physician-patient relationship and subjectivity of medical decision making. As a result, SURS concentrates its efforts with physicians on assisting with compliance rather than punishment.

Last year SURS saved Montana Medicaid \$450,000 by requiring prior authorization and recovered another \$300,000 in improperly documented claims. SURS refers twenty to thirty cases per year to the fraud unit for investigation, and in the three years of cooperation between these two agencies, only two referred claims have not resulted in a conviction.

B. Initial Investigation of Medicaid Fraud in Montana

The author interviewed Jimmy Weg, director, and Shane Shaw, lead investigator, of the Montana Medicaid Fraud Control Unit (Unit).²⁰¹ Medicaid fraud units were mandated by the Medicaid Reform Act of 1978, but Montana's Unit was not established until April, 1996. If the Unit had not been established in 1996, Montana would have lost the federal portion of its Medicaid funding. The Unit is comprised of a director, four agents and two support staff. Mr. Weg came to health care fraud investigation from an eighteen year career investigating securities fraud in New York. Mr. Shaw has fourteen years experience as a detective investigating primarily white collar crimes.

In order for the Montana Unit to investigate cases of fraud, it must have the potential for criminal prosecution. The Attorney General made this policy decision in order to reserve Montana's limited resources for criminal cases only. If an investigation is completed and there is insufficient evidence to warrant a criminal charge, but there exists sufficient evidence for a civil case, Mr. Weg refers the case to the U.S. Attorney for prosecution under their concurrent jurisdiction.

201. Interview with Jimmy Weg, Director, and Shane Shaw, Lead Investigator, Montana State Medicaid Fraud Investigation Unit, in Helena, Mont. (Apr. 6, 1999). The information discussed *infra* in Part V. B. regarding the initial investigation of Medicaid fraud in Montana was gained from this interview.

Mr. Weg opined that health care fraud investigation is more difficult than the investigation of securities fraud. One reason for the difficulty includes the newer, less well established, and constantly changing health care regulations. Additionally, there are more health care crimes than securities crimes, and these health care crimes contain many elements. Finally, the rules for Medicaid reimbursement differ for every type of provider, making the Unit more dependent upon other agencies and experts.

Medicaid participation gives the Unit the right to reasonably inspect any Medicaid providers records. This means they can go into the office during working hours and ask to see specific records. A warrant is required to seize those records. If records are seized, the fraud unit must make copies available as needed for the health care provider to deliver care.

The actual investigation of a case involves a large amount of paperwork. The investigators first review all the claims data and billing practices. This may involve several thousand individual documents. Then they proceed into the field and interview the provider, billing clerks, suppliers and patients. It takes about a year to fully investigate a complex claim but some investigations can be concluded in a few months.

The Unit averages 30-45 new cases per year and has 20-25 cases open at any given time. Most of the cases they have referred for prosecution have been successful and involve durable medical equipment companies. However, their work has resulted in the successful prosecution of three physicians with two convictions and one deferred prosecution and restitution agreement. The unit has successfully recovered about four million dollars in the three years of its existence. The recoveries have ranged from twenty-five thousand to seven hundred fifty thousand dollars.

A last interesting point that was made both by Mr. Weg and Ms. Ashley²⁰² is the ease with which Medicaid fraud is perpetrated. Ms. Ashley stated that any "clean"²⁰³ request for reimbursement will be paid. She further stated that since the review is retrospective, it takes from thirty to ninety days for a claim to surface as improper. Mr. Weg points out that this delay has been referred to as a "license to steal"²⁰⁴ and resulted in the

202. See *supra* note 195.

203. A clean claim is a claim with all the blanks properly filled out which has a valid Medicaid provider number and a valid Medicaid participant number.

