TESTIMONY BEFORE THE UNITED STATES SENTENCING COMMISSION

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Written Testimony Concerning Dodd-Frank and Patient Protection Act Amendments

Good morning, my name is Eric Tirschwell, and on behalf of the Practitioners Advisory Group, thank you for the opportunity to address the Commission with respect to some of the important issues under consideration during this amendment cycle. The PAG strives to provide the perspective of those in the private sector who represent individuals and organizations charged under the federal criminal laws. We very much appreciate the Commission's willingness to listen to us and consider our thoughts on the issues for comment with respect to amendments to the Guidelines.

This morning I will address the amendments under consideration pursuant to the Dodd-Frank Act (relating to securities fraud and other financial frauds) and the Patient Protection Act (relating to health care fraud).

I. PROPOSED AMENDMENT: THE DODD-FRANK ACT

The Dodd-Frank Act's directives to the Sentencing Commission regarding securities fraud offenses (P.L. 111-203, § 1079A(a)(1)(A)) and bank fraud and other frauds relating to financial institutions (*id.*, § 1079A(a)(2)(A)) evince a Congressional desire to be assured that the Sentencing Guidelines appropriately "account for the potential and actual harm to the public and the financial markets from these offenses." The PAG understands why, in the wake of the worst financial crisis our nation has seen since the Great Depression, Congress saw fit to put to the Commission the question of the adequacy of the federal criminal penalties for large scale financial frauds. The PAG most respectfully submits, however, that the fraud guideline more than adequately allows sentencing judges to appropriately punish and deter large scale frauds. Given the deferential phrasing of the Dodd-Frank fraud directives, the Commission could fulfill its obligation to review these provisions by advising Congress that the guideline already meets the needs identified by the Act. To the extent the Commission believes any changes may be warranted, the PAG believes such changes should be part of the comprehensive multi-year review that the Commission is contemplating.

As explained in the Commission's summary of its prior work, the provisions of § 2B1.1 have been expanded in recent years to add enhancements that specifically target and dramatically increase the Guidelines ranges for large-scale fraud offenses, including securities frauds and bank, mortgage and financial institution-related frauds. These new provisions have been accompanied by loss-table modifications that have dramatically increased sentencing severity for fraud offenses having substantial monetary losses. As one recent commentary notes, without considering any other guideline enhancements, the adjusted total offense level for a fraud offense causing just over 20 million dollars in loss has been increased in the last decade from a level 19, which equated to a Guidelines sentencing range of 30-37 months, to a level 29, or 87-108 months. In other words, the amendments to the loss table in 1989, 2001 and 2003 effectively *tripled* sentences for large-scale fraud offenses. *See* Allan Ellis, John R. Steer and Mark H. Allenbaugh, "At a

'Loss' for Justice, Federal Sentencing for Economic Offenses," *Criminal Justice Magazine*, Volume 25, No. 4, Winter 2011. In addition, the fraud guideline has become the most complex of all the sentencing guidelines, with more than 16 specific offense characteristics, 19 application notes, and more amendments than any other guideline—40 to date.

For these reasons, the PAG believes that the current fraud provisions are more than adequate to allow sentencing judges to consider and appropriately punish and deter potential and actual harm to the public and financial markets. To take a simple example, in securities fraud cases, the harm to the public typically is already captured, often in a very severe manner, by the increases set forth in the loss table based on the magnitude of the loss in value of the stock of a publicly traded company or other measures of investor or institutional losses. A large loss amount also often endangers the solvency or financial security of an organization or the financial security of 100 or more victims, resulting in further increases to the Guidelines range under 2B1.1(b)(14). And to the extent the defendant is an officer or director or registered person, the sentence is increased still further. 2B1.1(b)(17). Through these many interrelated and at times overlapping enhancements – not to mention role adjustment and many other specific offense characteristics – the PAG believes judges have more than adequate tools at their disposal to address to the full range of large-scale fraud cases brought in the federal courts.

