U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

December 8, 2010

The Honorable Patrick Leahy
Chairman
Committee on Judiciary
United States Senate
Washington, D.C. 20515

Dear Chairman Leahy:

Enclosed please find responses to questions for the record arising from the appearance of Tony West, Assistant Attorney General for the Civil Division, before the Committee on October 28, 2009, at a hearing entitled "Effective Strategies for Preventing Health Care Fraud."

We apologize for the delay in responding and hope that this information is of assistance to the Committee. Please do not hesitate to call upon us if we may be of additional assistance. The Office of Management and Budget has advised us that from the perspective of the Administration's program, there is no objection to submission of this letter.

Sincerely,

Ronald Weich
Assistant Attorney General

Enclosures

cc: The Honorable Jeff Sessions
Ranking Minority Member

Senator Specter – Questions for Assistant Attorney General Tony West

Senate Judiciary Committee:
Effective Strategies for Preventing Health Care Fraud

October 28, 2009

1. Mr. West, you mention the historic and groundbreaking prosecution of "Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc." in which they "agreed to pay $2.3 billion to resolve criminal and civil liability arising from the illegal promotion of" Bextra. (West Stmt. at 2). I understand two individuals were prosecuted in related cases but that, to date, no individual has been sentenced to jail time. **Do you think that white collar criminals who commit – or assist their corporations in committing – multi-billion dollar health care frauds would be better deterred if they were sentenced to a period of incarceration?**

Response:

The Department is committed to vigorously prosecuting those responsible for committing health care fraud. In determining whether charges should be brought against corporations and their executives, the prosecutors weigh all of the factors normally considered in the sound exercise of prosecutorial judgment: the sufficiency of the evidence; the likelihood of success at trial; the probable deterrent, rehabilitative, and other consequences of conviction; and the adequacy of noncriminal approaches.

In the Pfizer/Pharmacia matter, we have charged and obtained convictions for the most serious, readily provable offenses that were supported by the facts of the case. The prosecutors made those determinations based on an "assessment of the extent to which particular charges fit the specific circumstances of the case, [were] consistent with the purposes of the Federal criminal code, and maximize[d] the impact of federal resources on crime." *See* U.S.A.M. § 9-28.1200B. Also, "[a] charge is not 'readily provable' if the prosecutor has a good faith doubt, for legal or evidentiary reasons, as to the Government's ability readily to prove a charge at trial." Department Policy Concerning Charging Criminal Offenses, Disposition of Charges, and Sentencing (Sept. 22, 2003) ("Ashcroft Memorandum"). "[C]harges should not be filed simply to exert leverage to induce a plea." *Id.*

Two individuals were charged and convicted in connection with that matter based on the evidence the Government was able to develop in the course of its investigation. One individual was convicted of a misdemeanor offense, and a probationary term was appropriate. In the case of a second individual, the Government advocated for a term of imprisonment, but the court sentenced the defendant to a term of probation with six months of home confinement. Neither individual was a senior executive in the company.

To obtain a felony conviction of a corporate executive of a pharmaceutical or medical device company engaged in health care fraud, the United States is required to prove, beyond a reasonable doubt, that the individual had the requisite intent to commit the crime. Corporate executives are not vicariously liable for the felonious conduct of employees within the corporation. Therefore, a conviction of the company for feloniously misbranding a prescription drug product, for example, would require proof beyond a reasonable doubt that the executive had personal knowledge of the felonious misbranding activity *and intended to defraud or mislead.* In large organizations it can be very difficult to prove, beyond a reasonable doubt, that high level executives had knowledge of the illegal activity of their subordinates. It is especially challenging to prove the criminal intent necessary to sustain a felony conviction that could lead to a sentence of imprisonment.

Frequently, we learn of the allegations of criminal activity from the filing of a *qui tam* lawsuit by a company insider. The allegations are often about conduct that has occurred years before the lawsuit is filed. Therein lies another problem of pursuing individuals. We have limited time and resources to develop the facts and, as a result, the charging decisions are affected by the approaching statute of limitations.

2. Mr. West, you also mention the Department's prosecution of Eli Lilly and that the company "pled guilty to violating the Food, Drug, and Cosmetic Act (FDCA) for its illegal marketing of the anti-psychotic drug Zyprexa for uses that were not approved by the FDA." (West Stmt. at 4). That settlement in January 2009 "totaled $1.415 billion and included a $515 million criminal fine, $100 million in forfeiture and $800 million in civil recoveries . . . ." **To your knowledge, was anyone sentenced to jail time for the FDCA fraud perpetrated by Eli Lilly in its marketing of Zyprexa?**

   Response:

   No one was sentenced to jail in connection with the Eli Lilly matter.

3. Finally, Mr. West, you testified that "just last week, Mylan Pharmaceuticals, Inc. paid $118 million to resolve allegations that it had sold innovator drugs that were manufactured by other companies and had classified those drugs as non-innovator drugs for Medicaid rebate purposes." **Are you aware of whether any corporate actor or individual agent of Mylan Pharmaceuticals is expected to be targeted for the conduct that resulted in that prosecution and, if so, will the Department seek to have a sentence of incarceration imposed?**

   Response:

   We do not expect any criminal prosecution of any corporate actor or individual agent of Mylan Pharmaceuticals as a result of this conduct.