204. "Cheating Medicare is as easy as filling out a four page form that asks only for

penetration of organized crime into the health care field.²⁰⁵

C. State Prosecution of Medicaid Fraud in Montana

The author interviewed Barbara Harris, the assistant state prosecuting attorney who handles all the Medicaid fraud cases along with her job sharing partner Kathy Seeley.²⁰⁶ On a state level, Ms. Harris stated HIPAA has had very little influence yet. The state has prosecuted only ten fraud cases and three have been against physicians. Ms. Harris says her office is aware of the statute mainly because of the mandatory and permissive exclusions that are specified by federal program administrators after a state conviction.

D. Federal Prosecution of Medicare and Medicaid Fraud in Montana

The author interviewed Leif Johnson, Assistant United States Attorney in charge of Health care Fraud Prosecution in Montana.²⁰⁷ Interestingly, Mr. Johnson has not yet used HIPAA in the prosecution of health care fraud. The statutes he most commonly uses include mail fraud, wire fraud, false statements, false claims and conspiracy. Mr. Johnson felt that HIPAA has had minimal effect on his day to day work of prosecuting health care fraud, although he opined that it has had a profound effect on the administration of health care, particularly in the area of

basic information: name, address phone number and a statement saying the operators have not been in trouble with Medicare before. Most of the time that information is not even verified, allowing anyone with a \$15 per month mail box and a beeper to go into the Medicare supply business. What we have seen is a series of health care providers come into existence solely on paper. This allowed two Russian émigrés to open a fictitious company in Southern California, bill Medicaid for a billion dollars, collect fifty million dollars and disappear.” Sparrow, *supra* note 4, 8-9.

205. The FBI has intelligence showing cocaine traffickers in Florida and California are switching from drug dealing to healthcare fraud because healthcare fraud is safer, more lucrative, the risk of being caught is smaller and the sentences are much less severe. *Gaming the Health Care System: Trends in Health Care Fraud: Hearing Before the Special Committee on Aging*, 104th Cong. 12 (1995)(statement of F.B.I. Director Louis J. Freeh).

206. Interview with Barbara Harris, Assistant United States Attorney, United States Attorney’s Office, in Helena, Mont. (April 9, 1999). The information discussed *infra* in Part V.C. regarding the state prosecution of Medicaid fraud in Montana was gained from this interview.

207. Interview with Leif Johnson, Assistant United States Attorney, United States Attorney’s Office, in Billings, Mont. (Apr. 2, 1999). The information discussed *infra* in Part V.D. regarding the federal prosecution of Medicare and Medicaid fraud in Montana was gained from this interview.

administrations adopting corporate compliance programs.

Mr. Johnson praised HIPAA for the increase in funding provided to law enforcement. He stated that before HIPAA, the sparsely populated western states of Wyoming and Montana were not priorities of the FBI or Office of the Inspector General because there was simply not enough money at issue to make prosecution cost effective. However, in Montana alone, the enactment of HIPAA has resulted in the addition of an FBI agent specifically funded by HIPAA, a health care fraud investigator hired by the Office of the Inspector General, a health care fraud investigator hired by the Department of Justice, and Mr. Johnson's position. Additionally, Sherry Scheel Matteucci, the United States Attorney for Montana, stated that funding for a second health care prosecutor was recently approved.²⁰⁸ These changes resulted in the United States recovering in excess of 1.1 million dollars in 1998 from health care fraud perpetrated in the State of Montana.

Another provision of HIPAA that Mr. Johnson felt has impacted health care fraud is the delegation of subpoena power to the Office of the Inspector General. This broad subpoena power produces evidence that can be used in a civil proceeding in opposition to the criminal grand jury subpoenas which cannot be used civilly due to secrecy provisions surrounding the grand jury proceedings. Mr. Johnson also praised the misdemeanor health care fraud provision of HIPAA.

