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**THE HEALTH CARE FRAUD PROSECUTION PROJECT  
 DEMONSTRATION SITES IN MINNESOTA, WISCONSIN,  
 AND MARYLAND: THE FIRST TWO YEARS**

**by David Orbuch, Barbara Oswald, Sidney Rocke,  
 and The Financial Crimes Project of NAAG**

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## I. INTRODUCTION

### A. PURPOSE

This report is intended to advise the U.S. Department of Justice Bureau of Justice Assistance (BJA), Office of Justice Programs (OJP), of the work completed under its grant to three state Attorneys General to establish prototype Health Care Fraud Prosecution Units (HCFUs). It is hoped that this documentation will demonstrate to BJA, as well as to the other Attorneys General, the efficacy of this type of program and the value of these projects, or demonstration sites, in furthering the capability of state Attorneys General in the prosecution of health care fraud and related offenses. For those interested in a more detailed study of the overall effort of the nation's state Attorneys General, the National Association of Attorneys General (NAAG) has recently published its study, *The States' Response to Health Care Fraud*.

### B. BACKGROUND

In 1995, BJA initiated a project to develop and enhance the capacity of state Attorneys General to investigate and prosecute private health care fraud. BJA awarded grants to the Attorneys General in Maryland, Minnesota, and Wisconsin to create or expand existing HCFUs. BJA also funded NAAG's Financial Crimes Project to provide training and technical assistance to state prosecutors and to work with the three project sites to combat health care fraud. In funding these HCFU demonstration projects, BJA intended that these states develop or expand HCFUs separate from Attorney General Medicaid Fraud Control Units (MFCUs) which only target Medicaid fraud, patient abuse, and fraud in the administration of this government program. In particular, BJA's goal was that these units reinforce the independent capability of state Attorneys General and local prosecutors in coordinating statewide and local investigations and health care fraud prosecutions against claimants, providers, insurance companies, and health maintenance organizations.

As they complete a second year, the Maryland, Minnesota, and Wisconsin HCFUs offer rich experiences for the Attorneys General. In all three projects, prosecutors control and direct

investigations from the earliest stages. All of the projects employ resources within their Attorney General's office and coordinate with other local and state agencies in the prosecution of health care fraud. This joint effort is important, for example, when revoking professional licenses from corrupt health care providers. Other common project goals include: working with private insurers to develop cases; introducing state legislation to provide additional tools to prosecute in the fight against fraud; and developing training protocols for state health care fraud investigators and prosecutors. All three states have increased public awareness of private health care fraud and have created deterrence by publicizing prosecutions and penalties.

### **C. SCOPE OF REPORT**

This report, a collaborative effort of the directors of the three HCFUs and the NAAG Financial Crimes Project, will detail the experiences of the three state HCFUs developed under the BJA grant. Using experiences of the HCFUs, the report identifies techniques which state Attorneys General can employ to combat health care fraud. For example, Minnesota's experience is an example of marshaling the many resources of an Attorney General's office, while details of Maryland's experiences demonstrate organizational issues. The Wisconsin HCFU's experiences in developing case law and working with insurance companies are avenues that state Attorneys General may consider. By using these tools, the Attorneys General and local prosecutors can attack intrastate health care fraud through effective investigation and prosecution and can strengthen their roles in the effort to combat health care fraud.

## **II. THE HEALTH CARE FRAUD PROBLEM**

### **A. THE COST OF HEALTH CARE FRAUD**

Health care fraud in the United States, whether committed in the public or private sector, is pervasive and expensive. Annual health care spending in the United States is approximately \$1 trillion and estimates of the dollars lost to fraud vary from 3% to 14%. In May 1992, the U.S. General Accounting Office estimated that the loss amounted to as much as 10% of the total annual health

care expenditure. In 1995, the Coalition Against Insurance Fraud estimated that health insurance fraud costs Americans \$59 billion annually. In 1997, the National Health Care Anti-Fraud Association reported that its member private insurers estimated the proportion of health care dollars lost to outright fraud in the range of 3% to 5%. In July 1997, the Inspector General of the U.S. Department of Health and Human Services reported that an audit of Medicare claims paid indicated that approximately 14% were paid improperly. At least one author, Professor Malcolm Sparrow, maintains that the real dollar amounts lost to health care fraud are unknown but likely larger than reported, because no one systematically measures the problem and the art of fraud control is poorly understood within the industry.

More than 90% of people who responded to a 1996 survey conducted by the American Association of Retired Persons consider health care fraud to be somewhat or extremely wide spread, and over half of those surveyed (53%) believe it is increasing in volume and size. While the percentages differ, it is clear that the perception is uniform. Taxpayers, legislators, consumers, and the public and private health care industries agree that, whatever the loss, it is unacceptable.

**B. CLOSING THE GAP IN CURRENT PROSECUTION EFFORTS:  
UTILIZING STATE ATTORNEY GENERAL RESOURCES**

Health care fraud is a complex, paper intensive, economic crime. Most state Attorneys General have staff attorneys with experience in the investigation and prosecution of such crimes. Other avenues for prosecution are not currently available. Local district attorneys typically do not have the time, resources, or expertise to handle complex health care fraud cases. Further, these cases require supervision by a prosecutor at the initial investigation stage, include large volumes of records, and often involve insurance fraud with multiple insurers in different counties. As a result, these cases are not being prosecuted at the county level. Federal prosecutors, however, are not filling the gap. Generally, federally prosecuted cases must involve fraud above a certain dollar amount, and, according to insurers, cases referred to federal agencies are faced with a great deal of time between referral and prosecution.

