Thank you, Director Freeh.

The CHAIRMAN. Dr. A, as I am calling him, is a health care provider who is coming forward to give the Committee his first-hand knowledge of current and on-going schemes by doctors and other health care providers that are driving up the costs of health insurance.

We also have Agent B who will testify on drug diversion schemes that are continuing to occur in cities across this country, and so if we can arrange for the screen to be placed up here.

First, let me thank those operating those television cameras for accommodating this request. We're now going to hear from—not Dr. No but Dr. A. Why don't you proceed with your statement?

STATEMENT OF DR. A, HEALTH CARE PROVIDER, TESTIFYING ANONYMOUSLY

Dr. A. Good morning, Mr. Chairman, and Senators. I appreciate this opportunity to speak before this Committee today. I will begin my statement by giving you an overview of my experience with no-fault and personal injury cases. I will focus on the treatment of patients by doctors, both medical and chiropractic.

In my capacity as a paid consultant for various insurance companies as well as a practitioner in a profession that sees a high volume of no-fault claimants, I can state quite emphatically that it's not unusual for an individual with no injury or relatively minor injury resulting from a motor vehicle accident to have thousands, perhaps tens of thousands, of dollars in medical unnecessary treatment and diagnostic testing. I am going to outline several schemes which involve multiple levels of what is known as the "ping-ponging" of the patients.

Typically, in a motor vehicle accident, if an individual is legitimately injured, they will seek treatment from qualified physicians such as chiropractors or medical doctors. These providers will render appropriate treatment with a minimum amount of outside testing. However, in my review of patient files, it is very common for me to find that the alleged injured patient has first sought the advice of an attorney who specializes in personal injury cases and it is here that the ping-ponging of the patient begins.

The attorney accepts the case provided that the patient agrees to follow through on a treatment program. The attorney will then refer the patient to a doctor who is very often a chiropractor or an M.D., with whom he has an established relationship. The doctor will initiate a very intense treatment program, which usually involves several weeks or months of treatment. The chiropractor also refers the patient for expensive diagnostic testing, such as Magnetic Resonance Imaging or MRI studies. It is not unusual for patients to have six or more MRI studies, in addition to the x-rays performed by the chiropractor. In addition to the testing being ordered by the DC, treatment is being rendered three or more times per week.

Now the chiropractor frequently refers the patient to other specialists, such as a neurologist, medical neurologist. Many times this neurologist is a participant in this network loop of doctors and lawyers. The neurologist will most likely have at his disposal sophisticated diagnostic equipment with which to perform neurophysi-
ological testing and evaluation. A number of these tests costs insurance companies up to $1,000 each.

At this stage the patient is then referred by either the attorney, the chiropractor, or neurologist to an orthopedist who is a participant in this loop. The orthopedist typically will order unnecessary diagnostic tests, such as a C-T Scan or additional MRI studies and recommends that the patient see a physiatrist or a physical therapist for rehabilitative therapy. This scheme and similar schemes effectively run up costs to the insurance companies by several hundreds of thousands of dollars, and the scheme does not stop here.

I have repeatedly examined patients with alleged injuries. These patients are, for the most part, young and healthy, but as a participant in these schemes are receiving household assistance from health care services which are being paid for by the patient's insurance company. Fraud in the no-fault system is uncomplicated and easily committed. The patients in this instance are participants in this fraud, as are the doctors and the lawyers. The patient is motivated by greed thinking that he or she will receive financial benefits and will often do whatever is asked of them. In any case, whether the patient participates or not, the doctors will receive substantial remuneration, inasmuch as no explanation of medical benefits or EOBs are sent to the patient by the insurance company regarding the treatment rendered.

Therefore, the provider—that is the chiropractor, the physical therapist or M.D.—can submit bills for treatment that was never rendered without anyone's knowledge, most especially the patient's.

