not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

2. The provisions of this Convention are without prejudice to the provisions of any other international instrument or national law which prohibits cruel, inhuman or degrading treatment or punishment or which relates to extradition or expulsion.

PART II

Article 17: 1. There shall be established a Committee against Torture (hereinafter referred to as the Committee) which shall carry out the functions hereinafter provided. The Committee shall consist of ten experts of high moral standing and recognized competence in the field of human rights, who shall serve in their personal capacity. The experts shall be elected by the States Parties, consideration being given to equitable geographical distribution and to the usefulness of the participation of some persons having legal experience.

2. The members of the Committee shall be elected by secret ballot from a list of persons nominated by States Parties. Each State Party may nominate one person from among its own nationals. . . .

3. Elections of the members of the Committee shall be held at biennial meetings of States Parties convened by the Secretary-General of the United Nations. At those meetings, for which two thirds of the States Parties shall constitute a quorum, the persons elected to the Committee shall be those who obtain the largest number of votes and an absolute majority of the votes of the representatives of States Parties present and voting. . . .

5. The members of the Committee shall be elected for a term of four years. They shall be eligible for re-election if renominated. . . .

6. If a member of the Committee dies or resigns or for any other cause can no longer perform his Committee duties, the State Party which nominated him shall appoint another expert from among its nationals to serve for the remainder of his term, subject to the approval of the majority of the States Parties. . . .

7. States Parties shall be responsible for the expenses of the members of the Committee while they are in performance of Committee duties.

Article 18: 1. The Committee shall elect its officers for a term of two years. They may be re-elected.

2. The Committee shall establish its own rules of procedure, but these rules shall provide, inter alia, that:

(a) Six members shall constitute a quorum;

(b) Decisions of the Committee shall be made by a majority vote of the members present.

3. The Secretary-General of the United Nations shall provide the necessary staff and facilities for the effective performance of the functions of the Committee under this Convention.

4. . . . After its initial meeting, the Committee shall meet at such times as shall be provided in its rules of procedure.

5. The States Parties shall be responsible for expenses incurred in connection with the holding of meetings of the States Parties and of the Committee, including reimbursement to the United Nations for any expenses, such as the cost of staff and facilities, incurred by the United Nations pursuant to paragraph 3 of this article.

Article 19: 1. The States Parties shall submit to the Committee, through the Secretary-General of the United Nations, reports on the measures they have taken to give effect to their undertakings under this Convention, within one year after the entry into force of the Convention for the State Party concerned. Thereafter the States Parties shall submit supplementary reports every four years on any new measures taken and such other reports as the Committee may request.

2. The Secretary-General of the United Nations shall transmit the reports to all States Parties.

ON THE REAL STORY ABOUT WORKERS' COMPENSATION FRAUD

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. KUCINICH. Mr. Speaker, I rise to present the findings of a significant, new report on workers' compensation fraud, prepared for the Injured Workers Bar Association. The report finds that allegations of fraud due to false worker's claims are far out of proportion to their occurrence. I ask that my colleagues consider these findings.

WORKER'S COMPENSATION FRAUD: THE REAL STORY

(Prepared by the Labor Research Association, Greg Tarpinian, executive director)

Executive Summary

Escalating workers' compensation insurance premiums in the late 1980s and early 1990s set off a series of unsubstantiated charges about widespread claimant fraud as a major cost driver in the workers' compensation system. A number of states passed anti-fraud legislation and began to pursue fraud cases and to collect information about fraud on a serious basis. These efforts have uncovered no evidence to support the charges of widespread claimant fraud and, in fact, have revealed that employer fraud is a far larger drain on the system. The misplaced focus on claimant fraud has created an atmosphere of fear and intimidation for injured workers with legitimate claims. It has also distracted policymakers, law enforcement officials and the public from the real fraud problem in workers' compensation: employer fraud.

Dramatic increases in workers' compensation premiums throughout the late 1980's and early 1990's fueled unsubstantiated charges that costs were high in part because workers abused the system, fraudulently collecting benefits for faked injuries or remaining on benefits far longer than their recovery required. The American Insurance Association estimated fraud losses at 10% of the cost of claims paid, or about $3 billion. The National Insurance Crime Bureau doubled the ALA's estimate to $6 billion, even though it was involved in only 99 fraud prosecutions in 1994 and 134 in 1995 nationwide. The Coalition Against Insurance Fraud adopted the AIA's estimate. One insurance company president put the cost of workers' compensation fraud at $30 billion a year. These huge numbers grabbed the attention of the public and policyholders. The presumption in the press and in the state houses was that fraud was rampant and that most workers' compensation fraud was claimant fraud.