4. **Mr. West, do you think that if individuals were incarcerated that would tend to have a general deterrent effect upon other corporate executives tempted by the profits associated with health care fraud?**

Criminal prosecution is a critical component of an overall law enforcement strategy designed to detect and prevent health care fraud. Consistent with Department policy, upon conviction, we advocate for sentences of imprisonment within the advisory Sentencing Guidelines range in all but extraordinary cases. This policy reflects the Department's belief that the Sentencing Guidelines provide the best framework for achieving tough, fair and consistent sentences in the federal criminal justice system.

Despite the challenges of bringing charges against individuals, the Department of Justice has charged and obtained convictions of senior corporate executives and others engaged in illegal activity in connection with the sale and marketing of pharmaceuticals and devices. In several recent cases, such as Purdue Pharma discussed below, responsible corporate officers were prosecuted where they did not implement measures to ensure that violations would not occur and, as a result, widespread violations were committed by individuals within the company. In other cases, we charged individuals whom we could prove were directly involved in the criminal conduct.

Recent Charges Against Senior Executives Engaged in Health Care Fraud at Major Pharmaceutical and Device Companies

- **InterMune (N.D. Cal.)**. On September 29, 2009, a jury in San Francisco returned a guilty verdict for wire fraud against the former CEO of InterMune, Inc., a biopharmaceutical company in Brisbane, California. The CEO was acquitted of a misbranding charge brought under the Federal Food, Drug and Cosmetic Act. The charges stemmed from an August 28, 2002 InterMune press release that described the results of a clinical trial that tested InterMune's drug Actimmune as a treatment for the fatal lung disease, idiopathic pulmonary fibrosis (IPF). Despite the trial failing completely, the CEO wrote the press release to falsely portray the trial results as showing that Actimmune helped IPF patients live longer, claiming in his defense that a "subgroup analysis" of the test results justified the claim. In addition to distributing the press release to the public generally, InterMune's sales force used the press release with doctors to increase sales of Actimmune. The annual cost of Actimmune for one IPF patient was $50,000. The vast majority of InterMune's sales of Actimmune were for the purpose of treating IPF even though Actimmune was not approved by the Food and Drug Administration as a treatment for IPF. Sales of Actimmune made up 90% of InterMune's revenues. The guilty verdict followed a seven-week jury trial. Sentencing will take place early next year. Dr. Harkonen is facing a potential sentence of imprisonment.

- **Synthes, Inc./Norian Corp. (E.D. PA)**: In June 2009, four senior executives at a medical device manufacturer, Norian Corp., and its wholly owned subsidiary Synthes, Inc., were charged with offenses related to the off-label promotion of Norian XR, an unapproved bone cement developed by defendants. The defendants developed Norian XR by adding barium sulfate to Norian SRS, a device that was approved by FDA. The However, Norian SRS was approved only to fill bony voids that were not intrinsic to the stability of the bony structure, and the FDA specifically warned that SRS should not be mixed with any other substance. Despite the approved indications and FDA warnings, defendants mixed SRS with another substance and promoted it for off-label uses. The individuals pled guilty to misdemeanor offenses as "responsible corporate officers" in July and are awaiting sentencing.

- **Serono Labs (D. Mass.)**: In 2008, a medical director for Serono Laboratories, a subsidiary of Swiss drug manufacturer Serono, S.A., pled guilty to three counts of causing the dissemination of adulterated computer software devices used to interpret bioelectrical impedance analysis (BIA) test results, in order to diagnose AIDS wasting and to increase sales of an AIDS wasting drug. The device in question, a software package used to diagnose "AIDS wasting" (a profound involuntary loss of weight and lean body mass which was once a leading cause of death among AIDS patients), was adulterated because FDA had not approved or cleared it for this use. The President of the medical device manufacturer, RJL Sciences, also pled guilty to conspiracy in connection with the crime.

- **Purdue Pharma (W.D. Va.)**: In May 2007, three Purdue Pharma senior executives pled guilty to misdemeanor misbranding offenses, as responsible corporate officers, relating to misrepresentations the company made to health care providers that Purdue's drug OxyContin was less addictive, less subject to abuse and diversion, and less likely to cause withdrawal problems than other pain medications. As a result of their misconduct, the Department of Health and Human Services' Office of Inspector General excluded the three officers from participation in federal health care programs for 15 years. The exclusions have been upheld administratively and are on appeal in federal court.