To take this to another level, it is not unusual for the provider to bill the patient's private insurance company in addition to the no-fault carrier. Likewise, if the patient was previously being treated in connection with a worker's compensation claim, the worker's compensation carrier is billed as well. These double billings—and I must say sometimes triple billings—are possible because many States do not routinely send EOBs in connection with worker's compensation matters. Here again, the patient will never know what is being billed. By the mere flick of a pen the doctor is able to submit bills for payment without anyone's approval or knowledge. This is done at a cost of hundreds of thousands of dollars to private insurance companies.

Now moving on to yet another common fraudulent scheme, I would like to address the problem of kickbacks. Kickback schemes, like other health care frauds, can take many forms. One which I have observed is precipitated by the fact that the DCs or the chiropractors are not eligible for reimbursement for many of the same procedures as medical doctors.

For example, with regards to no-fault and worker's compensation in some States, DCs cannot bill for ultrasound, or for that matter, for muscle stimulation. Yet, medical doctors can and do bill for these services. In order to make the ordering of these tests profitable for both parties, the DC refers the patient to the M.D. and in return receives a referral fee, or in real terminology, a kickback. This practice becomes particularly lucrative when the DC begins referring patients who have no legitimate medical need for the tests, as previously described.
Another kickback scenario comes about when the service is in fact performed illegally by the DC but submitted for payment as if it had been performed by the M.D. In these instances, the M.D. is reimbursed for legitimizing the claims.

It is important to note that in many States reimbursements are based on the level of experience and training of the provider, which in most instances translates to a higher reimbursement rate for medical doctors, as opposed to DCs or chiropractors. Due to this perceived disparity, it is common for medical doctors to bill for services that were actually provided by the DC in order to receive the higher rate, and this overpayment is then split between the two providers.

As you can begin to see, the area of rehabilitative services is inundated with fraud and unscrupulous providers.

Now I would like to share with you a scenario about which I have personal knowledge which involves false billing and fee splitting. Now this example should help to clarify the points I've mentioned over the past few minutes.

I know of a chiropractor who owns and operates a large chiropractic care and rehabilitation facility. In this instance, the commingling of these two services is unusual inasmuch as in the State where this facility is located a DC, a chiropractor, is prohibited from performing rehabilitation or physical therapy services. A medical physician can perform and bill for these rehabilitative and physical therapy services, particularly if that medical physician is a physiatrist. Now a physiatrist specializes in muscular skeletal rehabilitation. The chiropractor in this case hired a medical doctor as a consultant. The M.D. was responsible for obtaining patient history information from the patient and conducting an initial physical exam.

However, this initial examination was often less than 5 minutes in duration. After examining the patient, the physician routinely prescribed physical therapy for the patient, and in many instances, the M.D. does not conduct any examination of the patient. Instead, he simply allows the chiropractor to use his or her name for billing physical therapy. In return for the use of the M.D.'s name, the chiropractor splits the collected fees with the medical doctor.

Typically, the patient would begin a physical therapy program immediately. This physical therapy at the facility was administered by an unlicensed and untrained employee of the facility. The claims for physical therapy was submitted to the patient’s insurance company and falsely indicated that a physician was the provider of physical therapy services.

Subsequently, the insurance carrier reimbursed the facility for physical therapy services, reimbursement checks were made payable to the facility and the medical physician. Upon receipt of the insurance reimbursement check, the DC and the M.D. split the fees.

As a chiropractor, I have known practitioners in my field to earn in excess of $2 to $3 million per year by committing the fraudulent acts that I have described to you today.

Now I would be remiss if I did not add that insurance companies at times do contribute to the health care crisis. The insurance companies, particularly the worker’s compensation carriers in some
States, appear to create an almost adversarial climate between themselves and honest doctors. Legitimate services rendered by honest providers are often going unpaid. Some honest doctors feel as though they are being encouraged by the insurance companies to break or bend the rules in order to get paid, and the chiropractic and medical fields are honorable professions. However, there are a small percentage of individuals in the medical and the legal fields that are tainting both professions by participation in these unscrupulous schemes, and these schemes net the participants incredible amounts of money and are largely responsible for the escalating costs of health care.