### C. THE ROLE OF THE STATE ATTORNEY GENERAL

State Attorneys General have historically taken an important and active role in combating fraud and are well placed to take a leadership role in the fight to restore integrity to the health care delivery system. Each Attorney General is uniquely positioned, by virtue of the office and the trust reposed in it, and situated at the crossroads of law, politics and public policy in the state. It is at this crossroads that the necessary steps will be taken, and indeed are being taken now, to make inroads against health care fraud. While the scope of their authority varies, state Attorneys General can be involved in the following areas where fraud has been identified as a problem:

- **Private Health Care Insurance**

Approximately 55% of the nation's health care budget goes to expenditures ultimately paid for by private health care insurance. Private health care insurance can be found in every state, and often private health care insurance companies feel that crimes against their programs do not receive the same degree of attention that is directed toward the federal and state health care programs. There is no federal agency, however, designated to specialize in the crime of private health care fraud.

- **Medicare**

While fraud in this program has recently received a great deal of attention from federal law enforcement authorities, this enforcement effort has not been all-encompassing. Many U.S. Attorneys' Offices have monetary thresholds which must be met before taking a case. This threshold amount is sometimes set above \$100,000 in losses. As a result, there are many examples of clear-cut fraud which are not appropriate for federal prosecution, but could be appropriate for the HCFU.

- **Workers' Compensation Fraud**

Workers' compensation fraud will generally overlap with health care fraud. Often, a fraudulent claim for workers' compensation will be supported by a phony diagnosis from a corrupt provider. This type of fraud has many of the same negative effects as the health care fraud schemes discussed in the two categories above.

- **Tort Claim Fraud**

Tort claim fraud can be assessed in much the same way as workers' compensation fraud. Often, a corrupt doctor will render a phony diagnosis to establish damages for use in a civil suit. When fraudulent claims flow from sham doctors visits, several insurance companies can be defrauded as part of the same scheme.

- **Criminal Licensing Violations**

The practice of medicine, dentistry, podiatry, and many other medical specialties requires a specific license issued by the states. Most states reinforce their licensing requirements by through criminal penalties for individuals who practice in these medical specialties without a license. In many instances, patients are directly defrauded by paying for the services of a licensed professional who must perform according to recognized standards, when in fact the services are rendered by an unlicensed individual having little or no medical training and no supervision by the state.

- **Sham cures and quackery**

Most states have the equivalent of the Federal Food, Drug, and Cosmetic Act which maintains a lengthy list of requirements for anyone selling medicine and foodstuffs. Violations are generally covered by criminal penalties. In addition, cures that have no basis in fact and food or medicine contents which can be misrepresented can also be characterized as unfair trade and be prosecuted under a consumer protection theory and applicable statutes.

Given the position of the Attorney General in state government, the Attorney General is an important part of the effort to deter and prosecute health care fraud, particularly in the following areas:

## 1. Coordination of State-Wide Anti-fraud Effort

Most local prosecutors are not equipped to handle complex health care fraud matters, but may run into them from time to time. As a result, there may be possibilities of working jointly. State and local law enforcement agencies can provide manpower, intelligence and other resources when an HCFU is investigating allegations of health care fraud.

Coordination of the efforts of all these entities is important. These agencies, insurance departments, licensing boards and private payers are repositories of data on fraudulent activity. Coordination of efforts at this level involves the state Attorney General as a keeper of the data base or information storage and retrieval systems regarding fraud reported to the various agencies. One of the problems that has been seen during the course of this project is the lack of communication among various recipients of information. In some instances this may be due to state confidentiality laws and in others it may be attributable to traditional practices. In either case, statutes and/or administrative regulations should provide for cross-matching of information, such as convictions, license sanctions, denial of privileges, and denial of claims.

Law enforcement efforts involving more than one local district or county are also appropriate candidates for in-state coordination. Training is another area where a statewide approach is appropriate to insure greater cooperation and less duplication of efforts. Training should cover fraud methodology, networking, and information sharing.

## 2. Legal Reform and Legislative Advocacy Issues

At the present time, health care fraud is a priority issue for state governments as it is for the federal government. Several state Attorneys General have held hearings on the subject resulting in a number of legislative proposals. NAAG has participated in several of these initiatives and maintains a database of existing and proposed state statutes on health care fraud. The state Attorneys General are uniquely positioned in state government to lead and influence these efforts. The lessons learned by the three HCFU demonstration projects will be of use to other state Attorneys General as they

focus on this critical area. NAAG disseminates the results of the demonstration projects and related anti-health care fraud efforts conducted in all states through its bi-monthly newsletter, *Health Care Fraud Report*, and in its studies and monographs, such as *The States' Response to Health Care Fraud* published in June, 1998.

### **3. State Litigation and Legal Opinions**

Wherever state jurisdiction allows, the state Attorney General should take the lead in prosecuting major health care fraud cases to ensure uniformity of charging decisions and to enhance utilization of available resources. Legal opinions issued by the state Attorney General have the potential for great impact within each state and can be used to deal with issues related to interpreting existing statutes, pointing out where changes are needed, delineating existing limitations, and making the best use of existing statutory and regulatory structures.

### **4. Public Advocacy and Consumer Education**

Consumer groups and senior citizens' organizations are good focal points for HCFU outreach and educational efforts. These efforts serve to warn consumers about health care fraud schemes so that consumers can protect themselves in the future and serve as an important source of referrals that should be cultivated.