Indeed, PAG's view is that the changes in the fraud guideline over the past decade too often lead to advisory guideline ranges that are overly severe in fraud cases. As one district judge put it, "we now have an advisory guidelines regime where … any officer or director of virtually any public corporation who has committed securities fraud will be confronted with a guidelines calculation either calling for or approaching lifetime imprisonment." *United States v. Parris*, 573 F.Supp.2d 744, 754 (E.D.N.Y. 2008). Critically, as the Commission has noted, and consistent with our experience as private defense practitioners, there is "a relatively high rate of non-government sponsored, below-range sentences" for high-loss fraud cases (pg. 49), which is powerful evidence that the judiciary shares the view that the fraud guidelines calculations often produce excessively long advisory prison terms. The PAG believes that if the Commission were to ratchet up or further increase the complexity of the fraud guideline, the result would be more – not less – variance and departure from the Guidelines-recommended sentences. Nor does the PAG believe the Commission needs to or should add more specific departure authority for "disruption to a financial market" or losses that may have resulted but for "federal government intervention." We believe that trying to assess and quantify such amorphous and immeasurable harms will make an already overly complex fraud sentencing regime even more unpredictable and inconsistent in application. We note in this respect that while the recent reports of the Financial Crisis Inquiry Commission cite to multiple wide-ranging causes of the financial crisis – including many regulatory failures – we are unaware of any suggestion that inadequately severe federal criminal penalties played any role.

We encourage the Commission to undertake the comprehensive review of § 2B1.1 that the Proposed Amendments say the Commission is considering (pg. 49). Any

guideline changes responsive to Dodd-Frank Act concerns should be considered in that larger framework, rather than attempted piecemeal in the current amendment cycle. As part of that review, the PAG believes that consideration should be given to other factors such as the motivation for the offense, the extent to which the offender profited from the offense, and whether other factors beyond the offender's control contributed to the amount of loss.

III. PROPOSED AMENDMENT: PATIENT PROTECTION ACT

There are three basic proposals at issue in response to §10606(a)(2) of the Patient Protection and Affordable Care Act (the "Act"). The first would, in part, provide "that the aggregate dollar amount of fraudulent bills submitted to the Government healthcare program should constitute *prima face* evidence of the amount of the intended loss by the defendant." The second proposal involves a graduated offense level increase for Federal healthcare offenses involving relatively higher loss amounts. The third proposal provides two separate options for defining a "Government healthcare program."

We discuss below certain potential problem areas in the first two proposals, and we provide our recommendation on the third.

A. The Proposed Definition of Loss

The Commission has proposed a new special rule to be included in the application note that deals with the definition of loss. Were the Commission writing on clean slate we would oppose any version of this additional special rule for a number of reasons. But the problem is that the Commission has a specific directive from Congress to create a special rule for determining loss in cases where the defendant "is convicted of Federal health care offenses involving Government health care programs." §10606(a)(2)(B).

The existence of such a directive compounds a problem that has plagued the increasingly severe and complex theft and fraud guideline for nearly a decade, as described above. Now that the guidelines are advisory, a growing number of Federal judges find themselves recoiling from this dramatic increase in the severity of punishment.

> Since *Booker*, virtually every judge faced with a top-level corporate fraud defendant in a very large fraud has concluded that the sentences called for by the Guidelines were too high. This near unanimity suggests that the judiciary sees a disjunction between the sentences prescribed by the Guidelines (in economic fraud cases) and the fundamental requirements of §3553(a) that judges impose sentences 'sufficient, but not greater than necessary' to comply with its objectives.[1]

[1] Frank O. Bowman, III, *Sentencing-Loss Corporate Frauds After Booker*, 20 Fed. Sentencing Rep 167, 169 (Feb. 2008).

Unfortunately, the recent directives from Congress threaten to widen this already significant chasm between sentences that comply with the purposes of the Sentencing Reform Act and those sentences that are recommended by the Guidelines.

The proposed application note—3(F)(viii)—would state:

> In a case in which the defendant is convicted of a Federal health care offense involving a Government health care program, the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall constitute *prima facie* evidence of the amount of the intended loss, i.e., is evidence sufficient to establish the amount of the intended loss, if not rebutted.