In summary, I would like to leave you with a few facts regarding the exorbitant amount of our tax dollars which are being funneled into the no fault and worker's compensation areas. Between 1982 and 1992 the Nation's workman's compensation costs soared to a staggering $66 billion. In 1993 alone, over $5.7 billion in losses were suffered by workman's compensation insurers as the average premium outlay for these benefits skyrocketed 153 percent. Citing figures supplied by private insurance carriers, approximately 25 percent of the total compensation claims filed are fraudulent.

Based on a survey conducted by the National Insurance Crime Bureau (NICB), the insurance industry has placed a $2 billion price tag on a scheme known as staged automobile accidents. These accidents relate directly to the scheme I described earlier pertaining to no fault claimants. Nowhere is the ping-ponging of patients more apparent than in the area of staged automobile accidents.

These costs cannot continue to rise, nor can unscrupulous providers continue to practice. They must be dealt with severely and insurance fraud must be turned into a not-for-profit business. The public and honest health care providers can be best protected by the adoption of a health care fraud statute. Such a statute will not only allow for the successful prosecution of unscrupulous providers, but will significantly deter providers who view the submission of fraudulent or inflated claims as a lucrative, acceptable way of doing business.

Sir, thank you for allowing me to speak to you today and for the opportunity to share my experiences and my resolve to help solve the health care fraud crisis, which exists in the United States today.

The CHAIRMAN. Dr. A, let me thank you for stepping forward and let me make it perfectly clear for the record that you yourself have not participated in these types of kickback schemes, or inflated billings, or fee-splitting scheme, but rather are personally familiar with colleagues who have. And, as you've indicated, chiropractors and others are legitimate medical specialists, and most are honest and forthcoming, but there is a small percentage who are in fact gaming the system and gaming it to the score of millions of dollars every year.

Dr. A. Right.

The CHAIRMAN. I want to take just a few minutes to go through your testimony a little bit because it may be confusing in terms of exactly how it all works as far as this ping pong scheme is concerned.
On the one hand, you’ve indicated that the patient never really understands what’s being billed by the doctors, and the lawyers, the chiropractors, the neurologists, and orthopedist specialists. But we have to draw a distinction, I would assume, between legitimate patients and illegitimate patients. On the one hand, you’ve indicated that a number of the people who come for the treatment are in fact young and physically in good shape—

Dr. A. Fit, robust individuals, right.

The Chairman [continuing]. And they may in fact be involved in fraudulent auto accidents that are really scams. They allege an injury and they come in to see a doctor or they see a lawyer first, and that lawyer is part of this loop of fraudulent activity that you’ve described. The lawyer then refers that individual, first, to either a medical doctor or a chiropractor who is part of the scheme.

Dr. A. Right.

The Chairman. They then conduct as many as six MRIs, and I would point out for the record that most MRIs go for about $1,000 per MRI.

Dr. A. It’s up there; it’s $800 to $1,000, yes.

The Chairman. On the medical therapy or therapeutic sessions at least three times a week. They then are referred to a neurologist, in turn referred to orthopedist specialists who in turn call for more—

Dr. A. Right. This patient, by the way, can enter this loop anywhere. It doesn’t have to begin with the attorney.

The Chairman. Exactly, but we’re talking about a fraudulent scheme right now in terms of someone who has not in fact been injured, who is really part of this loop of illegitimate patients, so to speak. Correct?

Dr. A. Right, yes.

The Chairman. That’s one situation that we’re talking about, and so whether or not that patient ever receives an explanation of medical benefits really is irrelevant because he or she is part of the fraud to begin with.

Dr. A. They don’t care about that.

