**TESTIMONY**
**OF THE**
**CONNECTICUT HOSPITAL ASSOCIATION**
**JUDICIARY COMMITTEE**

**Friday, March 22, 2002**

**SB 632, An Act Concerning Civil Penalties For Health Care Fraud**

The Connecticut Hospital Association (CHA) appreciates the opportunity to submit testimony in opposition to **SB 632, An Act Concerning Civil Penalties For Health Care Fraud**. CHA objects to SB 632 because it is duplicative and will add confusion to an already overly complicated area of legal and contractual requirements.

CHA agrees that providers who commit fraud should be investigated and penalized, however, the state has already created numerous mechanisms for state oversight, investigation and civil and criminal prosecution of healthcare fraud. There is simply no need for this bill.

Numerous state agencies already have jurisdiction over healthcare fraud. The Attorney General, the Department of Consumer Protection, the Department of Social Services, the Department of Insurance, and the Office of the State's Attorney all may become involved in investigating potential healthcare fraud.

Healthcare providers also are subject to ever increasing scrutiny by the federal government in its efforts to keep the Medicare and Medicaid programs solvent. The United States Department of Justice has made combating healthcare fraud a high priority, second only to violent crimes. Currently, the Department of Health and Human Services' Office of the Inspector General, the Department of Justice, the Center for Medicare and Medicaid Services, and the Medicare carriers and intermediaries all are actively involved in investigating alleged healthcare fraud. A list of current state and federal statutes designed to combat healthcare fraud is attached for your reference.

Our hospitals devote substantial resources to ensuring that they remain compliant with the staggering volume of applicable state and federal laws, regulations and accreditation requirements. Hospitals are confronted, however, with a vast array of requirements that are inherently subjective and often inconsistent.

The proposed bill inevitably increases the potential for further inconsistencies and subjectivity. For example, the bill would impose liability against a hospital for omitting "material information" concerning a claim filed with a managed care company. Yet there are frequent good faith disagreements between providers and payors in the daily

process of claims submission and review as to what information must be submitted with a health claim. The proposed bill will only exacerbate an already difficult process, by introducing the threat of an accusation of "fraud" for reasonable differing views.

Similarly, the proposed bill would impose liability for "falsely representing" that goods and services are "medically necessary" or for failing to provide services required under a health insurance contract. Disagreements between providers and payors about the "medically necessary" level of care for patients are at the heart of industry concerns about managed care. In a hospital, a physician makes a determination of whether a particular service is medically necessary based on the condition of a particular patient at a specific time. In reviewing a claim with the benefit of hindsight, a payor or the Attorney General may make a different determination, and such reasonable differences of opinion should not be considered fraud.

The existing Connecticut Health Insurance Fraud Act already provides a detailed process to address healthcare fraud, including omissions and misrepresentations of medical necessity. It is notable that the crime of "health insurance fraud" defined in Section 53-442 of the Act is very similar to the conduct prohibited by SB 632. The Act requires individuals to report health insurance fraud to the Department of Insurance (DOI), authorizes DOI to investigate the alleged fraud, and requires DOI to "refer such investigation to the appropriate state agency for criminal prosecution, civil enforcement or disciplinary action" if DOI believes a fraud has occurred. Given the inherently subjective nature of medical necessity determinations and material claims information, we respectfully suggest that DOI is in a better position to evaluate claims of healthcare fraud than the Attorney General.

Thank you for your consideration of our position.

**STATE AND FEDERAL LAWS**
**THAT PROVIDE HEALTH CARE FRAUD ENFORCEMENT MECHANISMS**
**For Consideration In Connection With SB 632**

The following are current Connecticut and federal laws that provide enforcement mechanisms for healthcare fraud.

## Connecticut Laws

(1) Health Insurance Fraud Act: Conn. Gen. Stat. §§ 53-440 to 53-445.

(2) Vendor Fraud (Medicare and Medicaid): Conn. Gen. Stat. §§ 53a-290 to 53a-296; Conn. Gen. Stat. § 17b-99.

(3) The Connecticut Antitrust Act: Conn. Gen. Stat. §§ 35-24 to 35-46.

(4) The Connecticut Unfair Trade Practices Act ("CUTPA"): Conn. Gen. Stat. §§ 42-110a to 42-110q.

(5) Corrupt Organizations and Racketeering Activity Act ("CORA"): Conn. Gen. Stat. §§ 53-393 to 53-403.

### Federal Laws

(1) Federal health care program fraud:

- (a) Exclusion of certain individuals and entities from participation in Medicare and State health care programs: 42 U.S.C. § 1320a-7.
- (b) Civil monetary penalties: 42 U.S.C. § 1320a-7a.
  - (i) Improperly filed claims: 42 U.S.C. § 1320a-7a(a).
  - (ii) Payments to induce reduction or limitation of services: 42 U.S.C. § 1320a-7a(b).
- (c) Criminal penalties for acts involving federal health care programs: 42 U.S.C. § 1320a-7b.
  - (i) Making or causing to be made false statements or representations: 42 U.S.C. § 1320a-7b(a).
  - (ii) Illegal remunerations (anti-kickback statute): 42 U.S.C. § 1320a-7b(b).
  - (iii) False statements or representations with respect to condition or operation of institutions: 42 U.S.C. § 1320a-7b (c).
  - (iv) Illegal patient admittance and retention practices: 42 U.S.C. § 1320a-7b(d).
  - (v) Violation of assignment terms: 42 U.S.C. § 1320a-7b(e).
- (d) Limitation on certain physician referrals (Stark statute): 42 U.S.C. § 1395nn.

(2) False Claims Act: 31 U.S.C. §§ 3729 to 3733 (civil).

(3) Criminal federal health care offenses (18 U.S.C. § 24) include the following:

(i) Theft or embezzlement in connection with health care: 18 U.S.C. § 669.

(ii) False statements relating to health care matters: 18 U.S.C. § 1035.

(iii) Health care fraud: 18 U.S.C. § 1347.

(iv) Obstruction of criminal investigations of health care offenses: 18 U.S.C. § 1518.

(v) False, fictitious or fraudulent claims: 18 U.S.C. § 287.

(vi) Conspiracy to commit offense or to defraud the United States: 18 U.S.C. § 371.

(vii) Theft or embezzlement from employee benefit plan: 18 U.S.C. § 664.

(viii) Theft or bribery concerning programs receiving Federal funds: 18 U.S.C. § 666.

(ix) False statements generally: 18 U.S.C. § 1001.

(x) False statements and concealment of facts in relation to documents required by the Employee Retirement Income Security Act of 1974: 18 U.S.C. § 1027.

(xi) Mail fraud: 18 U.S.C. § 1341.

(xii) Wire fraud: 18 U.S.C. § 1343.

(xiii) Offer, acceptance, or solicitation to influence operations of employee benefit plan: 18 U.S.C. § 1954.

(xiv) Money laundering: 18 U.S.C. § 1956.