Mr. Johnson was critical of the mandatory sentencing provisions of HIPAA because they make his job more difficult. As discussed above, HIPAA made Medicare and Medicaid exclusion mandatory after conviction of health care fraud.²⁰⁹ Mr. Johnson said this has made it virtually impossible for him to plead out minor offenders to any health care fraud claim because the financial impact of Medicare/Medicaid exclusion overshadows the financial penalties of the statute. Health care providers would rather take a chance in court with higher penalties than lose their Medicare/Medicaid base. This provision has increased the costs of investigation and prosecution and decreased the flexibility of prosecutorial discretion. Although Mr. Johnson did not state this, it also seems as if it would make many conspiracies that would be

208. United States Attorney Sherry Scheel Matteucci, Remarks at the Government Attorney Panel sponsored by the University of Montana School of Law's Clinical Program (March 24, 1999).

209. See discussion *supra* Part IV.D.

relatively easy to prove with a co-conspirator witness very difficult to prove because all witnesses are also parties to the fraud in some way and all stand to lose their livelihood if they admit guilt.

Mr. Johnson stated the Qui Tam actions²¹⁰ have been on a steep increase in response to the whistleblower provisions of HIPAA. He commented that this is very easy work for the plaintiff's bar which has only to bring the case to the government. The government does all the investigative work and the plaintiff whistleblower and her attorney recoup up to thirty percent of the settlement.

The federal prosecutor's office also works closely with the state Medicaid Fraud Unit. In Montana, prosecutorial and judicial resources are limited to prosecuting only criminal Medicaid matters. Accordingly, the Unit has many civil cases without the resources to prosecute them. The United States Attorney's office takes cases where there is the possibility of recovering significant resources, and, after prosecution, splits the recovery with seventy-five percent to the federal government and twenty-five percent to the state.

Criminal health care fraud cases are much more difficult to prosecute than civil cases because of the increased burden of proving all elements beyond reasonable doubt. Therefore unless the conduct was particularly egregious, the program severely damaged, or a patient was injured, prosecutions are usually civil, especially in smaller cases. A small case is considered a case involving five to twenty-five thousand dollars. A large case that clearly meets the standard of severely damaging the program is one hundred thousand dollars or more. Between twenty-five and one hundred thousand dollars is a middle ground where the direction of the case is subject to prosecutorial discretion.

VI. REPORTED CASES CITING HIPAA

As of 1997, only two cases had been reported which cited the HIPAA statute.²¹¹ Both these early cases dealt with the question of whether HIPAA was intended to completely preempt

210. See *supra* notes 161-63 and accompanying text.

211. Westlaw search in state and federal case databases using the terms HIPAA or HIPAA (a common typo) or "104-191." More recently, another case dealt with the HIPAA statute. A Wisconsin federal district court concluded that HIPAA non-discrimination provision did not apply in the year that the Act was passed. See *Stang v. Clifton Gunderson Health Care Plan*, 71 F. Supp. 2d 926, 932-33 (1999).

state law. In *Means v. Independent Life and Accident Company*,²¹² the insureds paid premiums for a hospitalization policy for more than forty years.²¹³ When they tried to use their policy, they were told it had been terminated at age seventy despite the fact the company continued to accept premiums and never notified the plaintiff of termination.²¹⁴ The plaintiff sued for fraud and bad faith in state court, but the insurance company moved to remove the case to federal court based on preemption by HIPAA.²¹⁵ The defendant claimed that the plaintiff referenced HIPAA and in order to adjudicate their claim a court would have to interpret HIPAA, making the case a matter of federal law.²¹⁶ The court examined the matter and concluded that the state claims did not require resolution of a *substantial* question of federal law and thus remanded the case to state court.²¹⁷

In *Wright v. Combined Insurance Company of America*,²¹⁸ the plaintiff filed suit in state court and the insurance company moved to remove to federal court on the basis of diversity and federal question preemption.²¹⁹ The court stated removal due to preemption can only occur if the state claim is completely preempted by federal law.²²⁰ The court then examined HIPAA and found no evidence of “manifest congressional intent” to create a new cause of action removable to federal court.²²¹ Rather, the court found the defendant failed to demonstrate that the federal court had subject matter jurisdiction and remanded the action to state court.²²²

Thus it seems clear both from the purpose of the statute and from these two early cases that courts are likely to hold that health care fraud continues to be a matter for both state and federal court.²²³ If a claim is brought under HIPAA, it will need

212. 963 F. Supp. 1131 (M.D. Ala. 1997)

213. *See id.* at 1132.