The Chairman. They don’t care about it. The second situation is where someone who is in fact injured in an automobile accident or similar type of accidental injury that he suffers and then goes to an attorney who then recommends that that individual go to see a whole series of specialists. That person may, who is legitimately injured, be treated legitimately by physicians, but is never apprised of what the charges are.

Dr. A. Correct.

The Chairman. So that even though that person in fact has suffered an injury that is required to be treated, that individual never gets a statement of what services have been rendered. Frankly, I should state for the audience that even in the Medicare and Medicaid system when patients do receive an explanation of medical benefits, you might be an expert in Egyptian hieroglyphics in order to determine exactly what that statement reads because it’s fairly complicated and confusing, and most people don’t understand it in any event.

But there is at least an opportunity if you see, for example, that you received six MRIs on a statement and you never had any, then
the bell should go off that something fraudulent is taking place. But in the schemes that you've just alerted us to, no such explanation of medical benefits is ever received by a legitimate patient, so that legitimate patient is never in a position to call anyone's attention to the fact that he is being—not he but his private insurance company, or Blue Cross/Blue Shield, or Medicare, or Medicaid—is being charged for services never rendered.

Dr. A. That's right.

The CHAIRMAN. So we have two different types of schemes involved here—one where you have an illegitimate patient who is part of the scheme and one where you have a legitimate patient who is completely unaware that the system is being gamed by his treating specialist, correct?

Dr. A. That's correct. Now would this legitimate patient—only to the fact that they are legitimate and if that patient goes through a treatment program rendered by the chiropractor or the physical therapist, for instance, that patient doesn't really want to be there. They want to get well, they want to get out of pain and get on with their lives. So, typically, that patient would achieve that goal of feeling well and getting on with their lives and not come back for services.

However, if the case is still open at that point in time, that provider of service can continue to bill unnoticed and unbeknownst to anyone.

The CHAIRMAN. So, in other words, assuming the patient—a legitimate patient—receives treatment, sound medical treatment, and the charges are never explained to him or to her—then he or she is cured for all practical purposes?

Dr. A. Right.

The CHAIRMAN. But the billing continues?

Dr. A. That's correct, until at which time the insurance company typically in the State where I practice will send out for independent medical examination, and that examiner would end the case if indeed he thought that the patient had achieved maximum medical benefits.

The CHAIRMAN. Now, is it your statement that this is something that is selective in your area of practice, or is it something that is widespread based upon your talk with other colleagues?

Dr. A. This is a widespread practice, depending on the type of service being administered. Seeing that chiropractic care or physical therapy care is usually on-going during an active phase of treatment, it's not unusual to see a patient three times a week for 4 or 6 weeks in the curative phase.

However, there are other doctors who are in this loop as well, and they might be having an appointment with an orthopedist or an internist for injections, trigger point injections. And if the patient is not there for the appointment, that doctor is free to just charge for the services that were not rendered. It's very easy and it's—

The CHAIRMAN. Now is the problem because we have a no-fault insurance statute in any given number of States? In other words, the whole concept of no-fault was adopted because the public outcry was that it takes too long. We have a backlog of cases, people who have been injured, who may have to wait 3, 4, 5 years before they
ever get to trial. They have medical expenses that are piling up. They need to get rehabilitative services, but since the providers can never be sure that they will ever get paid, the people are left out in the cold, so to speak. So many States have adopted the no-fault insurance policy or statute where you don't have to establish fault in order to receive these kinds of services.

The difficulty is if you had to establish fault in an accident and you had to go to trial to prove the fault, then you would have to prove the medical expenses.

That attorney would have to come forward with a sheaf of documents saying, "Dr. A, B, C, D rendered the following services on each and every date," and so you at least would have a check by forcing the attorneys, and the doctors to come forward to justify their expenses at that time. Is that what you're saying?

Dr. A. That's right, sir.

The CHAIRMAN. And by virtue of the fact that that never has to take place since it's no-fault, you don't have to establish liability. Liability is, in effect, been socialized. We all paid for it and no one person then has to pay for it out of his pocket or out of his insurance company's pocket.