### III. ORGANIZING AN ATTORNEY GENERAL HEALTH CARE FRAUD UNIT

#### A. MARYLAND

##### 1. Organizational Structure

The structure of a HCFU will be determined by a number of factors, including available resources and the scope of the matters assigned.

##### a. Personnel

The Attorney General determined that a dedicated unit consisting of a prosecutor, an investigator, and an auditor is a very efficient way of maximizing resources. Because health care fraud prosecutions are a technical area of prosecution, the Attorney General initially staffed the HCFU with an attorney experienced with health care fraud issues. It is a tremendous advantage for any prosecutor to have an investigator dedicated solely to his or her own area of expertise. The prosecutor and investigator become knowledgeable of each other's work habits which greatly facilitates efficiency. Furthermore, the investigator becomes familiar with the overall goals and priorities of the HCFU. This also bolsters efficiency. Because the prosecutor controls the investigators time, thereby allowing the prosecutor to designate "front burner" and "back burner" issues without the danger of conflicting investigations, the prosecutor is aware of the investigator's major assignments. In addition, this prosecutor-investigator relationship fosters increased communications.

In Maryland, resources permitted the hiring of only one investigator. Additional investigators would have resulted in greater investigative efforts and greater results in terms of case resolutions. Adding an additional investigator, however, does not necessarily result in a complete doubling of conviction statistics because the availability of an attorney to provide guidance and ultimately to prosecute matters would still remain finite.

The Attorney General decided to include an investigative auditor position in the HCFU. It is Maryland's view that in a document intensive area of law enforcement, such as health care fraud, the availability of investigative auditors is extremely valuable. The fact that an auditor is available solely to work on matters of the HCFU presents all of the same advantages discussed above regarding a dedicated investigator.

Health care fraud investigations are often document intensive, including patient files, claims, and payment and tax records. The HCFU uses the auditor to review patient files and to organize and systemize them in data bases. Investigative auditors review the flow of money, both to pinpoint individuals who may have some culpability in fraudulent schemes and to show the availability of assets as the prosecution nears its culmination. Review of tax records has also been invaluable as a method of learning about the structure of a target business. For tasks such as this, an investigative auditor with an extensive financial analysis background can provide the unit with tremendous advantages. The accounting experience of the investigative auditor proved to be extremely useful in situations where even a sophisticated investigator may have had difficulty analyzing and reviewing complex financial transactions and complicated financial documents.

#### **b. Security**

Because the HCFU is a criminal prosecution unit, it has established a regimen of physical security. The entire floor is locked and secured so that entry is permitted only by law enforcement personnel working for the Attorney General's Office or visitors escorted by one of the Attorney General's law enforcement personnel.

Closely related to the concept of the physical security of the office as a whole, is the issue of maintaining security for evidence and other items seized pursuant to search and seizure warrants which are technically the property of the individuals or corporations from which seized.. Most of the evidence that the HCFU maintains falls into two categories. Some items are obtained pursuant to a grand jury subpoena. These items are maintained under strict laws pertaining to the grand jury process and their security must be maintained not only for the integrity of the investigation, but also

as a matter of law pursuant to the grand jury process. These materials also must be maintained with a high degree of security. Maryland has established a separate, secured evidence room solely dedicated to materials held as evidence for investigations run by the HCFU.

### **c. Investigative Leads and Case Tracking Mechanisms**

All HCFUs need effective methods of tracking cases from inception to conclusion in order to operate efficiently. This is especially important when establishing a new HCFU in order to chart its growth and progress and would include referrals and investigative leads as well as active cases; grouping of referrals and investigative leads by type helps to determine trends and issues in fraud. For example, by tracking all referrals and cases dealing with ambulance fraud under the *Operation Clean Wagon* initiative, the Maryland HCFU has been able to determine whether concentrated outreach and publicity about one particular type of fraud benefits the unit.

### **d. Computer and Technology Requirements**

These requirements should not differ markedly from the requirements of any white collar prosecution unit. There is the obvious need for word processing and spread sheet capabilities. In addition, e-mail and Internet access are increasingly important both as a means of communicating within and outside the agency and as a way of keeping track of fraudulent health care advertising on the Internet. Litigation support is another important facet to be considered when determining electronic and computer requirements.

## **2. HCFU Education And Outreach**

Maryland's HCFU has had regular contact with the State Consumer Protection Division. The HCFU has provided training on health care fraud and the Consumer Protection Division, in turn, has provided this information to its consumer volunteers who receive a steady stream of consumer-oriented complaints, often about health care providers. As a result, the Consumer Protection Division has provided the HCFU with a number of referrals regarding problems with health care

providers that may lead to criminal prosecutions. Furthermore, the HCFU checks with the Consumer Protection Division frequently when investigating any particular provider to see if they have received any complaints. In this way, the HCFU often gathers valuable background information, and potential witnesses to contact in the course of its investigations.

Overlapping consumer protection and anti-trust concerns became apparent to the Maryland HCFU during the course of its *Operation Clean Wagon*, an initiative aimed at fraud and abuse in the ambulance industry. In addition to the traditional filing of false claims, the HCFU received information that there was a consistent pattern of offering kickbacks in order to lock in a stream of referrals from nursing homes to ambulance companies. Often the evidence of these kickbacks was not such that the HCFU could develop a criminal case, but frequently the evidence appeared to be strong enough to initiate an Antitrust Division civil enforcement investigation. The Antitrust Division was interested in pursuing the question of whether these kickbacks between nursing homes and ambulance companies were attempts at monopolization and an anti-competitive measure. As a consequence, the two units jointly interviewed cooperating individuals, and the HCFU provided the Antitrust Division with a number of investigative leads.