- **Stryker Biotech (D. Mass.)**: In October 2009, four executive officers at medical device manufacturer Stryker Biotech were charged along with the company with multiple felony counts related to an illegal marketing scheme to promote off-label the unapproved use of the firm's medical devices, OP-1 and Calstrux. OP-1 is a putty implant that is used for repairing and regenerating bone. Calstrux was a Stryker product approved to fill voids in bones. The charges allege that the executives at Stryker, however, promoted OP-1 and Calstrux together, and directed physicians to mix Calstrux with OP-1, a use not approved by FDA. The case is ongoing and no one named in the October 2009 indictment has been convicted. Four sales managers from Stryker were charged by separate Informations in late 2008 through spring 2009. Those four individuals pled guilty but have not yet been sentenced.

Questions of Senator Tom Coburn, M.D.
"Effective Strategies for Preventing Health Care Fraud"
United States Senate Committee on the Judiciary
October 21, 2009

1. What criminal statutes are used to prosecute health care fraud?

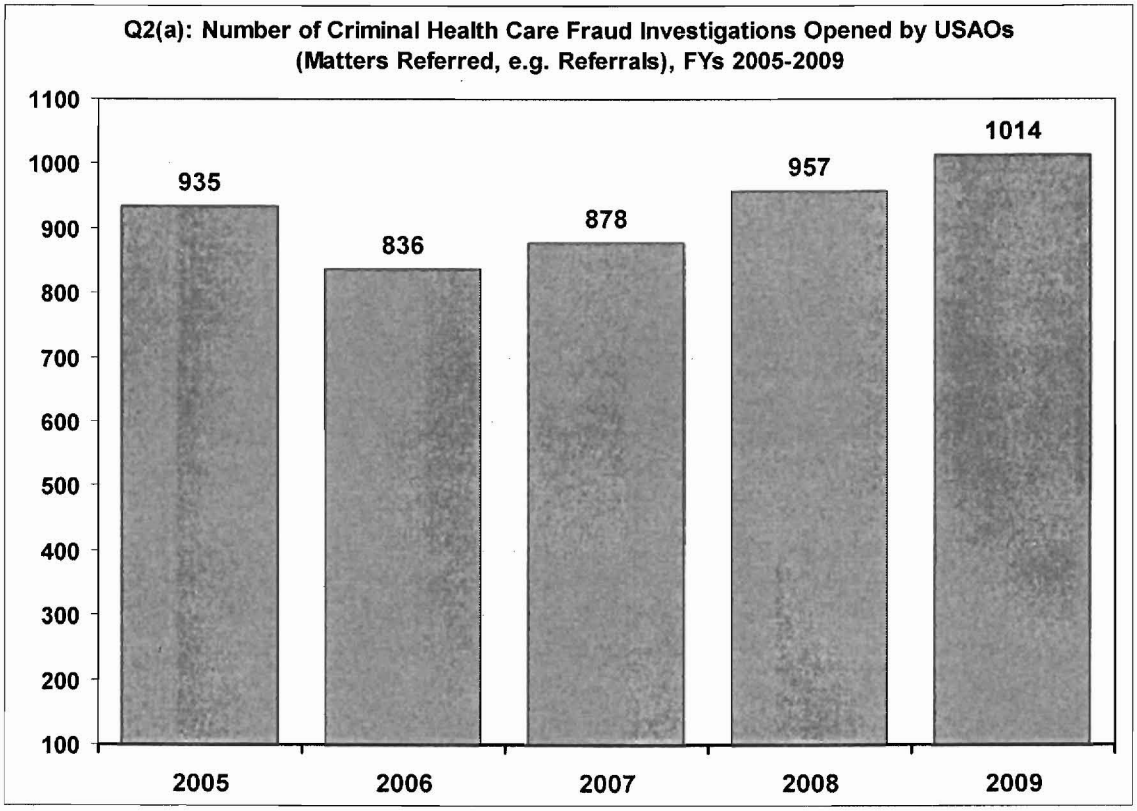
DOJ Response: The following table presents the criminal statutes used most frequently in the Department's health care fraud cases and matters in fiscal year 2009.