Dr. A. Exactly.

The CHAIRMAN. Therefore, we have spread the risk but we don't establish fault and we never then have to come forward and establish legitimacy of the charges involved.

Dr. A. Exactly.

The CHAIRMAN. Is that how-it works?

Dr. A. My view on that might be a little bit simplistic. In my State it's my understanding that given the—you know, there are advantages to the no-fault system.

Dr. A. Exactly.

The CHAIRMAN. Exactly.

Dr. A. To minimize a patient's payday, so to speak, when a settlement is made, I would tend to think that if a patient had no real injury that was seen on a MRI study or an x-ray, that there should be no claim. But the fact is in my States there are huge claims being settled with people with no injuries, and I don't understand the concept of that. In other words, if there is a patient with multiple herniations and fractures and they were wrongfully hit in an automobile accident, then a patient is due an award, a settlement. However, if a patient has a simple whiplash injury with no documented tissue damage other than subjective complaints of pain, the patient should not be awarded anything. So this would eliminate the lawyers taking on these people to begin with.

The CHAIRMAN. Okay, well, I'm going to come back to that in a moment because we may have some lawyers who would like to come forward and challenge that particular assumption, that just because an MRI doesn't show soft tissue damage, doesn't mean the pain doesn't exist.

Dr. A. And I agree with that to a certain extent. However, there should be some type of a constraint. As it is now, there is not even a skeleton of constraint on this.

The CHAIRMAN. All right, we've got to move on. I'm going to yield in a short time to Senator Jeffords, but I, first, want to hear from Agent B. I would like to talk about this a bit more because you're
really going to the heart of the entire tort system, or worker's compensation system or no-fault insurance system. And, as you've indicated, there is a legitimate argument to be made in favor of no-fault in order to expedite the processing of the claims. It's just that there doesn't seem to be much in the way of a paper trail in order to make sure that those claims in fact are justified, the charges are reasonable and not exploitive or fraudulent, as you've outlined. But we can talk a bit about that more.

Agent B, why don't you now testify?

STATEMENT OF AGENT B, TESTIFYING ANONYMOUSLY

Agent B. Good morning, Mr. Chairman, and Senator Jeffords. Thank you for the opportunity to talk to you today regarding my perspective as an FBI agent investigating health care fraud. I've been investigating health care fraud in New York City since 1986. During that time I've encountered hundreds of cases involving a spectrum of fraud scams. The most significant of my FBI investigations was an undercover operation which span from 1989 through 1993, which was code named Operation Goldpill.

This case involved the hard work of many FBI agents, as well as the expertise of the Food and Drug Administration, and the New York Department of Professional Discipline. The investigation focused on Medicaid recipients who obtained expensive noncontrolled drugs from Medicaid mills that were staffed by shady doctors and physicians' assistants in a blood for pill scheme. The Medicaid cardholder would allow a physician's assistant to draw blood and perform unnecessary medical tests in return for a prescription for expensive drugs that the patient did not intend to take. The Medicaid patients did not need the drugs and filled these prescriptions at pharmacies at taxpayer expense. The Medicaid recipients then illicitly sold the drugs to street level diverters, which were also called non-con men, for approximately 10 cents on the dollar. The street level diverters then sold the drugs to high level diverters, who in turn sold them to other high level diverters or directly to pharmacies. Pharmacists bought the drugs at significant discount from the price they would have had to pay legitimate suppliers. Then these same pharmacists dispensed the diverted drugs to the unsuspecting public. The Medicaid recipients and drug diverters frequently removed the drugs from the original bottles and repackaged them in plastic baggies or other containers. In other instances, diverters, using counterfeit labels and counterfeit safety seals, repackaged the drugs.