In Maryland, all state and federal agencies have created a health care fraud task force which meets quarterly at the U.S. Attorney's Office to discuss broad issues of health care fraud, ongoing initiatives, and concerns of both insurance companies and law enforcement. Of even greater value is its steering committee, chaired by the U.S. Attorney's Office, which meets every month. This committee is composed solely of government and law enforcement representatives and deals with specific cases, subjects, problems, and strategies.

Maryland insurance companies are required by law to maintain a Special Investigative Unit (SIU), or its equivalent. Many of Maryland's health insurance companies have created a periodic group meeting of SIUs devoted solely to health care fraud. The HCFU became a regular attendee, which produced a number of investigative leads for the unit. One member of the HCFU, either an attorney, investigator, or auditor, attend the SIU meetings to discuss potential operations and intelligence. The HCFU has sought actively engage the SIUs to improve both the quantity and quality of referrals.

The HCFU visited an insurance company claims processing unit. In addition to observing the claims process, the HCFU met with the claims processing department, explained the fraud issues, and identified key items to monitor. The insurance company employees identified problems they consistently see, doctors they believe file claims that may be indicative of fraud, and problems they have had in the past in dealing with the government and law enforcement. The HCFU offered to assist the insurance company by providing statistics and background information to further their investigations and by making presentations available to management which would increase their awareness of the value of anti-fraud efforts.

### 3. Maryland Results

As of January 1997, the Maryland HCFU had received 110 complaints. Forty resulted in the opening of cases and nine resulted in search and seizure operations. Eight separate criminal charges were filed against medical professionals. As discussed earlier, the HCFU initiated *Operation Clean Wagon* against fraud and abuse in the ambulance industry.

Maryland's HCFU focuses primarily on private insurance fraud and criminal licensing violations. It has worked closely and conducted joint investigations with a number of federal government agencies, including the Drug Enforcement Agency, FBI, the Federal Drug Administration, Department of Health and Human Services, and the Social Security Administration. The HCFU coordinates with state government, state licensing boards, affiliated agencies, and local prosecutors and maintains outreach programs in the private sector. It also meets regularly with insurance companies within Maryland to which it provides anti-fraud presentations. Maryland's HCFU drafted legislation revising the state's Health and Occupational Statute. The purpose of the legislation was to increase and standardize the penalties for all state licensing boards.

The HCFU provided health care fraud training to Assistant Attorneys General acting as counsel to Maryland medical licensing boards. The unit focused on training that identified patterns of fraud and referral procedures. Another goal of the training was to streamline and improve the communications between the HCFU and other state offices. This was accomplished by discussing

contact points and regulatory and legislative changes that might mutually enhance Maryland's ability to fight health care fraud.

## **B. MINNESOTA**

### **1. Background**

Minnesota has been a leader in the health care industry for over a decade. As a result, the health care industry makes up a significant portion of the state's economy. According to the Minnesota Department of Health, total spending for personal health care in the state in 1995 was \$14.1 billion, excluding expenditures on long term care. Private expenditures accounted for \$8.8 billion, or 60 percent of the state's total health care expenditures.

Using conservative industry estimates, health care fraud costs Minnesota taxpayers upwards of \$1.4 billion each year. Roughly \$800 million of that money is lost annually in fraud schemes that impact private expenditures.

In 1993, the Minnesota Attorney General's Office responded to this problem by creating a HCFU within the Attorney General's Criminal Division. The objective of the unit was to aggressively investigate and prosecute health care fraud that impacted private health care expenditures. This unit was started with two lawyers, one investigator, one investigator/auditor, and one secretary.

In 1994, with support from the HCFU, the Minnesota legislature enacted the Insurance Fraud Reporting Act. The Act requires insurance companies to report all instances of suspected fraud to one of several possible law enforcement agencies, including the Minnesota Attorney General's Office. It also provides immunity to insurers reporting fraud and allows companies to share information to detect fraud. At the request of the insurance industry, the HCFU agreed to become the primary receiver of these reports. As a result, the unit began to receive approximately twelve new referrals each month.

In early 1995, the unit identified two compelling needs to more effectively process these new referrals, many of which alleged fraud in the delivery of health care service, and to increase its ability to prosecute all health care fraud cases. The foremost need of the unit was to increase the its investigative staff. Two additional investigators were needed to provide a better ratio between prosecutors and investigators. This would allow the it to increase its caseload, handle more complex cases and increase its visibility.

The second need was to develop new tools to combat health care fraud. The current insurance fraud law was limited at theft of personal property. The unit determined that a general insurance fraud crime statute was needed that would cover all intentional insurance misconduct, including claimant, provider, and insurance company fraud.

The Unit believed that Minnesota did not necessarily need a specific law targeted to health care fraud. It reasoned that if the state's insurance fraud law was written broadly enough to take into account all lines of insurance, and all types of scam operations that can be perpetrated against consumers and industry, then a specific health care fraud law was not essential.<sup>1</sup>

In 1995 both needs were met. The Minnesota Attorney General's Office received a demonstration grant from BJA. This grant allowed the unit to hire two additional criminal investigators and one

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<sup>1</sup>There are elements of an insurance fraud law, however, that are essential for a state to combat health care fraud adequately:

First, insurance fraud should be defined as a specific crime and, depending on the severity of the crime, a felony. Attempted fraud also should be included in the definition. In states that do not have a separate crime of insurance fraud, prosecutors must use some nugget in their fraud laws or theft by deception laws. A specific law makes detection and prosecution easier.