Rank Frqcy	United States Code Title and Section "Short Title"	U.S. Code Title & Section	Pct Total FY 2009
1	Health Care Fraud	18 U.S.C. 1347	24.1%
2	Conspiracy to Commit Offense or Defraud United States	18 U.S.C. 371	16.8%
3	Criminal Forfeiture	18 U.S.C. 982	10.9%
4	Attempt and Conspiracy	18 U.S.C. 1349	8.3%
5	Mail Fraud and Swindles	18 U.S.C. 1341	5.1%
6	Laundering of Monetary Instruments	18 U.S.C. 1956	4.1%
7	False Statements Relating to Health Care Matters	18 U.S.C. 1035	3.4%
8	Criminal Penalties for Acts Involving Federal Heath Care Programs	42 U.S.C. 1320	2.7%
9	Prohibited Acts - Food, Drug and Cosmetic Act	21 U.S.C. 331	2.7%
10	Engaging in Monetary Transactions in Property Derived from Specified Unlawful Activity	18 U.S.C. 1957	2.0%
11	Fraud by Wire, Radio, or Television	18 U.S.C. 1343	2.0%
12	False Statements or Entires	18 U.S.C. 1001	1.5%
13	Fraud and Related Activity in Connection with Identification Documents, Authentication Features, and Information	18 U.S.C. 1028	1.4%
14	Principals - Crimes	18 U.S.C. 2	1.2%
15	False, Fictious or Fradulent Claims	18 U.S.C. 287	1.1%
16	Prohibited Acts - Drug Abuse Prevention and Control	21 U.S.C. 841	1.0%
17	Title 18 Civil Forfeiture	18 U.S.C. 981	1.0%
18	Attempt and Conspiracy	21 U.S.C. 846	0.9%
19	Theft or Embezzlement in Connection with Health Care	18 U.S.C. 669	0.9%
20	Prohibited Acts - Drug and Abuse and Prevention Control	21 U.S.C. 843	0.8%
21	Criminal Forfeiture	21 U.S.C. 853	0.5%
22	Public Money, Property or Records	18 U.S.C. 641	0.4%
23	Authorized Sentences	18 U.S.C. 3551	0.4%
24	Penalties - Food, Drug, and Cosmetic Act	21 U.S.C. 333	0.4%
25	Obstruction of Criminal Investigatins of Health Care Offenses	18 U.S.C. 1518	0.3%
26	Attempt to Evade or Defeat Tax	26 U.S.C. 7201	0.3%
27	Penalty for Failure to Appear	18 U.S.C. 3146	0.3%
28	Smuggling Goods into the United States	18 U.S.C. 545	0.3%
29	Destruction, alteration, or falsification of records in Federal Investigations and Bankruptcy	18 U.S.C. 1519	0.2%
30	All Other Statutes		5.0%
	Total		**100.0%**

2. How many criminal health care fraud investigations have been opened in the last five years? How many criminal health care fraud prosecutions have been brought in the last five years? How many criminal health care fraud convictions have been secured in the last five years?

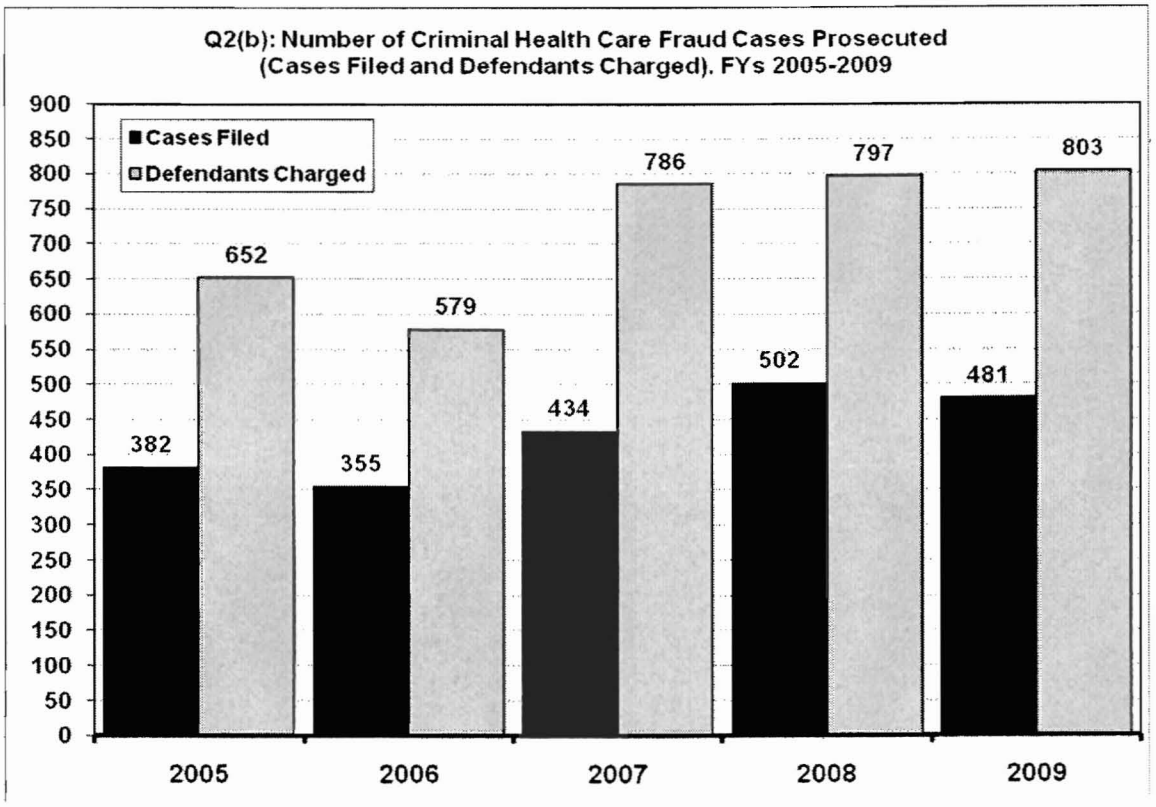
a. How many criminal health care fraud investigations have been opened in the last five years?