We agree with a decision to limit this new special rule to the minimum necessary to comply with Congress's directive. The dollar amount of a fraudulent bill submitted to a health care program—whether the program is public or private—rarely gives an accurate view of the loss that was in fact intended, much less does it provide a fair measure of the seriousness of the offense. It would be helpful for the Commission to address some of the reasons why this is so, including the observations that health care programs routinely pay only a percentage of the bill submitted and that many fraudulent bills are inflated (e.g., a bill for a more involved service than the one performed) rather than fabricated altogether. Examples like these should be included as a non-exhaustive list of acceptable ways to rebut the notion that the total amount billed was the intended loss. This, in turn, would make the special rule dictated by Congress more consistent with the rest of the Guideline, which routinely focuses on the *net* economic deprivation caused by the criminal conduct.[2] To presume that the net loss is equal to the aggregate dollar amount of bills submitted would be at odds with the general rule that loss shall be reduced by, for example, the fair market value of the services rendered. Additional examples are found in a number of healthcare fraud cases where, a healthcare provider renders a legitimate service, but then contrives additional claims over and above those services actually rendered.[3]

More broadly, it is a mistake to continue to move the fraud and theft Guideline in the direction of using loss as a proxy for culpability. That approach ignores or overlooks a variety of critical mitigating factors that sentencing judges have traditionally considered. Loss does not tell a judge the defendant's personal level of participation in the offense, whether he personally profited, what motivated him to engage in the fraud, or the efforts the defendant may have undertaken to minimize the harm from the fraud, to name just a few. Moreover, greater emphasis on intended loss tends to marginalize

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[2] See Application Note 3(E) Credits Against Loss.

[3] See e.g. *U.S. v. Freitag*, 230 F.3d.1019 (7th Cir. 2009), discussed more specifically below.

important offender characteristics such as age, hardship on dependents, community involvement, physical condition, and mental health.

A hypothetical to illustrate the problems.

In order to provide a concrete illustration of a number of the very real problems posed by this new special rule and the proposed amendments in general concerning healthcare fraud violations, we offer the following hypothetical factual scenario, based in large part on an actual case.

Dr. William Smith, currently 74 years of age, owns and operates a private medical clinic in one of the more impoverished areas of Chicago. Dr. Smith is a solo practitioner. His practice is very busy, with high volume. His clinic has been open since 2001. Dr. Smith suffers from coronary artery disease. Both of his parents and his older brother died from heart disease between the ages of 73 and 82.

Because Dr. Smith's patients were largely from lower income families, they frequently were unable to afford to make co-payments; nor could they pay their deductibles. Early on, Dr. Smith realized that he would lose the majority of his patient base unless he found a solution to these co-payment and deductible problems.

Dr. Smith decided to submit fraudulent insurance claim forms to the insurers for services and treatments that Smith knew were not actually provided, in order to exhaust his patients' co-payments and deductibles, and make available to him full payment for the services that he did perform. As part of the scheme, Dr. Smith had his patients sign multiple bills, falsely indicating that they were at the clinic on certain dates and received services.

The investigation confirmed that Smith actually rendered medical services to dozens of patients each week. These services were necessary and appropriate to the care of his patients. The sole objective of the fraud scheme was to exhaust the deductibles and cover the amounts of the unpaid co-payments.

Dr. Smith had a number of full and part-time employees who assisted him in managing the clinic. Employees A and B were specifically aware that patients signed multiple false bills. Employees A and B were also generally aware that Dr. Smith was using these bills to submit false claims to insurers, although they were unaware of the precise number or amount. Neither A nor B received any additional compensation for their relatively small part in the scheme. When Dr. Smith's fraud was discovered, he confessed immediately to authorities about his own role in the offense; however, in the initial interview he intentionally did not advise the authorities about the involvement of A and B. It was only in a subsequent interview that Dr. Smith eventually acknowledged that both A and B knowingly assisted him in the fraud.

Dr. Smith was personally responsible for creating the fraudulent bills, falsely reporting visits and treatments that never occurred. Over a nine-year period, from late

2001 to early 2010, Dr. Smith submitted approximately $1.1 million in fraudulent claims to insurers. The various insurers paid out about $650,000 on these fraudulent claims.