Second, fraud laws should include both civil and criminal penalties for committing insurance fraud. In addition, restitution should be required as part of any adjudication, thereby taking away the perpetrators' profit motive.

Third, individuals who are licensed by the state and earn a living from the insurance system should not be allowed to use that license as a way to defraud the system.

Fourth, strong civil immunity should be enacted to facilitate the exchange of information among insurers, and with law enforcement, for the purpose of investigating suspected insurance fraud, assuming the information exchange is made without actual malice.

In 1995, the Coalition Against Insurance Fraud drafted a model insurance fraud law that includes these four elements.

additional support staff. Furthermore, with the help of the unit, the Minnesota legislature enacted a general insurance fraud crime that covered all types of intentional insurance misconduct.

Since 1995 this unit has successfully demonstrated that health care fraud can be aggressively and effectively prosecuted at the state level. As discussed below, the unit has worked with local, state and federal agencies to develop solutions to combat health care fraud. The unit has also worked hard at developing a positive relationship with the victims of these types of fraud - consumers and insurance companies. Lawyers from the unit have met with numerous consumer groups and insurance companies to explain the rights and responsibilities of victims. Finally, the unit has begun to develop an educational campaign to inform consumers that they are the first line in the fight against health care fraud. Although aggressive prosecutors will deter many from engaging in fraud, an educated consumer will prevent the dollars from being initially stolen. One hundred thousand consumers who know the red flags of health care fraud and review their medical bills are as important as ten dedicated health care prosecutors. The unit has learned that with consumers, a significant dent can be made in the fight against spiraling health care costs due to fraud.

## **2. Organizational Structure**

The HCFU currently has two attorneys, three criminal investigators, one investigative auditor, and two legal secretaries. Two of these investigators and one legal secretary are funded through the BJA grant awarded in 1995 to demonstrate that health care fraud can be effectively and efficiently prosecuted at the state level. The three criminal investigators have an active docket of approximately ten cases. The investigative auditor works with all of the investigators when auditing expertise is required. Generally during a criminal investigation, an investigator works closely with criminal prosecutors and, at the completion of the criminal investigation, the investigator presents the matter to a HCFU prosecutor for a charging decision. Pursuant to the Minnesota Insurance Fraud Reporting Act, the two investigators review new referrals that are sent from insurance companies. Referrals that contain significant criminal allegations are fully investigated by the HCFU or referred to other federal/state law enforcement agencies.

### 3. HCFU Collaboration and Outreach

In 1997, the HCFU worked with various federal, state, and local law enforcement agencies, including the U.S. Department of Health and Human Services' Office of Inspector General, FBI, U.S. Postal Service, various state agencies, and local county prosecutors. The demonstrated advantage of these working relationships is that investigators and prosecutors can pool resources where needed and create the capacity to handle large, complex cases more efficiently. Increasing the investigative capabilities of the HCFU has enhanced its ability to assist other agencies and strengthen existing working relationships. In addition, because HCFU investigators do not have traditional law enforcement powers, they must work with local law enforcement to accomplish their jobs. Finally, HCFU staff members work with the private business community and consumer organizations to educate them on detecting and preventing all types of insurance fraud.

In Minnesota, the HCFU is involved with local and national health and insurance fraud-related organizations. A HCFU prosecutor is co-chair of the Midwest Insurance Fraud Prevention Association (MIFPA), an organization of private insurance companies and government representatives which meets monthly to discuss local insurance fraud trends. MIFPA puts on quarterly seminars for all insurance personnel on insurance fraud topics. A HCFU prosecutor is Co-Chair of the Coalition Against Insurance Fraud (CAIF), a national organization of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy. This organization is also a great resource for any state Attorney General considering a HCFU. In addition, a HCFU prosecutor is Chair of the National Prosecutors Insurance Fraud Task Force. This task force, made up of prosecutors and insurance representatives, is studying ways to increase the investigation and prosecution of insurance fraud nationally. HCFU prosecutors also speak regularly at continuing education seminars on health care issues and insurance fraud and work closely with SIUs within insurance companies in providing training or spotting fraud.

The HCFU has also worked hard at developing good relationships with the local business community and other law enforcement agencies. Based on this work, members of the HCFU have

been asked to speak to other state law enforcement agencies to provide advice on the investigation and prosecution of health care fraud matters. Although all of this "community building" takes time and resources, it has increased the HCFU's visibility and has assisted in its primary goal of demonstrating that health care fraud can effectively and efficiently be tackled at the state level.

#### **4. Minnesota Results**

Since its inception, the Minnesota HCFU demonstrated that there is a need for a unit that focuses its attention on the prosecution of fraud affecting the private health care delivery system as well as provides education and training to people within that health care system. On the prosecution front, the unit has obtained felony convictions in 18 health care fraud cases, three of which were prosecuted jointly with the Minnesota MFCU. Another case was prosecuted jointly with the U.S. Attorneys Office.

Minnesota's Health Care Fraud Unit has achieved its successes by focusing on three specific objectives:

- creating the necessary, statutory tools to fight health care fraud;
- working closely with insurance company and consumer victims in the investigation and prosecution of complex health care cases; and,
- educating consumers on the indicators of insurance fraud.

##### **a. Creating the Necessary Statutory Tools to Fight Health Care Fraud**

The Minnesota HCFU first determined the cost of health care fraud to Minnesota taxpayers by "following the money." This information was invaluable to the Attorney General in expanding the HCFU and demonstrating to the state legislature the need for new laws. In 1994 and 1996, the Minnesota legislature passed significant legislation initiated by the HCFU.