DOJ Response: Over the past five years, the Department of Justice has opened a total of 4,620 criminal health care fraud investigative matters. The following chart presents the number of new investigative matters opened during each fiscal year, 2005-2009.



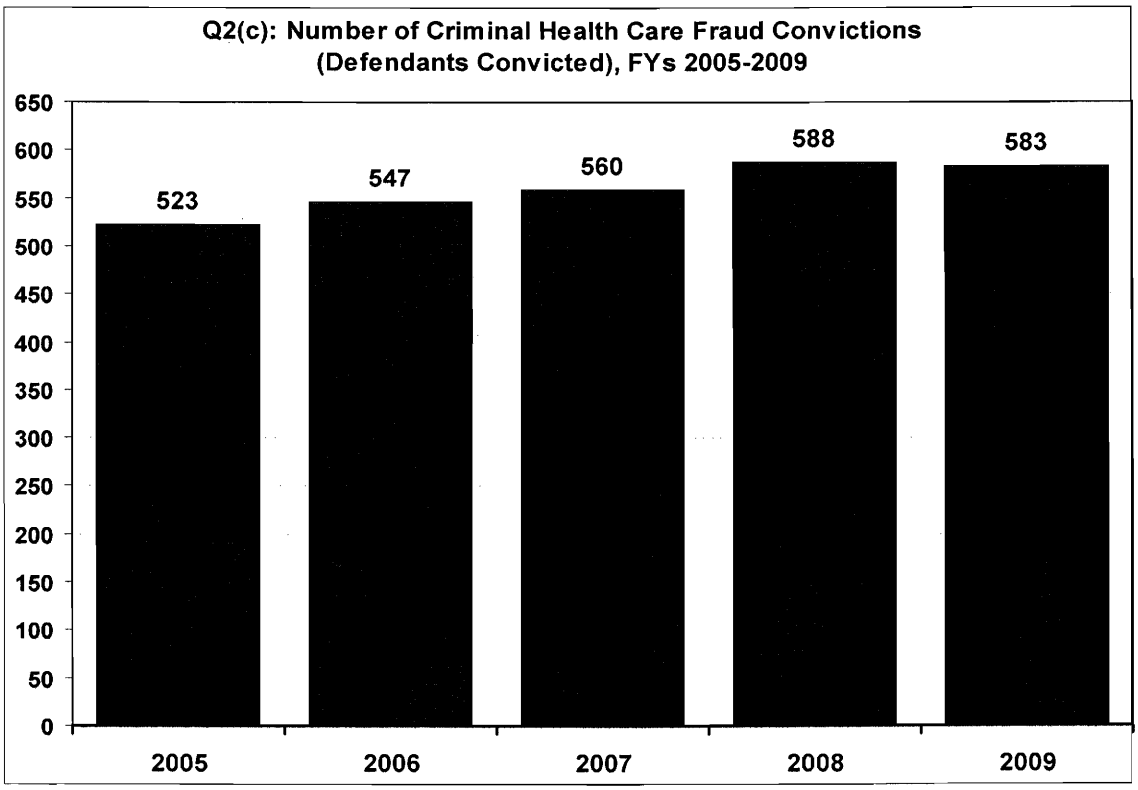
b. How many criminal health care fraud prosecutions have been brought in the last five years?

DOJ Response: Over the past five years, the Department of Justice has filed or opened a total of 2,154 criminal cases charging 3,617 individual defendants with health care fraud violations. The following chart presents the number of cases filed and defendants charged during each fiscal year, 2005-2009.



c. How many criminal health care fraud convictions have been secured in the last five years?

DOJ Response: Over the past five years, the Department of Justice has secured 2,801 convictions in criminal health care fraud cases prosecuted. The following chart presents the number of convictions in criminal health care fraud cases during each fiscal year, 2005-2009.



3. Which criminal statutes are used most often to prosecute criminal health care fraud?

DOJ Response: The criminal health care fraud statute, Title 18 U.S.C. §1347, is the most frequently used statute in criminal health care fraud prosecutions. Other criminal statutes that are frequently used include: conspiracy to defraud the United States, Title 18 U.S.C. §371, and attempt and conspiracy, Title 18 U.S.C. §1349; mail fraud, Title 18 U.S.C. §1341, and wire fraud, Title 18 U.S.C. §1343; money laundering, Title 18 U.S.C. §1956, and engaging in monetary transactions in property derived from specified unlawful activity, Title 18 U.S.C. §1957; false statements relating to health care matters, Title 18 U.S.C. §1035, and false statements, Title 18 U.S.C. §1001; and Food, Drug and Cosmetic Act violations, Title 21 U.S.C. §331 and §333. Collectively, these ten criminal statutes were charged in 70 percent of all health care fraud cases last year. The criminal penalty provisions of Title 42 U.S.C. §1320a-7b (Medicare Anti-Kickback Statute) were also charged in another 3 percent of health care fraud cases.

4. Is existing criminal law sufficient to reach the kind of health care fraud that you are seeing today?

a. If not, please give examples of the types of conduct you need to prosecute, but cannot reach with existing law.