Since that time, more than half of the states have passed legislation on workers' compensation fraud, with most of the laws directed primarily at claimants. Thirty-three states currently have active workers' compensation insurance fraud units, many of them geared to fighting claimant fraud. In every state, some claimant fraud has been discovered; publicity about these cases has created a deterrent for workers who might contemplate fraudulent claims. But it has also created an atmosphere that Frederick Hill, California analyst for Firemark Research of New Jersey, describes as the ''unwarranted and anecdotal vilification of the work force.''

In its extensive investigation of workers' compensation fraud, the Santa Rosa Press Democrat concluded that, ''The perception that workers are cashing in by faking or exaggerating injuries has created a climate of mistrust in which every person who is injured and files a claim can become the subject of suspicion by insurance adjusters, doctors and industry lawyers.'' Perhaps most importantly, the fixation on claimant fraud has distracted policymakers, enforcement agencies, and the public from growing evidence of the real problem: millions of dollars in employer and provider fraud.

Fixation on Claimant Fraud

Few experts believe that claimant fraud is a major cost driver in workers' compensation. But some estimates, including those adopted by California Governor Pete Wilson, suggest that fraud accounted for 25% of all employers' workers' compensation costs and 10% of the claims. In California, a wave of legislation in the late 1980s and early 1990s was fueled by allegations from employers that workers' compensation costs were too high and that fraud was rampant in the system. But between 1979 and 1991, insurance carriers in California reported only 532 cases of alleged fraud.

According to the Santa Rosa Press Democrat, ''Some insurance companies saw fraud as a way to explain why premiums were soaring, and politicians and the media jumped on the bandwagon.'' The Press Democrat found that, ''While some insurance companies claim one out of three workers lie about their injuries, or 33%, the actual number of fraud cases sent to prosecutors is less than 1 out of 100, or less than 1%.

In its estimates of fraud within its own state, Kentucky reversed California's estimate of fraud accounting for 10% of claims and 25% of costs, saying that ''as much as 25% of all workers' compensation claims involve some element of fraud, accounting for 10% of paid premium.'' Kentucky then calculated its own fraud losses as $60 million a year. It noted, however, that ''while the extent of the fraud cannot be quantified, there is no doubt that workers' compensation fraud is in the public eye. Reports of fraud . . . are proliferated by the media.''

High workers' compensation costs led to more anti-fraud efforts. The Arkansas legislature created the Workers' Compensation Fraud Investigation Unit in 1993, in response to then-escalating workers' compensation costs. In its first year of operation, the new Fraud Unit opened 116 investigations, leading to 10 claimant fraud prosecutions and five employer fraud prosecutions, and quickly discovered that the employer cases accounted for a large portion of the dollar value involved.

New York's massive 1996 workers' compensation legislation, including its fraud provisions, resulted a directly from employer claims that workers' compensation costs were out of control. New York State Controller H. Carl McCall announced flatly in October of 1997, ''Fraud is a factor in New York's compensation costs.'' A statement from his office made the link between rising costs and the presumption of widespread fraud, stating

that, ''In response to the high cost of workers' compensation, reforms aimed at fraud detection and prosecution were enacted in 1996.'' But according to the New York State Insurance Department's annual report on insurance fraud, workers' compensation fraud represented only 3% of all the fraud reports in the state in 1996, the year that the legislation was passed.

Of the more than $6 million in insurance fraud documented in the New York report, workers' compensation claimant cases accounted for less than 2%. The report cited cases of pharmacists, physicians, and medical clinics making a total of almost $3 million in fraudulent claims. Three cases of premium embezzlement totaled over half a million dollars. The report cited only five cases of claimant fraud totaling $107,300. Like other states that are pursuing workers' compensation fraud, New York is quickly discovering that the real drain on the system stems from employer and provider fraud.

Common Forms of Employer Fraud

The best evidence from the states that have pursued fraud and generated detailed records indicates that for every $1 lost in claimant fraud, at least $4 to $5 (and in some states as much as $10) are lost through premium fraud. Premium fraud includes a number of schemes used by employers to reduce the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experience. According to the National Council on Compensation, the most common frauds include:

Underreporting payroll. Employers reduce their premiums by not reporting parts of the work force, paying workers off the books or creating a companion corporation to hide a portion of the employees.