As a result, the consumer was put in jeopardy of receiving tainted on unsafe medications. In particular, these drugs often lacked expiration dates, which are necessary to monitor a drug's potency, and lot numbers which are necessary in case of a manufacturer's recall.

We found that the diverter drugs were often stored in conditions which were unsanitary and that were not temperature controlled. This posed further risk to the consumers who were ultimately dispensed these drugs.

For example, in a spin-off case in Miami, agents seized approximately $750,000 worth of loose pills from a storage shed. The heat and high humidity had caused some of the drugs to break down,
become powdery and contaminate other medications with which they were stored. In New York a similar search warrant uncovered antibiotics which had been stored in a roach infested closet.

Our first break in the New York case came in the summer of 1991 with the arrest of a high level diverter who operated a health and beauty aid store in the Bronx. When we arrested him, he had over $1 million in diverted drugs, which were packed in baggies and stored in plastic bins.

I've brought a few examples which reflect the manner in which these pills had been sold to the public. During this same search, we found approximately $500,000 in cash, and we seized over $100,000 in stolen over-the-counter medications. This particular diverter agreed to cooperate with the FBI and opened our eyes to the world of health care fraud pharmacy diversion. The diversion market is not isolated to New York City. Our cooperating subject and others that later cooperated described for us the national magnitude of drug diversion. The criminal network we investigated operated throughout New York, New Jersey, Florida, Puerto Rico, and California. In working with our cooperators, we found that penetrating this veil of criminal activity was very difficult. The existence of long-term personal and business relationships between the participants of the crime made it almost impossible to penetrate many of their activities using traditional investigative techniques.

As an example, the subjects developed their own warning system. Sources later confided that the diverters had agreed to order drug XYZ over the telephone to signal to their colleagues that someone had been arrested. Another interesting facet of this investigation involved the repackaging and resale of these loose pills. In a second floor room on the top of a health and beauty aid store in Harlem, illegal immigrants were paid pennies to clean up and bottle street drugs which were bought from non-con men by the owner of the health and beauty aid store. On a daily basis, these so-called employees would ship dozens of cartons of tainted drugs via overnight courier to another diverter operating as a drug wholesaler in San Juan, Puerto Rico. The drugs would once again be examined in San Juan so that their illegal nature could be concealed before being shipped back to the mainland United States where they were sold for a full retail price to unsuspecting businesses.

Another link discovered in the diversion scheme involved the backgrounds of many of the key diverters. As the chart entitled, "Diversion Scheme Class of 1964" reflects, drugs were shipped through a complicated maze from New York, to Miami, to San Juan and to Los Angeles. We discovered that many of the members of this particular conspiracy had all graduated from the same pharmacy college in 1964, but by the early 1990's most of the conspirators had relocated to cities throughout the United States but continued to remain in contact through their criminal activities.

Following the conclusion of the Goldpill case, cooperating subjects confided in our investigators that although they were aware of the criminality of their actions, they did not feel that it was a crime of interest to the FBI. In the last 6 months of the case we developed two more cooperating subjects who expanded this investigation and gathered evidence against 25 additional diverters. FBI
New York had now dedicated one full-time investigative squad to this singular case. We also dedicated full-time surveillance teams to monitor the daily contacts between the high level diverters and the pharmacies. The surveillance teams were able to successfully identify location where these contaminated drugs were stored. Agents similarly identified and tracked financial assets generated from the sale of these tainted medications.

In May 1992 we identified the three highest level diverters operating in New York. At that point, and after obtaining the approval of a Federal judge, we were able to establish a court-ordered electronic surveillance of their telephones. During a 45-day period of monitoring these telephones, the number of subjects of our investigation quickly tripled. The wire taps revealed these subjects did not limit their criminal activities to drug diversion alone. Their tentacles spread to include a plan to pay kickbacks to hospitals for patient referrals involved with home infusion therapy and laundering their money through an ambulance service and a real estate venture.