DOJ Response: As demonstrated by the Department's response to Question 1, there are a substantial number of criminal statutes available for prosecuting numerous forms of health care fraud. However, we regularly evaluate whether additional statutes may be helpful as changes to

health care financing and delivery systems occur. For example, in the private sector, the marketing and sale of fraudulent group health coverage to employee group health plans can be difficult to detect and prosecute. Additional enforcement tools may enhance efforts to curtail such abuses. .

5. What percentage of health care fraud can you not prosecute because of inadequacies in existing law?

DOJ Response: The Department is not aware of a significant amount of health care fraud schemes that cannot be prosecuted because of inadequacies in existing law.

6. How many prosecutors are currently assigned to health care fraud? How many of these prosecutors work health care fraud cases full time? On average, what is the health care fraud caseload for each of these prosecutors?

DOJ Response: The Department's health care fraud component agencies track attorney time by recording the amount of hours worked on health care fraud cases and matters. A single attorney full-time equivalent (FTE) equals 2,080 hours worked by any number of attorneys on health care fraud cases and matters. Therefore, the Department can only provide statistics for the number of attorney FTEs who recorded time worked on criminal and/or civil health care fraud cases and investigations.

In fiscal year 2009, approximately 125 FTE among criminal Assistant United States Attorneys and DOJ criminal attorneys were devoted to criminal health care fraud prosecutions and investigations. On average, each criminal health care fraud attorney FTE handled about 10 cases (which included new cases filed during the fiscal year and pending cases filed in previous years that were still being litigated in fiscal year 2009). In addition, each criminal health care fraud attorney FTE, on average, handled approximately 21 investigative matters (which included new matters opened during the fiscal year, plus matters pending from prior years that remained under investigation in fiscal year 2009).

Last year, approximately 140 FTE civil Assistant United States Attorneys and DOJ Civil Division attorney work years were devoted to civil health care fraud cases and investigative matters. On average, each civil health care fraud attorney FTE's case load was about 7 cases (which included new cases filed during the fiscal year and pending cases filed in previous years that were still being litigated in fiscal year 2009). In addition, each civil AUSA or DOJ attorney FTE, on average, handled approximately 15 civil investigative matters (which included new matters opened during the fiscal year, plus matters pending from prior years that remained under investigation in fiscal year 2009).

7. In your opinion, are the sentences available under existing law and Sentencing Guidelines sufficient to punish and deter health care fraud?

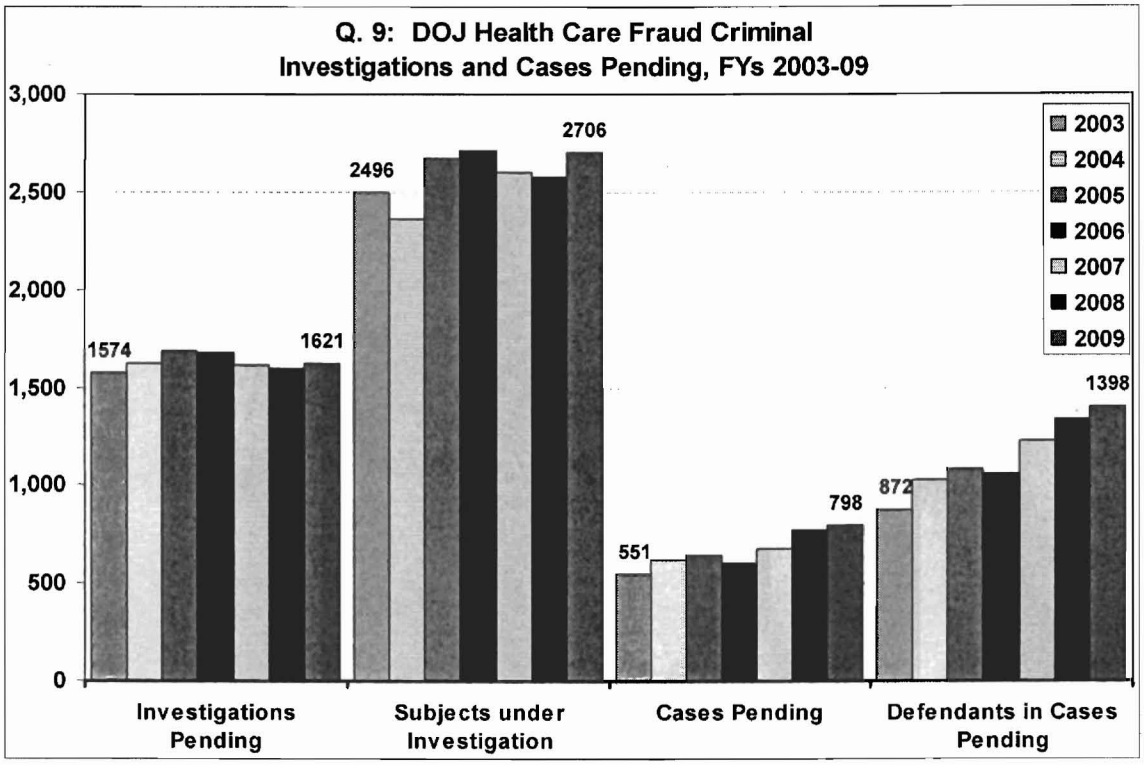
DOJ Response: The Department believes that prison sentences have an important deterrent effect on health care fraud. The Department also believes that the Sentencing Guidelines generally provide an adequate framework for achieving tough, fair and consistent sentences in the federal criminal justice system.