After the Smith investigation was concluded, the prosecution obtained an indictment for mail fraud under Title 18 U.S.C. §1341 and health care fraud under § 1347.[4]

Applying the new "aggregate dollar" formulation to the hypothetical in the case of Dr. William Smith will demonstrate a number of problems emerging from this presumptive loss. Dr. Smith's fraud occurred over a nine-year period. He actually rendered legitimate and necessary medical services to literally thousands of patients during the course of the scheme. Yet, taken to its logical extension, all the prosecution need do under this new special rule is aggregate the total dollar amount of all bills submitted during the nine-year period and call it loss. More specifically, where the prosecution is unsure of which bills were submitted for legitimate purposes and which were submitted fraudulently, it could take the total of all of the bills submitted and use that as a starting point for loss. Since the doctor actually treated all of the patients, only generating fraudulent bills to cover co-pays and deductibles, it would be a near-impossible task to break down every bill over this lengthy period of time. The doctor may roughly approximate that 1/10 of the bills he submitted were fraudulent, corresponding to the amount of co-pays and deductibles for which he fraudulently billed. How likely is it that the prosecution would simply accept such a rough estimate from a defendant? How many defendants prosecuted for a federal fraud after a lengthy criminal investigation, with the inevitable notoriety that follows such prosecutions, are still in the kind of financial shape that would enable them to hire the battery of forensic accountants necessary to undertake such a massive analysis on a bill-by-bill basis? It is evident from our collective experiences that precious few defendants would have such resources.

Assuming Dr. Smith has the resources, it does not take much of a stretch to imagine the time required to perform such an exacting review and the unavoidable extensive delays it would necessitate in the sentencing process. In the likely event that disagreements arise between those hired by the defendant and by the government to offer estimates of the intended loss, the court would be faced with a potentially significant expenditure of resources and time to resolve the disagreement. Even in the context of a guilty plea, litigation over the loss amount can closely resemble that of a trial.

An example of this burden is found in *United States v. Klein*, 543 F.3d.206 (5th Cir. 2008), where the Court reviewed a loss calculation for a doctor who defrauded Medicare by billing for the administration of drugs on days when he personally provided no treatment. The Fifth Circuit affirmed the sentencing court's employment of a net loss

[4] Since the maximum sentence for mail fraud is 20 years imprisonment, the base offense level under § 2B1.1(a)(1) would be 7. The heath care fraud statute carries only a ten-year maximum. With a conviction of health care fraud only, the base offense level would be reduced from 7 to 6. § 2B1.1(a)(2).

formula which required that the defendant receive a credit for the value of the drugs that the doctor's patients self-administered in those situations where the patients actually needed the drugs and the insurers would nonetheless have paid as long as those drugs been properly prescribed. From the *Klein* panel's perspective, this was the only reasonable way to arrive at a figure reflective of the actual harm. Using the "aggregate dollar amount" formulation in *Klein* would have enabled the Government to contend for a loss figure based on bills submitted even where the patients actually received the benefit of their properly prescribed drug. The burden would then have fallen on Klein to contact each and every patient to determine which of those patients self-administered their properly prescribed drugs, in which case the insurers would nonetheless have had to pay for those prescriptions. It is doubtful that Klein or any other similarly-situated defendant would have the resources to undertake such a burden. The risk is that Klein would be sentenced based on a loss formulation that blinks it eyes at economic reality.

Traditionally, prosecutors have been required to undertake an analysis based on their investigation, compiling a reasonably accurate estimation of loss far more realistic than an "aggregate dollar amount" formulation.[5] In so doing, they have shouldered the burden of proof and have been motivated to streamline the loss calculation in the process. At a minimum, the new provision should make clear that the ultimate burden of proof on the loss issue always remains with the prosecution. Thus, if a defendant presents enough to rebut the *prima facie* showing under the special rule, the government must prove the true intended or actual loss under the same criteria and in the same manner as it does in every case governed by § 2B1.1.

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[5] In *United States v. Freitag*, 230 F.3d.1019 (7th Cir. 2009), the government employed a sampling methodology. Freitag operated a small ambulance service from a funeral home she had purchased. Over time, the ambulance service became her principal business. The vast majority of Freitag's business concerned pre-arranged, non-emergency ambulance transportation primarily for elderly individuals. The fraud case arose because Freitag falsely billed Medicare for reimbursement on ambulance transportation that was not deemed medically necessary. Because there were approximately 8,000 fraudulent claims submitted over a 7-year period, a precise calculation was impractical. The government instead employed a group of statistical experts to devise a representative survey that would produce a reasonable estimate of loss. This group of experts selected a random sample of 200 claims from a 15-month period. The experts then determined how much of the Medicare money Freitag actually received with respect to those claims identified as fraudulent. After calculating an average per fraudulent claim on monies actually received, they then extrapolated that average to estimate how much of the Medicare money Freitag had fraudulently obtained over the 15-month period. Their final estimate was slightly over $500,000.