Finally, on June 30, 1992, 500 Federal agents took this case down as a part of the FBI's national health care initiative. In New York City alone 69 Federal arrest warrants, 58 Federal search warrants, and 12 Federal seizure warrants for the actual pharmacies were executed simultaneously. In addition to this, over 300 financial accounts which were used to shelter these illegal gains were restrained.

To date 65 defendants have pleaded guilty to felonies, 53 of the defendants pleaded guilty under a collective plea agreement. Under the plea agreements, those pharmacists who had licenses agreed to surrender them to the New York State Office of Professional Discipline. Those pharmacies where drug inventories were seized agreed to forfeit the inventories. Those who had bank accounts or other property seized agreed to forfeitures of all or part of their property. In all, the New York defendants have agreed to forfeitures totally in excess of $3.5 million.

Most of the pharmacists and street level diverters have received jail sentences between 8 months and 12 months, with fines ranging to $40,000. The high level diverters have received jail sentences ranging from 1 year to 3 years with similar fines.

The sale of these contaminated and adulterated medications directly affects the unsuspecting consumer and drains the Medicaid coffers. Up until we began this investigation, very little intelligence existed about this type of health care fraud, which reaped massive losses for the Medicaid program in New York City. Today drug diversion continues to be a serious problem. Sources tell us that the criminal activity is too profitable and the risks remain minimal, and thus it continues. We have seen diverters now tie themselves to elements of traditional organized crime, which are aiding them in the facilitation of this enterprise.

We learned a number of lessons during the course of this investigation:

Number one, these criminal organizations cannot be dealt with effectively using traditional investigative tools; two, these investigations require tremendous amounts of manpower in order for
them to be effective; and, three, there needs to be straightforward, legislative material for the prosecution of health care fraud.

I will be happy to answer any questions that you might have.

The CHAIRMAN. Thank you, Agent B.

Senator Jeffords, would you like to begin?

Senator JEFFORDS. Well, first of all, I want to commend you, Mr. Chairman. I think your questions were very precise and very helpful with respect to Dr. A—and I have no questions—and also with respect to Agent B. I deeply appreciate the information you have furnished us. This is an incredibly important area, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I don’t think as a result of the screen that many in the audience can see the evidence that has been furnished to the Committee. I will stand up and hold these items so that you can see them. I might say that they’re not as exciting as a bloody glove in a bag, but, nonetheless, I think perhaps even more dangerous under the circumstances. [Laughter.]

But these are the bags that were furnished by FBI’s Evidence of the kinds of volumes of pills that are now being diverted and placed in large bags and re-packaged and then sent to other areas.

Agent B, take us through again how this happens with the Medicaid beneficiary as such. What kind of inducements are made to individuals who come forward to seek some kind of a prescription? For example, I’ve heard that certain types of inducements—such as television sets and others, microwaves, health equipment—a number of inducements made to individuals saying here is something for free, please give us your card or go to a pharmacist who will fill a prescription. How does this all happen? What is the genesis of it?

Agent B. That is absolutely correct. I operated for a number of years a particular source that used to support herself financially through this drug diversion enterprise. So the actual inducement is a cash incentive, similar to that of which would be an inducement to be involved in low level narcotics. Your Medicaid card is equivalent to your Visa card with no payments. You would get up early in the morning, see your Medicaid physician, hand your card which would be billed for tests which were not performed on you. In return for letting this particular physician bill for these unnecessary tests, you would receive your laundry list of prescriptions, a prescription form from the physician’s assistant. Rarely would you even see the doctor. This particular Medicaid patient would then have these laundry lists collected from various doctors throughout the day filled at cooperating pharmacies.

The CHAIRMAN. In other words, I get up one morning and say I don’t feel well——

Agent B. Well, you may feel fine but you would still do this.

The CHAIRMAN. Well, I feel fine but I’m going to go see my doctor anyway. I go through the doctor and I don’t even see the doctor. I see a doctor’s assistant, and I tell that individual that I’m not feeling well?