8. Do improvements need to be made to any existing criminal laws to make them more useful in health care fraud prosecutions? If so, what are your suggested improvements?

DOJ Response: Although the Department is not in a position to offer any specific proposals at this time, we look forward to working with the Committee and with Congress on effective strategies for prosecuting health care fraud in all of its forms.

9. How much of the rampant health care fraud that we are experiencing is the result of lax enforcement of existing criminal law?

DOJ Response: The Department of Justice is vigorously enforcing criminal law to prevent, deter, and prosecute health care fraud to the fullest extent possible with our current levels of attorney, investigative, and support staff funded by the Health Care Fraud and Abuse Control (HCFAC) program. Between fiscal years 2003 and 2009, mandatory HCFAC program funds provided to the Department were largely fixed by statute at 2003 levels. The Tax Relief and Health Care Act of 2006 provided annual inflationary increases in HCFAC funding for fiscal years 2007-2009. The Department used the annual inflationary increases to launch the Medicare Fraud Strike Force. Last year, the Department also received an additional $19 million in discretionary funding through the HCFAC program for health care fraud enforcement. The Department used the added discretionary funding, in part, to expand the Strike Force from two to four sites, and for civil enforcement. In 2010, the Department received an additional $29.8 million in discretionary funding through the HCFAC program. During the seven-year period when health care fraud enforcement resources were increased only by annual inflation, the Department *increased* the number of criminal health care fraud cases filed annually by 34 percent from 362 cases in 2003 to 481 cases in 2009. Over this same period, however, the number of criminal health care fraud cases pending (e.g., awaiting settlement or resolution by trial) increased by nearly 45 percent from 551 to 798 cases (see following chart).



10. The new government plan proposed by Democrats is supposed to control costs by reducing the profits of insurance companies. Fortune Magazine found that the top 14 insurers earned a combined $8.61 billion in 2008. That may seem like a lot of money, but consider that Medicare lost an estimated $60 billion - seven times as much money - to fraud as those insurers earned in profits.

Moreover, GAO labeled Medicaid a "high risk" program, finding $32.7 billion in improper payments in 2007 alone -10 percent of the program's total spending. So the Medicare and Medicaid "public plans" lose more than $90 billion dollars to fraud each year - ten times the profits of the major insurers.

Question:
If the new government plan is anywhere close to the size of either Medicare or Medicaid, experience demonstrates that taxpayers will lose far more to fraud than they will save in eliminating insurer profits. Is that a good investment for taxpayers?

DOJ Response: A precise measure of the amount of fraud in Medicare and Medicaid does not exist. The Department's experience, from years of criminal and civil enforcement is that private health insurers suffer losses from fraud and abuse similar to those suffered by government health care programs. Because health care fraud drives up both public and private health care costs, the Department is committed to vigorously combating health care fraud in all of its forms.

We think it is important to note that the improper payment rate should never be confused with the rate of fraud in any federal government program. OMB Circular A-123 defines "improper payment" as any payment that should not have been made or that was made in an incorrect amount. Incorrect amounts are overpayments and underpayments (including inappropriate denials of payment or service). An improper payment in the Medicare program means that the documentation provided with a claim does not support a claim payment. The reason for a determination of improper payment could be poor record-keeping, a mistake by the provider or supplier, or a decision by a supplier or provider that not contesting a finding of improper payments is the less costly avenue. Therefore, the fact that a payment has been ruled improper does not mean that the service should not have been provided. Fraud, on the other hand, implies intent to steal from the program.

Senator Grassley – Questions for Assistant Attorney General Tony West

Senate Judiciary Committee:
Effective Strategies for Preventing Health Care Fraud

October 28, 2009

1) False Claims Act: Civil Investigative Demands (CIDs):

Please provide a specific date when the Department will implement and delegate the Attorney General's authority to sign off on Civil Investigative Demands (CIDs) as authorized by the Fraud Enforcement Recovery Act of 2009. In order for the Committee to properly exercise oversight responsibilities, please provide a specific time frame for implementation and to whom the authority will be delegated.

Response:

On May 20, 2009, the President signed the Fraud Enforcement and Recovery Act of 2009 (FERA), which included amendments authorizing the Attorney General to delegate his authority to issue civil investigative demands (CIDs) under the False Claims Act. On January 15, 2010, the Attorney General delegated to the Assistant Attorney General for the Civil Division all authority of the Attorney General under 31 U.S.C. sec. 3733. That authority is re-delegable by the Assistant Attorney General to other Department officials, including United States Attorneys. On March 8, 2010, the Assistant Attorney General issued a directive re-delegating this authority to United States Attorneys in cases that are delegated or assigned as monitored to their respective offices. For cases that are jointly handled by the Civil Division and a United States Attorney's Office, the directive provides that the Civil Division will issue a CID only after requesting the United States Attorney's recommendation.