214. *See id.*

215. *See id.* at 1132-1133.

216. *See id.* at 1135-1136.

217. *See Means v. Independent Life and Accident Co.*, 963 F. Supp. 1131, 1135-36 (M.D. Ala. 1997).

218. 959 F. Supp. 356 (N.D. Miss. 1997).

219. *See id.* at 358-59.

220. *See id.* at 362.

221. *See id.* at 363.

222. *See id.* at 364.

223. In July, 1999, an Alabama federal district court, relying on *Means* and *Wright*, concluded that HIPAA's first and second provisions did not mandate the application of

to be adjudicated in federal court. However, if a claim is brought under state Medicaid fraud law, it cannot be removed to federal court merely for referencing HIPAA.

VII. POSSIBLE FUTURE IMPACTS OF HIPAA IN MONTANA AND THE UNITED STATES

HIPAA is a new statute and although there has been a lot of press about its sweeping changes, its effects are only now becoming manifest. At this point it is premature to predict the magnitude and direction of those changes with absolute certainty. This section addresses the two areas where HIPAA is currently having the most impact.

A. Corporate Compliance Programs

HIPAA has had and will likely continue to have a major influence on the way health care entities transact business. The increased penalties and the "should have known" standard for owners and managers have created an atmosphere where proactivity is an absolute necessity. Philip H. Hilder says in his article on corporate compliance programs for HIPAA:

The health care system is being watched under a scanning bright light, and should that light fall upon the unwary, the consequences could be crippling or even fatal to an enterprise. . . The time has passed, if indeed it ever existed when the response to the detection of an aggressive billing technique was at most a disallowance or adjustment. Attorneys must now advise their clients about the parameters of the law before contracts are entered into or billing begins. . . The emphasis must be on prevention because the mere allegation and/or investigation, even without filed charges, can ruin a health care provider or supplier.²²⁴

Since the question of health care fraud often turns on the issue of intent, corporations can help themselves by establishing a clear record of intent. Corporate compliance programs (CCP) are one of the best ways to accomplish this. An optimal CCP must document that a company maintains written standards of conduct for employees, institutes written policies that promote

the complete preemption doctrine. See *Cowan v. Combined Ins. Co. of America*, 67 F. Supp. 2d 1312, 1320 (1999).

224. Philip H. Hilder & Lon Mullen, *HIPAA: Time for a Health Care Corporate Compliance Program*, FED. LAW., Mar/Apr. 1998, at 34, 34-35.

compliance and eliminate incentives for non-compliance, educates and trains employees, disciplines non-compliant employees and performs regular internal self audits.²²⁵ Further, the federal sentencing guidelines specifically outline that “[c]ulpability generally will be determined by the steps taken by the organization prior to the offense to prevent and detect criminal conduct . . . and the organizations actions after an offense has been committed” and specifically permit a downward departure in fines and other sanctions imposed if the organization is found to have an active CCP which addresses these areas.²²⁶

The HHS OIG has viewed CCPs favorably and has designed its own model plan “to help hospitals become good corporate citizens and better abide by the rules and regulations of doing business with the government.”²²⁷ Janet Reno supported this model and said, “[t]o medical laboratories who ignore this advice, our warning is clear: we will bring the full weight of the federal government’s powers to bear to enforce the law and protect the American people from being ripped off.”²²⁸ Thus, CCPs have become a necessity under HIPAA because they significantly improve a business entity’s negotiating position with federal authorities, and, even if an entity is convicted, the presence of a CCP provides relief under the sentencing guidelines.²²⁹