In 1994, the Insurance Fraud Reporting Act, Minn. Stat. §§ 60A.951-.955 (1994), was drafted by the Minnesota Attorney General with assistance from the Minnesota Insurance Federation, an

association of local insurance companies. This legislation permits insurance companies to share investigative information and, in certain circumstances, suspected fraudulent claims. While providing immunity for the mandated reports at the request of the insurance companies, the HCFU agreed to be the main contact for these reports. On average, HCFU receives two to three reports every week from insurance companies and from attorneys representing insurance companies. In 1996, legislation was enacted which provides that a provider, claimant or insurer, who, with the intent to defraud and for pecuniary gain, submits information in an insurance transaction that contains a materially false representation, is guilty of insurance fraud. (See P.L.104-191(1996)). Restitution must be ordered in addition to a fine or imprisonment but not in lieu of a fine or imprisonment if a defendant is convicted of this crime.

As part of the ongoing legislative effort with the Minnesota Insurance Federation, the Minnesota Attorney General's Office created an informal insurance fraud working group to address other issues of joint concern to both law enforcement and the insurance industry. Current participants in this working group are the Minnesota Attorney General's Office, the Minnesota Insurance Federation, the National Insurance Crime Bureau, the Coalition Against Insurance Fraud, the Department of Commerce, and the Workers' Compensation Fraud Bureau of the Department of Labor and Industry. This group meets to discuss new legislative initiatives and to develop new ways for local law enforcement and private industry to collaborate in combating insurance fraud. The working group has recently suggested developing a prosecutor's manual on insurance fraud investigations.

**b. Working Closely With Insurance Company and Consumer Victims in the Investigation and Prosecution of Complex Health Care Cases**

Referrals which look suspicious on their face but have not been investigated to determine whether the claims are in fact fraudulent, are returned to the SIU for further investigation. Limited resources prevent the HCFU from initially investigating referrals received from insurance companies. Referrals received by the HCFU that look promising and have been initially investigated by an SIU or the National Insurance Crime Bureau, an organization that investigates insurance fraud for its member companies, are assigned to a HCFU investigator or are referred to local law enforcement.

### **c. Educating Consumers on the Red Flags Of Insurance Fraud**

To educate consumers, HCFU officials have spoken to numerous organizations regarding the toll that insurance fraud takes on our economy. The HCFU also works with the CAIF to develop educational materials for consumers to prevent them from being swindled by illegitimate insurance companies. For example, across the nation, minority populations are being targeted by con artists who attempt to swindle money under the guise of providing legitimate insurance policies. This consumer education material will hopefully alert minority populations to these swindles. In addition, Minnesota is working with local insurance companies to teach insurance claim representatives the "red flags," or indicators, of insurance fraud. These meetings also serve to encourage the claim representatives to report suspected insurance fraud to law enforcement. This educational effort has increased referrals to the unit.

An excellent example of the Minnesota HCFU's work is the investigation and prosecution of a family practitioner who worked in St. Paul, Minnesota. In May 1995, an employee of this practitioner called the HCFU to report that she believed her employer was engaging in billing fraud. This employee was referred to the HCFU by an insurance company representative who had attended a HCFU educational seminar. The employee stated that she was aware that her employer charged many patients' insurance companies for more extensive and costly examinations than those he actually provided to them. The employee also stated that it was not uncommon for the doctor to see between 100-125 patients a day (6 patients every 15 minutes).

As a result of an 18-month investigation, the Minnesota HCFU uncovered an ongoing scheme in which the provider submitted claims for payment to more than 30 separate insurance companies which falsely represented the true nature of the medical care and/or services provided to patients. Based on the investigation, the HCFU filed a complaint alleging that while running a medical mill at his clinic, this provider engaged in a scheme to swindle over \$250,000 from his patients and patients' insurers within a 6-month time period. The doctor accomplished this by: (1) falsely representing the services provided to his patients; and/or (2) billing for medically unnecessary services; and/or (3) charging for more extensive services than provided. This case was both too large and time consuming for local authorities to handle and too small for federal prosecutors.

## C. WISCONSIN

### 1. Background

Health insurance experts estimate that the amount of money lost to fraud annually in Wisconsin is between 3% and 5% of health care expenditures. In 1992, the estimated losses for Wisconsin businesses and government as a result of health care fraud were \$400 to \$800 million. The Attorney General's Office is the only state-level agency that investigates and prosecutes health care fraud cases. Other state agencies have investigative and regulatory roles that relate to medical provider discipline, insurance, and workers' compensation. However, these agencies have neither criminal investigators with law enforcement authority, nor criminal prosecution authority. As a result, all of these state agencies must rely on the Wisconsin Department of Justice (DOJ) to conduct criminal investigations and prosecutions.

### 2. HCFU Collaboration And Outreach

The goal of the Wisconsin HCFU has been to increase the number of health care fraud prosecutions in Wisconsin by developing a partnership with private health care insurers and state agencies to produce an effective case referral system and workable division of labor in investigating health care fraud cases. Upon receiving that grant, the Wisconsin DOJ created the HCFU by choosing personnel for the three positions; making contact with insurers, other government agencies, and other law enforcement agencies; and implementing a system for receiving referrals and handling cases. The target in the first grant period was to receive referrals and initiate three to four criminal prosecutions.

The HCFU acts as a clearinghouse for referrals from private insurers, other state agencies, and members of the general public. Any cases that are not suitable for prosecution are usually returned by the HCFU with a letter explaining why prosecution is not appropriate. Cases that appear to have prosecutorial merit are either investigated by the HCFU or sent to the appropriate district attorney's office.