B. The Proposed Three-Tiered Loss Enhancements.

Prefatory Comment

Even prior to *Booker*, sentencing judges had already begun to escalate their use of downward departures in cases involving so-called white collar offenders where the application of multiple enhancements, although theoretically applicable, nonetheless substantially overstated either the harm caused by the defendant's fraud scheme, the level of culpability a particular defendant held in that fraud scheme, or both.

The Guidelines as Applied to Dr. Smith: Alternative Calculations

Returning to the case of Dr. Smith, an aggressive prosecutor may contend for guideline calculations that should include a base offense level of 7, a 16-level enhancement for loss and a 2-level enhancement for an abuse of a position of trust, but also a 4-level enhancement for leadership role, a 2-level enhancement for sophisticated means as well as the prospect of a 2-level enhancement for obstruction of justice. A Sentencing Court may find that each of these enhancements, from a technical standpoint, are sufficiently distinct to avoid exclusion for double-counting, while nonetheless significantly overlapping to the point where they generate an advisory guideline range which calls for a prison sentence well above that deemed necessary to accomplish the purposes of sentencing.[6]

In Dr. Smith's case, the total offense level, absent any consideration for acceptance of responsibility, would conceivably be 33. Again, Dr. Smith has no prior criminal record. The intersection of offense level 33 and Criminal History Category I generates an advisory guideline range of 135-168 months.

With the certainty that he will lose his license to practice medicine, the prospect that Dr. Smith could, much less would, ever offend again, is virtually nil. Specific deterrence is simply not a concern.[7]

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[6] For example, in a line of pre-*Booker* decisions from the 2nd Circuit, downward departures were employed because of the excessively punitive impact of multiple, closely-correlated enhancements. See *U.S. v. Laureson* 348 F.3d. 329 (2nd Cir. 2003), and cases cited therein.

[7] Dr. Smith was 74 years of age with a serious health condition. In U.S. v. Emmenegger, 329 F.Supp.2d. 416, 428 (S.D.N.Y. 2004), the sentencing court, in partial support of its rationale to impose a below-guidelines sentence, noted: "While the Guidelines discourage the use of age as a reason for departure, U.S.S.G. §5H1.1, it is entirely rational to consider this factor in setting a sentence in the Court's discretion." Further, Emmenegger was a licensed stock broker who engaged in securities fraud. In considering that factor,

Recall further that Dr. Smith's motivation for this scheme was to enable his generally impoverished patient base to continue to receive medically necessary services. Consider also that Dr. Smith actually rendered such medically necessary services to thousands of underprivileged patients. Given factors such as his age, his prior health considerations, his immediate confession, his guilty plea, and his lack of any prior criminal history, does a sentence of at least 135 months, more than eleven years, conform to the mandate that his sentence be sufficient but not greater than necessary to comport with the provisions of §3553(a)? It is highly unlikely that such a sentence would be deemed reasonable under all the circumstances in Dr. Smith's case.[8]

In its report, *Fifteen Years of Guideline Sentencing*[9], the Sentencing Commission itself characterized the addition of an ever-increasing number of adjustments to the sentencing rules as the phenomenon of "factor creep," observing that it has become "increasingly difficult to ensure that the interactions among them, and their cumulative effect, properly track offense seriousness."

It is against the backdrop of this phenomenon that the proposed amendment in Guideline §2B1.1(b)(8) is analyzed.

The Additional Proposed Loss Enhancements.

The proposed amendment in §2B1.1(b)(8) provides a 3-tiered sequence of enhancements. Where the loss is determined to be more than one million dollars, an additional two levels would be added to the offense level called for by the loss table in Subsection (b)(1). If the loss is more than seven million dollars, than three levels would be added. Finally, if the loss is more than twenty million dollars, a four-level enhancement would be added.

The purposes articulated in support of this tiered series of enhancements are to "ensure reasonable consistency" with the Guidelines, to "account for any aggravating or mitigating circumstances that might justify exceptions…," and to "provide increased

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the sentencing court concluded: "…Emmenegger yielded to a temptation and committed a crime particularly adapted to his chosen career. That career is over, and his potential to commit this particular type of crime has been eliminated." *Id*. at 428.