Declaring independent contractors. Employers avoid premium payments for employees by classifying them as independent contractors even though they are legally employees.

Misclassifying workers. Employers intentionally misrepresent the work employees do to put them in less hazardous occupational categories and reduce their premiums.

Misrepresenting claims experience. Employers hide previous claims by classifying employees as independent contractors or leased employees or creating a new company on paper.

Employers deliberately underestimate employment projections at the beginning of the premium year and essentially receive an interest-free loan from the insurance company for the amount that would have been required to insure new employees.

In addition to premium fraud, employers often fail to purchase workers' compensation insurance, despite state laws mandating that they do so. There are also reports of employers instructing injured workers to seek treatment under group health insurance than workers' compensation, employers discouraging workers from filing workers' compensation claims and firing workers who file claims.

Recognizing the Real Fraud

While some states and the media continue to focus on claimant fraud, states that have pursued workers' compensation fraud in a serious way are now concluding that the emphasis on claimant fraud is misplaced, and employer fraud is by far the greater problem. According to Jerry D. Stewart, the bureau chief of workers' compensation/law enforcement operations at the Division of Insurance Fraud in Florida. ''Historically, there has been a common presumption that those committing the most costly type of workers' compensation fraud have been claimants whose actions, such a double-dipping or claims for false injuries, drove up the cost of workers' compensation insurance. While claims fraud is a significant problem in Florida it pales in comparison with the occult type of fraud known as 'premium fraud,' where loss estimates range around $400 million. Stewart notes that, ''Premium fraud scams are costly to companies in Florida, causing workers compensation insurance rates to escalate and legitimate companies to lose business because they are less able to compete with companies shirking the system.''

In Florida, the construction industry, the state Workers' Compensation Oversight Board, and the House of Representatives Committee on Financial Services all lobbied for increased enforcement of premium fraud and stiffer penalties for employers. Since 1996, Florida has turned its attention to premium fraud, with dramatic results. Florida now has a special strike force mobilized solely to fight premium fraud. The state prosecutor has also impaneled a statewide grand jury to hear complex insurance fraud schemes such as premium fraud. During the last months of 1997, 11 persons were charged with racketeering and schemes to defraud, which involved $7.5 million in workers' compensation premium fraud losses.

In one case, a Palm Beach leasing firm misclassified employees and underreported their payroll, thus avoiding payment of more than $800,000 in workers' compensation insurance premiums. Another case involved underreporting of payroll at a large fruit harvesting company, with fraud charges totaling $3.5 million. Yet another employer in central Florida was charged with defrauding insurers of $2 million while operating one of the state's largest temporary employment agencies. The employer disguised the high-risk nature of the work done by many of the employees, concealed its claims history, prevented insurance companies from conducting audits and lied on applications for workers' compensation insurance. In January of 1998, two Florida insurance executives and their attorney were charged with multiple criminal counts in connection with the $100 million collapse of two insurance companies caused by kickbacks to reduce workers' compensation premiums.

Under a state law that took effect in 1994, Wisconsin's Division of Workers' Compensation now collects information and issues annual reports on fraud. In 1994, the division referred to the district attorney five cases of claimant fraud, involving $44,674, out of 73,678 work-related injuries reported for the year. In its 1997 study, the division concluded that, ''There is no evidence that criminally prosecutable fraud is more than one percent of all reported claims in Wisconsin—a far cry from the 20–30% estimates thrown about elsewhere.'' In 1996, there were 152 allegations of workers' compensation claimant fraud made to the division in Wisconsin. Eleven of those were referred to the district attorney, and seven were pursued, with fraud losses valued at total of $175,389. The division found that fraud is involved in six-tenths of one percent of all reportable claims in Wisconsin.

A Texas study of workers' compensation fraud conducted by the state's Research and Oversight Council on Workers' Compensation found that, ''In 1996, health care provider fraud was the most expensive type of fraud detected in the Texas workers' compensation system in terms of total dollars lost ($1,200,952), accounting for over eight times the dollar amount of injured worker benefit fraud ($134,351).'' In 1996, only 18 injured worker benefit fraud cases were referred to district attorneys, with an average fraud of $7,464 per case, compared with 46 health care providers, with an average fraud of $26,108 per case.