2) False Claims Act: Public Disclosure Bar:

In the last Congress, the Department provided views and supplementary materials to the Committee that stated the Department would not object to removing the jurisdictional component of the public disclosure bar of the False Claims Act, given certain modifications to the bill then pending. Has the Department changed it views on this issue? If so, please provide an update as to what the official position of the Department is related to Section 4 of S.458 (111th Congress).

Response:

Since the October 28, 2009 hearing, Congress and the President have acted to amend the False Claims Act's public disclosure bar. On March 23, 2010, the President signed into law P.L. 111-148, the Affordable Care Act (ACA). Section 10104(j)(2) of ACA revised the public disclosure bar in several respects, including removing the

reference to "jurisdiction" from the bar. As amended, the public disclosure bar provides as follows:

(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed--

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, `original source' means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

3) Working Capital Fund and the 3% Fund:

In 2002, Congress authorized the Attorney General to collect "up to 3 percent of all amounts collected pursuant to civil debt collection litigation activities of the Department of Justice." This authorization allows the Attorney General to retain 3% of all civil debt collections and place those funds in the Department's Working Capital Fund.

As civil settlements by the Department of Justice continue to grow in size, especially under the False Claims Act, I'm concerned with the size of this fund. I want to ensure that the expenditures are done in accordance with the law.

I have concerns regarding the 3% fund and how monies recovered from health care fraud cases that are supposed to be returned to the Medicare trust fund are diverted to the Department. The trust fund is ultimately back-filled by the Treasury Department, but this begs the question: Could this process could be simplified?

Do you agree it would be easier for Congress to provide an annual appropriation to DOJ equal to a percentage of civil debt collections instead of this system of moving money from the Trust Fund and refilling it? Why or why not?

Response:

The Department does not agree that it would be easier for Congress to provide an annual appropriation to DOJ equal to a percentage of civil debt collections for a number of reasons. At this time, the 3 % offset is available to the Department upon disbursement.

Disbursement usually takes place within a week after the funds are received by the Department. These funds are then available for expenditure as authorized. Therefore, this funding is not subject to the enactment of continuing resolutions or other full-year funding vehicles. Further, the 3 % fund is "no year" money, which means that balances may be carried over to subsequent years.

There are important reasons why Congress designed the 3 % fund in this manner. (*See* 28 U.S.C. § 527 (note)). The 3 % fund was established in order to provide the Department with additional resources to improve civil debt collection and to generate increases in revenue to the United States Treasury. The Department uses 3 % funds to advance critical financial recovery and collection efforts throughout the Department -- not just in the health care fraud area. Thus, Medicare Trust Fund deposits constitute only a part of the total 3 % fund. Large cases for the prior fiscal year which have contributed to the 3 % fund include cases in the areas of defense procurement fraud (*Walanpatrias Stiftung*), tax fraud (*UBS*), fire recovery (*Union Pacific Railroad*), and mortgage fraud (*RBC Mortgage*). The Department does not believe that it is reasonable to change the mechanism by which the entire 3 % fund is provided to the Department, because a portion of the offset relates to the Medicare Trust Fund.

With respect to your comments concerning the Medicare program, we note that the Department has a process in place under which documentation is provided to the Treasury's Bureau of Public Debt (BPD) each time a collection is transferred to the Medicare Trust Fund. The documentation shows the total amount of the collections and the amounts retained for the 3% offset in accordance with Public Law 107-273. The BPD is responsible for transferring from the Treasury General Fund to the Medicare Trust Fund the amounts due back to the Trust Fund as reimbursement, and the Department is not involved in those transactions. Therefore, we would respectfully refer you to the Department of the Treasury and the Department of Health & Human Services to determine the accuracy of your statement that "The trust fund is ultimately backfilled by the Treasury Department. . . ".

Would you object to Congress placing new restrictions on the 3% fund to ensure that Medicare funds are returned directly to the trust fund and not diverted to DOJ?

Response:

The Department would object strenuously to Congress placing restrictions on the 3% fund in the manner described above. The Department uses 3% funds to support financial recovery and collection efforts throughout the Department on behalf of the United States Government, not just in the health care fraud area. Many cases have substantial resource needs, and the 3% fund has been used to provide a portion of the resources needed, in addition to other appropriated resources.

Moreover, the Treasury Department reimburses the Medicare Trust Fund for all Medicare fraud recoveries allocated to DOJ as 3% offsets, which ensures that the Medicare Trust Fund receives 100% of civil recoveries for Medicare fraud litigation. Thus, the Medicare Trust Fund is made whole. The monthly deposits can be seen on the Financial Statements provided by the Treasury Department.