[8] In *Emmenegger*, the Court, in assessing that defendant's character, stated: "Fair consideration of (the history and characteristics of the defendant)…indicates that there is less need for incarceration to protect the public from future crimes committed by this defendant than is typical in cases of theft." *Id*. at 428. In the case on which the Smith hypothetical is based, the defendant doctor received a sentence of fifteen months.

[9] U.S. Sentencing Commission: Fifteen Years of Guideline Sentencing: An Assessment of How Well the Federal Criminal Justice System is Achieving the Goals of Sentencing Reform, 137 (2004).

penalties for persons convicted of healthcare fraud offenses in appropriate circumstances."[10]

In effect, a loss of more than one million dollars now requires an increase of 18 levels, rather than 16; a loss of more than 7 million dollars requires an increase of 23 levels, rather than 20 levels; and a loss of more than 20 million dollars requires an increase of 26 levels rather than 22 levels.

This would indeed provide increased penalties for persons convicted of healthcare fraud offenses involving significant loss amounts; however, it dictates these increases without regard to the individual circumstances of a given case, such as a defendant's role in the offense.

Consider, again for illustrative purposes, our hypothetical involving Dr. Smith. Now the prosecution seeks not only to indict Dr. Smith, but his two trusted employees, Individuals A and B. While Dr. Smith was busy maintaining his patient base and fraudulently obtaining the co-pays and deductibles from the insurance companies, the two employees were simply receiving a relatively modest salary. Their salaries were not tied in any way to their employer's profit margin. Moreover, while both A and B were aware that the patients were signing multiple bills, neither had any idea of precisely how their employer was using these bills. As the checks came in from the various insurance companies, the employees would simply enter them into a ledger and then make deposits into the Doctor's bank.

Still, both of the employees were with Dr. Smith since the very inception of the clinic. Both had a general awareness that Dr. Smith was engaging in some kind of improper billing which enabled his patients to satisfy their co-pays and deductibles. Dr. Smith frequently depended on A and B to obtain multiple signatures from the patients in order to effectuate his scheme.

Using the new proposed amendments for healthcare offenses, the aggregate dollar amount of fraudulent bills submitted was 1.1 million dollars. Assuming, for sake of argument, that such an amount was reasonably foreseeable to each of these employees, both would be subjected to an 18-level loss increase in addition to a base offense level of seven. Taking just those two components, these two wage earners have accumulated an adjusted offense level of 25, which, with a Criminal History Category of I, would generate an advisory guideline range of 57-71 months.[11]

Assume now that one of the employees, A, during the nine-year period of his employment for Dr. Smith, was placed on supervision of two years for a misdemeanor

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[10] See §10606(a)(3)(A)(ii), (C) and (D).

[11] In the actual case on which this hypothetical was based, Dr. Smith's advisory guideline range was 37-46 months. (Base offense level of 6, loss increase of 16, abuse of a position of special skill increase of 2, and an acceptance of responsibility reduction of 3.)

battery offense as a result of a relatively harmless altercation in a tavern. Applying the rules of Chapter Four of the Guidelines, Employee A finds himself in a Criminal History Category II, facing an Advisory Guideline Range of 63-78 months. Under these circumstances, would a sentence of at least five years in prison be regarded as reasonable?

It is not inconceivable that Dr. Smith, facing an advisory Guideline range of 70-87 months,[12] and finding himself before a sentencing judge who places great emphasis on the history and characteristics of the offender and the true motivations behind the crime, may receive a sentence well below five years. Yet, Employee A, in another jurisdiction, before a different judge drawn to the gravitational pull of the Guidelines, may sentence Individual A at the bottom of his range, three months above a five-year sentence. The prospect of Employee A, who neither conceived of nor directly profited by the scheme could receive a sentence as high, or perhaps even higher than that of Dr. Smith would be unconscionable, yet not beyond the realm of the probable.

At a time when the Commission has worked so hard to achieve more currency in the post-*Booker* era, these proposed amendments do little more than advance the phenomenon of "factor creep," placing the Guidelines even further out of touch with recent sentencing trends, thus only providing more grist for the downward variance mill.

Recommended Exceptions to the Three-Tiered Enhancement Proposal.

Lest anyone doubt the current sentencing regime's capacity or resolve to redress serious fraud offenses with significant penalties, they need look no further than the prosecution of Bernard Madoff who received a sentence of 150 years. The sentencing court that imposed this sentence did not have these new proposed enhancements at its disposal, nor did it need the provision for increased penalties in order to achieve this extraordinarily lengthy sentence.