The Texas report found, however, that insurance carriers spent more money investigating injured worker benefit fraud than any other type of workers' compensation fraud. In 1996, Texas insurance carriers spent an average of $1,257 per claimant fraud investigation, compared with $991 per employer premium fraud investigation and $823 per health care provider fraud investigation. In 1996, the nineteen insurers studied spent over $5.5 million investigating workers' compensation fraud in Texas, yet recovered a total of $1,520,179. Of the 4,077 cases of claimant fraud that the carriers investigated, only 18 were referred for criminal prosecution. The report concluded: ''It is clear that more resources should be spent fighting the most expensive and overlooked types of workers compensation fraud: employer premium and health care provider fruad.''

A 1995 law that requires the reporting and investigation of premium fraud has helped to shift the focus in California. ''In terms of dollar costs, there's no question that employer fraud today costs more dollars to carriers and to the industry than employee fraud,'' according to Richard Schultz, a spokesman for the State Compensation Insurance Fund, California's largest compensation insurer. A recent study by the California Department of Industrial Relations and the Employment Development Department (EDD) calculated that 19% of employers—nearly one out of every five—either underreport payroll to EDD or have no workers' compensation insurance. The California Department of Insurance concludes that, ''Losses on premium fraud can and usually do exceed the amount of loss in claimant fraud, and, in some instances, medical mill fraud. For example, in several cases where criminal charges have already been filed, losses due to premium fraud for each case are estimated to be in excess of $5 million.

New York's new anti-fraud efforts have dramatically increased arrests for workers' compensation fraud. In 1997, the New York Insurance Department investigated 408 cases of alleged workers' compensation fraud and made 37 arrests, with $900,000 saved by insurance companies and more than $1.2 million in court-ordered restitution. Although New York continues to focus on claimant fraud, its investigations have uncovered premium fraud cases of far greater significance than any of the claimant cases. In one recent case, the comptroller of a trucking company pleaded guilty to mail fraud after he falsified the company's payroll records to defraud the State Insurance Fund of more than $1.2 million in workers' compensation insurance premiums.

Massachusetts's largest workers' compensation fraud case for 1997 involved an employer who fraudulently reduced the premiums for his rubbish collection workers by classifying them as clerical workers, hiding payroll and using shell corporations to evade surcharges based on the business's unfavorable prior accident history. The employer concealed more than $1 million in payroll from insurance auditors.

Employers also abuse the system when they fail to provide workers' compensation insurance for their employees or take out a policy but then fail to pay the premiums. California is beginning to investigate employers who fail to provide workers' compensation insurance. In March of 1998, California launched a three-part pilot project to match computer databases from various state agencies to identify employers who are illegally uninsured for workers' compensation. According to John C. Duncan, Director of the California Department of Industrial Relations, the project is designed to ''level the playing field for law-abiding insured employers and reduce the taxpayer burden created by those who are not.''

California's Commission on Health and Safety and Workers' Compensation 1997 report concludes that, ''Especially in industries with high premium rates, the illegally uninsured employer is able to underbid the insured employer. Insured employers are again disadvantaged when taxes are raised to cover costs shifted to government services to assist the injured workers of employers who are illegally uninsured.''

Several other states, including Wisconsin and Colorado, are also using proactive programs to identify uninsured employers using computerized lists of employers and workers' compensation politics. In New York, a 1997 audit by the state comptroller's office revealed that employers owe more than $500 million in overdue unpaid workers' compensation insurance premiums to the State Insurance Fund. Failure to secure workers' compensation insurance is only a misdemeanor offense in New York. In West Virginia, the state has been forced to initiate a series of lawsuits to force payment of more than $100 million in unpaid workers' compensation premiums.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider upcoding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclusive patient report to supplemental reports, which add evaluations and incur separate charges.

Medical provider schemes include: creative billing—billing for services not performed; self-referrals—medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest; upcoding—billing for a more expensive treatment than the one performed; unbundling—performing a single service but billing it as a series of separate procedures; product switching—a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug.

Newer forms of fraud and abuse occurring under managed care arrangements include: underutilization—doctors receiving a fixed fee per patient may not provide a sufficient level of treatment; overutilization—unnecessary treatments or tests given to justify higher patient fees in a new contract year; kickbacks—incentives for patient referrals; internal fraud—providers collude with the medical plan or insurance company to defraud the employer through a number of schemes.

According to the National Council on Compensation, ''The increased use of managed care for workers' compensation, as well as for other insurance lines, is bringing new twists to old schemes,'' Managed care creates more opportunities for fraud because of the financial relationships and incentives between players.