In common with Maryland and Minnesota, one of the goals of the Wisconsin HCFU has been to improve the quality of referrals from private insurers. To accomplish this goal, the HCFU hosted a half-day training session in November 1997 for staff of insurance SIUs. The program consisted of presentations by the HCFU Project Director and investigators on the basics of criminal investigations and prosecutions and included lengthy interactive discussions on the problems and merits of hypothetical cases. The program informed insurers about the criminal prosecution process and what the HCFU needs in order to obtain convictions in criminal cases. In providing this training, the HCFU hopes to give insurers a better idea of what scenarios might involve potential crime and of the investigation needed. In addition to welcoming informal telephone contacts to discuss possible referrals early in an investigation, the Wisconsin HCFU has developed a short, user-friendly referral form based on a 10-page form required by federal prosecutors, to assist insurance companies.

The Wisconsin HCFU's project director has written articles for statewide newsletters aimed at introducing the HCFU to Wisconsin prosecutors, law enforcement officers, and Health Maintenance Organizations. This model was the subject of a discussion at a health care fraud symposium hosted by the Wyoming Attorney General's Office. This symposium included speakers involved in various government agencies responsible for fighting health care fraud, including individuals working with Medicare and Champus. At the symposium, the Wisconsin HCFU Project Director discussed examples of both Medicaid fraud and private health care fraud.

In Wisconsin, a number of task forces, associations, and commissions exist to combat health care fraud. Meetings between the HCFU and these entities are important for making contacts with other anti-fraud personnel, sharing information among agencies, becoming familiar with existing health-care fraud schemes, and coordinating multi-agency investigations.

### **3. Organizational Structure**

The Wisconsin HCFU was set up with one attorney, one investigator, and one half-time support person. The project director is an Assistant Attorney General in the Wisconsin Department of Justice Criminal Litigation Unit, with experience in white-collar crime and health care fraud

litigation. The Project Director is the sole prosecutor in the program and is responsible for making charging decisions, drafting pleadings, negotiating pleas, and handling all court appearances. In addition, the director administers the grant by filing periodic progress reports, reviewing all incoming health care fraud referrals, answering questions from members of the general public on health care fraud and fostering relationships with health care insurance carriers.

The HCFU investigator is a law enforcement officer with the White Collar Crime Bureau of the Wisconsin Department of Justice Division of Criminal Investigation. A law enforcement officer was specifically chosen for this position for several reasons. First, a sworn officer can execute search warrants, make arrests, and serve summons and complaints. Second, the selection of a law enforcement officer reinforces the fact that health care fraud is criminal activity and warrants the attention of investigative personnel. Third, the investigator handles all investigations for the project and represents the project at meetings of anti-fraud associations. Finally, the support staff person is a legal secretary within the Criminal Litigation Unit and is responsible for performing general secretarial duties and assisting with grant administration activities.

#### **4. Consumer Education**

The Wisconsin HCFU has created a brochure which describes the project and discusses common health care fraud schemes, and asks individuals to contact the Wisconsin DOJ to report possible health care fraud. These brochures are given to various law enforcement agencies, are passed out to different associations and insurers, and remain on display in the lobby of the Wisconsin Commissioner of Insurance.

To educate consumers, the Wisconsin HCFU was granted access to "Healthnet," the BlueCross BlueShield United of Wisconsin homepage on the Internet. At that web site, Wisconsin DOJ provides information on the HCFU and the Wisconsin MFCU and includes descriptions of what each program does, the names and addresses of people to contact, and press releases on health care fraud convictions.

Together with BlueCross BlueShield United of Wisconsin, the HCFU developed and issued a joint "Health Care Fraud Alert" to consumers and health care providers. The subject of the alert was durable medical equipment providers who engage in telemarketing scams in Wisconsin. Future alerts on other health care fraud schemes are anticipated.

At the inception of the Wisconsin HCFU, the Project Director met with the heads of the SIUs from 13 Wisconsin insurers, including BlueCross BlueShield of Wisconsin, Wisconsin Physician Services, and Employers Health Insurance, to discuss the HCFU and ways to work together. The insurers all agreed that sharing information was in everyone's best interest.

### **5. Wisconsin Results**

Since receiving its federal grant, the HCFU has received over seventy case referrals, the majority of which came from health insurers. The remainder of the referrals came from other state agencies such as the Office of the Commissioner of Insurance and the Office of Workforce Development. Out of all of the referrals received, the HCFU has opened approximately thirty active investigations to date and has relegated a number of other cases to "information only" status. All referrals are reviewed by the project director to determine if they warrant further investigation. The Project Director and the investigator together decide which referrals should be opened as active investigations. If a referral is relegated to "information only" status, the Director sends a letter to the referral source explaining why further investigation and/or prosecution is not warranted.

The Project Director regularly consults with insurers on potential referrals to provide guidance in the investigations and to assess the possibility of prosecution. The investigator and the Director meet weekly to review new referrals, open investigations, and discuss the progress of ongoing investigations. While the investigator works independently, the Director is available to offer guidance on legal questions and possible tactical decisions in the investigation. Any pleadings needed by the investigator, such as subpoenas for records or search warrants, are drafted and/or reviewed by the Director. Whenever the Director decides not to file charges based upon a referral, she sends a letter to the referring individual explaining why criminal prosecution is not warranted. In cases where criminal charges are brought, the director drafts the charging document.