B. Application of the Cheek - Ratzlaf Doctrine

As discussed,²³⁰ it is a long established principal of American criminal jurisprudence that ignorance of the law is no excuse for violating it. In *Cheek* and *Ratzlaf*, the United States Supreme Court carved out an exception to this maxim for statutes in which Congress includes the term “willfulness.” The Ninth Circuit applied *Cheek* and *Ratzlaf* to health care fraud in *Hanlester*.²³¹ The *Hanlester* decision generated a significant controversy both between the various circuits as mentioned

225. See *id.* at 37.

226. See Thomas E. Bartrum & L. Edward Bryant, Jr., *The Brave New World of Health Care Compliance Programs*, 6 ANNALS HEALTH L. 51, 57-61 (1997); See also UNITED STATES SENTENCING GUIDELINES MANUAL § 8A1.1 cmt. n.1 (1999).

227. Hilder & Mullen, *supra* note 224, at 35.

228. *Id.* at 37.

229. See *id.* at 38.

230. See discussion *supra* Part II.C.

231. *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

supra²³² and in the academic community.²³³ Recently, in a firearms case entitled *United States v. Bryan*,²³⁴ the United States Supreme Court clarified its exceptions in *Cheek* and *Ratzlaf* in a six to three decision holding that those decisions were limited to “highly technical statutes that presented a danger of ensnaring individuals engaged in apparently innocent conduct.”²³⁵ The language in *Bryan* strongly favors defendants in the interpretation of health care fraud statutes because health care fraud statutes are generally acknowledged as comparable in technicality to banking regulation statutes.²³⁶ Thus, based on their obligation to protect individuals from substantial punishment for inadvertent crimes,²³⁷ more circuits will likely join the Ninth Circuit in applying specific intent to health care fraud. If the United States Supreme Court is forced to resolve a split in the circuits over this issue, its jurisprudence in *Cheek*, *Ratzlaf*, and *Bryan* practically mandates that criminal conviction for health care fraud requires specific intent.

VIII. A FINAL CRITIQUE OF HIPAA’S INADEQUACIES

HIPAA will inevitably have a profound effect on health care financing and delivery in Montana. Already local insurance companies are anticipating the need to insure against the risk of inadvertent health care fraud,²³⁸ physicians are seeking out experts to conduct seminars in how to avoid billing mistakes,²³⁹ and health care entities are rushing to adopt corporate

232. See discussion *supra* Part II C and notes 30-37.

233. See, e.g., Sharon L. Davies, *Guidance on the Meaning of “Willfulness Looming? How Bryan Might Affect the Hanlester Debate*, HEALTH LAW, Mar. 1998, at 14. See also James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. LAW & MED. 205 (1996); Brian J. Hennigan & Arif Alikhan, *Willfulness and Specific Intent Under the Medicare Anti-Kickback Statutes: The Continuing Debate Over Whether Ignorance of the Law is a Defense in Medicare Prosecutions*, A.B.A. CENTER FOR CONTINUING LEGAL EDUC. NAT’L INST. CRIM. JUST. SEC. WHITE COLLAR CRIME (March 6-7, 1997).

234. 524 U.S. 184 (1998).

235. *Id.* at 194.

236. See generally Bucy, *supra* note 22, at 870-882.

237. See Andrea Tuwiner Vavonese, Comment, *The Medicare Anti-Kickback Provision of the Social Security Act—Is Ignorance of the Law an Excuse for Fraudulent and Abusive Use of the System?*, 45 Cath. U. L. Rev 943, 976 (1996).

238. Toole and Easter, *The Doctor’s Company*, Utah Medical and Physicians Insurance all are considering offering Inadvertent Healthcare Fraud Insurance to physicians. Interviews with claims representatives of various insurance companies, Missoula, Mont. (Apr. 9-18, 1999).