Although the campaign against California medical mills wiped out a substantial part of medical provider abuse in that state, new cases continue to emerge. In October of 1997, for example, a pharmacist plead guilty to 21 counts of fraudulent workers' compensation insurance billing. The pharmacist increased his revenues by up to 500% per prescription on more than $600,000 of drugs sold over a four year period.

Insult Added to Injury

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of ''fraud prevention,'' they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged form exercising their legitimate rights to workers' compensation benefits. As a recent Michigan study demonstrated, the real problem in workers' compensation is not that too many workers claim benefits, but that too few do so. The study, sponsored by the National Institute for Safety and Health, found that only one in four workers with occupational diseases file for workers' compensation. Unsubstantiated charges of rampant claimant fraud undermine public confidence in the system and discourage legitimately injured workers from seeking the benefits they need and deserve.

In California, a detailed investigation by state auditors found that ''workers' compensation insurers violated workers' rights in about half the claims it audited.'' The violations included ''unacceptably high amounts'' of unpaid benefits, late payments, inaccurate benefit notices and failure to notify injured workers of their rights. In describing the experience of many workers' compensation claimants. The Santa Rosa Press Democrat found that many injured workers slam into a wall of suspicion and distrust that will paralyze them with shame and frustration and delay their recovery. One of the injured workers interviewed by the newspaper commented: ''You get the feeling that even though you have a legitimate complaint and a six-inch scar, you're somehow a malingerer.''

The grossly overstated estimates of claimant fraud have not only subjected injured workers with legitimate claims to fear and intimidation, but have also obscured a more serious look at the workers' compensation system and the benefits it provides. The real question is not why there is so much claimant fraud, but why there is so little. In most states, workers' compensation benefits provide little more than poverty-level existence. Workers often wait weeks and months for payments.

Many employers refuse to provide light duty or alternative jobs for workers who might be able to go back to work in a modified capacity while they continue to recover, so workers are forced to continue on inadequate benefit payments even though they may be able to work in some capacity. Some injured workers lose their jobs or are only offered positions at much lower pay. It is little wonder that so many claimant fraud cases involve workers illegally continuing to accept benefits when they are in fact working at another establishment. Too many times, inadequate benefits put people in desperate straits, and they take desperate measures as a result. A system that leaves people in poverty invites abuse.

The presumption of widespread malingering and dishonesty undercuts any meaningful discussion of the adequacy of benefits and provides a convenient response for those opposed to the benefit increases that are so critically needed in many states. Until the misplaced focus on claimant fraud is overcome, district attorneys will continue to fry the small fish while the big fish go free, and the voting public will remain distracted by anecdotes.

PERSONAL EXPLANATION

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. DAVIS of Illinois. Mr. Speaker, on September 17, 1998, I was unavoidably detained from casting my vote on Roll Call number 448. However, if I had been present, I would have voted ''aye'' on this amendment.

PRESCRIPTION DRUG PRICING

HON. MARION BERRY

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Friday, October 9, 1998

Mr. BERRY. Mr. Speaker, I rise today to announce the formation of the Prescription Drug Task Force.

I have enjoyed working with Representatives ALLEN and TURNER to form the task force.

The task force will work to bring attention to issues involving the costs and availability of prescription drugs.

The task force will serve as a clearinghouse for information on these issues and will host educational forums, briefings, and hearings.

One of the things we will focus on is continuing to hold forums like the one we hosted last week, where members will be given an opportunity to participate in discussions and learn how consumers are being affected by the pricing decisions of pharmaceutical companies.

One thing I would like to talk about tonight is how the most profitable industry in existence (that is legal) and why that industry's practice of making excessive profits from the elderly and uninsured Americans is bad news.

According to industry ratings of Fortune 500 companies—pharmaceutical companies are the most profitable businesses in existence. They made $24.5 billion in profits last year. Pharmaceutical companies had a 17.2 percent return on revenues. That compares to telecommunication companies who had an 8.1 percent, computers and office equipment manufacturers who had 7.3 percent, food and drug stores that made 1.7 percent.

One might think the successful pharmaceutical companies would be of tremendous benefit to American consumers. This couldn't be more wrong.

And unfortunately, while the pharmaceutical companies are making tremendous profits, the American people are being gouged. Thousands of consumers, especially seniors, have found themselves affected by the price of prescription drugs in this country.

Studies that have been conducted by the minority staff of the Government Reform and Oversight Committee for several Members of Congress, including myself, over the last several months. These studies have shown the prices seniors and other consumers are