The number of active investigations is determined in part on the merit of the referrals and in part on the fact that the HCFU has only one investigator. Most of the referrals sent to the HCFU need substantially more investigation or constitute technical violations of insurance plans which do not rise to the level of criminal activity. In those instances where more investigation is needed, the HCFU personnel either request the referral source to investigate further or the HCFU opens the referral as an active investigation and does the necessary investigation. If prosecution is warranted, the Project Director then initiates the prosecution by drafting the charging document, filing criminal charges, and notifying the referral source.

The project has initiated four criminal prosecutions since receiving the grant. In the first case, the defendant pled no contest and was convicted of felony theft by fraud. The defendant had falsely held himself out to be a medical doctor and defrauded several insurance companies and a Wisconsin county out of more than \$125,000. He was convicted in federal court and later prosecuted by the HCFU and convicted in state court for theft of \$36,000 from the county that hired him. The defendant was placed on probation for three years, ordered to pay restitution of more than \$36,000 to the county and ordered to serve a term of confinement concurrent to the term he is serving in the federal case.

In the second case, the defendant was charged with and convicted of one count of theft by fraud and one count of insurance fraud, arising out of false workers' compensation claims. The defendant was placed on probation for 3 years and ordered to serve 30 days in jail and pay more than \$10,000 in restitution.

The third case also involved workers' compensation fraud. In this case, the defendant pled guilty to two felony counts of insurance fraud for false workers' compensation claims, which resulted in disability payments of more than \$6,000 and payments to health care providers totaling more than \$10,000. The defendant was sentenced to 4 years of probation and ordered to pay \$16,000 in restitution, serve 90 days in jail, and perform 200 hours of community service.

The fourth and most recent case involved a defendant convicted with one felony count of insurance fraud for forging documents to show that insurance premiums had been paid when in fact they had

not. In that case, the defendant was placed on probation for 2 years.

The Project Director also handled an insurance fraud case in the Wisconsin Court of Appeals which helped define this area of law in the state. The case involved an individual convicted for submitting a fraudulent insurance claim for property lost in a fire. In the claim, the defendant listed a number of items which he did not possess at the time of the fire. On appeal, the defendant challenged his conviction, alleging that the state failed to prove with specificity those items on the claim which were false, therefore, denying his right to a unanimous verdict. The defendant also argued that, under the Wisconsin insurance fraud statute, the penalty provision is determined not by the total amount of the claim, but rather only by the fraudulent portion of the claim. In upholding the conviction, the Wisconsin Court of Appeals for the first time interpreted Wisconsin's insurance fraud law finding that the statute required the state only to prove that the entire amount of the claim was over the felony threshold amount and that because each of the false items on the claim were alternative ways of committing insurance fraud, the defendant's right to a unanimous verdict was not violated by the fact that the jurors did not specify which items they had found to be false.

#### IV. CONCLUSION

The experiences of each HCFU demonstration site varies because each state developed its own emphasis based on its particular needs and conditions. In all instances, however, each demonstration unit established itself as an integral part of the statewide effort against health care fraud and brought something new to the table – a single state unit able to handle health care fraud cases which lack a Medicaid nexus and are not subject to MFCU jurisdiction. Also adding to the HCFUs' successful placement into the effort to combat private health care fraud was the insurance industry's frustrated experiences related to securing prosecution and restitution for its losses to fraud.

The establishment of the HCFUs and the emphasis placed on this area of financial crime by NAAG have helped to heighten state Attorneys General interest in health care fraud as evidenced by the increased number of states which are considering and adopting curative legislation. For example, many of these legislative efforts include reporting requirements which provide for reports of incidents of suspected health care fraud. This report of the three demonstration HCFUs identifies

only the beginning. The successes that have been occasioned by these and similar units in other states tend to build on themselves with the result that the anti-fraud efforts will undoubtedly be strengthened and play an even greater role in the future.

The HCFU experience has demonstrated the existence of four essential elements of an insurance fraud law. First, insurance fraud should be defined as a specific crime and, depending on the severity of the crime, a felony. Attempted fraud also should be included in the definition. In states that do not have a separate crime of insurance fraud, prosecutors must use some nugget in their fraud laws or theft by deception laws. A specific law makes detection and prosecution easier. Second, fraud laws should include both civil and criminal penalties for committing insurance fraud. In addition, restitution should be required as part of any adjudication, thereby removing the perpetrators' profit motive. Third, individuals licensed by the state and earning a living from the insurance system should not be allowed to use that license to defraud the system. Fourth, strong civil penalties should be incorporated to facilitate the investigation of suspected insurance fraud and the exchange of information among insurers and with law enforcement, as long as the information exchange is made without actual malice.

This program has also demonstrated the need for a more coordinated coverage of the health care fraud problem. It is a national problem; federal efforts alone will not be effective. What the three demonstration sites have shown is that there is no single approach to this difficult problem; rather, each state must design a program that will enable it to identify where the greatest needs are and to maximize the resources already available to respond to those needs. One of the most promising developments is the partnership that each project state has made with the insurance industry. Wherever the public and private sectors can join together in this fashion each sector benefits. Thus, the effectiveness of a state HCFU may not be best measured by the number of cases per attorney - and each one is, for example, smaller than the corresponding MFCU - but in the development of partnerships and strategies, and the coordination of resources to ensure a maximum benefit.

The same might be said for other state Attorney General efforts in combating private sector health care fraud. Connecticut, New Jersey and Pennsylvania are leading the way in legislative efforts while New York has had considerable success with specific denial-of-care issues. The three project

sites have demonstrated the benefits of working with the insurance industry, coordinating state efforts, and the value of educating the public. From each state there is now a font of experience upon which other might draw.

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