Section 10606(a)(2) of the Act directs the Commission, under Subsection (A) to "review the Federal Sentencing Guidelines and policy statements applicable to persons convicted of Federal and healthcare offenses;…" It further directs the Commission under Subsection (F) to "ensure that the Federal Sentencing Guidelines adequately meet the purposes of sentencing." Given that there is no empirical data providing a justification for this three-tiered enhancement, we recommend that the Commission, in looking ahead to its multi-year evaluation, consider undertaking such a study. It is our belief that this study may well reveal the need to create a category of exceptions to the application of proposed amendment (8) to Guideline §2B1.1(b).

Section 10606(a)(3) of the Act additionally requires the Commission, in implementing this directive under Subsection (D) to "account for any aggravating or

[12] This assumes a base offense level of 7, a loss increase of 18 and a 2-level increase for abuse of a special skill for a total offense level of 27.

mitigating circumstances that might justify exceptions…"[13]. The aggravating circumstances; that is, the three-tiered enhancements where high levels of loss are involved, have clearly been covered. Yet there is not a single provision in the proposed amendment which concerns the treatment of mitigating circumstances that might well justify an exception to these proposed enhancements in a particular case.

Returning to the hypothetical of Dr. Smith and Employees A and B, for instance, there is no provision which would permit a court to avoid application of Subsection (b)(8) to those individuals, despite the fact that both would likely qualify for a downward adjustment because of their lesser role in the offense. We thus encourage the Commission to give strong consideration to an exception to the application of a (b)(8) enhancement where the individual's role is no more than that of the average participant in the scheme. At a minimum, in the application note to this new provision, it should be made clear that individuals qualifying for a minimal or minor role, as those terms are defined in Guideline §3B1.2(a) and (b), are exempt from application of the Subsection (b)(8) enhancements.

Furthermore, consideration should be given to making a specific reference to Application Note 19(C) concerning Downward Departures. In the case of Dr. Smith, for example, his motivation for committing the crime was, in large part, to enable his patients to continue to receive necessary medical care. Moreover, Dr. Smith's claims experience with the insurance payout policies would bring the actual loss to an amount significantly below one million dollars. Finally, Dr. Smith actually rendered legitimate medical care to literally thousands of patients from under privileged backgrounds. These are but a few among many potential mitigating circumstances which, taken in their totality, may lead a sentencing judge to determine that the Guideline range substantially overstates the seriousness of the offense.

C. Definition of "Government Healthcare Program."

Finally, the proposed amendment provides two options for defining a "Government Healthcare Program." The PAG respectfully recommends to the Commission that it adopt the proposed amendment it styles Option 1. Option 1 provides a list of programs consistent with §1501 of the Patient Protection Act. Recognizing the fact that the Act provides a definition of Government Healthcare Programs, we feel that the definition found in the amendment should mirror the definition established by the Act.

[13] Emphasis added.

D. Conclusion.

In the wake of several recent Supreme Court decisions,[14] the Commission has undertaken efforts to adjust its Advisory Guideline Ranges so that they might more closely parallel the objectives of §3553(a).

The PAG has shared its concerns that the proposed revisions of the Patient Protection Act will serve to widen this gap between the Guidelines and §3553(a). In order to ameliorate the impact of these proposed amendments, we urge the Commission to develop a non-exhaustive list of factors which sentencing courts may consider in a defendant's efforts to rebut the *prima face* presumption in proposed Application Note 3(F)(viii).

Concerning the proposed revision in Subsection (b)(8) we further urge the Commission to engraft a provision which would provide that individuals who are not deemed to have an aggravating role[15] in the offense be exempt from the application of these enhancements.

These changes recommended by the PAG will do much to help bridge the otherwise widening gap between the sentences advised by the Guidelines on the one side and the balance of the §3553(a) factors on the other side.

* * *

Let me end by thanking you again, on behalf of the PAG, for providing us with this opportunity to provide input on the important issue of specific offender characteristics. We look forward to continuing to work with the Commission and the Staff.

[14] See generally *Kimbrough v. U.S.*, 552 U.S. 85 (2007).

[15] See Guideline §3B1.1. Eligibility for this exemption should be subject to the same criteria and policy provisions that apply in every case governed by §3B1.1.