239. Interview with Mike Swietzer, President, Montana Medical Association, in Billings, Mont. (Apr. 28, 1999).

compliance plans.²⁴⁰ However, the question of whether HIPAA will actually prevent health care fraud remains unanswered.

HIPAA is a far reaching, recently established statute impacting multiple areas of health care in a somewhat disjointed fashion.²⁴¹ This is because HIPAA is, in reality, the resurrected remains of the comprehensive Clinton health plan of 1994 and thus a political creature full of significant compromises.²⁴² Despite HIPAA's somewhat "schizophrenic" nature,²⁴³ Title II is a well conceived and executed attack against health care fraud in the existing health care system. Unfortunately, HIPAA merely addresses the existing health care system and does not mandate the changes necessary to eliminate fraud. In medical terms, HIPAA attacks the symptoms of health care fraud instead of the disease itself.²⁴⁴

Clearly, HIPAA has increased enforcement of the health care anti-fraud laws by increasing penalties and infusing more money into enforcement activity, but it fails to require Medicare and Medicaid to promulgate sufficiently specific guidelines to providers.²⁴⁵ Existing Medicare and Medicaid guidelines are a complex minefield of provisions²⁴⁶ now wrapped by HIPAA in more stringent penalties for non-compliance.²⁴⁷ The increased governmental scrutiny of providers coupled with failure to provide clear guidelines engenders an atmosphere of distrust between legitimate health care providers and the federal government. Further, the severity of the penalties promotes this adversarial relationship, thwarting cooperation between honest providers and Medicare/Medicaid administrators. This hostile environment is exemplified in the reticence of providers to consult the OIG seeking advisory opinions.²⁴⁸

Until there is a significant policy change in the way health care is delivered, fraud by dishonest providers is likely to

240. Interview with Jack Burke, Vice President, St. Patrick Hospital, in Missoula, Mont. (Apr. 28, 1999).

241. See discussion *supra* Part III and notes 59-61.

242. See *supra* note 61.

243. See *supra* note 61.

244. See discussion *supra* Part II.A and notes 15-20.

245. See generally Title II of The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

246. Medicare and Medicaid guidelines vary for each different category of provider and recipient and fill hundreds of volumes and thousands of pages. Terminology is complex and precise meaning of terms often varies within differing healthcare fields.

247. See discussion *supra* Part IV.

248. See *supra* notes 66-67.

continue at a high level.²⁴⁹ Willie Sutton robbed banks because that was where the money was, but he never stopped because Wells Fargo offered a generous reward for his capture and the federal government threatened to hang him. Similarly, dishonest health care providers are unlikely to alter fraudulent behavior when the remuneration is so great that cocaine dealers are changing professions.²⁵⁰ Moreover, honest health care providers now are at risk for prosecution for inadvertent errors and discrepancies of rule interpretation made in the complex morass of health care regulation.²⁵¹ These honest providers will simply insure against the risk, further increasing the cost of health care, although HIPAA will have successfully shifted this cost from the government to the private provider. The solution to the health care fraud problem is not to increase scrutiny, paperwork and punishment in a defective system. Only if Congress changes the health care delivery system to reduce the opportunity for and remuneration of fraud will hardened criminals forego transition from traditional illegal activities into health care²⁵² and intelligent, informed professionals comprehend and comply with the essential regulations governing their profession.²⁵³

The problem of health care fraud in the current system is not likely to decrease in the predictable future. Baby boomers will reach retirement age in the year 2010 and the retirement wave will not stop for twenty years.²⁵⁴ Accompanying this trend

249. See Bucy, *supra* note 22, at 931-32. See also Bucy, *supra* note 8, § 1.01[2], at 1-5 & 1-6.

250. See *supra* note 205.

251. See *Siddiqi v. United States*, 98 F.3d 1427 (2d Cir. 1996)(where an oncologist whose conviction for Medicare fraud over a \$640.88 billing dispute was overturned, but only after he lost an \$825,000/year practice, the interest on \$150,000 for a five year period and was reduced to working for \$85,000 per year at a Veterans Hospital). See also *United States v. Migliaccio*, 34 F.3d 1517 (10th Cir. 1994)(where the 10th Circuit overturned the district court conviction of two gynecologists who billed CHAMPUS for a "fallopian tube repair" (a reimbursable procedure) after they performed "reversal of a tubal ligation" (a non-reimbursable procedure) because the surgeons did not know that CHAMPUS did not permit tubal ligation reversal for infertility and in medical terminology the reversal of a tubal ligation may be properly described as a fallopian tube repair).

252. See *supra* note 205.

253. See Bucy, *supra* note 8, § 1.04 [2], at 1-46 (stating that the existing rules in health care are so complex that intelligent professionals can neither comprehend them nor figure out how to comply with them).

254. See WILLIAM STERLING AND STEPHEN WAITE, *BOOMERONOMICS: THE FUTURE OF YOUR MONEY IN THE UPCOMING GENERATIONAL WARFARE*, x -xi and 2 and 3 (1998) (the seventy-six million Americans born between 1945 and 1965 will begin to turn 65 in

will be a marked increase in utilization of health services by the aging population. Just as Post-War children reaching school age swamped public schools in the 1950s, baby boomer hormonal surges ignited a sexual revolution in the 1960s, and boomers housing their families inflated the real estate market in the 1970s and 1980s, the public health care system will likely be overwhelmed by graying boomers in the early 2000s.²⁵⁵ Because older people tend to be more conservative and more conscientious about voting, the aging baby boomers will exercise considerable political clout. It is likely they will wield that clout to protect their health and futures, infusing increasing financial resources into the health care system.²⁵⁶ As more money enters the system, more fraudfeasors will be attracted to the growing pot of government gold.

This author concludes that HIPAA is unlikely to significantly remedy the health care fraud problem. HIPAA is at once too narrow and too broad to efficiently accomplish its stated purposes. It is too narrow because it acts primarily retrospectively, applying penalties after the fraudulent actions. It fails to alter the fee for service structure of Medicare and Medicaid which provides fertile soil for fraud to flourish. Further, the current surveillance system is slow and ponderous and totally inadequate to monitor sophisticated schemes to defraud patients, private insurers and the government.²⁵⁷

HIPAA is at the same time too broad. Its provisions may ensnare honest health care providers who misinterpret complex rules as well as fraudfeasors. Further, actions of an individual can be imputed to an entity and actions of an entity can be imputed to an individual.²⁵⁸ An individual joining an entity at management level may be subject to permissive sanctions despite having had no relationship with the entity when activities prompting the sanction occurred.²⁵⁹ Similarly, inadvertently hiring a sanctioned individual may expose the entity to exclusion.²⁶⁰ Thus the newly created fraud fighting

2010).

255. *See id.* at 3.

256. *See id.* at 17.

257. *See* discussion *supra* Part V.A-B and note 177.

258. *See* Colleen M. Faddick, *Health Care Fraud and Abuse: New Weapons, New Penalties, and New Fears For Providers Created by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")*, 6 ANNALS HEALTH L. 77, 88-89 (1997).

259. *See id.* at 89.

260. *See id.*

mechanisms can trigger a domino like effect where the purposeful or inadvertent actions of an individual could topple an entire entity and bring the effects of exclusion, monetary penalty and criminal prosecution down upon affiliated entities which have minimal culpability.²⁶¹

What effect will HIPAA ultimately have in Montana? This author does not have a crystal ball and only time will reveal how many fraudulent acts will actually be punished, how many fraudfeasors will escape punishment and how many unwitting health care providers will be caught in HIPAA's widely cast net.

261. See generally *id.* at 86-96.

